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Case Study Exploring Perceptions Of Outcomes of Learning From Post-Graduate Advanced Practice Education Programmes And Their Transfer To Practice

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**CASE STUDY EXPLORING PERCEPTIONS OF OUTCOMES
OF LEARNING FROM POST-GRADUATE ADVANCED
PRACTICE EDUCATION PROGRAMMES AND THEIR
TRANSFER TO PRACTICE.**

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**This Thesis is submitted in Part Fulfilment of the Doctorate in
Healthcare**

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DECLARATION

This thesis is presented in partial fulfilment of the Doctorate in Healthcare, King's College London.

To the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made within the text.

I consent to make this thesis available for view within King's College London, if accepted for the award of Doctorate in Healthcare.

Signed:



Print Name: Lesley Bridges

Date: July 2015

ABBREVIATIONS

A & E – Accident and Emergency

ANP – Advanced Nurse Practitioner

CCG – Clinical Commissioning Group

CHRE - Council of Healthcare Regulators Executive

CNS – Clinical Nurse Specialist

CPD – Continuing Professional Development

CPE – Continuing Professional Education

ENB – English National Board

GP – General Practitioner

HEI – Higher Education Institution

HEE – Health Education England

ICN - International Council of Nursing

IMD – Inherited Metabolic Disorders

LBR – Learning Beyond Registration

LET B – Local Education Training Boards

Medics – Medical Practitioners/Clinicians

NHS Trust – A healthcare organisation

NMC – Nursing and Midwifery Council

NP – Nurse Practitioner

OSCE – Objective Structured Clinical Examination

OT – Occupational Therapy

PQ – Post qualifying students

RCN – Royal College of Nursing

RCT – Randomised Controlled Trial

SLT – Speech and Language Therapy

UK - United Kingdom

Y1 – Year One Students

Y2 – Year Two Students

Y3 – Year Three Students

GLOSSARY OF TERMS

Breaches – Failure to meet organisational or policy standards

Clinical Commissioning Groups – Clinical Commissioning Groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. To a certain extent they replace primary care trusts (PCTs), although some of the staff and responsibilities moved to the council Public Health teams when PCTs ceased to exist in April 2013.

Health Education England – Established as a special health authority in June 2012. It provides leadership for the new education and training system to ensure the shape and skills of the future health and public health workforce evolve to sustain high quality patient outcomes.

Local Education Trust Boards – A group of local providers of NHS services that must co-operate with Health Education England in the performance of its functions.

Safety Netting – In healthcare, safety netting refers to the provision of information to help patients or carers identify the need to consult a healthcare professional if a health concern arises or changes.

Service Provider – A NHS healthcare organisation delivering care to patient's /clients either in an acute or community setting.

ABSTRACT

Aims: The study aimed to determine the expectations and effectiveness of postgraduate advanced practice education programmes from the perspective of a student, a qualified advanced practitioner and a NHS Trust manager in England. Additionally, exploration of the translation of student learning from education programmes to practice, and identification of the similarities and differences between postgraduate advanced practice education programmes offered by different institutions were compared, in order to demonstrate outcomes on practice.

Background: The past decade has witnessed a proliferation of advanced practice roles within healthcare practice both nationally and internationally. There is evidence to suggest, that service providers perceive that advanced practitioners are ill prepared for practice and lack specific competencies to deliver effective healthcare. Education programmes preparing advanced practitioners are developed in isolation and their professed effectiveness is currently not supported by sufficient evidence.

Methods: A multiple case study design that incorporated three cases from different geographical areas within England was used to investigate the study aims. Documentary evidence provided contextual evidence of the programmes of study. Participants were selected from higher educational institutions and their associated healthcare partners. Semi structured student interviews (n=32) and advanced practitioner and manager focus groups (n=8) were conducted.

Results: Findings demonstrated variation in the structure and organisation of the programmes and in the support provided to students. Perceived outcomes of the learning by participants included improved quality of patient care, improved advanced assessment, diagnostic, consultation and management skills, and behavioural changes. A lack of understanding of advanced practice roles by organisations and healthcare professionals was identified and supports earlier research evidence. A three-stage implementation and

evaluation model was constructed to demonstrate an effective process for advanced practitioner preparation and evaluation.

Discussion and Conclusions: This study provides evidence that advanced practice programmes can prepare practitioners to positively effect healthcare delivery. Evaluation of educational programmes is achievable and can provide valuable evidence to relevant stakeholders to promote and facilitate consistency and effectiveness in the preparation of advanced practitioners.

CHAPTER 1 INTRODUCTION

An ageing population and increased numbers of patients presenting with chronic conditions has necessitated the reorganisation of services to meet demographic changes (DoH1999; DoH 2000; DoH 2004a). Simultaneously, the reduction in junior doctors' hours and the shortfall left by an inability to recruit sufficient doctors to meet service needs, has provided an opportunity for nurses to expand their practice, expedite and improve patient care, and manage nurse led services autonomously (Griffiths 2008). Advanced practice roles have developed in this context as a way of utilising resources more effectively to meet these changing need and in so doing facilitating the redesign of the current system of care using existing staff (DoH1999; DoH 2000; DoH 2004a; Maben & Griffiths 2008; DoH 2008; DoH 2010a; DoH 2010b; NHS England 2014).

Contemporary literature is limited concerning the development and utilisation of advanced practice roles, despite this being a focus of workforce reconfiguration in policy (DoH1999; DoH 2000; DoH 2004a). Defining advanced practice has proved to be challenging with multiple definitions and perceptions of the concept. An additional complication of the role is that both nurses and allied health professionals undertake the role making it more difficult to align the concept within a distinct professional group. Por (2008) argues that the terms 'advancing nursing practice', 'advanced practice nursing' and 'advancing healthcare practice' are used interchangeably within the literature leading to confusion. Indeed, defining advanced nursing practice has been the subject of continuous debate largely due to the variations in clinical contexts and settings in which advanced nursing roles have evolved, especially between the periods 1990 - 2000 (Woods 1999; Carnwell & Daly 2003; Bryant-Lukosuis *et al* 2004; McGee & Castledine 2003). Advanced nursing practice as conceptualised by Woods (1998) is a generic title encapsulating many and varied

extended or expanded nursing roles practised in a diverse range of settings. The following International Council Nursing (ICN) (2002) definition of an advanced practitioner fits with this concept. It also offers a broader and flexible approach facilitating application to multifarious advanced practitioner roles. For this reason it has been adopted for use within this thesis:

'A registered nurse who has acquired the expert knowledge base, complex decision- making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level' (ICN 2001, p3).

Nursing by its nature is diverse and because of its often intangible end product, it has proven difficult to verify its contribution to the effectiveness of healthcare (Hoeve *et al* 2014). It is unsurprising that specific advanced nursing practice literature is often ambiguous regarding the direct outcomes on healthcare (Draper & Clark 2007). In the current climate of economic scrutiny and value for money it is imperative that nursing provides evidence to support the contribution it makes from its varied roles.

This chapter presents the historical development of advanced practice highlighting the evolution of the advanced practice concept in response to contextual factors, and the complex debate regarding its contribution to innovative and effective healthcare delivery. The debate continues with a focus on the educational preparation of advanced practice roles and the apparent disparity in the education programmes provided in England. With no clear regulation of advanced practice programmes of study within England, the potential for variability is apparent. With the healthcare landscape and working practices changing in the NHS, the following discussion supports the necessity to evaluate education to support the continuance of professional education at a time of fiscal scrutiny.

1.1 Historical Development of Advanced practice and Policy

Context

The initial concept of advanced practice arose in the United States (US) in response to socio-political and professional forces, specifically a shortage of doctors and difficulties in accessing healthcare for disadvantaged groups (Griffiths 2008). The development of advanced practice within the UK has been fragmented and poorly documented (McGee & Castledine 2003) and reportedly began between the 1970's and 1990's with advanced practitioners that were associated with a form of specialisation, namely nurse practitioners (NP) within nursing services (Griffiths 2008). In response to criticism of the government regarding the neglect of patients, alternative role development opportunities for nurses were promoted and initiated (Griffiths 2008), for example, the use of the nurse practitioner to manage minor injuries in accident and emergency departments to reduce waiting times.

The United Kingdom Central Council (UKCC), the forerunner to the Nursing and Midwifery Council (NMC) in issuing the 'Scope of Practice' document (UKCC 1992), facilitated the development of extended and expanded roles consistent with advanced practice roles. This document advocated personal competence as the key defining factor for practice. Evolving political, environmental, professional and patient-led demands provided further incentive for nurses and midwives to develop their scope of practice, however this proved problematic, specifically in relation to governance (Barton & Bevan 2012). Despite an attempt by the UKCC (1997) to regulate the advanced practice role the development remained stagnant until 2001.

The NMC (2001) as the new professional nursing regulator specified key features of advanced practice in its 'Specialist Education and Practice' communication. These included exercising higher levels of judgement and decision-making, and the

development of roles in the context of local guidelines rather than discrete roles (Griffiths 2008). In so doing the concept of advanced practice moved away from specialisation in an attempt to broaden the scope of practice (Mantzoukas & Watkinson 2007). However, the ambiguous nature of the NMC (2001) paper highlighted blurred boundaries between advanced practitioners and specialist practitioners, because of the shared common characteristics, knowledge and clinical practice.

The twenty first century has seen a convergence of ideas regarding the nature and scope of advanced practice in response to the need for role clarification and role understanding by healthcare professionals and managers (Spross & Heaney 2000). Momentum from UK advanced practitioners increased in an attempt to gain recognition of their knowledge, expertise, and skills, and to provide leadership in the regulation of advanced practice roles. The RCN (2002; 2012) responded by proposing an accreditation framework adapted from one used in the United States (NONPF 1995): this provided a definition, set standards and competencies for educational preparation, specifically the nurse practitioner role (Bryant-Lukosius *et al* 2004; Chang *et al* 2010). The competencies were considered transferrable to some advanced practice roles though not all. Carnwell & Daly (2003) argue that this initiative did not solve the issues of the more generic advanced practice role, or provide clarity regarding the underpinning level of knowledge or competence required. Furthermore, this level of specificity limits the opportunity to develop roles flexibly in response to service changes and local contexts.

The NMC (2005) sought approval from the Privy Council following a consultation for advanced practice regulation that was based on the RCN (2002) proposal. This was never sanctioned and instead, in response to public scrutiny following the Bristol Inquiry into healthcare practice (BRII 2003), the Council of Healthcare Regulators

Executive (CHRE) (CHRE 2008; 2010), consulted on the subject of revising regulatory frameworks. The consultation outcome indicated that no further regulatory measure was required for advanced practice because the current 'Scope of Professional Practice' was adequate, since it provides an individual practitioner with the flexibility and independence to determine how they advance their practice in response to local context. The NMC endorsed these recommendations, a decision that proved contentious for practitioners, who viewed regulation unobtainable or unnecessary. Barton (2011) suggested a positive outcome, arguing that indirectly the decision led to the development of the Advanced Practice Toolkit under the auspices of Modernising Nursing Careers initiative (DoH 2006), and postulated a degree of national conformity and guidance to employers, practitioners and educators.

The Modernising Nursing Careers (DoH 2006) initiative sought to clarify, evaluate and develop structures for future developments and preparation for Nursing and Midwifery, and involved all four countries of the UK. Scotland led the advanced practice consultation and in its findings proposed the development and utilisation of the 'Advanced Practice Toolkit' to link education to broader workforce issues (NHS Scotland 2007). Welsh and Scottish Health Boards responded by using the guidance papers to direct the development, implementation and evaluation of advanced practice roles, and these responses are similar in content (NHS Scotland 2010; NHS Wales 2010). The documents promote consistency in the operationalisation of future advanced practice roles including advanced practice education. Additionally, they describe a level of practice rather than a specific role, and promote advanced practice roles as appropriate to all staff working in clinical education and research, and in management and leadership roles (NHS Wales 2010).

In England the Department of Health (DoH) responded by releasing a governance document 'Advanced Practice Position Statement ' (DoH 2010b) as a mechanism of employer led, local regulation. The paper promotes a benchmark to enhance patient safety and the delivery of high quality care, by supporting local governance and encouraging consistent practice (DoH 2010b). It encouraged much-needed minimum practice standards in the key areas of governance and standardised measures for education in England. The document is less prescriptive and comprehensive than the Welsh and Scottish papers, and arguably perpetuates an inconsistency in the clarity and understanding of the advanced practice role within England and the UK. The paper aligns with the Scottish and Welsh Boards papers that set out a minimum level of band 7 for advanced practitioners against the Agenda for Change framework (DoH 2004a). It also recognises advanced practice as a level of practice rather than a role, and supports education to master's level (NHS Scotland 2010; NHS Wales 2010). However, the DoH (2010b) paper falls short of providing legislation to ensure that comparable and consistent processes are used to prepare and implement advanced practice roles.

England is demographically very different to Wales and Scotland. NHS England provides healthcare to a population of approximately 53 million users, in comparison to NHS Wales and NHS Scotland with populations of approximately 3 and 5.2 million respectively (NHS England 2013). Furthermore, NHS England currently comprises thirteen Local Education and Training Boards (LETBs) plus Clinical Commissioning Groups (CCG) established in 2013 that are responsible for local training and education of NHS staff, both clinically and non-clinically. This difference militates against advanced practice role uniformity within NHS England, and has recently been acknowledged by the RCN (2014) who plan to undertake further research. The provision of healthcare in England is complex, but this should not prevent clarity in

the guidance to support implementation of advanced practice roles or address current weaknesses in the system.

In summary, the development of advanced practice roles has evolved ad hoc, and has been fitted into on-going policy development rather than be the primary focus of it. The introduction of advanced practitioners arose in response to the need to address the issues of an increased number of patients presenting clinically with increased acuity, together with a reduction in junior doctors' working hours. A lack of government support and understanding of the role has subsequently contributed to role uncertainty, and a lack of role clarity. The adoption by government of a minimal position statement in England has seen deferral to local governance, and given rise to potential variance in the scope of practice, thereby causing problems. In order to challenge this entrenched position it is important to examine evidence of similarities and differences of advanced practice role preparation, and the subsequent outcomes from the learning in practice.

1.2 Preparation for Advanced Practice Roles

Despite continuous debate, ambiguity remains in legislative and regulatory mechanisms, nomenclature, role autonomy, prescriptive authority, educational preparation and evaluation of advanced practice roles, both nationally and internationally (Bryant-Lukosius *et al* 2004). Advanced practitioners require high levels of professional autonomy and advanced skills in order to provide an equitable alternative healthcare service to doctors in the UK (Buchan & Edwards 2000; Bridges *et al* 2003). Hardwick & Jordan (2002) emphasise the lack of evidence relating to the educational effectiveness of advanced practice programmes and note that service providers perceive advanced practitioners as ill prepared for practice and lacking in specific competencies needed by current health care services. The protracted

debate over the academic level of educational preparation for advanced practitioners compounded these issues (Gerrish *et al* 2000). What is now certain, is that in order for advanced practitioners to be fit for purpose, advanced practice programmes need to prepare practitioners to translate and demonstrate critical and reflective skills in professional practice at master's level (DoH 2010b).

For advanced practitioners, achieving clinical competence in a relatively brief period of time is essential for practice; however, the nature of this competence is poorly defined. Acquisition of knowledge and skills required by advanced practitioners cannot be met through experiential learning alone, and needs resources in the form of mentors and time to support effective practice development. This directly conflicts with the demands of the service, which requires immediacy in the implementation of these roles. A further constraint to advanced practice learning is that formal educational requirements have until recently been poorly constructed (DoH 2010b) leaving Higher Education Institutions (HEIs) to develop programmes in isolation (Distler 2007). This potentially culminates in differences in learning content and support. In the absence of evidence that directly evaluates the outcomes of advanced practice education, inconsistency in advanced practice preparation is the perceived conclusion.

1.3 Continuing Professional Education Evaluation

The outcomes of learning from advanced practice education programmes needs to be recognisable, relevant and measurable. Education commissioners require programme outcomes to be identified, which is challenging for HEIs (Francke *et al* 1995; Draper & Clark 2007). They could be measured by identifying any improvement in patient outcomes from the care delivered by advanced practitioners who have completed a programme of study. Currently, HEIs collect student

evaluations of their learning experience to inform programme development. They do not explore changes in healthcare delivery. A failure to measure how learning is transferred to practice, suggests that this phenomenon is not fully understood by educationalists although it is critical to the success of the teaching-learning process (Wong 1979; Rafferty et al 1996; Corlet 2000; Henderson 2002). Furlong & Smith (2005) argue that the advancement of art and science of nursing is essential for the betterment of individuals and can only be met if nursing is developed as an academic as well as a practical discipline. The tension between academic detachment and practical relevance is evident within the literature (Corlet 2000; Henderson 2002). In order to demonstrate that advanced practice is practice-focused and underpinned by theory, the outcomes of learning from a programme of study on practice need to be better understood and evaluated to demonstrate discernable outcomes.

All educational activity demands evaluation (Herbener & Watson 1992), and involves the systematic assessment of the nature or worth of the programme through analysis of its design, implementation, management and interventions in order to judge efficiency, efficacy and inform programme development (Attree 2006). Cohen *et al* (2011) concur, stating that evaluation research is applied research that uses the tools of research to provide answers to the effectiveness and effects of programmes. Programme evaluation of educational interventions is challenging. The interventions are multifaceted and complex due to the variables that influence and impact on them (Wilkes & Bligh 1999). There are also fundamental difficulties in addressing key questions of what works? In what context? With which group? At what cost? (Hutchinson 1999). It is nevertheless crucial that educational provision is evaluated to ensure it delivers its intended outcomes, is fit for purpose and practice, and attracts continued investment.

Significant investment in healthcare education between 2000 and 2007, with an estimated £1.5 billion on 2,000 healthcare education programmes, undertaken by 75,000 students within 80 higher education institutions and partner healthcare providers is reported (Clark *et al* 2008). Currently a five-year planned investment to the NHS nursing workforce is proposed, in line with a 9% increase in nursing commissions in 2013. A protected budget for workforce transformation, specifically an increase in post-registration specialist nurse commissions by nearly 1,400, and advanced clinical practice commissions, is also promised (NHS England 2014). A lack of evidence relating to advanced practice education and outcomes, prevents us from knowing whether this proposed investment has been estimated accurately in order to meet need.

Gijbel's *et al* (2010) systematic review demonstrated a dearth of evidence regarding the outcomes of post-qualifying nursing and midwifery education. The review contends that whilst international studies have attempted to evaluate this, the interpretation and application of findings across countries is difficult because of the diversity in education systems (Gijbels *et al* 2010). Post-qualifying nursing and midwifery evaluation studies predominantly researched undergraduate programmes using self-report from students, and suggest that positive reported outcomes cannot be solely attributed to the programmes (Jordan 1998; Pelletier *et al* 2003; Carpenter *et al* 2004). The review acknowledged the evaluation of the outcomes of Continuing Professional Education (CPE)¹ from a student's perspective. A minority of studies only examined perspectives of service providers or course leaders (Jordan 1998;

¹ A range of terms is used within the literature relating to post-qualifying professional education and inconsistently applied. For example: Continuing professional education (CPE); continuing professional development (CPD); continuing professional and personal development (CPPD); and Learning beyond registration (LBR). For the purposes of this study CPE will be used when making reference to these phenomena.

Pelletier *et al* 2003; Carpenter *et al* 2004). Many of these programmes were often evaluated out of, or without attention to, context, making it difficult to provide explanations of how and why programmes work (Zwarenstein *et al* 2005; Gijbel's *et al* 2010). Curran *et al* (2007) concur that evidence related to effectiveness of educational programmes is mixed, and requires thoughtful consideration. Ellis & Nolan (2004) argue that the paucity of research results from a failure by different groups to acknowledge the variance in the value of learning and outcomes, and demands that evaluation of success be measured in different ways.

The most rigorous studies reported relate to mental health (Gijbels *et al* 2010), with no studies found evaluating postgraduate advanced practice programmes. Conversely, Zwarenstein *et al* (2005) and Reeves *et al* (2010) reported an increased body of evidence that suggested positive outcomes from CPE on the delivery of care. Zwarenstein *et al* (2005) promoted the evaluation of interventions using the active participation of practitioner and qualitative methods. This suggestion is pertinent here, because it potentially captures relevant influences on programme success, and the translation of knowledge to practice. It also indicates that future research should engage the active participation of practitioners from well-motivated sites to facilitate exploration of interventions in various sites through parallel qualitative research.

1.4 Conclusion

In an era of change uncertainty and diversification, practice development is required to ensure that nursing remains responsive to contemporary societal health care needs and demands while meeting patient needs. The ad hoc generation and evolution of a plethora of new advanced practice roles without a clear strategic intent is evident (Woods 1999; Carnwell & Daly 2003; McGee & Castledine 2003; Bryant-Lukosuis *et al* 2004). Meanwhile, professional regulation has remained elusive and

educational providers of advanced practice programmes operate outside a defined regulatory framework (Thompson 2003).

It is essential that there is cohesion and parity between institutions that provide advanced practice education programmes in order to promote consistency of programme graduates. This would then ensure consistency in knowledge, critical thinking skills, expertise, levels of autonomy, and subsequently healthcare delivery. In the current healthcare climate there is a drive to make public services accountable by confirming that scarce resources are used effectively. This process is determined through evaluation. Commissioners of education require HEIs to provide evidence of the outcomes on practice of advanced practice education in order to justify and ensure sustainability of future resources. Providing factual data to demonstrate the link between advanced practice education and healthcare delivery is challenging.

Achievement of a balance between external drivers, professional expectations and academic rigour also needs to be established. This necessitates an innovative, critically reflective curriculum design that simultaneously establishes and maintains high quality standards. The changing political climate necessitates that education needs to be responsive, and focused on the application of knowledge to underpin practice (Gerrish *et al* 2000; Furlong & Smith 2005). The extent to which education programmes effectively prepare advanced practitioners theoretically and practically to meet patient needs remains unclear. The aim of this study is to explore the outcomes of learning from post-graduate advanced practice education programmes; in doing so, the perceived outcomes on practice are considered. Findings from the study will be used to inform advanced practice curriculum design and advanced practice policy development.

1.5 The Structure of the Thesis

A preliminary review of the literature was undertaken to gain an understanding of published research associated with the research aim. Evaluation of this literature indicated the need to use a theoretical framework to assist the analysis, the search, and the presentation of findings as clear outcomes for students, healthcare communities, and patients. The development and subsequent use of the framework is described in Chapter Two. It was identified that a multiple case study design (Stake 1995; Yin 2009) to provide an in depth exploration of geographically distinct advanced practice programmes within England was a suitable methodology. The design of the study, the development of instruments to elicit meaningful data, and the development of a framework for data analysis are described in Chapter Three. Individual results from the three cases are presented in Chapters Four, Five and Six, followed by integration and comparison of the results that make a significant contribution to the current knowledge base associated with advanced practice education in Chapter Seven. Strengths and limitations of the study are indicated together with the identification of future research as a direct consequence of the findings in Chapters Eight and Nine.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

In the development of a research process, appraisal of previous research outputs facilitates the development of empirical knowledge, identifies inconsistencies and omissions in the literature, and stimulates new ideas for the future research (Green & Thorogood 2009). A comprehensive, systematic search and review process identified both published and unpublished literature pertinent to the topic being investigated, and was not limited by dates to ensure seminal pieces of work were included.

A preliminary search of the literature focussed specifically on the implementation effectiveness and outcomes of advanced practice roles. A second search focussed on the outcomes of advanced CPE (initially advanced practice CPE), and identified current debates, including the appropriateness of master's level education for the preparation of advanced practice roles and the outcomes of CPE on practice for nurses. This was extended to include evaluation of inter-professional education due to the paucity of evidence available related to nurse education.

2.2 Developing a Research Question

The development of a more focused and exact research question needed to be established to facilitate and direct the literature search. Greenhalgh (2006) offers a strategy for the development of a researchable question by breaking down the review question in terms of the client group (WHO), the intervention (WHICH), and the outcome of learning (OUTCOME(S)). For the purposes of this study:

Who: Advanced practitioners and stakeholders

Which: Postgraduate advanced practice programmes

Outcome(s): Transfer of learning to practice.

This process enabled the development of the following research question:

‘What are the perceived outcomes of postgraduate advanced practice education for students and stakeholders on practice’.

Prior to undertaking the literature search it was important that keywords and concepts were considered to assist in the identification of all relevant literature. A flexible and broader approach to thinking was therefore applied (Polit & Beck 2006). The key words derived from the question were *outcomes*, *postgraduate education*, *advanced practice*, and *stakeholders*. These in turn were developed into concepts that could be used interchangeably within the search because authors commonly use different synonyms to describe the same phenomena. Table 1 provides an overview of the key words and concepts used within the search.

Table 1 Key Words and Synonyms utilised for the Literature Search Strategy

Concepts	Outcomes on Stakeholders	Postgraduate Education	Advanced Practice
Synonyms	Evaluation Impact Performance Measurement Competence Increased effectiveness Students Managers Education Leads Commissioners	Master's Continuing professional development Continuing professional education Staff development Course evaluation Nurse education Inter-professional education Post-registration Increased knowledge Theory to practice Knowledge Translation Knowledge Transfer	Nurse practitioner Extended roles Role redesign Levels of practice Specialist practice

2.2.1 Inclusion and Exclusion Criteria

To maintain validity and assist in structuring the review it was important to define the parameters of the research by setting inclusion and exclusion criteria. Inclusion and exclusion criteria provide transparency on how sources were selected, and allow in-depth appraisal of the evidence in the review. Table 2 presents the inclusion and exclusion criteria used within this study.

Table 2 Summary of Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
English language Only research reports and systematic reviews Research specifically related to the focus question: • Advanced practice • Postgraduate education • Impact Papers published after 1982 International literature	Non English Language Secondary research or anecdotal evidence Research not specifically related to the research question • Prequalification evaluation studies Papers published prior to 1980

2.2.2 Locating the Literature

Locating relevant literature was undertaken systematically using a variety of sources including, reports, books, journals and grey literature. Grey literature includes government documents, for example those from the Department of Health and professional organisations like the Royal College of Nursing. These were important because they enabled familiarisation with key policies and guidelines that have supported healthcare education and service transformation. Books were used to provide an overview of the topic under consideration, the historical development of advanced practice and related theoretical concepts, for example knowledge and learning theory.

The predominant source of data retrieved was research articles obtained from journals, identified using electronic databases. Electronic searches provided the

capability to search huge bibliographic files online quickly and effectively (Polit & Beck 2009). Databases searched provided access to journals used in nursing and allied health, and included: OVIDMEDLINE®, CINAHL®, TRIP™, DARE, Cochrane Database, EMBASE and ERIC. The principal aim of the searches was to retrieve primary research studies to inform and develop the focus of the intended study.

The search began in April 2011 with a subject search related to the keywords identified within the research question. Most retrieval software translates or maps the topic entered into the most plausible subject heading, and initially when the whole question was entered into each database '0' hits resulted. An advanced search was then undertaken including previously identified synonyms for each concept to ensure complete coverage of the topic. The use of inclusion and exclusion criteria, together with Boolean operators was used to manage and refine the search. Boolean logic incorporates the operators **and**, **or** and **not** to either broaden or refine a search (Houser 2008). Duplications were also removed. An example of the process is demonstrated in figure 1.

The literature search initially identified studies from both paradigms; in total $n = 20$ qualitative articles, $n = 20$ quantitative articles, $n = 2$ mixed method articles and $n = 11$ systematic reviews. References from retrieved articles were further scrutinised to identify additional references that were previously unidentified through the database searches. This proved beneficial locating $n = 10$ additional articles. References relating to theoretical frameworks were also identified in this way. In July 2012 when no new studies could be located, it was considered that the initial search was complete.

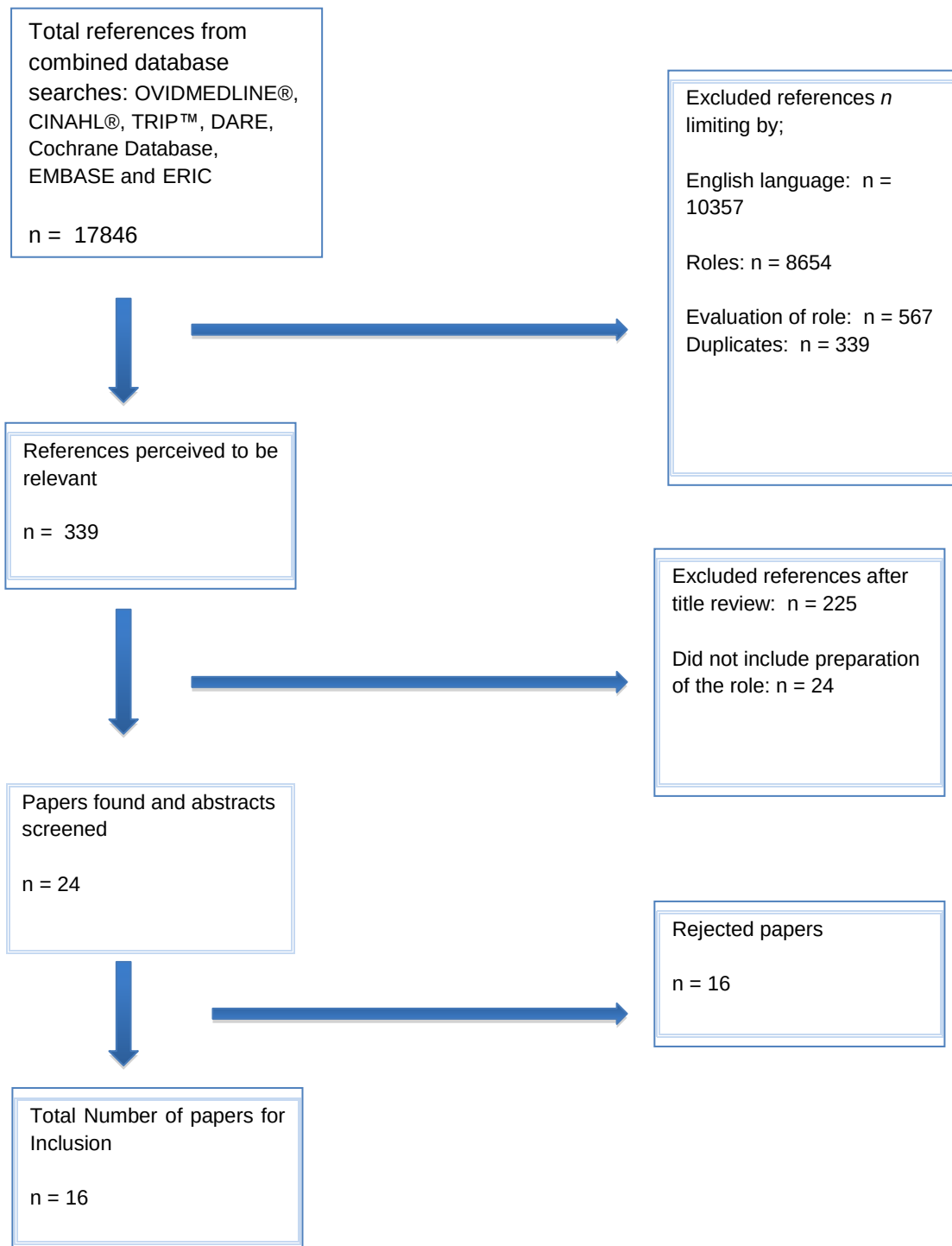


Figure 1 Summary of a database search: Outcomes of Advanced Practitioners in practice

2.3 Literature Appraisal

Using components of appraisal methods (Forbes & Griffiths 2002; Greenhalgh 2006) the studies meeting the inclusion criteria were initially scanned for relevance to the aim and objectives of this study and to gain further insight into the topic. Subsequently they were evaluated for sufficient description of the methodology that included criteria for sample selection, credibility of the research, and conclusions drawn. In order to gain a wider understanding of the background to the study aim, more classical original historical studies were included in the review. In order to minimise bias and improve validity (Weisman *et al* 2003), two frameworks were selected to appraise the studies. Spencer *et al*'s (2003) qualitative evaluation framework was used to appraise qualitative studies. This framework was originally devised for use in the evaluation development and implementation of social policy, and qualitative enquiry (Spencer *et al* 2003). It was therefore considered to be an appropriate framework for use in this study. For quantitative studies the Critical Appraisal Skills Programme (CASP), tools specific to the design was selected, for of ease of use and because of its systematic approach (Public Health Resources Unit 2006).

Descriptive summaries of the data synthesis were tabulated and used to generate themes from the identified studies. This chapter presents the evaluation of findings arising from the analysis, and begins with an examination of advanced practice roles and the outcomes of their practice, as presented in the literature. It subsequently considers aspects of educational preparation for these roles. The review was on-going and integrated throughout the study.

2.4 The Implementation of Advanced Practice

Wanless (2002) and DoH (2008; 2010a; 2012) reports that the current pattern of service provision is unsustainable in meeting patient needs and outcomes because of significant gaps in the workforce. A challenge for governments and human resource healthcare

planners is to transform the workforce to deliver healthcare that meets local needs. Successive healthcare policies encouraging entrepreneurship and the perceived realisation that nurses have the capacity to develop their roles have led to the acceleration of advanced practitioners being recognised as a way of reforming service delivery whilst making cost savings (DoH 1999; Buchan & Edwards 2000; DoH 2000; DoH 2002; DoH 2004b; DoH 2008; DoH 2010a; NHS England 2014).

The introduction of advanced practice roles is a positive concept. Advanced practitioner roles are, however, regularly introduced opportunistically, without clear frameworks or needs assessment to aid and support implementation (Bryant-Lukosius *et al* 2004). Consequently this results in a lack of congruence between organisations. Inconsistent role terminology used in governmental reports and frameworks throughout the world exacerbates this, and is perceived as a major barrier to advanced practice implementation (Bryant-Lukosius *et al* 2004; Furlong & Smith 2005; Jones 2005; Gardner *et al* 2010). If standards for practice, education, and governance are to be consistently established in support of patient safety and effectiveness of practice, these challenges for professionals need to be addressed (Lowe *et al* 2012). Equally, there is a need to retain some flexibility in the design of programmes to be reflective of, and accommodate, local differences that can lead to innovation.

2.5 The Effectiveness and Outcomes of Advanced Practice Roles in Practice

Various researchers/writers recognise the need to evaluate the outcomes of advanced practice roles on patients in order to ensure future continued investment (Carroll & Fay 1997; Bryant-Lukosius *et al* 2004; Furlong & Smith 2005; Jones 2005; Gardner *et al* 2010; RCN 2014). Advanced practice roles are built around general nursing outcomes that make it challenging to articulate or attribute specific outcomes from healthcare delivered by them in

practice. Byers & Brunell (1998) advocate that both quality and cost of healthcare provided should be considered. This can be difficult because of the individual disparities regarding perceptions of quality between stakeholders. Studies attempting to measure these are now reported and are summarised in Table 3, and essentially relate to nurse practitioner rather than advanced practitioner roles.

Table 3 Summary of Studies: The Outcomes of Advanced Practitioners on Practice

Author and Study Design	Findings	Evaluation
Shum <i>et al</i> (2000) Multi Centre Randomised control Trial (RCT) - England	• Patients more satisfied with nurses than doctors • Nurse Consultations were longer than doctors • Similar number of prescriptions written • Nurses gave more advice • Practice nurses offer an effective service for same day appointments.	• The study did not examine the content of the consultations in depth; aspects of safety netting could not be made • Level of experience of nurses in the study, were newly trained in minor illnesses • Long term effects of behaviour not studied • Comparisons were made to other studies.
Kinnersley <i>et al</i> (2000) RCT - UK	• Patients consulting with NP significantly more satisfied in some GP practices • No difference in resolution of symptoms NP Vs GP • NPs gave more information to patients, however consultations were longer.	• Study supports wider acceptance of the NP role • Dated study and context of practice is currently different • Trial procedure changed the routine of the practice • Smaller sample than anticipated due to sampling strategies being modified.
Venning <i>et al</i> (2000) RCT – England & Wales	• NP consultations significantly longer • NPs carried out more investigations, and asked patients to return more frequently • No difference in patterns of prescribing or health for both groups • Patients were more satisfied with NP consultation outcomes.	• Clinical care and health service costs were equal • If NP consultation times could be shortened they would be more cost effective • Study is dated; context of practice is now different.
Horrocks <i>et al</i> (2002) Systematic review of RCTs	• Patients satisfied with care from NPs • No differences in prescription rates, return consultations or referrals • Quality of care in some instances was reported as better for NP consultation • Ambiguities in definitions of NPs in studies reviewed • Parameters for outcomes were set and clearly defined	• Observational studies were reportedly poor quality • Nurses need to be evaluated under similar conditions • NP consultations need to be examined with patients presenting with wider and greater acuity • Further research to provide greater understanding of what patient satisfaction refers to; and working environments.

Author and Study Design	Findings	Evaluation
Laurant <i>et al</i> (2004) RCT - Netherlands	- The number of contacts in the intervention group increased significantly in the intervention groups (NPs) to that of comparison (GP) group - No significant changes were found in subjective workload - NPs did not reduce the GP workload implying NPs were supplements rather than substitutes.	- Sample for NPs were experienced community nurses not qualified NPs and did not meet ICN (2002) advanced practice definition. - The study captured data in only one region, and therefore not generalizable - Several GPs were lost to follow up - The drop out rate was higher in the intervention group; may be reflective of policy changes occurring at the time of the study - Evidence conflicts with similar studies undertaken at the same time.
Seale <i>et al</i> (2006) Qualitative Study - England	- NPs talked significantly more about treatments and side effects. Nurses offered more holistic care; GPs focused on gathering information relevant to diagnosis and treating the immediate problem. - NPs demonstrated greater concern regarding the acceptability of care and cost to patients.	- Data collected in 1998, and may now not be representative of current practice - The sample size may not be totally representative of the GP practices in the UK.
Caldow <i>et al</i> (2006) Quantitative study - Scotland	- Majority of patients would prefer to see a doctor - Women, younger people, the less well educated and those on a higher income demonstrated a more positive attitude to being seen by nurses - Academic ability and qualifications were the most frequently reported differences - Patients want choice to select first point of contact. - Respondents stated nurses should be able to prescribe drugs and treat minor illnesses - Shorter nurse consultations are needed.	- Some missing values were excluded from the analyses - A large study representing patient's views - The questionnaire was a validated tool - Practices represented a range of locations - Some qualitative data was collected to clarify patient views - Response rate could have been higher.
Gardner <i>et al</i> (2007) Qualitative Study - Australia	- Supports the use of the Strong Model of advanced practice in representing the practice experience of advanced practice nurses in Acute care - Supports definition of service parameters and the design of an operational framework for implementing and evaluating advanced practice roles.	- Tool was not validated - Sample drawn from only one Australian state and therefore not generalisable.
Chang <i>et al</i> (2010) Delphi Study - Australia	- Tool used to address previously identified issues of NP role - Offers a tool for defining the core activities of advanced practice to ensure evaluation of advanced practice roles.	- Three rounds and five modifications were made prior to the tool being validated - Good response rate.

Author and Study	Findings	Evaluation
Gardner <i>et al</i> (2010) Descriptive study - Australia	30 individual activities were identified describing advanced practice work - Direct care by NPs accounted for 36.1% of time; indirect care 32% and service related activities 31.9%.	- Large number of observations undertaken - Results provide useful baseline data for evaluating NP work - The best use of NPs and barriers to practice are issues raised that require further investigation - Research design does not measure other aspects of work activities, e.g. length of time and quality of work - Limited training provided to observers that may lead to subjectivity differences.

2.5.1 The Effectiveness and Outcomes of Nurse Practitioner Roles in Practice

Research activity has predominantly focussed on exploring the specific nurse practitioner role in order to evaluate the outcomes on patients and cost effectiveness in comparison to a medical role, principally in primary care (Touche Ross 1994; Coopers & Lybrand 1996; Kinnersley *et al* 2000; Venning *et al* 2000; Laurant *et al* 2004; Seale *et al* 2006; Dierick-Van Daele *et al* 2009). Multi centre randomised controlled trials (RCT) were used by Kinnersley *et al* (2000), Venning *et al* (2000) and Laurant *et al* (2004), and a single centre study by Dierick-Van Daele *et al* (2009). These were the first studies that offered research to support the standardisation and regulation of NP roles (Gardner *et al* 2010). Key outcome measures were used in all studies except Laurent *et al* (2004), who considered workload based on diaries and were considered as key indicators in determining the effectiveness of the role, patient needs, and expectations.

Shum *et al* (2000) and Venning *et al* (2000) reported positive patient care outcomes provided by nurse practitioners. Conversely Dierick-Van Daele *et al* (2009) reported no significant differences in satisfaction in relation to treatment provided by nurses and General Practitioners (GPs). Difficulties in evaluating and equating costs were identified given the longer nurse practitioner consultation times and a shortage of role outcome measures in all studies. There were no reported differences between the groups in outcomes related to

prescriptions issued, investigations ordered, or referrals to secondary care, in any of the studies. More patients, although only statistically significant in the Dierick-Van Daele *et al* (2009) study, were likely to re-attend after visiting a NP, although the numbers of patients who actually re-consulted were similar.

There was a lack of homogeneity between the studies regarding the remit and qualifications of the nurses used as participants. Laurant *et al* (2004) used nurses additional to the team for allocated tasks, while Kinnersley *et al* (2000), Venning *et al* (2000), Shum *et al* (2000) and Dierick-Van Daele *et al* (2009) substituted nurses for GPs randomly for any patient presentation. This is an important difference, because nurses in the Laurant *et al* (2004) study had potentially less autonomy within their role, and reviewed a more limited patient case mix that may not have matched their clinical expertise. Differences in educational preparation and post qualification experience were also evident between the study samples. They ranged from an advanced practitioner with an RCN Diploma and one-year's experience (Kinnersley *et al* 2000), to a nurse with a Master's degree yet recently qualified (Dierick-Van Daele *et al* 2009), and consequently made comparison of the findings difficult.

Studies examining the introduction of new services in primary care are complex because of constraints cited by practice regarding choice of interventions and evaluation methods, affecting trial strengths and limitations. While RCT's stand at the pinnacle of clinical research, hierarchy of evidence adverse reporting can provide a threat to the internal validity of a study, affecting its integrity; and the external validity addressing generalisability of the results of the study (Becker 1996; Biggs & Buchier 2007; Chang *et al* 2010). The external validity only appeared to be problematic in the Laurant *et al* (2004) because of the nursing participants' backgrounds; the remaining studies (Kinnersley *et al* 2000; Venning *et al* 2000; Shum *et al* 2000; and Dierick-Van Daele *et al* 2009) appeared to be well constructed and conducted.

Later studies by Caldow *et al* (2006), Gardner & Gardner (2005), and Gardner *et al* (2007; 2010) using qualitative methodologies sought to evaluate the outcomes of both the nurse practitioner and the advanced practitioner role in practice. Caldow *et al* (2006) reported that patients were satisfied seeing a nurse providing they had undertaken professional development to improve their academic ability and qualifications. Gardner *et al* (2010) reported findings demonstrating that advanced practitioners spent similar amounts of time on indirect care direct care and service-related activities, and significantly less time on research activities. Both studies reported that no role differentiation existed between nurse practitioners and advanced practitioners regarding practice or service parameters. This reaffirms the lack of understanding of roles and the breadth of abilities and skills required (Caldow *et al* 2006; Gardner *et al* 2007).

Despite heterogeneity in the results from these studies that may be consistent with the reality of practice or with the limitations of the studies, the findings should be cautiously interpreted as a means of evaluating effectiveness. Lowe *et al* (2012) argue that while patient satisfaction correlates strongly with patient adherence and is important, it is not reliable as a measure of care standards in diagnosis and providing medical care. Furthermore, Lowe (2012) suggests that increased length of consultation time and increased frequency of ordered investigations may suggest that participants in the studies were unable to diagnose conditions and manage care as efficiently and effectively as general practitioners.

The aforementioned studies primarily focus on primary care and limit the evidence to support the use of advanced practitioners in workforce transformation. The increased complexity of healthcare delivery and the need for fiscal control means that further evidence reflective of current practice is now required. Differences of role definition, role clarity and educational preparation illustrate differences in variables that could not be controlled, making direct comparisons of results problematic. This suggests that future research is required to explore

and understand the identified issues that remain inconclusive. For example, if patient satisfaction is greater with advanced practitioners, factors causing this effect need to be identified.

There is a paucity of research that identifies current gaps and attitudes arising from changes in healthcare delivery, healthcare policy and the implementation of advanced practice roles from the perspective of practitioners, managers and service users. Research evaluating the outcomes of direct role functions of advanced practitioners in relation to the quality of care skills and their capability to provide the care, is also scarce. With the roll out of non-medical prescribing some of the issues that were identified in inflating costs of nurses and increasing consultation times previously, may now not be relevant. Where robust research literature is available it is no longer current or reflective of the changes to healthcare policy and healthcare delivery, having used data collected in the late 90's. What the literature specifically omits is an evaluation of the educational preparation required to ensure that, in fulfilling these new roles and dealing with complex healthcare needs advanced practitioners, are fit for practice and purpose. Within this context it is important to establish whether the current academic preparation of advanced practitioners provides the correct composite skill set in order to determine if care outcomes are directly influenced by advanced practice education preparation.

2.6 The Appropriateness of Master's Level Education in the Preparation of Advanced Practice

Advanced practice educators need to understand the role and preparation required for advanced practitioners if they are to fulfil policy objectives in delivering healthcare in innovative ways. Furlong & Smith (2005) advocate that advanced practice education programmes should be delivered within an inter-disciplinary framework and have clinical competence at an advanced level as a key requirement. Advanced practice literature

identifies shared key components of the education required and includes expert clinical practice, clinical and professional leadership, decision-making, consultation, education and research skills. The purpose of this next section of the literature review was to gain a perspective of the current outcomes of advanced practice educational programmes on practice and in so doing determine if these core components were a reality.

Gerrish *et al* (2003) and Nicolson *et al* (2005) suggest advanced practice education currently seeks to prepare practitioners with the knowledge and skills required to autonomously manage clients with multiple care needs within their sphere of competence. Advanced practice education ranges from a Bachelor of Science to a Master's degree, and in the United States this is moving to doctoral level with the transition anticipated as complete by 2015 (Tuaoi *et al* 2011). Significant debate surrounding the academic level of preparation for advanced practitioners has occurred (Tuaoi *et al* 2011), culminating in recognition of Master's level education in the UK by statutory professional bodies and government policy (NMC 2005; DoH 2010b). Reform in pre-qualifying nurse education to degree level preparation confirms this view. Despite these changes uncertainty remains for advanced practitioners regarding what type of academic preparation and what knowledge is required to support the role. The paucity of research evaluating the outcomes of master's level education in the preparation of advanced practitioners exacerbates this issue and needs to be improved to assist educators, practitioners and organisations in addressing this ambiguity.

Findings from studies aiming to evaluate the influence of master's level programmes on professional development are summarised in Table 4 (Page 48). Findings included, improved career opportunities, organisational benefits, behavioural changes and perceived professional credibility, and improved relationships with other healthcare professionals (Gerrish *et al* 2000; Whyte *et al* 2000). Core academic skills, for example, presentation and search skills, reportedly increased the practitioner's ability to clearly articulate and support

arguments effectively with evidence. The integration of academic and clinical skills facilitating growth and enabling a more in-depth approach to learning was also enhanced (Whyte *et al* 2000).

Table 4 Summary of Studies: The Effectiveness of Masters Level Study

Author and Study Design	Findings	Evaluation
Whyte <i>et al</i> (2000) Quantitative Study - Scotland	• A masters degree created greater job opportunities, and was perceived to enhanced clinical practice, personal satisfaction and acquisition of new skills • The intensity of the study, writing skills, assessment deadlines and the dissertation were perceived as the most difficult • Personal constraints, financial concerns, accommodation and family demands were identified.	• Focussed period of follow-up • Only one institution used in the study • Time lapse between completion of the course and gaining promotion was not identified • Low response rate • Questionnaire was partially closed affecting the breadth and depth of responses • Questionnaire was self-developed and not validated • Older study limiting its currency.
Gerrish <i>et al</i> (2000) Qualitative study - UK	• The credibility of the master's level nurse was of central importance re professionalism and in enhancing credibility and legitimacy of nursing as an occupation • Clinical capability attributed to the nurse was interpreted as increasing authority and expertise, and attributes to autonomous skills ▪ Qualification was perceived as enabling exercise of influence and leadership ▪ Education was perceived to deepen and broaden the participants' existing knowledge base ▪ Learning needed to be relevant to practice in order to facilitate change in the student's practice ▪ The use of creative thinking facilitated students to work beyond traditional boundaries by expanding modes of critical thinking ▪ Participant's perceived that they needed to work in a senior position within the organisation in order to benefit from the education. • The perception that programmes were predominantly designed for and accessed by experienced students who were developing or wanting to develop new services.	• Illustrates some instabilities that lie between healthcare workforce demands, professional aspirations and the social value of education • Findings were selected from a larger study, and may be affected by selection bias • Sample represented a small number of the university population overall.

Gerrish *et al*'s (2000) two-staged UK based qualitative study exploring the meaning of master's level performance in practice for nurses, physiotherapists and occupational therapists initially identified six themes of benefit. Variances between different disciplines were not identified within the study (Gerrish *et al* 2000). In the second stage of the study, Gerrish *et al* (2003) questioned lecturers to gain their perspective of the characteristics of nursing graduates exiting master's level programmes. The interviewees were rarely able to articulate characteristics they believed typified master's level practice, instead perceiving them as aspirations. Participants inferred that nurses attempted to legitimise nursing to other professionals as an occupation of standing, rather than promoting credibility derived from the qualification, and believed that graduates would lead new and innovative practice in the development of the nursing profession (Gerrish *et al* 2003), supporting the work of Drennan (2009). These findings conflicted with the aspirations of the graduates, who alternatively communicated their development in terms of medicine, and in so doing supported early literature relating to doctor substitution (Furlong & Smith 2005). The paucity of the evidence relating to masters level education limits the conclusions that can be made in terms of a consensus of the opinions and debates within the field and provides an opportunity for this study to explain these.

2.7 The Development of Nursing Knowledge

The development of nursing knowledge has occurred in phases, beginning in the 19th century with a set of descriptive rules regulated by an authoritative figure that nurses were trained to follow (Manzoukas & Jasper 2008). In the 1950's nursing knowledge, attempting to rationalise and develop nursing practice based upon theories, shifted to asking the questions 'how' and 'why' (Manzoukas & Jasper 2008). Two influential theorists, Carper (1978) and Benner (1984), attempted to explain nursing knowledge in a linear manner in the form of objective and subjective knowing. Carper's (1978) and Benner's (1984) theories are used consistently within the advanced practice literature alongside reflective practice, to discuss

practice relevant knowledge. Carper (1978) theorised that there was a body of knowledge that provides a rationale and platform for thinking about nursing phenomena that is organised in patterns, forms and structures. Four fundamental patterns of knowing are noted in Table 5; and are distinguished by their logical type of meaning (Carper 1978).

Carper's (1978) theory integrates the positions/dimensions into a 'whole' nursing knowledge that are dynamic, emerging in the development of a mastery of the discipline. The theory provides philosophical underpinnings of nursing knowledge not previously considered, and it encourages nurses to reflect on nursing from different perspectives in knowledge advancement. However, Carper (1978) does not explicitly define what nursing is making any search for patterns in it, challenging Kenney (1999). Manzoukas & Jasper (2008) argue that Carper (1978) fails to distinguish between knowledge and knowing, and in so doing alludes to specific pathways of knowing leading to particular types of knowledge. Carper's (1978) portrayal of dimensions as discrete entities creates a false illusion that the patterns are mutually exclusive, and makes application difficult to advanced practice, where definitions incorporate levels of practice related to all aspects interdependently.

Table 5 Ways of Knowing (Carper 1978)

Type of Knowing	Description
Empirics: The science of Nursing	How do I come to know the knowable? How do I find meaning in what I do? The development of an empirical body of nursing knowledge to describe, explain and predict phenomena specific to nursing. The theory contends there is no specific structure generally accepted as representing this, although the representation of health as more than an absence of disease is a crucial change viewing health as a dynamic process. This pattern of knowing is factual, empirical descriptive and concerned with developing theoretical explanations.
Aesthetics the Art of Nursing	How do I come to know the artistry? What does my perceptual sensibility to art reveal to me? The knowledge gained from subjective acquaintance, the art of nursing; the difference between recognition and perception, being empathetic experiencing others' feelings. The more the nurse is able to be empathetic of others the more knowledge or understanding is gained.

Type of Knowing	Description
Personal Knowledge in Nursing	How do I come to know who I am? Who am I? Seen to be the most problematic dimension, but the most important in understanding the meaning of health in terms of individual well-being. It is concerned with the knowing of the individual self, the nurse rather than seeing the patient as an object instead develops a relationship.
Ethics; Moral knowledge in Nursing	How do I come to know what I morally ought to do? Who ought I to be morally? What is right or wrong in the ethical conduct of nurses when treating patients, and focuses on what we are obligated to do.

In contrast Benner's (1984) theory, founded largely on the work of Dreyfus & Dreyfus (1980) computer scientists (Cash 1995), is based on the difference between practical and theoretical knowledge. Benner (1984) argued that there was a difference between 'knowing how' and 'knowing that', and subsequently developed a theory represented by five levels of nursing practice termed '*From Novice to Expert*'. The underpinning research attempted to determine distinguishable characteristics in the novice and expert's description of the same clinical incident. The results were themed and are set out in Table 6.

Table 6 Novice to Expert Classification (Benner 1984)

Title	Stage
Novice	Learns to recognise situational facts and features relevant to a particular skill and their actions are based on these facts and features.
Advanced Beginner	Identify global characteristics of a situation, and these can be identified through experience with them.
Competent	Has the confidence and ability to cope with a wide range of nursing situations, but lacks speed and flexibility when making the decision. Through feedback and reflection the ability to recognise urgency and priorities is developed.
Proficient	Is analytical and fluid, can recognise when the expected normal picture does not materialise. Development to the final stage is not clear-cut.
Expert	Unconsciously aware of their practice because it has become part of their being. The individual does not see the problem in a detached way; they simply see a problem and react automatically, ' <i>intuition</i> '.

Benner's (1984) theory of expertise presents an individual as an expert in a specific undetermined context characterised by a specific way of thinking. Benner (1984) perceived experts as individuals who find answers to clinical problems 'intuitively', and who could not always justify or provide a rationale (Rolfe 1997). Benner (1984) promoted experience as the difference between the novice and the expert. However, experience is a nebulous

concept, and the measurement of how much is required to become an expert is intangible. Benner's (1984) research did not utilise selection criteria that included master's preparation, and therefore it is difficult to extrapolate if the experts in the study were experts by experience or exhibited expert practice as one of the domains of advanced practice following master's education (Manzoukas & Jasper 2008).

The literature suggests that nursing knowledge required for advanced practice is a process and necessitates the individual practitioner possessing a critical and enquiring attitude (Manzoukas & Jasper 2008). The process of knowing is confirmed by the consistency in which it fits with the individual's other beliefs and potentially alters over time; how this influences nurses, or is integrated into nursing care, is not identified.

Christensen (2009) proposes that advanced practitioner development is on-going, and involves the acquisition of problem-solving, analytical and synthesising skills. Christensen (2009) argues that this allows the integration of the 'knowing how', theoretical knowledge and experiential learning into a pragmatic 'know that' knowledge or practical knowledge. Practical knowledge is interpreted as the sum of all forms of knowing and determines what educationalists need to understand and provide in advanced practice programmes (Manzoukas & Jasper 2008). Alternatively, the theory of andragogy suggests that adult learners are self directed, reflective, motivated to learn, and bring with them the quality of life experience (Hean 2009; Jarvis 2010). This argument emphasises the responsibility of the teacher as a facilitator of students enabling them in their efforts to learn. Knowledge and clinical competence are promoted in advanced practice literature as essential; however, the scope of practice of advanced practitioners has confounded health care practitioners and nurses for some time. This serves to feed dissonance, which needs to be addressed to facilitate understanding of its nature of inquiry and to determine whether nursing and the nature of nursing, fits with current advanced practice programmes.

2.8 Advanced Learning for Advanced Practice

In order to determine the effectiveness of advanced practice programmes on practice research needs to address the relationship between the learning from educational preparation and the outcomes in practice. Learning is a process intrinsic to our being, is experiential, and can be affected by previous experiences and contexts (Jarvis 2010). Education provides the medium for learning opportunities; these are determined by the provider of the learning (Jarvis 2010), and involve understanding and theories to explain it.

The assessment of evidence and arguments, consideration of different perspectives, and the reflections of new information, facilitate personal understanding (Meizrow 2000). Kuiper & Pesut (2004) claim that reflective clinical reasoning in nursing practice is dependent upon the development of both cognitive and meta-cognitive skill acquisition that involves reasoning, whilst reflective thinking is metacognition and concerns experiences (Kuiper & Pesut 2004). Critical thinking is an emerging topic in nursing literature that has arisen in response to changes in healthcare education and the need for the scope and complexity of nurses' clinical reasoning and critical thinking skills (Drennan 2009). Daly (1998) and Drennan (2009) reason that it is a purposeful, cognitive and retrospective process that requires further investigation regarding its relationship with nursing.

Drennan's (2009) cross-sectional design study measured the critical thinking abilities of students who had completed master's degrees, and found a statistically significant higher level of critical thinking skills for the graduate group to the comparison group, after controlling for age and years qualified (Drennan 2009). These results support the argument that master's level programmes influence the development of critical thinking skills. A comparison to graduate scores outside nursing revealed variable results, with nursing students having similar scores to nurse managers and nurse educators but lower than other comparable education or occupational groups (Drennan 2009). The reported changes in the

study were, however, modest, and question the pedagogical methods used to facilitate the development of critical thinking skills.

The development of critical thinking skills to promote questioning and debate of issues under consideration in the generation of new knowledge is challenging in higher education. Many programmes are delivered part-time and provide limited time to discuss wider issues important to the learning. If Daly's (1998) theory is accepted that cognitive thinking and reasoning are retrospective activities, it can be argued that critical reflection, as a learning strategy may be advantageous for advanced practitioners, especially where direct classroom activities are reduced. Christenson (2009) adds that reflection can only be appropriate in advanced practice education if the practitioner has a sound theoretical or experiential knowledge base. Another priority in advanced practice is a requirement to develop psychomotor skills of health assessment and advanced technical procedures founded upon expanded knowledge and intellectual development. While significant investment in academic development to achieve this is currently made, its alignment with what is achieved clinically is under researched.

In conclusion, the evidence suggests that further exploration of how acquired knowledge and skills from postgraduate education changes learner satisfaction, attitudes and behaviours is required in order to evaluate the outcomes in practice.

2.9 Continuing Professional Education for Nurses

The importance of continuing professional education for nurses has been emphasised since Nightingale's annotations encouraging nurses to continue to learn (Gallagher 2004; 2006). Definitions of CPE promote it as a process of life-long learning that is built upon educational and experiential bases of the profession, in order to enhance practice, education, research, and theory development (Gallagher 2006). The need to respond and prepare professionals

to work in a dynamic yet financially austere healthcare arena, challenges curriculum development and design of programmes to provide education that is relevant, context appropriate, and fit for practice and purpose (Finn *et al* 2010).

The literature identifies outcomes of CPE that can be categorised into the outcomes on patient care, implementation of research-based practice, and personal, and professional development (Barriball *et al* 1992). This may be overly simplistic because of difficulties associated with measuring outcomes of CPE on practice and quality of care, the lack of consensus on what constitutes nursing knowledge, and the influence of other factors that affect the use of knowledge gained from CPE. These issues cannot prevent development of effective programmes in the preparation of new roles and pre-existing established roles.

Curriculum development provides the framework for developing education programmes within higher education to promote transfer of learning to practice (Finn *et al* 2009). Concern has been raised about the effectiveness of the knowledge gained in the classroom and its usefulness in practice (Wong 1979; Tolley 1995; Henderson 2002; Baxter 2007), with the suggestion that academics are perceived to teach inappropriate content for use in practice. The disparity between what is delivered through education programmes and what practice wants, may arise because of the inherent tension between nurses and academics; nurses perceiving practice 'as what nurses do' and academics perceiving practice as 'what they should do'. Despite a lack of empirical evidence to support the idea that theory and practice are discrete entities, theorists continue to identify a 'gap' in the transfer of theory to practice (Armitage & Burnard 1991; Tolley 1995; Le May *et al* 1998; Bero *et al* 1998; Baxter 2007).

2.10 The Outcomes of Advanced Practice Education in Practice

Two small studies were identified via a literature search with four other reports accessed at local level, commissioned by NHS North West, and are summarised in Table 7. These four

reports evaluated the introduction and outcomes of advanced practice roles in Greater Manchester prior to further advanced practice curriculum development in 2009. The following discussion considers the collective findings of these three studies to identify what are the outcomes of implementing advanced practitioner roles in practice.

Table 7 Summary of Studies: The Outcomes of Advanced Practice Education in Practice

Author and Study Design	Findings	Evaluation
Nicolson <i>et al</i> (2005) Mixed methods study – UK	• Most students value their experience and advanced practice role • Confidence develops post course experience • advanced practices better equipped than medics in conducting skills and effective communication because of their commitment, skills and experience in neonatal setting • The main reason for undertaking the programme was for self-development. • Students perceived themselves to be more confident in counseling, providing leadership, acting as a resource for others, linking medical and nursing activities, facilitating research skills and knowledge, and carrying out complex clinical procedures. • Experience was the most valuable element to increasing confidence for nurses • Programme satisfaction levels were high.	• Study does not consider practice outcomes • Potential sampling bias with survey • Small sample for qualitative aspect of study, and only focused on Neonatal advanced practice programmes limiting generalisability.
Acton Shapiro (2009a;2009b;2009c;2009d) Evaluation Study – England	• Four reports evaluating implementation, and effectiveness of Advanced Practitioners that demonstrated: widening skill base; improved relationships with colleagues; increased autonomy and empowerment • Barriers included lack of opportunities for work based learning; lack of strategic direction; lack of governance structure; prescribing progress limited • Reduced workload for medics and emergency admissions • Other findings: a lack of clarity of the role; some supportive managers; an inability to work as an advanced practice due to financial constraints and workload issues; difficulties in accessing work based learning experiences; and differences in effective mentorship because of unclear	• Provided recommendations for future planning linking advanced practice role development to service development; ensuring critical mass; clear purpose of the advanced practice role; management support; and wider promotion of advanced practice roles • Measurement of outcomes was problematic • Poor attendance during some data collection was reported • Diversity in professional backgrounds of trainees leading to wide variance in responses • Only common themes reported • Situated in one geographical location.

Author and Study Design	Findings	Evaluation
Acton Shapiro (2009a; 2009b;2009c;2009d) Evaluation Study – England (Cont)	arrangements between managers, universities and professionals. Practitioners reported a lack of trust from their colleagues regarding their role. Increased confidence manifested as improved communication, and positive patient benefits such as; reduced waiting times, reduced length of stay; and increased continuity of care. • Roles should not be developed in isolation.	
Shearer & Adams (2012) Descriptive qualitative study - England	• Five themes emerged: improved clinical assessment; benefits of education framework; increased confidence; importance of networking and increased autonomy that resulted in positive changes to students in advanced practice roles.	• Small sample drawn from researchers own university and cohesion bias may have occurred • Single centred study • Nature of student funding not identified • Outcome for student not reported • Exemplars to support perceived changes were not reported • Study identified positive perceived outcomes and supports the development of competent professionals arising from the education.

Nicolson *et al* (2005) and Shearer & Adams (2012) evaluated the impact of advanced practice education using participants from their own place of work. Nicolson *et al*'s (2005) mixed method study aimed to identify the education and working experiences and subsequent training needs of graduates on an advanced practitioner neo-natal nursing programme. Findings reported positive changes in improved clinical competence and behaviour. However participants reported that the relationship between theory and practice had left them feeling unable to implement practice on completion, with only 5.4% (n = 2) feeling prepared. Participants also reported they had inadequate time to practice and absorb theoretical aspects of clinical work in order to professionally develop and transform their practice (Nicolson *et al* (2005).

Shearer & Adams' (2012) descriptive qualitative study explored the views of students undertaking a master's level advanced practice programme and five themes were identified

(Table 7). Self-reported student outcomes arising from the advanced practice education tentatively suggest that the advanced practice programme did lead to competent professionals. The sample was, however small and students provided no concrete exemplars to substantiate these outcomes.

The North West commissioned reports were undertaken in response to the Strategic Health Authorities aim in '*Delivering the workforce*' (Acton Shapiro 2009a; 2009b; 2009c; 2009d). This evaluation study used mixed methodologies and participants from two local universities and five Trusts. Student participants from two cohorts of advanced practice programmes from diverse professional backgrounds were surveyed and a smaller sample later interviewed that resulted in a wide variance of responses, affecting comparability. Colleagues and key staff from HEIs and Trusts were also interviewed. Data collection occurred throughout the training to reduce the impact of recall bias. Participant findings reported variation in experiences, and the identification of factors that enabled and/or hindered the use of effective advanced practice roles (Table 7). Recommendations to develop the workforce were identified (Table 7) and in so doing provided a baseline against which future evaluations can be measured.

2.11 The Outcomes of Continuing Professional Education in Practice for Nurses

One systematic review, three literature reviews, and a number of small studies evaluating nursing modules and programmes were identified in the review. Findings from these studies are summarised in Table 8. The systematic reviews demonstrated a lack of empirical evidence evaluating the outcomes of nurse CPE, and demonstrated that analysis was largely based on participant self-report (Barriball *et al* 1992; Wood 1998; Griscti & Jacono 2006).

Table 8 Summary of Studies: The Outcomes of Nursing CPE

Author and Study Design	Findings	Evaluation
Crotty & Bignell (1988) Evaluation study - England	- Course and facilities highly rated - Increased insight into helping learners - Increased clarity in thinking - Improved team work - Greater understanding of colleagues roles - A deeper knowledge of related issues.	- Old study that is not reflective of current practice - Small sample - Single centre study - Results were directed at the specific course with no intention for wider generalisability - Study consistently referred to in the literature.
Hogston (1995) Qualitative study - England	- New skills learnt that positively influenced delivery of patient care reported - Increased motivation and confidence to develop professionally - CPE was seen as a reward and increased knowledge improved their ability to influence medics - Nurses integrated theory into practice although transfer of the learning was dependent upon the teacher, the students and the curriculum - CPE was inadequate in facilitating all individuals to develop professionally as aspired to by nursing's professional regulators - Managers were possible barriers to supporting individuals in CPE.	- Small single centre study - Self-reported perceptions only - No other outcomes reported.
Barriball & While (1996) Qualitative study - UK	- Most participants attended less than 5 study days, 80% of which were qualified practitioners - Difficulties in attending CPE were attributed to clinical grade, duty hours and types of shifts worked, and budget constraints.	- Evaluated CPE delivered as 5 independent study days - CPE attendance was not reported - Only two healthcare providers were evaluated.
Jordan <i>et al</i> (1999) Exploratory study - Wales	- Improved nursing practice especially in terms of prescribing side-effect monitoring - The nurses capacity for autonomous practice was limited - Heavy caseloads and lack of resources affected ability to learn - Course content may be crucial in determining clinical outcomes, and CPE that is publically funded should prioritise improving care.	- Single geographical location - Objective measurable outcomes were problematic due to confounding variables - Quality was not defined and therefore patients and nurses may not share the same priorities, and therefore needs further exploration.
Endacott <i>et al</i> (2000) Literature review	- Reflective practice contributed to linking theory with practice - Managers defined their own range of competencies based upon local need.	- Diversity of results requires further exploration - The study aim and objectives were not made explicit for the study - Multiple methods were used to collect data with good response rates.

Author and Study Design	Findings	Evaluation
Brown (2000) Evaluation study - England	- A degree accelerated participants career progression - The initiative to study for a degree came from the student not the manager - Half of managers expressed doubts about a programme that was not nursing focused.	- Only one course was evaluated - Specific details of improvement were not reported - Only 3% managers asked about the programme content prior to the student starting the programme.
Smith & Topping (2001) Case study - UK	- Improved knowledge and relationships with the multi-professional team that influenced the delivery of care - Criticism of course content: bio- medically focussed.	- Information relating to data analysis was limited e.g. coding, sources of bias - Single centre study - Over dependence on self-assessed and self-reported data.
Armstrong & Adam (2002) Phenomenological study - Scotland	- Increased confidence, knowledge and self-assertiveness - Ability to use learning in practice on completion was varied for participants and challenging due to organisational culture - Students returned to current role on completion.	- Small study - One cohort of students used - Students perceptions self reported - Issues with external validity - No patient outcomes were reported - Researcher was known to the participants
Hardwick and Jordan (2002) Evaluation study - UK	- Increased satisfaction and confidence - The link of the teacher was beneficial to learning transfer to practice - Lack of time for learning - Idealism versus realism.	- There was an absence of clinical outcomes reported - The ability to determine the breadth and depth of change is difficult because of the lack of evidence reported - Authors reported publication bias towards negative findings - Interviews were not held because of limited resources.
Henderson (2002) Grounded Theory - Australia	- Focus from the learning was to become competent - The nursing role became apparent through reflection on learned knowledge and observations from practice - Nurses could not internalise the concept of holistic care - Complacency in care delivery.	- Provides examples of how nurses can narrow the theory practice gap - Single centre study - Small sample size.
Gould et al (2006) Qualitative study - England	- One approach to CPE is not suitable for all individuals - CPE enhances service provision - Learning bridges the theory practice gap - Demands from CPE encroach on personal life, and can contribute to the unattractiveness of nursing work - Inability to access CPE due to workload - Organisations used CPE as propaganda to attract nurses to work in Trusts.	- Related to one specific patient group limiting generalisability - Small scale, single centre study - No details of data analysis included - Did seek the views of all stakeholders.

Author and Study Design	Findings	Evaluation
Griscti & Jacono (2006) Literature review	▪ Engagement in CPE arises as a result of individual, professional and organisational needs that include motivational factors such as, improving knowledge, personal satisfaction, the joy of learning, and increasing self-assurance. ▪ Education promoted nurses to become life long learners ▪ Many programmes use didactic learning methods ▪ There was difficulty in ascertaining if learning was transferred to practice	▪ No date restrictions were imposed ▪ CPE attracts considerable attention in nursing ▪ Research is restricted to evaluation of isolated CPE programmes that were not validated through replication ▪ Organisations should adopt a more participatory approach to address CPE in nursing ▪ Greater awareness is needed regarding what nurses need to learn ▪ Serious gaps in the number of empirical studies
Meyer <i>et al</i> (2007) Qualitative study - UK	▪ Positive learner satisfaction, increased confidence, assessment skills and inter-professional team working. ▪ Real examples of change provided e.g. positive treatment of patients, including reduced waiting times, and efficiency of service provision ▪ Managers observed higher morale and reduced absenteeism in nurse participants ▪ Reduction in doctor's workload ▪ Respondents reported that the education involved both academic and practice learning in order to facilitate implementation of new skills. ▪ Relevance of the training to role was an important factor, and determined the ease at which skills were learned. ▪ Medics were perceived by the nurse participants to both help and obstruct support from others ▪ Negative outcomes; financial constraints placed upon hospitals as a barrier to implementation of new learning ▪ Assessment of competencies in practice by mentors was also reported as a barrier to implementation.	▪ Results presented using a theoretical framework ▪ Used the literature to examine the gaps ▪ Findings provide relevant implications for educators and commissioners to collaborate to ensure the outcomes of training.
Gijbels <i>et al</i> (2010) Systematic review	• Dearth of evidence evaluating the outcomes of education programmes • Terms used to describe CPE used interchangeably, with varied meaning • There were limited direct organisational outcomes on service delivery and benefits to patients explored • Diversity in nursing and midwifery education systems across countries make interpretation difficult • Findings were consistent across settings • Evaluations have predominantly been undertaken using student perspective only.	• Theoretical framework used to evaluate the outcomes • Variances in terminology may lead to differences in outcomes whilst attempting to explore similar aims.

Author and Study Design	Findings	Evaluation
Lee (2011) Evaluation study - UK	▪ Learner satisfaction, increased confidence, assessment skills and inter-professional team working. ▪ Real examples of change provided e.g. positive treatment of patients, including reduced waiting times, and efficiency of service provision ▪ A lack of engagement with practice peers ▪ A lack of strategic support and ignorance of how to access support hindered change ▪ Learning needs were often identified through appraisals or personal development planning, however little systematic follow up, review and support following learning. ▪ The motivation of the individual undertaking the learning was perceived as the most effective factor influencing change with policy drivers and national targets secondary.	▪ Researchers underestimated the time to contact participants ▪ Poor uptake on survey ▪ Variables not controlled e.g. learner recall ▪ Examples of outcomes were provided ▪ Evaluation was sought at the outset but not revisited during or post CPE ▪ Expectations of the participants were not met.

Griscti and Jacano's (2006) literature review aimed to identify factors that facilitated and inhibited CPE in nursing and to identify ways to make CPE more effective. Forty articles met their inclusion criteria, and findings (Table 6) demonstrate behavioural and clinical outcomes arising from educational programmes. The review identified a dearth of empirical studies related to CPE issues, and advocated the need for further evaluation research to identify the outcomes of learning on healthcare delivery.

Gijbels *et al*'s (2010) systematic review used Barr *et al*'s (2000) analytical framework to analyse evaluation studies. Study findings identified that multiple and unqualified terms for CPE were used in the literature that produced uncertainty when evaluating the studies; half of the studies included used a quantitative design, with remaining studies using either mixed method or qualitative designs. Most studies evaluated a specific programme for a specific group of students, no studies analysed cost benefit analysis, and few studies used a conceptual framework to facilitate the evaluation (Gijbels *et al* 2010). A failure to evaluate outcomes, follow up or replicate studies was also apparent. These findings present a fragmented and inconsistent approach to the analysis of CPE.

An evaluation study by Meyer *et al* (2007) used Kirkpatrick's model together with a framework adapted to consider the return on investment in training. The aim of Meyer *et al*'s (2007) study was to understand 'subjective realities' of a situation, and to report obstacles and support mechanisms for learning transfer. To do this they did not aim to test preconceived hypotheses, rather to explore what was learned and how this learning was subsequently translated into practice (Meyer 2007). The results demonstrated that learning had taken place at levels indicating learner satisfaction, increased confidence, assessment skills and inter-professional team working. They provided real examples of change in relation to improved assessments, positive treatment of patients including reduced waiting times, and efficiency of service provision (Meyer *et al* 2007). Findings (Table 8) indicate that the relevance of the training to role was an important factor, and determined the ease with which skills were learned.

Lee's (2011) commissioned evaluation study aimed to explore how the learning from CPE changed critical care nursing delivery using a pluralistic approach to enhance methodological rigour (Biggs & Buchler 2007; Draper & Clark 2007). CPE participants, a convenience sample of managers and university module leaders were interviewed. Findings similar to those reported by Meyer *et al* (2007) suggest that professional peer attitudes and support, when harnessed effectively in the practice setting, strongly enhance positive change. Conversely a lack of engagement with practice peers, a lack of strategic support and ignorance of how to access support hinder change (Lee 2011; Tame 2011). The motivation of the individual undertaking the learning was perceived as the most effective factor influencing change, with policy drivers and national targets secondary (Lee 2011).

The findings from the studies of Meyer *et al* (2007) and Lee (2011) provide evidence of differences in practice and the complexity in organisations, illustrating that knowledge sharing between nurses and their peers often fails to occur. The perspective of managers, indicating that they are influenced by competing priorities, is indicative of further exploration.

Overall evaluation of the literature demonstrates a paucity of evidence evaluating the outcomes of nursing/advanced practice programmes on practice from the perspectives of relevant stakeholders. The majority of studies reviewed comprised small, single centre studies evaluating one programme or module (Crotty & Bignell 1988; Hughes 1990; Hogston 1995; Barriball & While 1996; Jordan 1998; Jordan *et al* 1999; Endacott *et al* 2000; Brown 2000; Smith & Topping 2001; Armstrong & Adam 2002; Hardwick & Jordan 2002; Henderson 2002; Pelletier *et al* 2003; Spencer 2006; Gould *et al* 2006). The design of the aforementioned studies mean they would need to be replicated elsewhere to validate the data and eliminate selection bias because they failed to identify multiple confounding variables affecting the measurement of outcomes, particularly in relation to quality of the learning. Generally there was a lack of congruency in terminology and language and differing definitions of competency within the studies.

In many studies the tutors were the researchers, possibly biasing results through the potential coercion of participants generated by the power differential between them. In addition, reduced sensitivity to features within the data may have occurred because of the researcher's inherent existing knowledge (Polit & Beck 2006). Gerrish & Lacey (2010) argue however that conducting research within one's own culture is positive, in that the researchers have intimate knowledge of the participants enabling a deeper understanding of the phenomenon. The generalisability of these studies nationally is limited, because findings presented arise from inadequately designed methodologies and small participant sample sizes. The inadequacy of this evidence base is concerning because it illustrates failure to substantiate continued resourcing of CPE. The reality of the studies is that they only represent evidence comparable with current HEI post programme evaluations undertaken for annual monitoring and review process.

In summary, the studies (Crotty & Bignell 1988; Hughes 1990; Hogston 1995; Barriball & While 1996; Jordan 1998; Jordan *et al* 1999; Endacott *et al* 2000; Brown 2000; Smith &

Topping 2001; Armstrong & Adam 2002; Hardwick & Jordan 2002; Henderson 2002; Pelletier *et al* 2003; Spencer 2006; Gould *et al* 2006) are useful in that benefits and barriers to CPE were identified that require further investigation, they provide an insight into the differences in the uptake of CPE, and they indicate improved patient care. With the exception of the Meyer *et al* (2007) and Lee (2011) studies, there is an over-reliance on participant self reported outcomes rather than tangible evidence in the form of discernable, measurable outcomes.

2.12 International Studies

Advanced practice has developed internationally simultaneously in response to policy drivers in meeting healthcare needs for the respective populations. The use of international literature to support and enhance advanced practice development by educators and advanced practitioners is normal practice within the field, providing the findings can be situated in the context under consideration. Therefore international studies were included when evaluating the outcomes of CPE in practice. A summary of the studies is presented in Table 9 (Page 66).

Table 9 Summary of Studies: International Study

Author and Study Design	Findings	Evaluation
Curran <i>et al</i> (2007) Mixed method study - Canada	- Students were satisfied with competencies learned on return to clinical practice - Course was positively evaluated.	- Inter-professional CPE is effective in enhancing understanding of roles for different professional groups, and fosters respect and positive attitudes - There was no evaluation of practice outcomes - Response rates were high across four provinces - A framework for evaluation was used to evaluate data.
Pelletier <i>et al</i> (2003) Longitudinal study - Australia	- Identification of categories that illustrate outcomes both negatively & positively, with only decision-making reported across both - Researchers acknowledge the difficulty in quantifying outcomes - Increased autonomy, increased motivation and patient communication, and improved quality assurance in students.	- Predetermined attributes used may not be comprehensive or applicable to all - No information reported re regarding loss to study - Single locality study relating to one programme of study.

Pelletier *et al*'s (2003) ten-year longitudinal study conducted in Australia, aimed to evaluate nurses' perceptions of the outcomes of their postgraduate studies on patient care activities. Nurse practitioner education programmes were included within the evaluation, although the level and details of the programme are not provided in the paper. Findings from five cohorts were reported two years after completion of the programme (Table 9) and concur with earlier studies (Crotty & Bignell 1988; Hughes 1990; Hogston 1995; Barriball & While 1996; Jordan 1998; Jordan *et al* 1999; Endacott *et al* 2000; Brown 2000; Smith & Topping 2001; Armstrong & Adam 2002; Hardwick & Jordan 2002; Henderson 2002; Spencer 2006; Gould *et al* 2006). Curran *et al*'s (2007) evaluation study in Canada used a mixed methodology to evaluate CPE in primary healthcare using Barr *et al*'s (2000) outcomes framework. Findings support those of previous studies and include increased knowledge and improved user and inter-professional communications (Carpenter *et al* 2006; Meyer *et al* 2007).

From the international literature it is suggested that, while the intentions were to measure the outcomes of education on the individual personally or professionally, there was difficulty in

quantifying those directly related to patient care. A reluctance or inability to recognise the indirect effects for individuals from the learning prevent this because participants may be consciously unaware of all aspects of their learning or be prevented from subsequently using it (Pelletier *et al* 2003).

Evidence evaluating advanced practice and nursing educational programmes on practice is limited, specifically a lack of comparative studies to provide evidence of similarities and differences. Current healthcare and workforce policy advocates inter-professional working and workforce transformation (DoH 2010a; 2012a; NHS England 2014). Specifically, workforce transformation proposals assert the use of advanced practitioners working alongside and in place of medics to address shortages (DoH 2010a; 2012a; NHS England 2014). A decision to examine the outcomes of inter-professional education was subsequently made in order to understand how other professional disciplines whose learning could be considered congruent with advanced practitioners, was applied in practice. In so doing, it was anticipated that an appreciation of similarities and differences could be identified and, simultaneously, a more coherent and comprehensive body of knowledge be presented.

2.13 The Outcomes of Inter-Professional Education in Practice

A series of systematic reviews by Barr *et al* (1999; 2000) and Reeves *et al* (2009; 2010), punctuated by papers by Oandasan & Reeves (2005), evaluated inter-professional education. Between Barr *et al*'s (1999; 2005) reviews, six studies were identified. The studies compared learning from inter-professional education with control groups that had received no education. Table 10 summarises the findings from these studies. The review indicates a lack of rigorous evidence of the effects of CPE on practice, and suggests further evaluation using theoretical frameworks to enhance credibility and rigour. The clinical contexts, educational level, and multiple variables of the studies reviewed, make it difficult to

generalise or draw conclusions of effectiveness of inter-professional education to professionals undertaking advanced level education.

Table 10 Summary of Studies: Inter-professional Studies

Author and Study Design	Findings	Evaluation
Gerrish <i>et al</i> (2000) Qualitative study - England	- Seven themes identified when exploring masters level performance: Features defining masters level practice; criteria to judge performance; location of skills development; contribution of other disciplines; characteristics of students undertaking the programmes; critical stance adopted. - Educators were inhibited from introducing new material into programmes because it was argued that practice should be secured by building on known foundations.	- Students reported they were questioned on concepts they were unfamiliar with - The study was reported as a pilot with no identification of how the outcomes would be used - Small sample of nurse educators - Used multiple sites.
Sharples <i>et al</i> (2003) Evaluation study - UK	- Outcomes relating to skills development were short term - Students reported the need for additional support - of change to managers was reported as limited on follow up - Managers were satisfied with improved skills.	- Design used attempted to control variables - Participants were only matched according to job responsibilities and gender and not experience or others - Single centre using one course - Control group were more experienced than intervention group - Staff and managers reported data collection issues.
Carpenter <i>et al</i> (2004) Two phase descriptive study - Canada	- Respondents judged course as valuable in enhancing their ability to engage in inter-disciplinary practice - Learners placed value on the learning environment.	- All healthcare disciplines were represented, and participants were considered as similar - Poor response rate to questionnaire; no information was provided for non respondents - Questionnaire failed to prompt responses relating to determining the relationship between the course and application to practice - The analysis was retrospective.
Carpenter <i>et al</i> (2006) Longitudinal study – England	- Some students found the programme stressful - The programme can be used effectively to help students learn new knowledge and skills and to implement learning into practice - Modest benefits to service users identified - Positive satisfaction from students particularly regarding inter-professional learning and partnership with service users - The mean level of stress increased	- Comprehensive evaluation of a mental health programme - Researchers were independent, and data was gathered over 5 years tracking 3 cohorts through two years of study - Validated instruments were used - Programme had a high attrition rate - No independent evaluation of students acquisition of skills - A theoretical framework was used to evaluate outcomes using students self

Author and Study Design	Findings	Evaluation
Carpenter <i>et al</i> (2006) Longitudinal study – England (Cont.)	- Attrition within the study was one quarter of participants - Increased knowledge and skills, and increased role conflict reported by participants were statistically significant.	- report - Participants were only mental health practitioners.
Reeves (2010) Systematic review	- There is a lack of rigorous evidence relating to the effects of CPE on staff in the inter-professional practice area - Only 4 studies used a longitudinal design - Quantitative designs were used more frequently.	- A theoretical framework for evaluation was used - Process outcomes were not reported - Research design details were not always reported and this led to difficulty in assessing the quality of the research - Publication bias limits the reporting of results as negative effects are preferred - Some evidence is over 15 years old and is dated - More evidence is required.

The evaluation study by Sharples *et al* (2003) used mixed methods to assess the impact of training for staff working in social services, and successfully identified areas of change and potential change in practice. Short-term outcomes related to the skills gained by participants, and reported by managers, demonstrated statistical significance in relation to participants recognising personal stress, improved decision-making, and recognising and solving problems. These were similar findings to those reported in nursing studies by Hogston (1995), Jordan *et al* (1999), Hardwick & Jordan (2002), and Traynor *et al* (2010). Participant findings regarding difficulties in accessing CPE included workload, financial support, frequent policy and legislative changes, and lack of supervision and concur with the findings of Meyer *et al* (2007) and Lee (2011).

Carpenter *et al*'s (2006) longitudinal evaluation of a two-year postgraduate mental health programme in England reported outcomes in relation to the Barr *et al* (2000) framework. The study used a mixed methodology to track three successive cohorts of students and an evaluation framework to report outcomes. Findings demonstrate that learning can be effectively transferred into practice although this may result in additional stress for the

student. Gijbels *et al* (2010) promoted the study design used by Carpenter *et al* (2006) as an exemplar of practice, because the use of an outcomes framework enabled a comprehensive and coherent picture of the analysis of the education based on the evidence collated.

The positive use of frameworks to evaluate outcomes is evident within some of the inter-professional literature (Carpenter *et al* 2006; Curran *et al* 2007). Waddell & Summers (1993) and Gijbels *et al* (2010) suggest that nursing CPE is not based on valid and reliable measures of success and express the need to increase this to provide improved accuracy when measuring responses. Francke *et al* (1995) and Attree (2006) argue that a disadvantage of most evaluation studies is the absence of a conceptual framework that impedes the interpretation of the outcomes of programmes on behaviour and prevents an explanation of the relationship between intervention and outcomes. Therefore, in order to evaluate the effectiveness and outcomes of education, evaluators require valid and reliable indicators of interventions/practices, processes and outcomes, which in healthcare education are translated into reliable assessments of knowledge acquisition and its application to practice (Attree 2006).

Results of this review support the need to use a theoretical framework in this study, however a challenge to the evaluation of education programmes is the selection of an appropriate and valid tool to measure the outcomes. A literature search was used to identify and evaluate previously used theoretical frameworks/tools, and the results are now presented.

2.14 Theoretical Frameworks used in the Evaluation of Continuing Professional Education

A small number of studies and reviews were identified that considered the use of theoretical frameworks and CPE, and are summarised in Table 11. The scope of the work, while

lacking depth and breadth, provided much needed insight, and a critique of the tools from which an informed decision could be made to select a suitable framework for use in this research.

Table 11 Summary of Studies: Theoretical Frameworks used in the Evaluation of CPE

Author and Study Design	Findings	Evaluation
Waddell & Summers (1993) Quantitative - USA	The goal of evaluation is to improve rather than prove accurate and consistent assessment of participant satisfaction in order to provide consistent information to improve CPE.	- Dated study - The study only evaluates student satisfaction.
Fleck & Fyffe (1997) Quantitative - Scotland	- Increased knowledge and willingness to change practice - The development of a suitable tool for evaluation was time consuming.	- Used only self-reported data from participants who were perceived to be poor at identifying their learning needs - A single centre, small sample study.
Barr <i>et al</i> (2000) Systematic review	- Data collection tools are mainly questionnaires - Most studies do not use a framework - Evaluations were mainly undertaken by a trainer or member of staff only - There is scope for comparative studies that apply the same methodologies - Evaluations were seen to be a political act in monitoring learner achievements for awards - The majority of studies reported related to primary care.	- Developed an existing framework – Kirkpatrick's (1967) - Transferability is limited because only one evaluation related to a programme, the remainder were used to evaluate study days or training programmes - Implications to improve and extend methodology, to improve presentation and putting the review into the wider context.
McLean & Moss (2003) Qualitative study - Canada	- Kirkpatrick's framework proved useful for evaluating the data - The results led to significant changes to a leadership programme over 18 months - Changes in knowledge, attitude and skills were reported.	- Small study - Levels three and four of the framework could have been reported more robustly; researchers reported they found these levels challenging to evaluate
Shaneyfelt <i>et al</i> (2006) Systematic review	- Three levels of instruments were identified - Most behaviour instruments measured performance of evidence based practice (EBP); newer instruments measured patient outcomes - Instruments with reasonable validity are available for evaluating some domains of EBP; some further testing is required.	- Search was limited to English language, and therefore may not have identified all relevant studies - Specific inclusion criteria were met, and may have led to exclusion of relevant tools that should have been in order to meet the research aim.

Author and Study Design	Findings	Evaluation
Yardley & Dornan (2012) Mixed methods study - UK	• 14 papers were identified in the review • Kirkpatrick's tools make implicit assumptions that make it only suitable in simple instructional designs; the tool has hierarchical application of the levels and adds little value as a critical appraisal tool; it leaves reviewers to make global judgements of the trustworthiness of the data • The art of synthesising evidence lies in making well considered choices rather than using one methodology • Both qualitative and quantitative methodologies need to be considered to fit the construct of the evidence base.	• A small number of studies were reviewed • A thorough analysis was undertaken to review the suitability of Kirkpatrick's tool for appraising interventions in medical education, albeit the authors had previously participated in 'Best evidence Medical Education' that presents a conflict of interest • No comparative analysis against other tools was undertaken.

Waddell & Sumners (1993) used learners' perceptions to determine the success of an education programme to develop the Georgia Nursing Association evaluation tool, which was subsequently pilot tested with nursing participants in order to validate it. Findings demonstrate that learner behaviour and outcomes on patient care need to be measured in order to evaluate true effectiveness, and concur with findings from later studies (Barr *et al* 2000; Sharples *et al* 2003; Carpenter *et al* 2006).

Fleck & Fyffe (1997) used goal attainment scaling in an attempt to evaluate behavioural change resulting from CPE. Collecting data at the beginning and end of the study, participants ($n = 58$) were interviewed. Although limited results overall were presented, the authors described how the use of the instrument was positive in demonstrating increased knowledge skills and attitudes of the participants.

In a later study, Barr *et al* (1999) utilised a four-stage hierarchy evaluation tool devised by Kirkpatrick (1967) to evaluate the effectiveness of diverse inter-professional education programmes. This offered a three-dimensional frame of reference for the evaluation of inter-professional education, namely, a classification of evaluative methodologies, the classification of educational outcomes, and a classification of inter-professional education.

The original framework was developed in the US and became a standard framework to evaluate training programmes in the 1960s and 1970s.

Kaufman *et al* (1995) and Barr *et al* (1999) argued that the framework was incomplete and inappropriate for CPE evaluations where unexpected outcomes arise. Barr *et al*'s (2000) subsequent study used a modified version of the original framework to compensate for these criticisms to classify methodologies used in inter-professional evaluations in health and social care studies. The modified Barr *et al* (2000) framework incorporated two revised categories that emphasised the need to measure change in multiple domains at the individual, organisation and patient level (Curran *et al* 2007). The added dimensions to this framework result from a separation of two of the levels, simplifying them by making each more mutually exclusive.

Barr *et al* (2000) suggest that evaluation increases in complexity from level one to four with reactions from students being the implicit outcome measure of the education programme, and the higher levels of 3 and 4 implying greater quality of the evidence (Mays & Pope 2000, 2005; Rolfe 2006). A comparative overview of the two frameworks is presented in Table 12.

Table 12 Comparison of the Kirkpatrick (1967) and Barr *et al* (2000) Frameworks for Evaluation.

Kirkpatrick (1967)	Barr <i>et al</i> (2000)
Level 1: Learners' reactions	Level 1: Learners' reactions
Level 2: Acquisition of knowledge, skills, and attitudes	Level 2a: Modification of attitudes/perceptions
	Level 2b: Acquisition of knowledge/skills
Level 3: Changes in behaviour	Level 3: Changes in behaviour
Level 4: Changes in organisational practice	Level 4a: Change in organisational behaviour
	Level 4b: Benefits to patients/clients

McLean *et al* (2003) used the modified Barr *et al* (2000) framework to evaluate outcomes of learning and participant satisfaction in a pilot leadership program to gain funding for a second programme. This study adds to the evaluation literature in two ways. Firstly, it reports evaluation practice prospectively, and secondly it provides an exploration of the Barr *et al* (2000) framework facilitating greater understanding of its application and potential applicability to evaluate CPE. McLean *et al* (2003) reported that researchers found evaluation against levels 3 and 4 challenging because of the difficulty in attributing measurable changes to the programme or intervention, and consequently often avoided it completely.

Shaneyfelt *et al*'s (2006) systematic review sought to identify instruments for evaluating evidence-based practice. Studies that met pre-set inclusion criteria were identified. Results indicated that the majority of instruments sought to measure student perceptions related to the acquisition of evidence based practice skills (57%), knowledge and behaviours (38%), and attitudes (26%). These results concur with earlier studies undertaken by Griscti & Jacano (2006) and Gijbels *et al* (2010). Conclusions of the review indicate that instruments measure different things, and consequently researchers should be guided by the purpose of the evaluation when selecting suitable instruments.

Clark *et al* (2008) developed a four-dimensional outcomes framework based on the findings from an 'Impact of Practice project'. The project included consultation with employers, patients/service users, post-qualifying students, expert advisory group members, and a structured literature review. While personal evidence provided by the authors supports its utility, it is yet to be evaluated in practice (Clark *et al* 2008), limiting its validity.

Yardley & Dornan (2012) in a mixed method study investigating medical evaluations using Kirkpatrick's framework, identified three primary research studies and fourteen literature reviews. Results indicated that the levels of the framework assume a hierarchy rather than

outcome measures, are inter-correlated, infer causal links between them, and concluded that its effectiveness was inconclusive (Yardley & Dornan 2012).

2.15 Summary and Conclusions

Advanced practice is a complex combination of knowledge and experience applied in a unique way in different situations by an individual. Developing congruency in the understanding of advanced practice within healthcare requires evidence to support it. Current literature attempts to conceptualise and classify the advanced practitioner role by outlining definitions, key role components, and standards for practice (RCN 2002; NMC 2005; NHS Scotland 2008; DoH 2010b). Mantzoukas & Watkinson (2007) contend that definitions are either too restrictive to allow understanding of the wider picture, or too broad, preventing associations with them. This review suggests that research is needed to explore the preparation for advanced practice roles, effectiveness of the roles and outcomes for practice.

From the studies reviewed it is apparent that learning affects change within the participant following CPE. The outcomes differ in the extent to which practice change is affected and may not automatically lead to alterations in knowledge, skills or attitudes. Many of the early studies used single-centres for sampling and self-devised un-validated tools, rather than a conceptual framework, that made interpretation of variables difficult (Francke *et al* 1995; Gijbels *et al* 2010). No relationship between content of programmes and the effect size of behavioural changes were demonstrated in the studies reviewed. Many studies also failed to fully assess the implementation and outcomes of a programme to establish whether, and to what extent, the outcomes could be solely attributed to the intervention. Many of the studies did not explain how the intervention caused the outcomes. The consequence of this is that the evidence base demonstrating the outcomes of CPE, and specifically the outcomes arising from advanced practice CPE is inconclusive and incomprehensive.

The identification of the effectiveness of the transfer of learning to practice is a key outcome of this study, and is supported by the literature relating to evaluation (Hardwick & Jordan 2002; Meyer *et al* 2007; Gibjels *et al* 2010; Lee 2010). Evaluation of the outcomes of CPE needs to assess multiple stakeholder perspectives, for example purchasers, patients and educators, if outcomes for the organisation and individual undertaking advanced practice preparation are to be identified. Additionally, evaluation of change is needed in relation to knowledge, skills, and professional practice. At a time of fiscal control and scrutiny, needs-led education and outcomes-driven healthcare means that money spent on education should lead to sound judgement and improved healthcare outcomes. What is evident is that currently policy decisions appear to be based on rhetoric in the absence of available robust evidence (Draper & Clark 2007). The dearth of evidence to demonstrate discernable benefits from education acquired from HEI programmes may influence organisations to deliver in-house training rather than commission education in this way in the future with the potential negative outcomes to the status of nursing as a profession. The need to strengthen the rationale for implementing advanced practitioners can be made by providing evidence that demonstrates quality related and/or cost benefits. Evidence of outcomes of advanced practice education programmes may incentivise providers to commission education and in turn support advanced practice implementation. The need to use a multi-dimensional framework appropriate to the study aims and objectives, and the research approach used in order to provide meaningful evidence, was consistently demonstrated. Following consideration of the evidence, Barr *et al*'s (2000) modified framework was selected for use in this study because it was perceived to best evaluate this study's aim and objectives.

CHAPTER 3 RESEARCH METHODS

This chapter sets out an overview of the research process and provides an account of what actually occurred during the study period (2011 – 2014). The context of the study is outlined together with a description of the processes used to derive the sample group and data collection tools. Analytical procedures are explained and illustrated, with examples from the findings of this research, to reveal the process as an authentic one. The ethical imperatives of the study are also presented, and the trustworthiness of the findings is described and established.

The aim of evaluation of advanced practice CPE involves a systematic assessment of the nature, worth or merit of a programme through the provision of robust evidence. The ambition of this study is to address this by using a design that represents a departure from prior research in the field through the use of Barr *et al's* (2000) theoretical framework to analyse and measure outcomes. The aim and objectives for the proposed study are based upon the perceived gap, strengths and limitations of the current evidence base. The study uses a robust methodology that incorporates valid and reliable indicators of education processes that are sensitive to evaluating programme learning outcomes, in order to measure outcomes effectively (Attree 2006).

Randomised Control Trials (RCTs) were considered and discounted. RCTs require large sample sizes organised equally between all factors to accurately measure infrequent outcomes (Bowling 2009), which would be difficult in this study. RCTs also exclude participant preferences, which this study sought to identify in collecting rich data to explain, in a local context, why and what behaviour and practice changes occur in real life. Observation was also considered because of its ability to understand how and why people behave as they do. This study aimed to explore and gain a wider understanding of outcomes for various stakeholders, including managers, advanced practitioners and

students. The intention to evaluate more than one advanced practice education programme led to a pragmatic decision being taken to discount this method because of the number of observations that would have been required to generate meaningful data across the various sites, and the limited availability of resources (time and being a lone researcher).

At the outset of the research no evidence was available regarding the specific outcomes of advanced practice programmes of study on practice. The review (Chapter 2) identified a need to capture evidence from more than one academic programme in order to better understand their composition, delivery, and outcomes in practice through evaluation. The aim of the study to explore the appropriateness and effectiveness of post-graduate advanced practice programmes made it evident that the methodology would need to be placed in a constructivist paradigm. A multiple case study design was selected to evaluate three geographically unrelated advanced practice programmes of study to prevent the distortion of results, control confounding variables (Bowling 2009) and to meet the study aim and objectives. The collection of data from multiple sources ensured that findings considered more than one perspective. Collection of data directly from patients was considered but discounted. The literature review identified that understanding of advanced practitioner roles and responsibilities is poor, and there was a belief that patients would be unable to clearly identify the relationship between specific advanced practice learning and delivery of care. Following completion of this study and improved evidence, there is an intention to undertake a secondary study post doctorate to investigate the direct impact on patients. The use of a theoretical framework to measure outcomes provided consistency across cases and facilitated cross comparison of their outcomes in practice.

3.1 Case Study Design

This study used a multiple case study design as a disciplined mode of inquiry in order to explore the outcomes of postgraduate advanced practice education programmes. A case

study design provides a flexible methodological approach that permits extensive, intensive and detailed investigation of a contemporary phenomenon within a real life context using multiple sources of evidence in order to answer the research question or aim (Hewitt-Taylor 2002; Luck *et al* 2006; Rosenberg & Yates 2007; Yin 2009). Sandelowski (2011) argues that there is considerable diversity in methodological texts that define case studies. Yin (2009) and Stark (1995) describe a number of types of case studies that Sandelowski (2011) argues are misleading. Sandelowski (2011) explains that the case study specifies neither any particular methodology nor number of cases, but rather a concentrated number of cases allowing intensive study of a selected empirical unit of study set by the researcher (Sandelowski 2011).

When used in education the case study can offer a means of recognising similarities and unique characterises of a programme by building explanations of causal links (Stake 1995; Bergen & While 2000; Yin 2009). Where theory is used to explain the links/outcomes the case study is considered more credible (Rosenberg *et al* 2007; Procter *et al* 2012). Yin (2009) argues that case studies cope with situations where there is a multiplicity of variables because of the use of multiple methods to collect and synthesise evidence from different perspectives. This was essential in this study because the transfer of learning to practice was perceived to be associated with various stakeholders.

In this study, by recording what was happening and by examining perceptions, an exploration of the outcomes of learning from postgraduate programmes of study in practice was interpreted. The ability of the case study to answer 'what' 'and 'how' questions also supported the use of this design, because it offered an explanation of events consistent with the research aim, and dealt with operational links traced over time rather than frequencies of incidence (Stake 1995; Luck *et al* 2006; Yin 2012).

This study's intention was to explore from different stakeholder perspectives what learning, and how learning from advanced practice CPE, is used in practice (Draper & Clark 2007). In order to do this, a meaningful definition of impact-on-practice outcome measures was devised, against which data could be benchmarked. Hardwick & Jordan (2002), Draper & Clark (2007) and Gibjels *et al* (2010) argue that evidence of cognitive gains and behavioural changes that demonstrate the outcomes of education programmes on practice should include student experience, defined patient outcomes and feedback from employers, commissioners, educators and patients, rather than retrospective self-reported perceptions alone. However, the literature review undertaken (Chapter two) demonstrated that robust evidence to support improved care as a consequence of learning is scarce. While many existing evaluation studies of CPE claim to demonstrate cognitive gains they fail to report any discernable differences of behavioural change, or indicate if transference of learning to practice has occurred (Ferguson 1994).

3.2 Study Aims and Objectives

The identification of the phenomena of interest to formulate the case was initially defined as a postgraduate advanced practice programme of education delivered by a specific HEI, and is subsequently referred to as the case unit. This was a new phenomenon at the onset of this study, with no previous studies initially identified in the literature review. Following the identification of the case, Stake (1995) and Yin (2012) suggest creating issue statements that direct attention to questions that can be measured within the scope of the study. Latterly these become the units of analysis that link the data to the study objectives developed. The generation of a research problem in the form of a study aim in order to frame the research ensued, and is provided below:

Aim of the study: To explore the perceptions of outcomes of learning from post-graduate advanced practice education programmes and their transfer to practice to inform advanced practice policy and curriculum design.

Stake (1995) and Yin (2012) support the notion of designating a unit smaller than the case for the purposes of analysis in order to build up the case picture. The individual case was therefore subdivided into two subunits, namely the perceptions and practice of individual students, and the perceptions of managers/advanced practitioners. Students accessing these programmes are typically nurses, but could be from other allied professional groups. A foundational action of this study was to situate the case in the context of national and local policy, and theoretical and professional evidence derived from the literature review, in order to develop learning outcomes. Figure 2 provides a pictorial representation of the case.

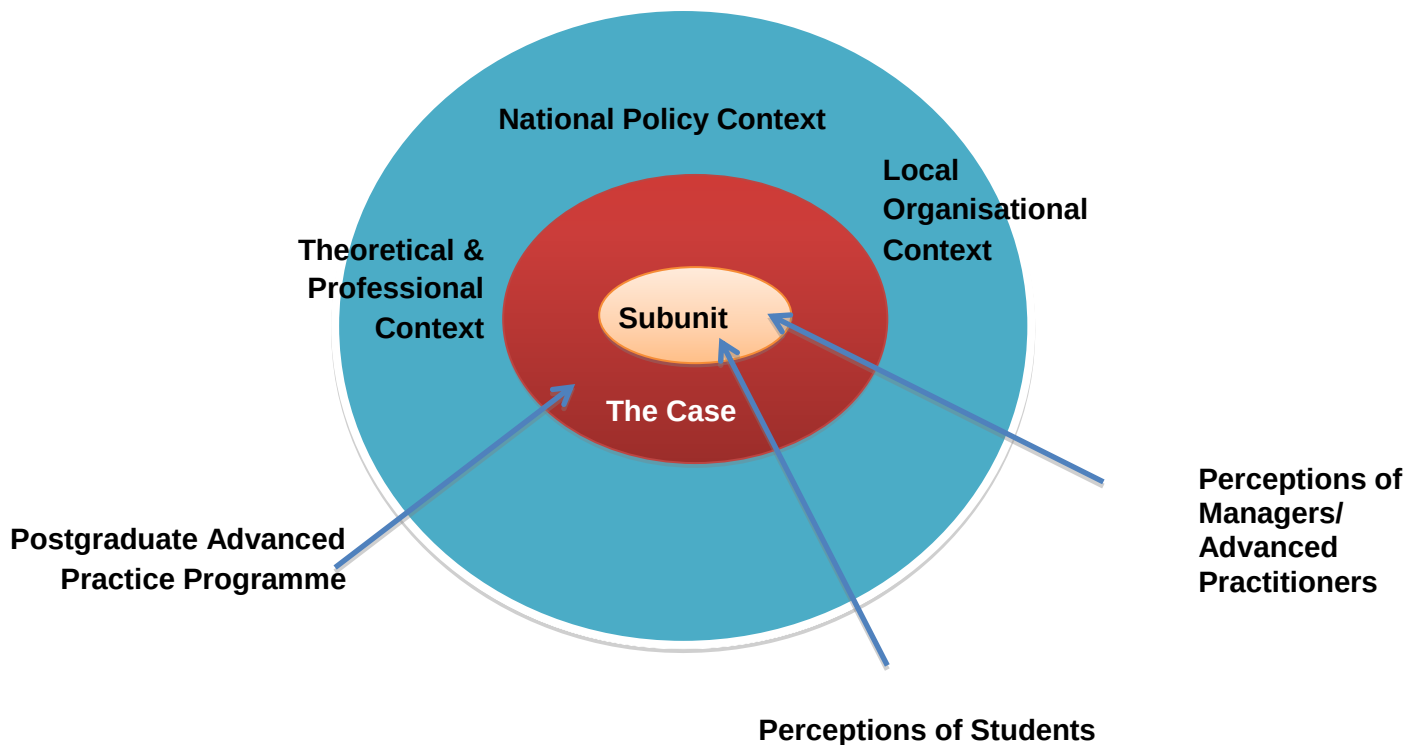


Figure 2 The Case and the Context

Commissioners of education currently demand evidence of the outcomes of learning in practice. In stark contrast the literature review demonstrated an inadequate evidence base of CPE evaluation studies, specifically related to advanced practice, and instead

emphasised the need to produce substantive evidence of the outcomes of CPE on practice. Evaluation of the literature identified themes perceived to require further exploration, for example learner satisfaction, attitude and behavioural changes, the acquisition of knowledge and skills, changes to the organisation, and benefits to patients, and was used to develop the study objectives set out below.

Specific study objectives

1. To determine the expectations of students undertaking post-graduate advanced practice education programmes.
2. To determine the expectations of managers/advanced practitioners supporting staff to undertake post-graduate advanced practice education programmes.
3. To establish if students/stakeholders perceive postgraduate advanced practice education programmes facilitate theory to practice knowledge transfer.
4. To identify factors that enable or inhibit the integration of learning to practice.
5. To examine similarities and differences between post-graduate advanced practice education programmes.
6. To explore managers/advanced practitioners perceptions of the utilisation and effectiveness of advanced practice roles in practice.

3.3 Selection of Cases

Multiple case designs have the advantage that the results are more compelling and trustworthy, although very resource intensive (Yin 2009). Advantages of using multiple cases include: the ability to derive wider inferences from multiple sources of data, the identification of variations or similarities between cases, the expansion of current literature in a meaningful way, and the ability to overcome limitations of single-centre studies identified within a literature review (Crotty & Bignell 1988; Hogston 1995; Hardwick & Jordan 2002).

With multiple case study designs the issue of how many cases to include is arguably based on replication logic, where an individual case is able to predict either similar or contrasting results, and, because each case is treated as a single entity, the number of cases required is dependent on the findings (Yin 2009). The first case selected used students from my own organisation, and was driven by the initial stimulus for the proposed study and the need to demonstrate outcomes of learning from CPE to locality education commissioners. Bias associated with the researcher knowing the participants (Gerrish & Lacey 2010; Cohen *et al* 2011; Ritchie & Lewis 2012) and the potential loss of autonomy in the participant due to over disclosure are well documented (McDonnell *et al* 2000). In order to address these issues, consistent dialogue with participants throughout the study regarding consent was maintained; the use of anonymous marking within the HEI reduced the potential recognition of student participants when marking assessments, and consequently reduced the potential for coercion, and students in year two and three of their programmes had completed all of their assessments at the time of data collection, removing any potential researcher influence. The willingness of students to volunteer as participants together with the content of the data collected also demonstrated objectivity and unbiased responses.

Within the UK there are over fifty postgraduate advanced practice programmes delivered by HEIs, forty of whom are members of the Association of Advanced Nursing Practice Educators (AANPE)(AANPE 2014), from which the remaining cases were selected. Following a request for volunteers, five responses were received. The use of purposive sampling, promoted in case study designs, facilitated the selection of two additional cases that were characteristically dissimilar to the first case and each other, aiding generalisation (Stake 1995; Luck *et al* 2006; Yin 2009; Silverman 2011). The sampling criteria applied were, that the case

- delivered a version of postgraduate advanced practice education
- represented a different geographical location in England (Scotland and Wales were excluded because they already have a framework for advanced practice in place)

- represented a different sized organisation
- was not an RCN accredited programme (the first case was).

Following discussions with Academic Heads of Departments at these two case sites, a formal letter of approach was made in order to gain consent from the respective organisations, and accepted. The programme teams were subsequently visited and the aims and objectives of the study, together with associated documentation were presented to generate understanding and gain commitment. Following these meetings a pragmatic stance was taken that three cases would be sufficient to meet the sampling criteria and to ensure that workload and available resources were manageable. The cases in this study are referred to as Case A Case B, and Case C respectively.

To overcome documented issues of case studies lacking precision and to maintain rigour and methodological integrity of the study (Meyrick 2006; Rosenberg & Yates 2007), a schematic representation of the research design was developed providing clear procedural steps, and is presented in Figure 3 (Page 85).

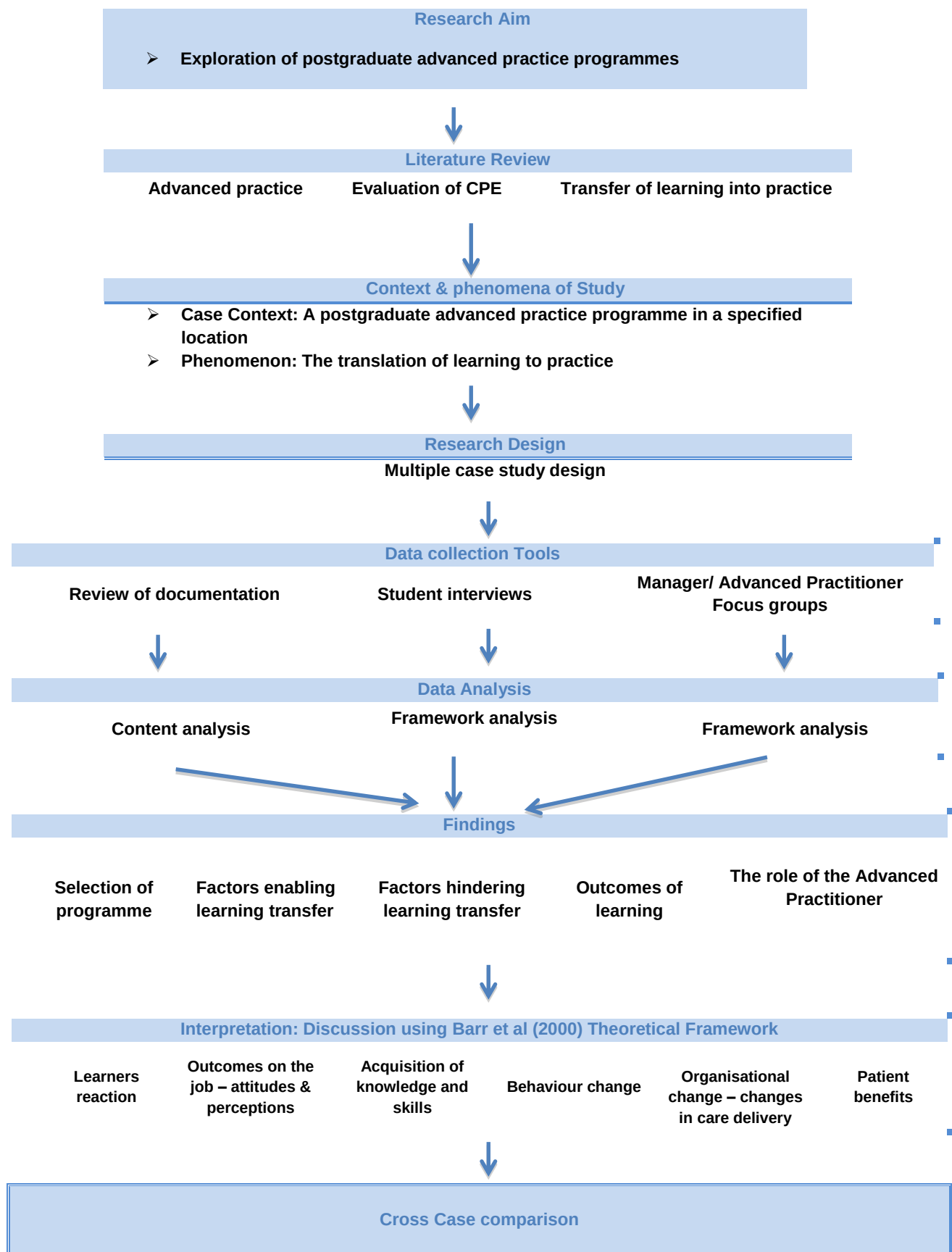


Figure 3 Research Design Overview (Adapted from Rosenberg & Yates 2007)

3.4 Case Study Profiles

All three HEIs had associations with respective healthcare providers within their wider geographical areas and encompassed inner city, suburban and rural locations that offer a range of practice settings. The healthcare providers that purchase advanced practice programmes from the cases include, Health Science Centres, University Hospital Teaching Trusts, Foundation Trusts and Primary Care Trusts.

3.4.1 Case A

Case A is an advanced practice programme delivered at an HEI in outer London. The HEI was first established as a college of higher education and attained university status in the 2000s. Of the three HEI's in the study it has the smallest number of enrolled undergraduate and postgraduate students. A comparison of the number of enrolled students for each HEI is presented in Table 11. The HEI has a faculty providing education for health and social care professionals with nursing being one of the largest groups. The faculty's predominant market is for pre-qualifying nursing students. It has delivered advanced practice programmes since 2002. Manager/ advanced practitioner participants were drawn from three different Trusts within the geographical area.

Table 13 Student Enrolments 2006 - 2007.

Case	Total Number of Enrolled Students	Number of Enrolled Undergraduate Students	Number of Enrolled Postgraduate Students
Case A*	Approximately 9,000	Approximately 8,000	Under 1000
Case B*	Approximately 20,000	Approximately 16,000	Approximately 4000
Case C*	Approximately 24,000	Approximately 20,000	Approximately 3000

* Data rounded up to assist anonymisation

(Higher Education Statistics Agency 2008)

3.4.2 Case B

Case B is an advanced practice programme delivered at an HEI situated in a Metropolitan Borough in the North West of England. The HEI was first established in the nineteenth century and gained university status in the 1960s. It has a college providing education for health and social care professionals, and is one of the largest providers of healthcare education in the area. HEIs and Trusts in this location worked in partnership with a former Strategic Health Authority to develop a concordant agreement for the preparation of Advanced Practitioners. The agreement means that Trusts bid for funding for individual clinical areas prior to appointing trainee advanced practitioners into a post and securing education at one of two preferred provider HEIs.

The sample for the focus group participants was drawn from a large acute care Trust and a private research facility within the area. The aim of this Trust's senior nursing management is to have at least one advanced practitioner in each clinical area (more if clinical effectiveness can be demonstrated by the role) and is working towards achieving this.

3.4.3 Case C

Case C is an advanced practice programme delivered at an HEI situated in Central England. Of the three cases, it has the largest overall number of students enrolled on programmes, although fewer postgraduate students than Case B. The HEI delivering the programme was established in the nineteenth century and gained university status in the 1990s. It has a faculty providing education for health and social care professionals with nursing being one of the groups. Manager/advanced practitioner participants were drawn from a speciality Trust and a Community Trust that use the HEI for advanced practice education as a preferred provider.

3.5 Data Collection - Students

The use of interviews and focus groups in this study allowed depth of exploration of the issues and, by situating these contextually, allowed insights to be reported and ‘related’ or ‘transferred’ to different settings (Ellis & Nolan 2004). Denzin & Lincoln (2006), Ritchie & Lewis (2012) and Yin (2012) suggest that the use of multiple data sources creates a rich and deep data pool that enhances the understanding of the phenomenon being investigated. In respect of this, three major data collection tools were utilised in this study, analysis of programme documentation, in-depth semi structured student interviews, and focus groups with Trust managers and advanced practitioners. Contextual field notes written following interviews were used to supplement this data. Data collection and analysis occurred simultaneously as an iterative process to enable the linkage of field data to the theory, and explicate themes to facilitate modification of the question guides when necessary. An exploration of the decision-making processes for each method of data collection used in this study is now presented.

3.5.1 Data Collection - Documentation

Yin (2009) and Silverman (2011) suggest that documentary evidence provides contextual details for case studies, corroborates information from other sources, and provides opportunities to generate new questions about communications and networking within selected cases. Programme documentation was requested, and provided freely upon confirmation of confidentiality from the programme leaders, for each case used in the study. Documents were ordered chronologically and by type, and were read, reread and annotated to gain an understanding of the cases under investigation. Analysed documents included programme specifications, module descriptors, and associated information provided to students prior to and during induction to the programme (e.g. mode of delivery, duration of the programme, content of the programme, teaching, learning and assessment strategies, and details pertaining to practice). Documents were examined independently and

subsequently cross-compared to identify similarities and differences, and to inform subsequent analysis and discussions. Results are presented in Table 30 (Page 236).

3.5.2 Data Collection – Student Interviews

In-depth interviews were used to collect data from students and to explore their experiences of learning in relation to study objectives. Interviews enabled the researcher to view opinions and thoughts and gain personal insights directly from participants whose responses were contextualised through the addition of local factors that influenced them (Luck *et al* 2006). Interviews also provided participants the opportunity to present their own personal or independent account of the case without fear of conforming to, or coercion from, the group (Silverman 2011). To meet the objectives of this study, the interview was treated as a contextual account of how individuals translated theory to practice, enabling the interview data to be considered valid (Green & Thorogood 2009).

This study gathered data from thirty-two student interviews between September 2012 and June 2013, and represented students from across all year groups in all cases. Data collected represented current learning experiences, negating the frequent criticism of memory recall and bias associated with retrospective studies used in previous outcome studies (Sandelowski 1996b). In this study student data were corroborated using other sources, for example programme documentation and Trust representatives via focus groups. This negated an identified weakness proffered by theorists that people say what they think rather than what they do, reducing bias and strengthening the trustworthiness of the data (Burns & Grove 2007).

3.5.3 Development of the Interview Schedule

Semi-structured interviews were selected for use in this study to ensure that the research objectives were met, and to afford the interviewee an opportunity to provide individual

experiences relating to key topics within their accounts (Green & Thorogood 2009). In-depth interviews require the active participation and judgement of the interviewer to be able to ask both open-ended facilitating questions and specific probing questions when necessary, without potentially biasing the interview resulting from over involvement or asking leading questions (Bury & Gabe 2004).

The interview guide needed to have sufficient scope and depth through the clarity of the questions to fulfil the criteria of qualitative research and generate meaningful rich data (Ritchie & Lewis 2012). Design of the questions importantly needed to ensure participant data represented their views and not those of others. Phrasing of questions was key, for example questions were open ended, and sought to ask how? Can you describe? what? Identified themes generated from the literature review were subsequently developed into questions, for example; factors influencing the selection of programmes of study, factors that facilitated or hindered the transfer of learning to practice, and exemplars of how students' practice had changed as a direct result of the learning.

To ensure that these topics were explored in sufficient depth to meet study objectives, specific probes were developed for each question, for example when questioning students regarding the most beneficial aspects of learning, the following probes were used:

- Critical thinking / problem solving?
- Acquisition of new skills, which are?
- Knowledge?

For first year students eight topics were identified and for second and third year students nine topic areas. Biographical questions were added to generate data regarding age, length of professional experience, gender and area of speciality, to determine the characteristics of the sample population. This information facilitated cross comparison of the case participants.

3.5.4 Student interview Guide - Expert Panel

Following development of the question guide an expert panel independently reviewed them prior to pilot testing. This added to the credibility of the research (Cohen *et al* 2011). The expert panel were asked to provide feedback regarding quality, readability and interpretation of the questions to ensure they were fit for purpose. The expert panel were five experienced researchers who had previously developed and used similar types of data collection tools.

3.5.5 Student Data Collection - Pilot Study

A pilot study was undertaken to test the interview schedule and facilitate the development of interviewing skills. Assessment of the interview guide was essential to ensure that it allowed participants to provide full and coherent accounts of both central and perceived related issues, and not constrain responses or thoughts. A sample of three past postgraduate advanced practice students who had completed their study within the past two years at Case A, and who had maintained contact post graduation, was used in the pilot study. The students were all employed full time within local Acute Trusts in different advanced practice type roles, were nurses, two were female and one male, and they had a mean age of 41 years. The sample was based on accessibility. Interviews were arranged at mutually convenient times and lasted between twenty and sixty minutes. The interviews were digitally recorded, independently transcribed verbatim, and subsequently analysed to inform the development of the question guide.

The data from the three pilot interviews was sufficient to demonstrate that participants provided relevant and meaningful responses to the questions in sufficient depth. This inferred that the interview questions were understandable and appropriate. Following the interviews, participants were asked to identify ambiguous, misleading or confusing questions, and none were reported. This refutes arguments that suggest interview guides should be pre-tested by at least ten representatives from the population (Dixon-Woods *et al*

2005; Bowling 2009). The final interview guide used to collect data is presented in Appendix I. Richie & Lewis (2012) advocate that data from pilot studies do not have to be excluded from main study data when no radical changes are made to the interview guide, and therefore the pilot study findings were integrated into Case A findings.

The pilot work provided a developmental opportunity to practice interview technique that proved invaluable, particularly in reacting to unanticipated responses, and using the probes to generate greater depth in participant answers (Ritchie & Lewis 2012). The use of the question guides promoted the need to ask the questions in the same way to different respondents, in sequence using the same format, and in doing so helped to control reliability (Silverman 2011; Cohen *et al* 2011).

3.5.6 Student Sample and Sampling Strategy

Sampling criteria were developed to ensure the student sample was representative of the total population for each case and comparable between cases, facilitating reliability and generalisability of qualitative case study work (Silverman 2011). The approach taken focussed on recruiting a sufficient sample to allow adequate depth of exploration of the identified issues, rather than identifying a specific sample size, and was informed by the data yielded within the on-going interviews (Silverman 2011). The sampling criteria applied were:

- All students (total population) currently undertaking a postgraduate advanced practice education programme within each case were eligible for inclusion, providing they consented. The total population of students at the time of data collection was: Case A (n = 39), Case B (n = 40), and Case C (n = 46).
- Convenience sampling of the accessible sample population (Green & Thorogood 2009) to ease recruitment particularly in Cases B and C that were located at a distance geographically.

- Student participants were drawn from each stage of the programme (Year 1, Year 2 & Year 3 or within one year post qualification²).

Student representation across all years in all cases was achieved. The total sample for the cases were; Sixteen students in Case A, year one (n = 6), year two (n = 3), year three (n = 4) and post qualification (pilot students) (n = 3); Eight students in Case B, year one (n = 2), year two (n = 3), and post qualification (n = 3); and eight students in Case C, year one (n = 3), year two (n = 4), and year three (n = 1). Interviews were held in each case site for two or three students initially and themes analysed to identify similarities and differences from individual participants. Further recruitment was then undertaken until it became evident that replication of themes was occurring and saturation of data had been achieved, when data collection then ceased (Silverman 2009).

Direct access to the student population for Case A facilitated unproblematic sampling, with many students volunteering as participants. Theorists advocate minimising the distance between the researcher and the participants to reduce the risk of bias, and allow the respondents' true feelings and thoughts to be voiced (Bowling 2010; Cohen *et al* 2011). The participants in Case A were known to the researcher, and potentially created bias. This did not appear to occur; students in Case A over-volunteered for recruitment and, following comparative analysis of the three cases, findings demonstrated similarity. Participants from cases B and C were previously unknown to the researcher, minimising potential bias in this way.

In this instance purposive sampling was used to select a heterogeneous sample enabling variation in terms of differing characteristics e.g. age, gender, clinical role, for diversity.

² Post qualification refers to students who have completed a postgraduate advanced practice programme within the previous 12 months.

the remaining cases (Case B and C), programme leaders acted as an initial conduit for recruitment, once ethical approval had been obtained. Recruitment in these cases initially proved problematic, largely because of the reliance on conduits to recruit the participants, and this delayed the organisation of response times in communicating with volunteers to arrange interviews. Subsequent assistance from student participants to identify prospective students assisted this, and ensured representation from a sufficient number of student participants.

No exclusions to selection were made on the basis of age, sex, ethnicity or any other factor to ensure diversity within the sample group. It was difficult to anticipate the gender mix until the volunteers were known, however, representatives from both genders were included in all cases. Students not selected were informed by confidential email.

3.5.7 Negotiating Access to Student Participants for Main Data Collection

Negotiating access to recruit student participants, and the collection of data via interviews occurred simultaneously across the cases from September 2012 to June 2013. Initial ethics approval by the study sponsor, organisational consent and approval for the research from senior managers and Research and Development offices (R&D) in Trusts (Section 3.7), preceded initial meetings with the education teams in each case. The proposed strategy to recruit student volunteers to the study, together with the study aims and objectives, were presented, and a mechanism for future feedback agreed.

In Case A, students in all three year groups were directed to a recruitment poster (Appendix II) on the virtual learning environment (VLE), and information sheets (Appendix III) were circulated to them that provided more detailed information about the study. For example: more expansive details of their potential role in the research, details of what they would have to do, and contact details of how to obtain further information, confidentiality, and aims and

objectives of the study. Interested students subsequently expressed their interest via email, and were contacted following purposive sampling.

In Cases B and C, initial meetings were set up to meet the programme team in order to determine who would act as the conduit for recruiting the students. In Case B this was a Clinical Facilitator, and in Case C the Programme Leader. These two individuals subsequently introduced the research to their student groups and requested volunteers. They also distributed copies of the same poster and information sheets used in Case A in hard copy and by email to interested participants. Following a request from the programme leader, the students in Case C were visited in person to provide additional information. Reinforcement of their right to withdraw at any point was emphasised together with confirmation of the aims of the study, and its contribution to a Doctoral Thesis.

Following successful recruitment of a number of participants, interviews were organised in advance within the organisations where students attended. Interviews were held in small, pre-booked quiet rooms. At the commencement of the interview, study information was reiterated to participants to reinforce earlier information, and to ensure participants were fully informed of all aspects of the study. Students completed a consent form (Appendix IV), prior to data collection using a digital recorder.

The recordings were numbered for anonymity, downloaded and stored on a computer which was password protected. The recordings were erased following download from the recorder. The data were only accessible to the researcher, research supervisors, transcriber and the participant. The transcriber was an audio typist who regularly undertook work of this nature and who was aware and compliant with the Data Protection Act (ICO 1998). Transcripts will be retained for one-year post completion of the study in line with ethical approval. Signed consent forms, together with the transcripts were stored in a locked cupboard, which was only accessible to the researcher. Access by participants to their own transcript for

verification and comment, at their request, safeguarded their views and, ensured trustworthiness of data (Gerrish & Lacey 2010).

3.5.8 Data Analysis Process

Framework analysis was used to analyse student data. Framework analysis assists the classification and organisation of data according to key emergent themes, and concepts, subdivided by related topics as they evolve (Ritchie & Lewis 2012). Descriptive statistics were used to collate biographical data relating to ages of participants, length of experience, clinical speciality, and gender in order to draw conclusions about the nature of the student group who have accessed postgraduate advanced practice programmes.

3.5.9 Development of the Analytical Framework

Two separate analytical frameworks were developed, one for the student interviews and one for the focus groups, generated from data from the pilot interviews and actual focus groups respectively. The stages of the process used within the framework are set out in figure 3.

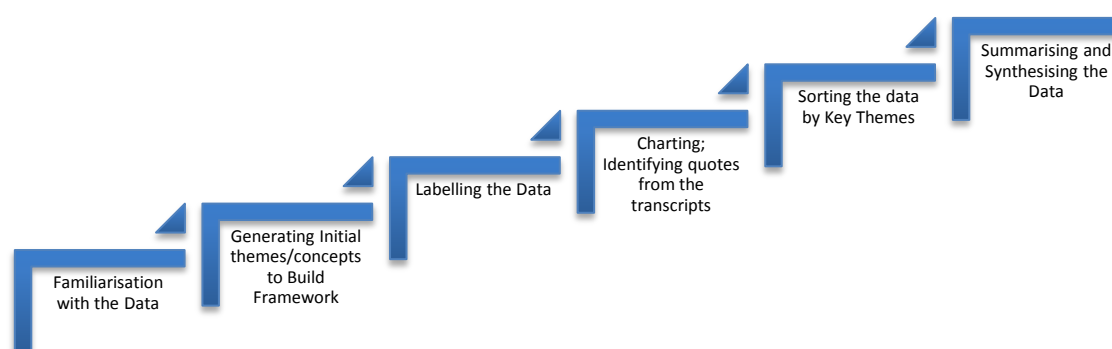


Figure 4 Analytical Framework used within this Research Study (Adapted from Ritchie & Lewis 2012)

It was important to be able to link clearly the analytical framework used within this study to the concepts under evaluation, namely, the students, the organisation, the patients and the HEI in order to ensure the framework was an appropriate and valid measurement tool from

which the aims and objectives of this study could be met. Brainstorming led to the construction of Figure 5 that provides an overview of the relationships between the concepts and the analytical framework used within this study.

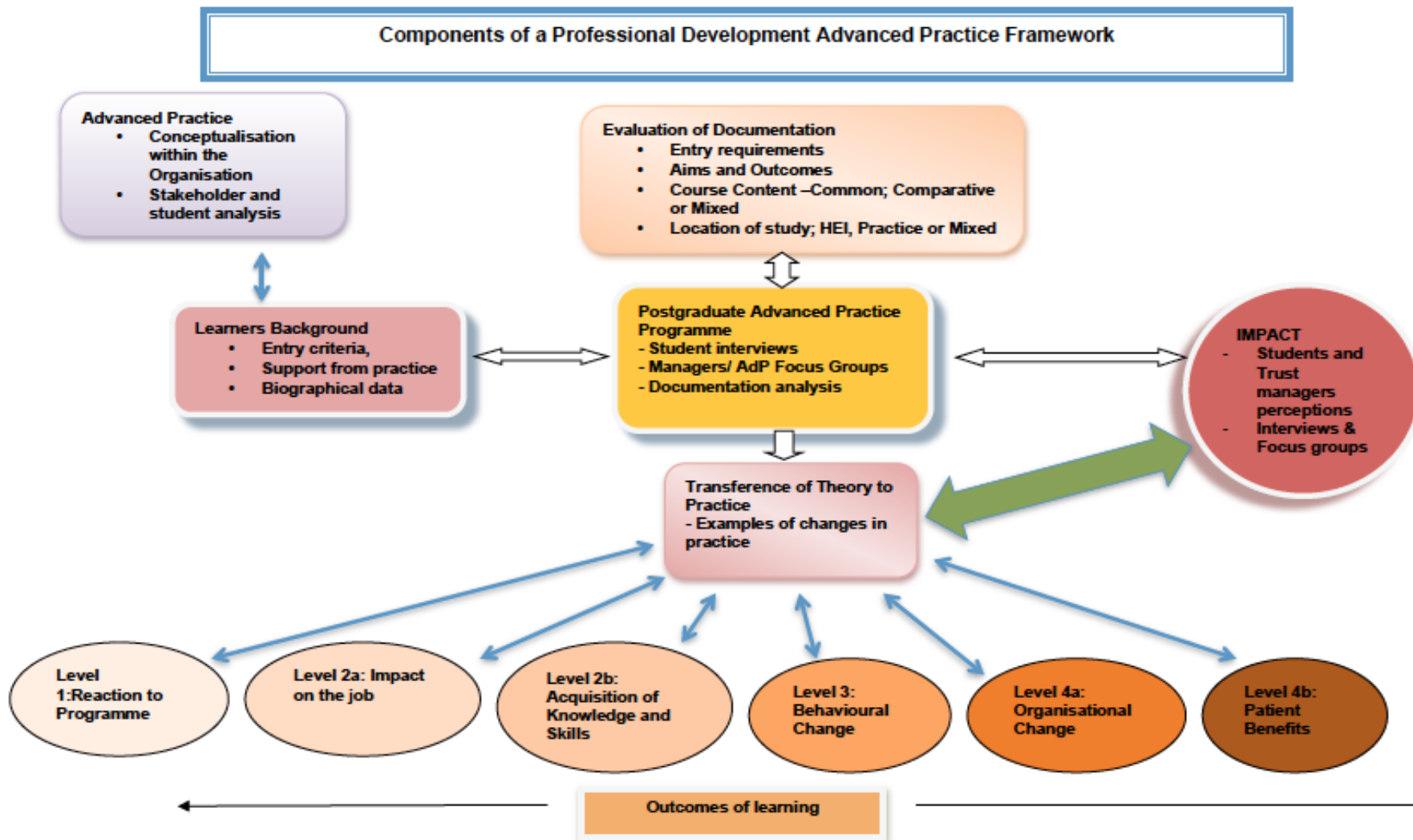


Figure 5 Theoretical Framework: Overview to Evaluate the Outcomes of Postgraduate Advanced practice Programmes

3.5.10 Data Analysis

A continuous and iterative process began immediately after completion of the student interviews and focus groups, with the digital recordings of the interviews and focus groups transcribed verbatim. Transcripts were initially individually analysed by reading, rereading and listening to the recordings to gain familiarity (Familiarisation, Figure 4). During this process reflection of first impressions and simple meanings were noted separately, and contextualised against field notes taken during data collection to aid interpretation (Stake 1995). The data were rich in detail yet unmanageable in this original form, and therefore it was essential to reduce it. Stake (1995) suggests asking the question 'What did that mean?' in order to assist the interpretation and classification of data, and this proved useful. Summaries and notes were made to aid the identification of key concepts/themes that were manually transferred into an Excel database (Labelling the data, Figure 4). Included within the spreadsheet were references to quotes that supported particular themes/concepts to ensure they were not lost when reducing the data (Charting Figure 4). Early stages of data analysis were revisited throughout the process to ensure consistency of approach and accurate interpretation. This approach is suitable for the analysis of qualitative research data with an applied focus that seeks to find patterns of meaning across data sets (Silverman 2011). It also provided a way of linking the data to the literature, study objectives and theoretical framework in order to explicate and interpret the findings (Denzin & Lincoln 2006; Silverman 2011).

The framework for analysis was developed from the emergent data arising from an evaluation of individual transcripts, and a priori textual themes initially aligned with topics from the question guide and theoretical framework. Examples of themes identified were behaviour, perceptions of learning, effects of learning, transference of learning and the contexts that frame these. External experts were used at this stage to independently analyse a selection of the transcripts in an attempt to verify themes increasing the trustworthiness of

the study (Ritchie & Lewis 2012). Emerging themes/concepts were discussed with the experts to compare the consistency and accuracy of identified themes, and to allow modifications to the framework to be made. This process proved beneficial and this is illustrated by the following example taken from the data: A student when questioned about anything they would change regarding the learning, replied '*advanced practice, You realise that its more than just your clinical practice*' S45. This was interpreted as the research and leadership modules providing other knowledge and skills, though this was not made explicit. The expert queried the interpretation because of the lack of explicit reference to the module, and prompted additional consideration of the transcript, to ensure accuracy of interpretation.

A second Excel spreadsheet was subsequently developed with subthemes/concepts organised against the transcript numbers (Summarising and synthesising data, Figure 3). This enabled the organisation and collation of data sets for students into programme year groups for each case, which were colour coded to aid identification. This facilitated comparison and incidence of each theme within, and subsequently across cases. This process proved positive in mapping data against the study objectives aiding evaluation, and interpretation of the results (Cohen *et al* 2011). This process was initially tested on pilot data and repeated for the actual study data. Additional (sub) themes were identified and added into the framework at this point. Table 14 (Page 101) presents an overview of the development of the themes/concepts within the framework.

Table 14 Key Stages of Framework Development.

Initial Framework Based on questions and First Read. Reread of Transcripts	Framework used for Indexing – Examples for each category	Subthemes used for Summarising and Mapping
Initial application	Self-Directed Self-Motivation Manager	Commitment
Choice of university	Link to Contract Course Content Previous Study	Choice of University
Rationale for study	Career Development Masters Qualification Increase Leadership knowledge Increase Clinical Knowledge Increase Autonomy	Expected Outcomes of the Learning
What do they want to achieve from the learning?	Assessing and Diagnostic Skills Leadership and Management Skills Questioning Use of Research	Application of Theory to Practice
Barriers to transferring their learning	Time Difficult to Transfer Learning Ignorance of the Role	Perceptions of Other Health Care Practitioners
Enablers to transfer learning	Medics Networks Organisational Support	Student Support
Effectiveness of learning	Increased Knowledge Application of Research to Practice More Vocal Others Belief in you	Behavioural Changes Attitudinal changes
What assisted transfer of learning?	Act on Learning University Staff Mentors – Medics, clinical facilitator Self	Student Support – Healthcare professionals Appropriateness of the learning
Benefits to Patients	Increased Confidence and autonomy Increased clinical Knowledge – Improved consultation skills Ability to Challenge others.	Improved quality of care Exemplars from practice
***Additional Categories for second and third year students added		
Changes they would have made to the postgraduate programme	More anatomy and Physiology Teaching	Course Development Minimal changes
How will their role change as a result of the learning?	Role will not change Improved Care Delivery Increased Corporate Level of understanding of the role Increased Maturity More Strategic Input	Role change 'Pseudo' roles

Where more than one linked theme occurred this was cross-indexed on the spreadsheet to ensure the data were not lost (Mays & Pope 2005), for example initial application and rationale for study both generated 'commitment' as a theme. Quotes that supported specific

themes were noted for use in presenting the findings. During this phase creative interpretation of the evidence was required to develop typologies that convey the range of views and responses under study (Bury & Gabe 2004). Table 15 provides an example of a key theme supported by examples from the transcripts.

Table 15 Interpretation of Data into Themes.

Key Theme/Concept	Transcript Examples – Case A
Self Motivation	<i>'I went to them and said I'd like to do the advanced nurse practitioner course because I felt that I was working at a much more advanced level at work than your normal practice nurse...they needed persuading in terms of they thought that I was doing the job, why did I need the qualification...so I am self-funding and doing it in my own time'</i> <i>'It was self-directed...I was looking to consolidate my learning. I've seen my nurse education as a journey'</i> <i>'It was my choice. I had no input really from people at work. It was purely my choice to do it and I'm self funding'</i>
Behavioural Changes – Increased Confidence	<i>'I think I am a much more confident practitioner. I am more reflective and more able – when I think back to when I, before, when I was doing my job and I hadn't done the course, I think my view was narrower, my critical thinking skills and ability to look at the wider, picture of the patient – so I think I broadened it, it made me take a bit of a back step and look, as I say, the wider issues, rather than trying to solve the problem immediately.'</i> <i>'More confident as a clinician and also just that bigger picture of just, you know, why are we doing it this way'</i>

This process aligns with Sandleowski's (1996a; 2011) belief that the analysis of each sampling unit is worthy of independent study within case studies. Sandleowski (1996a; 2011) argues that by making sense of this data, the researcher may then move to cross-case comparisons, generate hypotheses, and interpret data originating from the data sources while remaining faithful to individual cases.

3.6 Data Collection - Focus Groups

Focus groups were used to collect data from managers/advanced practitioners, the second subunit of the case. The literature review identified a lack of evidence regarding the organisational, and specifically the line managers', perspective in supporting and evaluating the outcomes of learning from CPE in relation to, for example, managers' experiences, perceptions and views of the selection processes and the outcomes of the programme of learning in practice.

Focus groups are considered suitable for exploring professional values and feelings from a cohesive group whose purpose is to develop an understanding of the perceptions, attitudes and beliefs of individuals within it (Armstrong & Adam 2002). Managers from a variety of professional disciplines within Trusts commonly discuss practice related issues at multi-disciplinary meetings, and are therefore familiar with this type of forum. Homogenous groups result in individuals feeling less inhibited when revealing views (Bury & Gabe 2004), and can stimulate other participants to reveal broader insights and individual revelations that may not occur from individual interviews (Bury & Gabe 2004). The need to capture multiple views in a timely way, together with these factors led to the decision to use focus groups.

A potential disadvantage of focus groups is the difficulty in determining how the effects of social desirability and conformity influence the expression of views (Seale 2004). This was overcome by asking whether anyone held a different view, and by challenging unanimity by presenting a different viewpoint, for example Case C, FG65: Managers wanted paediatric specific programmes and were changing their provider to attain this; however, earlier they had said that generic programmes were suitable as the Trust provided supplementary paediatric specific learning. The earlier view was reflected back to the focus group, challenging them to clarify what they really required from the learning.

3.6.1 Focus Group Interview Schedule

A semi-structured interview approach was used to ensure that the study objectives were met whilst also enabling the interviewees to elaborate on the individual experiences relating to key topics within their accounts (Green & Thorogood 2009). Themes identified within the literature review as gaps, and feedback from commissioners in terms of aspects of Key Performance Indicator information for end of year evaluations were noted, and developed into generic questions. The question guide was developed using the same process described for student interviews (section 3.5.3), where the addition of probes to questions ensured that all specific areas requiring examination were included. A form to collect biographical data was developed to generate data regarding age, length of professional experience, gender, and area of speciality to determine the characteristics of the sample population to facilitate cross comparison. This form was circulated to all participants prior to commencing the focus group interview.

3.6.2 Pilot Study

The question guides for the focus groups were pilot tested using an expert panel. Access to a similar sample group to the one to be used within the actual study was challenging, because of the use of three Trusts in the actual study limiting the accessibility to individuals with the experience required to provide a critical viewpoint. The expert panel therefore provided an alternative strategy (Denzin & Lincoln 2006) and consisted of twenty managers responsible for purchasing CPE, and managing staff education within their respective NHS Trusts that represent acute, mental health and community practice areas. The expert panel were briefed at a contracts meeting at Case A, where members agreed to take part. The question guides were sent by email to these Trust Education Leads, with the aim and objectives for the study. Feedback was requested for each question, in respect to the clarity, interpretation, and appropriateness of the question in generating meaningful data to meet

the aim and objectives of this study (Bowling 2009). Following two reminders, six respondents sent feedback.

Modifications following the feedback were made to questions 2 and 8 by the addition of a probe related to the organisational needs. A definition of 'facilitators' was also considered necessary, because one manager was unfamiliar with the term. It was subsequently adopted for use during the focus group interviews. The general consensus held was that the guides were comprehensive, straightforward and would generate relevant responses. Appendix V presents the finalised interview schedule for the focus groups following pilot testing.

3.6.3 Focus Groups - Sample and Sampling Strategy

Purposive sampling was used to select Trusts for each case that regularly sent employees on postgraduate education programmes. Purposive sampling demands consideration of the parameters of the population to select cases of interest (Silverman 2011). The sample needed to be meaningful and reflect characteristics that would address study objectives (Silverman 2011). Initial organisation of focus groups in Trusts was difficult due to a lack of knowledge and unfamiliarity of the organisational structure and gatekeeping activities of personnel working within them, which limited the recruitment of managers as participants. In response, names of key senior managers within each of these Trusts were accessed and the managers subsequently contacted, to brief them and request their assistance to act as conduits for recruitment. Three Trusts accepted for Case A, two in Case B and two in Case C.

Following ethical and research and development approval at each site, meetings were set up with the conduits to arrange the focus groups. Convenience sampling was then used to select and recruit Trust managers/Advanced Practitioners to join the focus groups, via the

conduits. Convenience sampling uses ease of access as the basis for selection (Ritchie & Lewis 2012).

In this study the conduits recruited participants who were managers/advanced practitioners with experience of working with staff who had attended a postgraduate advanced practice programme or who were an advanced practitioner. Dates were set for the focus group interviews by the conduits, and invitations to participate were emailed to identified individuals and the researcher to facilitate follow up introductions and provide study information via an information sheet (Appendix VI). The conduits arranged focus groups at times that would facilitate optimal attendance. Focus groups were held at individual Trust locations during November 2012 and June 2013.

3.6.4 Main Data Collection

The sample quota for the study consisted of eight focus groups held across the three cases; three in Case A, one in Case B, and four in Case C. Focus groups for each case consisted of four to ten managers/advanced practitioners, typical of the norm for focus groups (Polit & Beck 2006), except in Case B and Case C where on the day of scheduled FGs excessive workload led to frequent cancellations by managers. This resulted in proposed focus groups becoming individual interviews on some occasions. However, some participants were keen to contribute and provided data by email enabling more than one view to be captured in an area when attendance was impossible (Case B). All managers were consented, and the principles of the research reiterated prior to commencement of the focus group interview. Representation from across clinical areas was achieved, with a mix of genders in all cases. Each focus group lasted one to one and a half hours, which allowed sufficient discussion and responses to generate meaningful and rich data. They were held in quiet, private meeting rooms that facilitated digital recording verbatim.

Biographical data were collected from participants at the start of each focus group using the predesigned form. Field notes were also made during and immediately after the focus group interviews to note interpersonal communications that occurred during the interviews and to report contextual information. This proved very beneficial in identifying hidden cues and events likely to influence the answers. Field notes captured an example; *'in Case C a senior manager was present in one focus group and when the group were probed regarding support received from medics there was anxious laughter, and pauses indicating discomfort in how to answer the question in front of the manager. The senior manager sensing this responded frankly about past and current problems and in doing so prompted others to contribute'* (FG 65).

3.6.5 Analysis of Data

Data analysis was undertaken using the same framework analysis process used for the student sample (section 3.5.8). Documentary evidence together with the focus group interview data and field notes were used to build themes and subthemes during this process, and were collated both for individual focus groups and individual cases prior to cross comparison, where commonalities and differences were noted.

3.6.6 Interpretation and Integration of Case Study Data

Findings for each Case are reported in consecutive Chapters (4,5 and 6) using themes arising from the data. Quotes are used to support the analyses where appropriate. The Barr *et al* (2000) theoretical framework provided a comprehensive and coherent structure to explore the interface between postgraduate advanced practice programmes, the transference of theory to practice and the outcomes of the learning in practice by evaluating evidence against set criteria. This ensured the findings were judged with a level of confidence independently, and provided congruence between the multiple sites evaluated when cross-compared.

3.7 Ethical Considerations

Ethical consent from the study sponsor, HEIs, and Trusts' R&D offices to enable access to the sites for data collection was sought and approval gained prior to the commencement of data collection. The process of obtaining ethical consent was undertaken to protect the individuals and organisations in their privacy. This is a principle on which the research community depend (Bowling 2009). In total ten demanding and protracted ethical/R&D applications were made during April 2012 – May 2012 in addition to completing the Integrated Research application System application. Appendix VII provides confirmation of approvals.

The ethical approval applications also sought to recognise that participants are autonomous in their decision making. In fulfilling this intention, supportive informative literature and consent were provided to participants prior to data collection to ensure that they could make an informed decision to take part in the study. If the data collection techniques traversed areas which participants did not wish to recount, they were free to withdraw or abstain at any time. Recording interviews and identifying them by number only ensured confidentiality. Only the researcher knew the association of a specific number to an individual participant.

The open-ended nature of case research and data collection tools exploring participants' reasons, beliefs and actions means that the research can be probing in nature and potentially provoke anxiety and distress, which is difficult to predict. In designing the question guides, consideration was given to asking questions that would not cause unnecessary distress, for example a potentially problematic issue for students was the perception that information given regarding access and support on the programmes by the Trust, if negative, could have been interpreted as whistle blowing, this proved unfounded. Consideration to the conduct of the focus groups was also given, specifically in relation to potential conflicts that may have arisen between members in relation to contentious issues.

The risk was a small one because of the type of participants being included (professional individuals). However, a strategy to deal with this was prepared, though not used.

3.8 Trustworthiness

Trustworthiness is the term used to assign rigour to a qualitative research process, and is reportedly achieved by demonstrating transparency, credibility, confirmability, dependability and transferability (Lincoln & Guba 1985). Transparency is seen when there is a clear audit trail through the account that others could follow if the study was replicated (Bowling 2009). The processes outlined previously in this chapter allow replication and enabled the same conclusions from the data to be drawn by an independent researcher, providing confirmability.

Field notes and participant correspondence, in the form of received emails, were produced and retained and aided memory recall to facilitate production of an accurate account of the methodological process. It also allowed reflection of initial thoughts and contextual and personal evidence to be collated during data collection and, in so doing, added credibility to the research (Sandelowski 1986). The ability of the researcher to maintain objectivity and report findings accurately was anticipated as potentially conflicting with participant responses, due to personal values, beliefs and judgements developed over time in educating advanced practitioners (Ritchie & Lewis 2012). The incorporation of reflexive reporting (Chapters Seven and Eight) as a strategy within the discussion of the results to describe, contextualise, interpret and critique reactions to unanticipated participant data demonstrates an attempt to be open and honest in the analytical and evaluation process. Additionally, it demonstrates a further level of scrutiny of the analyses and an attempt to minimise the level of subjectivity that may have biased the findings.

The iterative data analysis process described in (Section 3.5.8) facilitated transparency and confirmability. Credibility within the study was met by considering the relationships of the students to the researcher, by using excerpts from the data to explain results, and by validating themes with supervisors (Beck 1993). Feedback received at associated meetings and conferences, for example whilst presenting at the Multi-professional Association Spinal Cord Injury Patients conference in 2012, and the RCN Research conference in April 2014, also enhanced credibility. The use of multiple referents or data sources to draw conclusions was additionally useful (Bowling 2009). Within the study, frequency of concurrence, building to an overall interpretation, was explored using different data sources from nine different organisations. This was used to offset potential weaknesses of using a single data collection tool and single case study design, criticised in earlier studies (Hughes 1990; Pelletier *et al* 1994; Jordan *et al* 1999; Hardacre & Keep 2003).

Comparison is said to drive and facilitate the identification of key themes and exceptions in order to build typologies within case study research (Lincoln & Guba 1985; Green & Thorogood 2009). This study responded to weaknesses identified in the literature review in a number of ways. For example, this case study used three methods of data collection to provide evidence, and accessed and gained views from different stakeholders ensuring comprehensiveness. Additionally, the contextual data from three different types of programmes were obtained and evaluated to differentiate between programme components. Data were analysed initially independently, and then compared and contrasted against earlier literature and a theoretical framework, from which emerging theory could be developed.

The intention of this study was to provide evidence that could be generalised to the wider education sector regarding the outcomes of postgraduate advanced practice preparation. The provision of background information in the study allows other practitioners to understand the context in which the study was conducted, and use this as a basis for comparison. The

use of three different cases across England in this study increases the likelihood that the results obtained, and the inferences drawn from the results, are more representative, and therefore more transferable (Sandelowski 1986; Green & Thorogood 2009). The comparison between dissimilar cases, the sample sizes, the use of students across all years, and the use of managers and advanced practitioners allowed adequate depth of exploration and analysis from which a wider picture that is representative of the total population could be built.

3.9 Conclusion

This chapter has presented an overview of the research methods utilised to operationalise the research aim and achieve the study objectives. The process of gaining ethical approval and recruitment of participants proved particularly difficult and complex at times, yet was worthwhile in delivering a comprehensive study. Figure 4 has provided an overview of the framework used within this study, and demonstrates the links to the concepts within the evaluation. It is hoped that a concise and coherent account has been presented that enables understanding of the results presented in the next four chapters.

CHAPTER 4 FINDINGS - CASE A

4.1 Introduction

This chapter presents the findings related to Case A and comprises analysis of documentary evidence, student interviews and Focus Groups with Trust managers and advanced practitioners. Details of the organisation can be found in section 3.4.1. This chapter presents in sections findings that represent an exploration and evaluation of participants' perceptions of the outcomes of the advanced practice programme of study in practice.

In presenting the results of the study, quotations supporting the analysis are used to illustrate points throughout the reporting process, in order to provide a coherent account consistent with the constructivist paradigm. Verbatim text is presented in italic script, with the origin of the text identified by a number in brackets. The numbers correspond with the participant list that was maintained during data collection. The text is representative of the findings from the data sets for students in year one (Y1), year two (Y2), year three (Y3) and post qualification (PQ), and are derived from the themes identified during the framework analysis. Where more than one respondent indicated a similar view this is noted to demonstrate the extent to which inferences are established. Year groups are indicated within the results presented in order to recognise the students' length of exposure to the programme of study that could impact on their perceptions and experiences.

Barr *et al's* (2000) theoretical framework used within the study, sought to measure change in multiple domains at individual, organisational and patient level. In order to generate evidence to evaluate these domains thoroughly, participants, during the interviews were asked to provide exemplars in the form of stories from their practice. These stories report the outcomes of the learning from the programme of study, by illustrating changes to care delivery, and accordingly demonstrate practice outcomes. These stories are presented

within the findings as verbatim vignettes. The same format will be used to present the findings for Cases B and C.

4.2 Documentary Evidence: Case A

Silverman (2011) and Yin (2012) purport that documentary evidence provides valuable contextual details for case studies. In this instance it was used to enhance understanding of the organisations used within the study, details of the key characteristics of the programme of study, and to support understanding of some of the data presented by students and focus groups. Documentary evidence was collated from documents outlined in Section 3.5.1.

4.2.1 The Programme of Study

At the point of data collection Case A was an RCN Accredited postgraduate advanced practice programme delivered at a HEI that was re-validated in 2008. Royal College of Nursing (RCN) Accreditation means the programme documentation meets the quality standards developed by the RCN (RCN 2007), in addition to the standards required by the Higher Education/Quality Assurance Agency. Key characteristics of Case A include:

- The programme of study is normally delivered over three years part-time and leads to a Master's degree. Students can 'step off' the programme with a Postgraduate Diploma award after two years of study if they do not wish to undertake the dissertation module, with 120 level 7 academic credits.
- Student fees for the programme are funded either through an NHS contract, employer funded or self-funding.
- The MSc programme is modular, and comprises six core and optional modules organised and selected around a number of pathways, studied in a set format, and totalling 180 level 7 academic credits. Details of the modules are presented in the Summary Table18 (Section 4.3.7). Students select the pathway that best represents

their professional development needs. Independent and Supplementary Prescribing is available as an optional module.

- Admission criteria include qualified registered professional, demonstrate previous level six study, currently working in practice, two years professional experience in the specialty area, and written agreement of support from an identified mentor.
- Students work in their normal role whilst accessing the taught modules. (Employed minimum 18 hours per week in a professional role).
- The programme has a strong clinical focus and is assessed using a variety of methods including Objective Structured Clinical Examinations (OSCE's) with a pass mark of 70%. All assessments are examined within the HEI; no assessments are examined in practice.
- The Masters qualification requires submission of a final research based dissertation.

4.2.2 Student Participants – Biographical Profile

The student sample was drawn from three NHS Trusts previously identified. Participant characteristics are presented in Table 16 (Page 115). Students (n = 16) in the study were recruited from years one, two and three, and one year post qualification (PQ) of the programme, between March 2012 and December 2012 using the process described in Section 3.5.6. Students were employed in a range of practice settings, and held a variety of titles. Participants were nurses (n = 15) and a physiotherapist (n = 1), with twelve females and four males. The age range of the participants was 27 – 52 years with a mean age of 41 years. Students had a mean of 19 years professional service.

Table 16 Biographical Data - Case A Students.

	Age Range (Mean)	Gender	Years Professionally Qualified Range (Mean)	Current Role	Current Clinical Specialty	Employment Status
Case A Year 1 Students (n = 6)	27 – 46 (36)	Female: 6 Male: 0	4 – 21 (19)	▪ Staff Nurse • Deputy Sister • Senior Practice Nurses • Practice Nurse • Band 6 Nurse • Senior Staff Nurse	• ITU • Gastrointestinal Care • Primary Care x 2 • Infectious Diseases • Renal Care	Full Time (n=4) Part Time (n=2) (21 & 25 Hours)
Case A Year 2 Students (n = 3)	38-52 (46)	Female: 2 Male: 1	12 – 30 (23)	• Charge Nurse • Locality Nurse • Community Specialist Nurse	• A & E • Renal Care • Primary Care	Full Time (n=3)
Case A Year 3 Students (n = 4)	41 – 46 (43)	Female: 3 Male: 1	12 – 20 (16)	• Team Leader/ Physiotherapist • Gastrointestinal Band 6 Nurse Practitioner • Emergency Practitioner • Team Leader	• ITU • Gastrointestinal • A & E • End of Life	Full Time (n=3) Part Time (=1) (28 hours)
Post Qualifying (PQ) (n = 3)	31 – 54 (41)	Female: 1 Male: 2	11 – 23 (17)	• Advanced Practitioner • Nurse Practitioner • Ward Sister Band 7	• Cardiothoracic Nursing • Angiography & Cardiology • Rapid Response	Full Time (n=3)

4.3 CASE A - STUDENT FINDINGS

Findings are presented under themes identified during data analysis.

4.3.1 Expectations of Students

In order to establish an understanding of the priorities influencing the preparation of a suitable workforce for healthcare delivery, students were asked to identify how they recognised their personal and professional development needs and how they determined the programmes of education suitable to meet these needs.

4.3.1.1 Initial Interest and Application to the Programme of Study

All participants reported that a perceived outcome of the programme of study was to increase confidence as an advanced practitioner, provide role clarity *'explore and specifically strengthen their role because it was currently vague (S29)'*, and facilitate independent or autonomous working. For example Y1 and Y2 students reported: *'I loved the knowledge base that previous study gave me' (S24)*, *'to enhance my knowledge' (S34)* *'improve my knowledge of anatomy and physiology to underpin the assessment of patients' (S28)*. The accompanying rationale to support this contention was incomplete at times; *'Improving my assessment and diagnosing and things like that' (S24)*, and *'Definitely increase knowledge, pathophysiology and all that' (S28)*.

One student described how the learning primarily provided a sense of self-satisfaction and empowerment, rather than financial gain, *'my own development is important, for my own disport and entertainment, if you like, I like to try and keep up to date (Y1, S26)*.

Students from all four years reported self-motivation, initiative in identifying their own personal and professional education needs, and finding appropriate and relevant education programmes to support it; *'I have the motivation to learn' (S23)*. Only two Y3 students (S33, S45) were approached by their managers to apply for the programme. A further student was offered support to undertake a programme of their choice in order to retain them within the organisation *'I was head hunted for another position in another trust...manager knew I wanted to do a masters and so part bribery' (S32)*. Having already undertaken a prescribing module, (S34) reported *'it was natural progression'* and a belief that completion of the programme would *'support me using this qualification in practice'*.

All students perceived they were confidently able to perform in their current role and meet service responsibilities despite describing a desire to further develop underpinning knowledge for their practice:

'I was working at an advanced level of practice and thought I should be appropriately trained for the role I was being asked to do'. (Y2, S35)

Of the sixteen students interviewed only four students (S17, S29, S33, S45) received full study leave to attend the HEI. Eight students (S18, S19, S24, S25, S26, S32, S34, S44) received partial support for HEI attendance *'I get five days to attend university per year, the rest of the time I come on my days off or use holiday, but I do get my fees paid'* (S28). The remaining four students (S23, S28, S30, S35) were self-funding of programme fees and studied in their own time, *'I supplemented study leave with annual leave to do some work'* (S45).

One PQ student (S18) perceived the study without the full support of their organisation as a necessary sacrifice to develop professionally. They described this as self-motivation and a *'bigger push factor'* (S18) despite a lack of understanding by peers; *'Colleagues are comfortable and don't see anything beyond that.... I'd like to do it, I'm prepared.... to make sacrifices'* (PQ, S18).

Only two students (S33, S45) reported that managers had interviewed them to determine the appropriateness of the programme of study. All students were interviewed in person or by telephone by the HEI prior to acceptance onto the programme.

4.3.1.2 Which Higher Education Institution to Choose?

Students identified single or multiple factors associated with the selection of the programme of study and HEI and reported having researched more than one programme before making a final selection. Two students (S24, S35) selected the programme because *'It wasn't my first choice, only due to distance, it was the specific content I wanted'* (S24); and *'I looked at one other university, but what they offered did not fit with my needs'* (S35).

Additional reasons for selection included the following. Seven students (S18, S19, S23, S28, S30, S34, S45) were familiar with the HEI, for example: *'I did my prescribing here last year' (S28), I did the higher Diploma here ...I liked it' (S29)*. Six students (S23, S26, S30, S32, S33, S35) reported the specific content of the programme (identified in marketing material) as relevant and important to practice, specifically the clinical nature of the programme and its relevance to the advanced practice role, articulated as:

'I looked at a number of courses that were accessible to me; my manager directed me to this one because of the link between the Trust and the organisation, linked to my area of practice – the content I saw I liked' (Y2, S32), 'The programme was best suited to what I actually wanted' (S26)

Five students (S17, S18, S19, S44, S45) reported the HEI was a preferred provider for their Trust, *'that's where the funding comes from' (S44) 'Primary care Trust had a contract with...' (S45)* which meant their fees would be paid, and four students (S17, S29, S32, S33) reported the close location of the HEI to where they lived. Only one student commented that selection was because the programme was accredited *'Only university that provided advanced practitioner's with RCN Accreditation' (S25)*.

4.3.1.3 Expected Outcomes from the Programme of Study

All students were asked to provide the rationale and perceived benefits of undertaking the programme of study. Seven students (S17, S18, S19, S32, S33, S35, S44) reported they were playing *'catch up'* fearing being academically less qualified than newly graduating nurses, expressed as:

'Been in nursing a long time, done everything...but nothing I have says degree...like playing 'catch up' no point doing a basic degree.... as newly qualified nurses are going to be graduates and I am working above that level'. (Y2, S44)

and

'I had to have a masters qualification and ideally you would have to have the advanced nurse practitioner course under your belt to do that'. (PQ, S19)

These students also perceived they were currently working at an advanced level, *'I've been in nursing a long time...done everything they asked me, done the specialist renal qualification, I have the experience'* (S44); *'I felt my career had moved forward, I was being asked to see sicker patients by the doctors and I wanted to underpin that with theory'* (S45). Furthermore, these students supposed the programme would develop their confidence, *'it will improve my confidence, by having more knowledge to make my decisions'* (S24). Three of these students (S32, S33, S44) however perceived the learning from the programme would enhance career progression because it would more effectively and overtly support their practice role and responsibilities. *'Having the masters would open doors'* (S32); *'Developing myself'* (S33); *'Move my career forward'* (S44).

Two Y1 students (S24, S29) expressed aspirations to develop professionally in new areas including education and management; *'In five years time I want to move...I want to teach nursing students'* (S29), while five students (S19, S26, S28, S35, S45) indicated that the learning would enable them to remain in a clinical role; *'Its pertinent to what I am doing now and where I see myself in the future'* (S26); *'I see my career moving towards a clinical advanced practice role'* (S45). Two students (S28) perceived taking on new autonomous roles, *'I can motivate others to work more effectively and enhance care delivery'* (S23). Four students (S25, S32, S35, S44) similarly expected the learning to provide greater autonomy and increased flexibility to facilitate working in new nurse led roles, and described currently fearing *'becoming deskilled, feeling frustrated, and bored in my current role'* (S32).

Six students (S19, S23, S26, S28, S33, S45) reported receiving negative opposition from medics in undertaking the programme, for example: *'There is a kind of element of banging against a glass ceiling...if I've heard 'you're not qualified' once, I've heard it a gazillion times'*

(S26). They expected the learning would improve behaviours and skills to support working; *'Improve my confidence as an advanced practitioner'* (S28); *'Knowledge, knowledge, definitely, and confidence'* (S29). Five students (S30, S34, S35, S44, S45) expressed the desire to use the programme to develop a broader healthcare perspective *'to look at the bigger picture'* (S35), and facilitate a future strategic role.

All PQ students (S17, S18, S19), reported that the development of examination and assessment skills, and the underpinning knowledge were more important than specific clinical education, in order to achieve their career goals, for example:

'We extend our roles and boundaries... I need to be grounded in what I do...formal training, which the programme has enabled me to gain... not just the practical skills I would be competent...without doing the programme, you just work by guess and by what other people have instructed you to do' (PQ, S18).

Post qualifying students (S18, S19) also reported the programme of study benefitted them by developing their skills in questioning, academic writing; *'Improve clinical thinking and critical thinking skills. More around writing at that level.... decipher research, the whole thing'* (S19).

One student (S44) reported that, while the initial driver for the programme was to attain a master's degree, expectations of the programme were surpassed because the learning changed their practice unexpectedly in a short period of time, described as:

'My expectations were the end point ...a bit of paper next to my name... to validate what I do... the nice surprise is what is happening along the way, I didn't expect it... It changed my practice pretty quickly.' (Y2, S44)

Overall, all students considered the learning from the programme of study benefitted practice.

4.3.2 Factors Affecting the Learning Process

Students were asked to identify factors that either facilitated or hindered their learning in order to determine contextual factors affecting the transfer of learning to practice and the subsequent outcomes in practice.

4.3.2.1 Facilitating the Learning Process for Students

First year students were in their first semester of study when data collection occurred and although their experiences were limited, identified similar factors to Y2, Y3 and PQ students. Factors identified by students to facilitate learning included support from healthcare professionals, family members, and HEI academic staff.

4.3.2.1.1 Student Support – The Role of Healthcare Professionals

All participants considered that support and guidance received from healthcare professionals throughout the programme was important in facilitating learning transfer to practice. A first year student reported *'Support has been more from two nurse practitioners, they are supportive of my role...one is currently attending a masters programme and in their final year... provide good role models, I see them as inspirational, encouraging, and motivational (S30).*

Eight students (S17, S18, S19, S25, S33, S34, S35, S44) believed that medics were important because they actively involved them in a multiplicity of activities that enhanced their learning, for example: *'Some of the consultants have been very supportive, they give you hints and tips' (S19); and 'Medics, you can see their way of thinking, the way they think,.. when we do our assessment it is general but for them they go through general first then they go with their system...they let us help with the development of new patient care pathways (S33; the development of new assessment and diagnostic skills and underpinning pathophysiological processes (S44); and, assistance with teaching and assessment of*

practical clinical skills through observation, supervised practice and Objective Structured Clinical Assessments (OSCE) examinations’ (S25).

Medics also helped them to gain experience in other related clinical activities, such as: understanding X-Rays, development of writing skills analogous with other professionals e.g. medical transfer letters; and developing confidence in questioning.

Medics were reported to respect the academic learning being undertaken by the student because they appreciated the level of difficulty associated with it. Consequently the students felt valued and undertook more responsibility, described as:

‘Expectations of you grew leading to greater involvement in managing more complex scenarios’ (PQ, S17).

One Y3 student (S33), a physiotherapist, described *‘trailblazing’* for allied health professionals and this limited the number of peers they could look to for support. However, they described; *‘I have close working relationships with medics who act as a mentor’*. Four students (S23, S25, S26, S32) reported having to be proactive in finding their own support, because it was not always freely offered.

Only a minority of students found their line managers supportive. One Y3 student reported a manager as: *‘Inspiring and a good role model, in that they viewed nurses as the crux of the team’* (S45), and a further student reported that the nurse consultant was *‘amazing’* (S44). Both students (S44, S45) further commented that *‘These two individuals work beyond the traditional role of the nurse and act as a nurse advocate...they promote nurses as leaders and innovators both within the Trust and externally, and this encourages and motivates me to develop my practice through education’*.

4.3.2.1.2 Student Support – The Role of Academic Staff

Overall, students' perceived the support received from academic staff as positive: *'There was never a time when we needed help and we didn't have it'* (PQ, S18). Students, however accessed academic staff support in different ways, and with different frequencies. One student stated *'I was not proactive in seeking help and would have benefitted from more frequent support'* (PQ17). A second student reported a mixed level of support ranging from *'fantastic'* to *'none'* (PQ17). Academic support was provided in a number of ways that included: *'Assistance with assessments'* (S25); *'academic writing skills'* (S19); *'assignment feedback'* (S18); *'liaison with clinical practice mentors in practice'* (S 24).

The latter was seen as particularly valuable in helping students to articulate what help was required within the time frame from mentors. For two Y1 students this was facilitated by; *'Guides on Blackboard, I found very beneficial'* (S30), *'Resources were good, library staff were excellent'* (S29). Two further students, reported teaching methods employed by lecturers as beneficial: *'My research module helped me to realise that there are different ways of teaching things and quite powerful ways'* (S45); *'Some lecturers were fantastic'* (S19). A Y3 student (S33) found that the lecturer's ability to apply theory to practice facilitated wider application of learning in practice:

'University staff relate learning to reality, even if we've been talking about 18th century philosophers!...how they impact... that's really important... When you've worked in an organisation for a long time you become pigeon holed and forget there's, other hospitals out there... lecturers have been good in bringing that back to the real world and getting us to think about how we transfer that to practice'. (Y3, S33)

One Y3 student (S34) suggested that without support from academic staff they would not have been able to complete their learning, *'pushing them'* (S34), and inspiring them to become more self-confident and have greater self-belief culminating in them publishing an article.

4.3.2.1.3 Student Support – The Role of Family and Significant Others

The support of family members and significant others was a common theme across year groups. Support from partners and spouses was described by a Y3 student as a *'double-edge sword...my wife is very supportive but it means having less family time'* (S32). Two, Y1 students' identified spouses support: *'I have a supportive husband and family, he said "what you can't find in funding, we'll find" (S30); 'my husband helps with child support' (S23).* One Y1 student described themselves as a good role model by promoting the benefits of learning to their teenage sons, *'if they saw I could do it, so can they'* (S30). A babysitter was described as *'instrumental to their ability to study'* (S19), by providing additional help at short notice.

4.3.2.1.4 Attitudes and Motivation to Complete the Programme of Study

An over-arching theme identified by students, was the need to be self-motivated in the absence of continuous support from others, and the workload from the programme. Students reported having to be creative with time management in order to manage the associated workload, illustrated by the following: *'I grit my teeth and get on with it'* (S30), and *'I'll pick up some reading, sit in a pub, have a pint and read it'* (S26).

Three students (S17, S18, S19) perceived that organisations lacked understanding regarding the value of the education: *'She said, it's your choice to do the programme...I am struggling in the role because it's not well defined and lots of people don't understand the role'* (S19). Supportive attitudes within organisations were valued when offered.

'They are very supportive of us in our roles... they realise I we weren't there, there would be no one to see patients we reduce waiting times....they say 'You've done your recognised course, you've been tested get on with it' (Y3, S33)

Conversely, a student working within the same Trust in a different location reported a manager's paradox *'My line manager did her best to stop me doing the course...but the*

Trust are paying for it' (S26). Students (S18, S19) identified the need to change roles or Trusts in order to gain recognition as an advanced practitioner, *'I will have to leave the Trust if I want an advanced practitioner role, I am considering doing this'* (S18). Overall, students reported that a sense of responsibility and a positive attitude were essential in order to successfully complete the programme.

4.3.2.2 Barriers to Learning

Participants described multiple factors that impeded their learning, for example the attitudes of other healthcare professionals, lack of time, and impact on family life. Additionally, changes affecting work/life balance, tiredness and safety were identified. One Y1 student (S28) conversely, reported *'I don't think I had any barriers where I work everyone is helpful and encouraging...I have been given study leave and they pay my fees'*.

4.3.2.2.1 Perceptions of Healthcare Professionals

Three Y1 students (S23, S26, S30) identified a lack of support from managers as a barrier to learning; *'I feel a lack of support from my senior managers maybe it's not in their benefit to send nurses on masters courses'* (S23).

Five students (S18, S26, S28, S30, S35) reported that their managers/ organisations were not fully convinced of the contribution of the learning from the programme on practice. Four students (S19, S30, S34, S35) reasoned that the arguments the student had used to try and gain support were insufficient, described as:

'I don't think I explained fully enough to them the benefits from me doing this course they see it as the job I do anyway'. (Y2, S35).

Three students observed that managers who were not academically qualified to master's level themselves lacked an understanding of the relevance of postgraduate learning, for example: *'I got support to a point where they understood as much as they knew...but they*

haven't done a masters' (S18); 'If you have senior nurses you go to them for support...and you're expecting them to have something very similar behind them, and they haven't, your perception of that person does change' (S19). Two of these students (S18, S19) reported that this then led to managers becoming obstructive by increasing workload and by setting them additional work objectives: 'I think I am a threat to them' (S18). Two PQ students (S18, S19) perceived that managers failed to recognise the value of their study:

'Other people are getting away without even going through all of this stress and doing the same job and being paid the same...if it's not going to matter if you do the educational component, you know your family is struggling...' (PQ, S18).

A change in management for two students (S32, S45) led to '*frustration*', because it made them feel isolated, and reduced support to cover their study leave to attend the HEI.

A contra case to Section 4.3.2.1 was described:

'I think some senior doctors find it challenging...they view us as a nurse and if we wanted to do the role that they are actually doing, because many view the outreach role as a medical one....become defensive'. (S19)

The students reported this as challenging because it restricted access to support.

4.3.2.2.2 Time as a Barrier to Learning

An issue reported by all students was that of conflict because of insufficient time to manage their workload while undertaking the programme. One student (S18) reported having insufficient time due to workload to consolidate classroom learning in practice described as:

'I should examine the lower half of the body as part of an assessment, but it is not cardiac related... so I would bypass that... It's safe.' (PQ, S18)

Students from all year groups expressed difficulties in obtaining study leave that reduced the time available for study. Three students (S33, S40, S44) reported that this led to hidden

costs, for example: 'use of annual leave to attend the HEI' (S35); 'reduced holidays' (S24); 'effects on family life' (S29); 'fatigue' (S35); and:

'It's all done in my own time... I'm really tired because I had a week off at the beginning of July and I've got no annual leave between Christmas and New Year. I need my annual leave to come to uni...it's a sacrifice... I have a supportive family'.

(Y2, S35)

Overall, students identified the qualification as paramount to their development and proactively managed their time to overcome barriers, described as:

'I self-fund, I set the timing myself. I am using my three years of annual leave as a sacrifice.... I'm still glad at least the GP's agreed to mentor me'

(Y1, S28)

and

'I now take annual leave for my study leave it's a massive barrier... it impacts on my home life...we're extremely busy at work...I'm kissing goodbye to my home life and find it very hard to juggle everything '.

(Y3, S32)

As a result of insufficient time and management support, one student reported that she attended the HEI between night shifts, and described this as 'creating time' (S23). On further probing, the student described this as an extension of her daily life, (the student had a child with special needs and was used to having little sleep). Overall, students perceived the learning from the programme of study as highly valuable and used this belief to focus when faced with adversity.

4.3.3 Programme Evaluation

Interview questions sought to evaluate student expectations of the learning, by asking them to identify the most beneficial aspects of the programme of study, the rationale for this, and any areas where improvement could be made. Students were also asked about their overall satisfaction with the programme of study.

4.3.3.1 Beneficial Aspects of Learning

All students considered the most beneficial and advantageous aspect of their learning was the ability to make comprehensive health assessments of patients using theory and practice gained on the programme of study, for example *'Physical assessment, I could do the basics but there's huge chunks, which I couldn't'* (S44). All students (S17, S18, S19, S25, S32, S33, S34, S35, S44, S45) reported that these skills were used daily in their current role together with previous experience, enabling a more structured approach to patient management, illustrated as:

'It gives you the tools to be able to decipher the information that you've actually stored in the past' (PQ, S19).

and

'I don't think my critical thinking skills were particularly good if I am honest...but the course has given me the confidence to ask' (PQ, S19).

Four students (S19, S32, S35, S44), expressed surprise at how much new knowledge they had gained having previously considered themselves senior nurses.

Developing research skills, specifically reading and critiquing papers was seen as advantageous by six students (S18, S19, S32, S35, S45): *'The knowledge side is astronomical...you accept, I think when people say that the way it should be done...now I'm more inquisitive, the research stuff the ability to search, get the information'* (S32). Students reported increased use of evidence based practice, for example, as, *'transferred into work'* (S33). Another student suggested:

'It made me re-evaluate how I provided a rationale when following prescribed national drug cardiac guidelines. Previously I never questioned guidelines, now I evaluate evidence by comparing guidelines using global literature to determine the most appropriate, including alternatives I have previously not considered'. PQ (S18)

Students' reported that modules undertaken had been valuable to them in different ways. The knowledge gained benefitted them in developing and extending existing knowledge, for example: *'It opened my eyes' (S32) and 'Given me a voice' (S34)*. Additional comments included: *'My initial expectation was learning would be purely clinical and related predominantly to health assessment and diagnosis, which was not so' (S19); 'knowledge gained through classroom discussions, and with my manager increased my confidence, and strengthened my critical thinking and problem solving skills' (S44); and 'development of leadership and management skills increased my ability to motivate others and their sphere of responsibility... led me to feel less isolated' (S34)*.

In the current climate of service and workforce transformation, students demonstrated an increased level of awareness of themselves their role and the organisational demands, particularly relating to change. Five students (S17, S18, S19, S35, S44) perceived that the organisations in which they worked had a very insular culture, and failed to utilise opportunities to reconfigure the workforce: *'The current austerity and things...I have to apply for my own job again in order to move forwards or stay put, the organisation are using cutbacks to change workforce' (S44)*. Students reported feelings of frustration and inactivity regarding their role on completion of the learning; *'My role won't change unless I move' (S34); 'What I'm employed to do won't change' (S33)*.

4.3.3.2 Satisfaction with the Programme of Study

Students overwhelmingly reported that undertaking the programme of study was a positive experience and met their expectations, specifically in respect of the learning's relevance to advanced practitioner roles. Despite this positivity, when probed further, students identified aspects of the programme of study that could be improved: *'I think the assumption was that regarding biology, pathophysiology we were all taught that...but I wasn't...its making sure that people have enough information' (S19); 'I wasn't sure what the minimum level of biology I needed, I found I didn't have it when I started the course' (S17)*.

All students reported the workload to be considerable and having underestimated the amount of time they would need for study in addition to work: *'I think starting with two modules simultaneously for somebody that hadn't studied for a number of years was tragic as my results bore out (S33); 'You underestimate the workload' (S35).* Two students (S30, S33) reported initial modules as challenging, yet set the benchmark required to develop the requisite commitment. Two final students' (S32, S45) comments demonstrated development of personal and professional growth, and increased reflexivity, for example:

'You don't understand how valuable things are until later on, the course is set out in a way that builds to an end product'. (Y2, S32)

and

'I am more reflective and more able than before..... It's made me take a back step and look at the wider issues, rather than trying to solve the problem immediately'. (Y2, S45)

Varied teaching styles and types of modules were appreciated in facilitating students' personal and professional development. All students reported that though the programme was demanding and stressful, it was very stimulating.

4.3.4 Evaluating the Effectiveness of Learning and its Application to Practice

Transference of learning to practice is a key aspect of the evaluation process. It was important to determine the outcomes from the programme of study to meet this study's objective. Outcomes identified by students included the appropriateness of learning, knowledge, and behavioural and attitudinal changes.

4.3.4.1 Appropriateness of Learning

When providing an account of their learning experiences there were variances between students in the presentation of tangible changes. Two Y1 students when questioned about

the effectiveness of the learning responded, *'it was too soon to make a judgement'* (S26, S29). They subsequently reported the content and learning from it, as *'challenging'*, *'thought provoking and immediate'*. Learning through associated group work was described: *'It's the class discussions, I get to know how other clinical areas, how far is expected in this role'* (S29). These students suggested they were developing greater Initiative in making things happen and getting others to follow. One-off comments were provided by participants that included: *'senior consultants as mentors influenced a change in understanding of the advanced practice role'* (S23); *'clinical modules were more valuable'* (S30); and *'learning raised awareness of issues within nursing, specifically my limited knowledge and naivety in relation to advanced practitioner roles and governance'* (S30).

Exploration of related legislation in a student's own practice led to an evaluation of their own current practice as unsafe, described as:

'It made me realise that I have to be more careful of the decisions I make and at what point I stop and think, I'm not completely competent to make that decision... the strength to call the duty team....no I'm not going to print off a prescription because it's easy I am going to call someone to take responsibility for this'. (Y1, S30)

The programme of study empowered one student to challenge practice from a more informed perspective (S26), for example, *'there is a little difference in practice between band '5s' and '6s' in fact some Band '5s' are more clinically experienced and educated, this is wrong and should be challenged'*.

4.3.4.2 Increased Knowledge and Its Application to Practice

Students identified knowledge of anatomy and physiology as valuable for practice, in underpinning health assessment and examination skills to enable a more proactive approach when initiating assessments. Knowledge was also perceived to enhance confidence, for example:

'I've got more knowledge I know what I am talking about, so I can challenge them, I am more confident to do that'. (Y2, S25)

Learning was reported to develop student's existing experience and knowledge. The following quote describes how one student used self-reflection to evaluate consultations they thought had improved and developed their practice:

'Reviewing the way I undertake consultations, that whole history taking process, examination skills... diagnosis... making the right decisions, sometimes you come to those decisions too quickly, before you've put all of the right processes in place, you have only 10 minutes '. (Y2, S35)

Enhanced knowledge was perceived to lead to improved questioning skills. Eight students (S18, S19, S32, S33, S34, S35, S44, S45) reported being now more inquisitive and questioning in their practice; *'I find the learning extremely beneficial...I'm not scared of things, I look things up more'* (S32). Having learned the process of critical enquiry students expected to use these skills to support future work when they had more time: *'I think it will be more relevant after I have done the course... I can give more time to look up other things'* (S32).

Learning related to research and its use in practice was also viewed very positively. Students across all years (S32, S33, S34, S35) identified skills related to searching and reviewing literature as invaluable, because it promoted an inquisitive mind and facilitated access to information that enhanced practice, explained as:

'All of the topics I have been interested in learning more about.... I've used essays I have written to argue points at MDTs. They say, 'Well this is the way it is produce something' and I already have...for example, sleep at night time...having a rest period with lights off should be a no-no.... and I have evidence for that'. (Y3, S32)

and

'I remember a meeting and somebody was presenting data and me research and I said 'hang on a minute, that's a very small sample I am not an expert but the little I know indicates we need to look at this more'.... they all agreed. (Y2, S35)

Overall, a variance between participants was noted in terms of how they valued the importance of transferring learning from the programme of study to practice. Some students valued the clinical learning as paramount while others, recognising this as important, equally valued the learning pertaining to professional issues, for example, *'the scope you taught me it made me appreciate other things as important it is not just the assessment stuff'* (S19); *'it has made me reevaluate what I do...I work in a drug centre outside work and I have thought about the legal and accountability issues that we talked about, and I realised I am working beyond what I should be doing...I have now stopped, I pass them to the medics now'* (S26)

4.3.4.3 Behavioural and Attitudinal Changes and Application to Practice

All students described how increased confidence improved their ability to challenge other healthcare professionals in practice regarding patient diagnosis and in interdisciplinary meetings. Learning motivated students and resulted in improved services:

'Learning has motivated me to move forward, develop further in the Trust... recently I set up the inflammatory bowel disease MDT group, which has been promised for a long time...I don't know how it will help the patients but it will help me'. (Y3, S34)

Students reported that other healthcare professionals afforded them increased credibility: Clarity of communication, using *'the language of the medics'* (S44) specifically, the increased use of unambiguous language, for example: *'I think I am more confident about making referrals, to use the language of medics, "These are the problems" giving clear concise history'* (S35); *'I now know how to describe symptoms properly now, I think it gives me more credibility...a letter to a GP is now written in the correct language, I think they read it and think "This person knows"'* (S44). These were perceived to have led to this change. One

student reported that they now were seen as *'Someone who knows'* (S35) rather than, *'The nurse has written to me'* (S35). Students reported that their opinions were sought more frequently because they perceived for example: *'I am seen as an expert resource, and I am used to reduce the workload of the GP's by seeing an increased number of sicker patients'* (S35).

Improved communication was described as improving patient consultations because of the students' ability to consider the *'bigger picture'* (S35) when decision-making. One student (S35) reported: *'Patients have increased confidence in me as a clinician...GPs are more accepting that I can make a referral to secondary care'* (S35) Increased autonomy and scope of practice was cited, for example: *'I am becoming more autonomous, so I'm going to the doctors less and less, they say "gosh she sees 12 patients in a clinic, I can't do without her"'* (S44). Extended role boundaries facilitating independent working were reported by some students as a consequence of their learning being appreciated by managers, although this was less prevalent in secondary care.

4.3.5 Outcomes of the Learning on Practice – Perceived Patient Benefits

All students (S17, S18, S19, S25, S32, S33, S34, S35, S44, S45) perceived that improved quality of patient care was an outcome of their learning. First year students (S23, S24, S26, S28, S29, S30) anticipated using the knowledge gained to improve patient care in a variety of ways, for example; *'By increasing their confidence'* (S23); *'I use research more effectively to provide more holistic care'* (S28); and *'I can communicate with healthcare professionals better'* (S30). They described cliques at work, for example, *'I feel I now have the ability to discuss and challenge tribalism between competing hierarchies, through the improvement of links within the organisation'* (S26); and *'I can give better education to both my patients and their carers'* (S26). Interestingly, Y1 and Y2 students who were in a limited position to identify actual benefits also reported these factors, supporting the notion that student

perceptions of the anticipated benefits of the programme of study on application were accurate. Being a more confident and reflective practitioner was also another consistent benefit identified.

All students in Y2, Y3 and PQ reported being more able to effectively manage patients presenting with complex healthcare problems that required a multi-dimensional approach, for example: *'The ability to prescribe, it makes me more autonomous...I don't have to keep asking doctors to write prescriptions that have never seen the patient...I can choose from a better range of drugs'* (S33); and *'I'm more likely to challenge practice, especially if I feel it is inappropriate for the patient'* (S19); *'Patients are getting a better assessment, quicker...I can initiate treatment, to more patients with more complex problems'* (S25).

Problem solving of clinical presentations in addition to solving strategic service management issues were also reported; *'It's given me a clearer view of government policies, of legislation, of how to access information, more questioning'* (S33). The following two vignettes provide examples of care management changes made by students when asked to identify the outcomes of their learning on practice.

'In my locality nurse lead role, somebody asked us to consider a problem with referrals to the district nurses at the weekend and suggested organised training for all the practice nurses. A couple of other people agreed, but I said 'Hang on a minute, let's stop, actually what is the problem? Is there a problem first? Is there data backing up this problem?' I wouldn't have had the confidence previously or the knowledge to have said, "what is the actual problem".

Y2 (S35)

Vignette 1

'I used essays to argue points at MDTs.... Delirium, lights out during the day, sleep at night time I didn't think we were doing benefit to our patients having lights off during the day. It was a practice they bought in.... more for the nursing staff benefit to catch up rather than the patient's'.... The flipside is you're not benefitting the patient...they're losing their diurnal rhythm... it was completely wrong and I had evidence to prove it, that is the benefit of knowing'.

Y3 (S32)

Vignette 2

Overall, students reported greater use of lateral thinking in their problem solving and were able to support these with exemplars from practice, for example: *'A lady had a degenerative condition, they kept putting calls out for this lady when she became acutely ill. It was looking at the simple things, because it was an unusual condition that she had medics were looking at the extreme things...'* (S19). Additionally, students viewed that they now based patient management on evidence, knowledge and skills learned from the programme *'Two days ago I saw someone with a squirrel bite and there was a big argument about giving prophylactic antibiotics...and I was able to successfully demonstrate to the directors that's not what we are going to do, well not what I was going to do'* (S33), rather than what one student *'considered guesswork'* (PQ 19). Consequently, students considered they now delivered safer care and safety netted more consistently. Second, Y3 and PQ students generally reported benefits more generically, rather than specific examples of change, for example; *'I am more effective and efficient in managing patients'* (S23); *'I manage patients with more complex needs'* (S35); *'I manage more complete care episodes'* (S30); *'I reduce patient waiting times'* (S35); *'I have reduced pressure on medical staff because I am now able to see patients previously only seen by the doctor'* (S44); *'I make fewer referrals back to doctors'* (S34); and *'I have a wider strategic view and input within the organisations in which I work'* (S35).

Three PQ students (S17, S18, S19) commented that their confidence and subsequent behavioural changes continued to evolve post learning as a consequence of advanced applying and consolidating their new knowledge and skills in practice, for example: *'My role clinically has changed, research I am contributing regularly I am more confident to do this'* (S18); *'I am still learning everyday, but I am more confident and ask more questions when I am not sure'* (S17); *'My confidence in making decisions, sending people home or refer patients'* (S33). The importance of being able to corroborate these outcomes is important: manager focus groups were used to ascertain this (Section 4.4.5.2).

4.3.6 Role Change as an Outcome of the Programme of Study

Second and third year students were asked how their roles might change, and the PQ students asked how their role had changed as a result of the programme of study. Ambition to change was reported, for example: *'It will only change if I move, but that gives me opportunity, it will open doors'* (S34). Students supposed they would need to provide convincing arguments in order to demonstrate the benefits of advanced practitioner roles to professionals who had no previous knowledge and understanding of the role, which was challenging, for example:

'Development of my role is restricted by current resources... I am becoming more autonomous, I'm going to the doctors less, they say I can't do without her... I found other nurses they had in similar roles work at a much lower level, they don't think they do, ...they say 'I would rather have a doctor than a nurse' but they haven't had one of me... experience of an advanced practitioner to realise the benefits'. (Y2, S44)

Six students (S18, S19, S25, S32, S34, S44) identified a need to influence the organisational culture in order to change their role: *' Things are missed an awful lot in Trusts, improving this to make it more appropriate...you need to the right environment and the right approach to change'* (S19). Despite this, they reported changing aspects of their current role as a consequence of their learning that included expansion of organisational responsibilities beyond their clinical remit. Students recognised that self-development precipitated increased strategic involvement. A Y2 student who was already a representative of a local Clinical Commissioning Group (CCG) reported an outcome as, *'it is raising the profile of nursing'* (S35), and implied some recognition of their development by others, for example:

'Previously I would have said I don't think I can do that I know I have a standing in the local area, from what we achieve in practice...I feel less stressed sitting there with the chief exec, and 'Okay I can do this!' (Y2, S35)

Of the remaining students who were still completing the programme, one student (S45) had changed role as a result of their learning, taking up a more senior post during their final year of study. Only one student overtly described themselves as '*Developing maturity*' (S32), although the transcripts overall generated a feeling that this was common to the majority of participants, demonstrated through the use of adjectives used to describe changes, for example: '*Experience*', '*responsible*', '*reliable*', '*autonomous*,' '*capable*' and '*knowledgeable*'. Post qualifying students having completed the programme eighteen months previously, reported different outcomes. Examples included: '*It is a continuous role change following my learning, natural progression*' (S17). However, they saw themselves as '*I am an advanced nurse, I undertake advanced assessments more effectively and efficiently to manage my patients*' (S18). One student (S19) did report changing jobs, albeit without significantly changing roles. Post-qualifying students also commented that these changes had occurred without any consequential financial reward or promotion.

4.3.7 Summary

Students in Case A were predominantly working in critical care or specialist areas of clinical practice, and were generally experienced professionals, with all but one participant nurses. Students in Case A provided rich data in response to the questions posed that generated many themes that have been presented. All students described self-motivation and a determination to complete the programme of study, even when faced with conflicting organisational, personal and family challenges that were often on-going throughout the programme of study. Field notes emphasised this, for example: '*The hardships outlined are over shadowed by the passion and conviction of them to complete the education for personal gain...they have worked out what they want and their non verbal cues (wide eyes and increased tone of voice) support this. I am surprised they want to do it*'. Students persevered despite awareness that the learning from the programme would not directly benefit them financially or enhance their career.

All students individually viewed the education positively, claiming that it changed their thinking and behaviour within current roles. This enabled them to deliver enhanced care more efficiently. The transcripts however, generated a sense of powerlessness of the student being able to change their current practice and opinions of others regarding the advanced practitioner role. Field notes supported this, for example: *'Students waved their arms holding them up as if to say I am helpless to stop this. They perceived an inability to change, or rather an acceptance of this is how it will be, resignation'*. Students demonstrated a sense of frustration in being unable to apply their learning, because, of current limited opportunities for advanced practitioners. Students also described an inability by organisations, and specifically management, to understand the outcomes of advanced practice education, resulting in students being unable to convince them of the value of advanced practitioner roles or instigate changes to either their individual role or service delivery. Table 17 (Page 140) provides a summary of the themes and findings identified during data analysis.

Table 17 Summary of Student Findings.

Theme	Findings
Expectation of Students	▪ Self-motivated and self-directed in seeking the opportunity to undertake the programme of study ▪ Students accessing the programme of study experienced barriers yet saw the potential benefits of the learning as professional development ▪ Playing catch up, academically ▪ Students displayed an initial naivety of programme content and the implications of advanced practice, however within the first three months of study they were able to articulate perceived benefits to self, their patients and the organisation
Factors affecting the learning process	▪ Support from healthcare professionals, academic staff and family or significant others ▪ Funding (lack of) by the organisation; Students perceived support by managers was prioritised for mandatory training ▪ Managers having limited academic qualifications was reported as a reason for not supporting the students on the programme of study
Facilitating the learning process for students	▪ Support from healthcare professionals particularly medics enabled consolidation of learning in practice ▪ Self-motivation and positive attitude of the student to complete the programme
Barriers to Learning	▪ Workload ▪ Managers, and other healthcare professionals perceived lack of understanding regarding the purpose of the programme of study and the benefits of the learning to the individual and the service ▪ Some doctors actively supported students whilst other professionals including doctors, and nurses perceived the students as threatening and subsequently presented obstacles
Programme evaluation	▪ Preparation for learning was considered insufficient by some students, specifically in relation to the academic level and workload required ▪ Modules and teaching strategies effectively enhanced learning.
Evaluation of the effectiveness of learning and its application to practice	▪ Increased knowledge of anatomy, physiology, and research were frequently reported as a benefit, which in turn enhanced patient care ▪ Some students expressed concern that they were currently working outside their scope of practice and as a result of the programme of study altered their practice ▪ All students demonstrated increased confidence in their behaviour that in-turn improved their ability to challenge other healthcare professionals using appropriate language, and underpinning knowledge and understanding; improved patient consultations including more extensive assessments and diagnoses; reducing waiting times and the need for increased medical resources. ▪ Students were more able to clearly articulate communications to colleagues and patients, however, this is not supported by the language used by participants in their responses ▪ Workload impacted on learning time
Role change as an outcome of the programme of study	▪ There were few reported changes of role following completion of the programme of study largely because of contextual NHS changes occurring at the time of data collection

4.4 CASE A - FOCUS GROUP FINDINGS

Three focus groups were held between November 2012 and April 2013 in three different locations, referred to as FG1, FG2 and FG3. The organisations selected had previously purchased the programme from the HEI and currently had students enrolled on the programme. The three Trusts consisted of; Trust 1, a Foundation Trust based in an urban area; Trust 2, a University Teaching Hospital based in an urban area and Trust 3, an Academic Health Science Centre in an inner city location. Participants who took part in the focus groups were managers, Trust education leads, consultant nurses and Advanced Practitioners, from a variety of clinical areas. Professional groups represented by participants were nursing, allied health professionals and midwives.

4.4.1 Biographical Profile of the Participants: Trust Managers and Advanced Practitioners

Fourteen managers or advanced practitioners joined the three focus groups held, and comprised ten females and four males. Focus Group 1 (FG31) consisted of three managers and one Education Trust Lead; Focus Group 2 (FG46), four managers and three practice educators; and Focus Group 3 (FG60), two advanced practitioners. Ages ranged from 31 – 60 years with a mean of 49 years. The mean length of service in their current professional role was 5.5 years. Key responsibilities of the participants included identifying the educational needs of staff, commissioning education, and supporting staff undertaking education. Further data regarding the profiles of the participants are presented in Table 16.

One focus group was rescheduled due to a poor initial response. Attendance was poor at two further focus group interviews held (FG1, FG3), with expected participants citing heavy workload on the day for non-attendance.

Table 18 Biographical Details - Trust Managers and Advanced Practitioners Case A.

	Age Range (Mean)	Gender	Years Professionally Qualified (Mean)	Length of Time in Current Role (Mean)	Current Role	Current Clinical Specialty
Focus Group 1 (FG 31)	44 – 60 (53)	Female: 4 Male: 1	22 – 39 (33)	4 – 11 years (6)	• Lead Nurse Education (n = 1) • Senior Nurse Manager (n=1) • Manager Medicine (n = 1) • Clinical Nurse Manager (n = 1) • Consultant Nurse (n = 1)	• ITU (n=2) • Medicine (Nursing) (n =1) • A & E (n = 1) • Nurse Education (n=1)
Focus Group 2 (FG46)	31 – 58 (42)	Female: 4 Male: 3	7 – 37 (20)	8 months – 7 years (3)	• Audit Nurse (n = 1) • Critical Care (n =1) • Outreach Nurse Manager (n = 1) • Lead Nurse Matron (n = 1) • Practice Development – Midwife (n = 1) • Head of Faculty of Nursing (n = 1) • Practice Educator (n = 1)	• ITU (n = 2) • Critical Care (n = 1) • Acute Medicine – A & E (n = 1) • Maternity Services (n = 1) • Learning and Development (n = 1) • Theatres (n =1)
Focus Group 3 (FG 60)	46 - 56 (51)	Female: 2	19 (19)	23 months – 13 Years (7.5)	• Clinical Breast Specialist (n = 1) • Cardiology Nurse Specialist (n = 1)	• Breast Services (n = 1) • Rapid Access Chest Pain Clinic (n = 1)

Framework analysis of the data identified a number of themes that are now presented, and include the expectations of participants who support staff to undertake advanced practice programmes, factors considered when purchasing advanced practice education, factors facilitating and hindering the transfer of learning to practice, and the outcomes of the learning in practice.

4.4.2 Expectations of Managers and Advanced Practitioners Supporting Staff to Undertake Postgraduate Advanced Practice Programmes of Study

Focus group participants were asked to describe the selection process and mechanisms used to identify and support staff to undertake post-qualifying education. Advanced practitioners in FG 3 were also specifically asked how advanced practitioners were used and perceived within their organisation in order to determine the prominence and prevalence of the role.

4.4.2.1 Factors Considered When Purchasing Advanced Practice Programmes of Study

Manager's prior to purchasing education from HEI's considered a variety of factors that included; *'Existing contract with the university'* (FG2); *'I need to identify if its funded'* (FG1); *'To establish if there is a need in the department, personal and professional development as well'*; *'Ability of the person to pass the course'* (FG46); *'Feasibility to release that person'* (FG1); *'What is fashionable'* (FG3). All focus groups described the aim of the selection process as: *'Considering the vision and the planning of the Trust as a whole, where the Trust is going...we look at the person and their experience matching eligibility and suitability of staff to organisational need and relevant education and training'* (FG2). Managers prioritised education and training within all Trusts and acknowledged that mandatory and mentorship training and clinical courses received precedence in funding.

4.4.2.2 Organisational Support

Participants in all of the Focus Group's expressed the need for the HEI delivering the advanced practice programme of study to be *'a preferred provider in order for the programme to be commissioned as part of an education contract with the NHS'* and *'obviously location is usually a priority because of getting to and from'* (FG1). Participants described certain education as *'fashionable'*, later qualifying this as:

'How far the Trust is taking outreach. At the moment we have a limited service.... If they take it to 24hours, that will increase the need for nurses with the advanced practitioner courses' (FG2)

and

'When the Care Centre was coming in.... we sat with directors, identified what the department would need ... senior nurses to assess patients and things, ANPs which led them going on the course... it was a two year project.' (FG2)

Advanced practitioners (FG3), described a more cynical rationale, reporting that their Trust responded to adverse press reports, *'The Daily Mail'*, and specifically, *'After Stafford'* (FG3), as the driver for influencing and increasing the amount of education undertaken by nurses.

Reference was made to individuals being encouraged to seek external funding in response to the current climate of financial austerity (FG3); *'I was told to look for funding outside, I said ok and did and I got some money from the...and they also gave me half'* (FG3).

Participants described self-funding; *'Sometimes a nurse will ask to do the course and pay for it themself, in which case...we have to agree whether we'll release the person, the funding we get is only for the college, you don't get money to replace them from work...there is an impact on their colleagues to be considered'* (FG1). This did not, however, correlate with the students who self-funded, and who reported having discussed this with their manager for example, *'I fit it in around my work, I request the day off to go to uni, and mostly people don't mind'* (S23). Participants in FG3 also described unfair variances in organisational funding, *'You used to be able to go anywhere to do it but now it depends on the driver in response to bad press...then some are partly funded in this case, some go outside. But you know...it gets to the end of the financial year and all of a sudden, there is so many places and they've got to be filled tomorrow, what a waste'* (FG3). Differences between different sites across an organisation were also reported.

4.4.2.3 Selection Process for Staff Within Trusts

All three Focus Groups described a similar selection process used within their respective organisations, for example: *'We use a proper interview, with three people and many assessments...a portfolio, and an interview, we want to make sure they can pass otherwise it is a waste of resources'* (FG2). *'We also use performance review to help identify the professional and personal development needs of individuals, we do this the year before so that we can commission it, get funding'* (FG2). Alternatively, *'We use a profiling tool that identifies grades of staff needed in the clinical area... and to provide four monthly data targets demonstrating skill mix to NHS commissioners'* (FG1). This process contradicts student's views of being self-directed in making applications.

4.4.2.4 Perceptions of Advanced Practice Roles

Advanced practitioner participants (FG3) described a lack of clarity and uncertainty in their organisation regarding the role of advanced practitioners and their contribution to practice:

'I don't think they know what the role is...they advertise for a band 5 with an ECH course, that's a specialist course, which is ridiculous. They are not quite sure what to call them...I have been called a senior sister, cardiac nurse specialist, advanced nurse practitioner' (FG3).

Field notes captured a perceived note of *'there is evident frustration, and a feeling of inevitability and indifference to this, her tone of voice, they sighed a lot!'. There was also a degree of anger when (FG1) identified that "the men are lucky, they wear a stethoscope around their neck, and in the community they don't wear a uniform, so immediately they look like a doctor, they the public don't tend to know, never mind management'*. Two advanced practitioners supported this: *'I don't think it will change, get better, the title advanced practitioner means different things to different people'* (FG3). One advanced practitioner stated she consistently referred to herself simply as *'nurse'* (FG3) for this reason. Participants (FG3) reported a lack of consistency in titling, pay and ways of working within Trusts, for example, Band 6 to a Band 8C of *Agenda for Change* (DH 2004a). Most

advanced practitioners were reported to work in roles in specialist areas, more commonly associated with a specific disease group (e.g. Diabetes, Heart failure).

Awareness and understanding of advanced practitioner roles by some healthcare professionals was variable within and across Trust sites, and was challenging: *'I think the medics do some, it has been quite traumatic, especially at... its much better at... they were recognised amongst everyone. It's about different values and philosophies that have not merged...At .. the clinic I run used to be run by a medic now they say a nurse has been brought into do this'* (FFG3). They believed this required 'integration' if a collective group of advanced practitioners was to emerge (FG2, FG3). Participants supposed that more traditionally trained medics held less respect and recognition of the advanced practitioner role, however they reported, *'It's got better but still there is ...'oh you know a nurse shouldn't do that'* (FG3).

Student findings concur with this observation (Section 4.3.2.2.1) by indicating variance in support of advanced practice education in practice. Advanced practitioners reported resistance by peers in that they described the advanced practitioner role as an *'extension of the doctor's role'* (FG3) rather than that of a nurse; *'Why do you want to do that, we're nurses, not doctors'* (FG3), which again concurs with student observations, who reported that peers were threatened by the academic level of the education (Section 4.3.2.2.1). Advanced practitioners recognised that, *'Trust reorganisation adds to this confusion, because it has led to separation of nurse specialists and advanced practitioners within the same clinical specialty into different directorates, it leaves us feeling isolated in our decision-making'* (FG3). Field notes recorded that FG1 participants lacked understanding; *'They never really identified what an advanced practitioner role is. They appear anxious, and avoided eye contact with me when I asked questions about role ... I get a sense of uneasiness that they don't know what the role is. They keep talking about prescribing instead.'*

4.4.2.5 Multifactorial Support of Students Undertaking a Programme of Study

Focus group participants like student participants reported gaining support from others in practice was challenging. *'Giving them time is major support, otherwise they do it in their own time and getting someone else to do their job while they are away I think is....'* (FG1). Providing time for learning was considered important, although limited and governed by Trust protocols (FG1). Using an example of supporting a past student, a manager (FG1) described: *'An individual's role was operationally pressurised reducing the number of study days that could be granted to them. This meant the student had to use annual leave to support her attendance at the HEI. The rest of the staff had increasing workloads during her absence, and this was difficult to manage, although her peers seemed to accept this willingly'* (FG1). Participants (FG1) perceived that support of individuals undertaking advanced practice education was *'a joint responsibility between the medical and nursing teams'* (FG1). FG3 reported: *'The support is only there from the supervisor that the student may approach, if they are willing to teach them and for them to shadow them...they come in on their days off to follow a medic on call'*. This was said to limit support.

Participants (FG2, FG3), reported a variety of reasons for individuals finding support difficult in practice, that included; *'There is tension arising from medical students and trainee doctors who believe that advanced practice education removes or reduces their learning opportunities'* (FG3); and *'Inconsistent approaches to support...they have to gain experiential learning in alternative clinical areas external to where they normally work, there seems to be an unwillingness of some medics to support them...they think we interfere with their intakes, we are going to take away their work'* (FG2). This concurs with student findings (Section 4.3.2.2). Participants (FG3) in the following quote reported that students had to learn in isolation, and questioned the effectiveness of this:

'There was no real support. I did my physical assessment and yet, you were out there doing them as a nurse thinking, "Hmm. Am I doing this right?" you know.... heart sound is'. (FG3)

Conversely, other individuals reported good support and the development of successful personal relationships. Support was reported; *'they assist with assessments, some teaching and shadowing'* (FG2).

Managers (FG1) perceived a lack of clarity and some misunderstanding of what individuals on the programme needed to learn. Subsequently medics acting as mentors reportedly placed a greater emphasis on the learning of facts rather than reasoning, for example: *'Medics have a tick box approach, I've seen it recently with a Troponin test, they don't have to think about anything else. We delve deeper ask a lot of questions, ask about their life, in terms of safeguarding'* (FG3). Advanced practitioners (FG3) argued that there was a shortage of nurse mentors for student advanced practitioners *'I wanted an advanced practitioner mentor, but there was nobody available. Either too busy, or they are finishing their masters, and didn't feel happy to be my supervisor...there is this culture in nursing they don't have the qualification, so they couldn't be my supervisor, yet they are working at that level'* (FG3). When advanced practitioner mentorship was provided it was viewed positively and described as, *'a different more comprehensive approach to assessment being practiced by the advanced practice'* (FG3).

Managers expressed difficulty in finding time to facilitate alternative placements for individuals on the programme, which made them feel as if they were *'letting staff down'* (FG1). *'Academic help from me and the university if they need it, though clinically its down to them'* (FG1) was an attitude related to gaining alternative support.

4.4.3 Factors Affecting the Integration of Learning to Practice

Managers and advanced practitioners were asked to identify factors that facilitated and hindered the transfer of learning from the programme of study to practice for students. A

number of factors were identified that, again included student support previously described (Section 4.3.2).

4.4.3.1 Factors Facilitating Learning Transfer

Participants identified a number of factors that facilitated the transfer of learning to practice. *'The relevance of the learning to the role is considered essential, and should involve more than just the use of clinical assessment skills'* (FG1). Participants in (FG2) concurred suggesting that *'individuals undertaking the programme should be supported to use their learning to improve practice'*. Examples of positive changes were described in Theatre and Midwifery clinical settings. However, Accident and Emergency participants described this as *'difficult without the use of evidence based research to support proposed changes'*, because *'medics doubted the nurses capability in managing more complex presenting conditions'* (FG2). Motivation and a positive attitude by the individual undertaking the programme of study was seen as essential in countering negative attitudes and the lack of understanding by others illustrated in the following example:

'You're colleagues - their lack of understanding or their lack of learning as well. They don't want to move on or change... 'what do you have to do that for?' And a lack of knowledge about linking evidence to practice'. (FG3)

Learning associated with assignments was also perceived to enhance and improve care delivery. One manager described how they had used the evidence provided by a student to persuade Trust Directors to develop nurse led ambulatory care facilities (FG2).

4.4.4 Barriers to Learning Transfer

Participants in all focus groups identified the lack of peer support as the predominant barrier to students being able to transfer the learning from the programme of study to practice. A lack of understanding or failure to recognise the expected outcomes from the programme of

study by the student and organisation were also perceived to contribute to poor transference of learning to practice.

4.4.4.1 The Role of Peer Support

Difficulty in engaging clinicians to support the learners during the programme was a reoccurring theme in all Focus Groups. In addition to providing support to develop various aspects of the student learning, participants' found barriers in facilitating the individual to apply the learning to practice. Participants in FG1 and FG2, identified; *'some medics do not allow nurses to prescribe for patients despite the Trust supporting the student to gain the qualification, this is a waste of resources'* (FG2). Managers reported the need to improve some medic's attitudes by; *'We need to increase their confidence to work with those with an extended scope of practice...by recognising the value of having advanced practitioners working within the team'* (FG3).

4.4.4.2 Peer Support and Funding

In all focus groups, managers described the provision of study leave to attend the HEI as problematic. Discussions regarding the provision of study leave led to a discrepancy within one Trust, where different clinical areas supported staff by providing differing amounts of study leave for individuals attending the same programme of study (FG2). Field notes captured that *'participants were embarrassed that this had occurred especially with it identified in front of an outsider. They seemed keen to ask colleagues to collude with them so that it would not be reduced, that made me inwardly smile'*.

4.4.4.3 Peer Support and Clinical Liability

The issue of vicarious liability for advanced practitioners was raised and demonstrated contradictory knowledge regarding the Trusts' stance and legal support of advanced practitioners; *'Liability is difficult, our protection is vague... the doctors have their own indemnity insurance and for us to try and get it..it is not easy...I would have thought the*

Trust covered you if you're doing the course' (FG2). One manager (FG2) stated; *The Trust need to strengthen and extend existing support to ensure that advanced practitioners are provided with appropriate legal cover for the extended responsibilities encompassed by the role'*. Field notes captured my evident surprise at the fundamental lack of understanding around an important issue, they stated, *'this is another issue that needs solving!'*.

4.4.5 Managers' and Advanced Practitioners' Perceptions of the Outcomes of the Programme of Study

Participants in all focus groups, found it difficult to articulate outcomes of the learning from a programme of study for individuals and their practice. Further probing to identify specific examples of outcomes indicated a lack of understanding for some, *'It is difficult to say... Over to you!'* (FG1). Field notes captured my thoughts of, *"Obviously no idea"*.

Re-evaluation and reconsideration of roles that had led some individuals changing roles within the Trust to become more clinical were described; *'She was a matron and was happy in her role, however because of the increased clinical contact, I think it made her reconsider what she wanted to do, and she's moved into a role that is almost entirely clinical'* (FG1). Behavioural changes and changes to patient care delivery were also reported: *'Their practice improves, assessing in more depth, I don't know, it's hard to say going in depth'* (FG2); *'Confidence, I think, huge amount of confidence...you're listening to heart sounds and you think "that's a murmur, you know"'* (FG3). However, examples of specific outcomes were not identified. Increased knowledge and behavioural changes were identified as changing, and are described below.

4.4.5.1 Increased Knowledge

Development of clinical and prescribing knowledge were said to underpin changes to the way in which students practiced. Learning was perceived to have led to individuals

becoming more ‘*accomplished*’, and better able to deal with emergency and complex situations independently (FG1, FG2). Conversely, the following quote demonstrates how articulation of this was difficult:

‘How has it improved? I don’t know. I guess... I think it was probably more what, perhaps I wasn’t doing as in depth. I don’t know, it’s hard to say.’ (FG1)

Participants described changes in managing consultations, for example:

‘She looks at, drug prescriptions and being responsive to patient needs, often they are first responders and have to be the first to deal with the situation...with their knowledge they take it to a level further than previously’ (FG1).

Again no exemplars were provided, which led to one senior manager following the interview, captured in field notes: *‘Sorry...I feel embarrassed I don’t think they really had much idea of this type of role...I am quite upset that I didn’t realise’*.

4.4.5.2 Behavioural Changes

Participants (FG1) identified that increased confidence enabled students to act differently, for example:

‘His confidence has improved immensely, he’s able to take on the role of medics...it’s quite motivating, and you know, a good role model for the juniors’ (FG1).

Students were also reported to have *‘gained greater respect from medical and nursing staff’* (FG1), although no specific examples were provided. Participants (FG2) concurred, and tried to identify changed practice following the learning. The ability of the managers to clearly articulate this was limited and incomplete, indicated by the following quotes:

‘They are actually in a position to be a bit better in everything they do’. (FG2)

and

‘In terms of challenging and being confident in what you’re told, although, they may ask why you’re doing it that way as well. And to be able to answer that, sometimes I can’t answer it, because sometimes I can’t explain myself’. (FG3)

Participants (FG2, FG3) described how learning from the programme increased knowledge confidence and awareness to use supporting evidence, to manage the expectations of a more informed and educated public who were challenging nurses regarding their conditions and treatment regimes, for example:

'A patient described chest pain and shortness of breath and diagnosed heart failure'; I responded, 'how do you know you have heart failure?' he replied 'We went on Google and put in symptoms and this is what I've got'. It takes an educated person to say 'Well no what you've described is not heart failure because of XYZ'. (FG3)

Increased confidence reportedly increased individual self-awareness, *'I can challenge more, I'm assertive to the point where some of my medical colleagues are getting annoyed, the juniors, but the consultants support me...you're in a position to be a bit better, and I would challenge bad practice'* (FG46). This finding concurs with the student example (S28) presented in Section 4.3.4.3 who reduced their scope of practice as a consequence of the learning.

4.4.6 Outcomes of the Learning on Practice - Patient Satisfaction

Practice outcomes were indirectly determined by asking participants to describe perceived improved patient outcomes resulting from individuals undertaking a programme of advanced practice study. Participants in all Focus Groups described the outcomes individuals made in a number of ways rather than recalling stories, summarised as:

'Providing greater choice to patients who they see' (FG2, FG3); 'An increased desire by patients wanting to see a nurse rather than a medic because of increased scepticism of the medical team following 'Shipman' (FG3); 'Advanced practitioners are more thorough in managing patients as a result of increased depth of assessments' (FG2, FG3); 'Advanced practitioners shared more information across and within teams' (FG3);

'Advanced practitioners provide the first route for escalation for the ward staff when they need additional input rather than the junior doctors' (FG1).

Additional comments included:

'Junior medical staff increasingly rely upon advanced practitioners for example in critical care outreach' (FG1, FG2, FG3); 'Advanced Practitioners provide more holistic care by bringing a nursing philosophy and perspective to the consultation'. (FG2)

Participants reported that *'advanced practitioners offered an alternative approach to the medics, they give patients more time in consultations, provide more education as part of the management and listen more, resulting in increased patient satisfaction' (FG2); 'they feel the door isn't closed on them' (FG3).*

Evaluation of the outcomes of the learning was said to occur at a performance review, with the discussion based on the individual's perception of what they had learnt and achieved. There was no indication within the Focus Groups that on completion of a programme of study any individual had subsequently received financial remuneration or progressed in their career, confirming PQ student reports presented in Section 4.3.6

4.4.7 The Current Role of the Advanced Practitioner in Practice

The advanced practitioners (FG3) were asked how current workforce configurations within the NHS impacted upon the advanced practitioner role. The respondents felt this was *'an interesting question' (FG3)* and reported that *'the impact was dependent upon the context in which they worked' (FG2).* Participants supposed that other healthcare professionals viewed the advanced practitioner role as *'cheap labour' and 'a way of the Trust saving money' (FG3).* Overall, participants felt the advanced practitioner role was *'incompletely understood within the Trust and consequently this limits the benefits to patients'.* This was further

described as *'no confidence and no appreciation of advanced practitioners being introduced'* (FG3). One advanced practitioner demonstrated their frustration as follows:

'We are clinging to a wreckage of a job.... They see it as taking on a doctor's role. ...They actually believe that the introduction of this advanced practice role is not a nurse rather glorified cheap labour'. (FG3)

Advanced practitioners professed to have no real voice within the Trust (FG3), explained by; *'being located on three different geographical sites that stop us from forming a cohesive group despite attempts made to get us to meet monthly'* (FG3). Advanced practitioners in this Trust were, however, provided with a generic job description that could be modified by individual clinical directorates to aid consistency between roles in the Trust.

4.5 Summary of Findings

Focus groups were held between November 2012 and May 2013 in three Trusts that regularly sent individuals to Case A. Poor recruitment within two Focus Groups limited the level of discussion anticipated. However, despite this, those participants in attendance contributed fully and provided interesting and rich data in response to all questions. The Focus Groups were held at a time when the NHS Trusts involved were undertaking significant reorganisations in response to austerity measures and government policy. There was a sense of managers having to thoroughly justify all financial decisions that subsequently reduced their capacity to support staff to undertake advanced practice programmes, and prompted them to prioritise education funding for mentorship preparation, other clinical courses and mandatory training.

Managers' responses were provided in an uninhibited way, albeit at times demonstrating a lack of knowledge and understanding of the advanced practitioner role, its preparation and subsequent use within their respective Trusts. The use of advanced practitioners together

with managers from a variety of clinical practice areas provided a balance of perspectives to the questions asked. The advanced practitioners provided insight into the use of advanced practitioners in practice supplementing and corroborating the literature review undertaken previously (Chapter two). An overall summary of the focus group discussions is presented in Table 19. This is followed by an overview of the results from Case A compiled from the analysis of documentary evidence student interviews and focus groups, and presented in Table 20 overleaf.

Table 19 Summary of Findings Case A: Managers and Advanced Practitioners.

Key Theme	Finding
Expectations of Managers to support Staff	▪ Programme of study meet organisational objectives ▪ Managers prioritise mandatory training and mentorship programmes. All Focus Groups described a selection process ▪ Students normally initiated the application for study leave or managers used personal and professional review meetings to identify individual need ▪ Resourcing study leave is difficult. Programme fees are commonly paid by the Trust, however study leave to attend is restricted commonly to five days per academic year.
Factors affecting the integration of learning into practice	▪ Barriers and enablers for study were identified across the three Focus Groups with common issues including: lack of time, academic study support, support in practice by healthcare professionals, peer understanding and support, historical perceptions and reorganisation in response to austerity measures. ▪ The need for more advanced practitioner nurse mentors ▪ Strong HEI links
Outcomes of the learning from the programme of study	▪ Increased knowledge and confidence in the student. Increased assertiveness. This afforded greater respect from peers and enabled advanced practice's to act as good role models. ▪ Issues of resistance to the role, lack of clarity and titling of advanced practice's within Trusts was apparent in some clinical areas ▪ The ability to gain promotion or move into an identified advanced practice role was very limited or non existent
Outcomes of the learning on practice	▪ Increased patient satisfaction: Improved patient consultations, increased effective use of healthcare assessments, improved patient consultations.
The current role of the advanced practitioner in Practice	▪ Variations between Trusts and across Trusts ▪ Lack of clarity and understanding of the advanced practitioner role ▪ Advanced Practitioners practice in isolation ▪ Perception of advanced practitioner as medic substitution and cheap labour

Table 20 Summary of Results: Comparison Table.

Awarding Institution	Case A
Year of Programme Validation	2008
Links with Partner Institutions/Drivers	Multiple purchasers within South East England
Programme Accreditation	RCN
Final Award	MSc Advanced practice with pathways in: ▪ Nurse Practitioner ▪ Nursing ▪ Critical Care ▪ Respiratory Care ▪ Cancer and Palliative Care ▪ Gastro-Intestinal Care May exit with Postgraduate Diploma level (120 Credits)
Level of Qualification	Level 7 (masters) 180 Credits
Length of Programme	Part time mode 3 years normally maximum term 5 years
Mode of Attendance and Support	Part time mode day release over two academic semesters per year. Days are pre set and students are supported in clinical practice by a work based mentor (Normally a Medical Practitioner) and a clinical link tutor employed by the university. Normal attendance one day per week
Funding	NHS London, Employer and Individuals.
Cost of Programme	Year 1 £3480; Year 2 £3480; Year 3 £2270. Total Cost £9230

Awarding Institution	Case A
Entry requirements	- Registered Practitioner, currently in practice - Normally hold a first degree or minimum of 60 credits at level 6 - Working in a practice arena that will support and facilitate the development of advanced practice - Have written agreement of support from their employer for practice and financial support - Working in clinical speciality for a minimum of two years. Minimum employment in practice 15 hours per week
Relevant Subject Benchmarking	Framework for Higher Education Qualifications (FHEQ) (QAA 2008). Descriptor for a higher level qualification at level 7 NHS Knowledge and Skills Framework (DoH 2004b) RCN Competencies for Advanced Nurse Practitioners (RCN 2007).
Aims of Programme	- To promote an advanced level of scholarship; develop skills of interpretation and effective synthesis of knowledge within a specified field, to inform practice and develop healthcare practice and policy at both operational and strategic level. - Foster refined levels of clinical judgement and autonomy concerning the full range of healthcare interventions, equipping the student to support the development of advanced practice and practitioners and operate collaboratively within a specified field of care.
Programme Structure and Content	All students are required to follow the programme in the sequence outlined within the programme specification for a given pathway. advanced practice may be obtained with appropriate evidence. There are four core modules. Year one Modules: - Assessing Needs and Outcomes: methods and Measurement (15 Credits) Core - Scope of Professional Practice (15 Credits) Core - Pathophysiology and Assessment of Illness and Injury (30 Credits) Year Two Modules: - Clinical Judgement, Diagnostic Reasoning and Pharmacology (30 Credits) or Independent and Supplementary Prescribing (60 Credits) - Generating knowledge for Practice (15 Credits) Core - Leadership and Management (15 Credits) Core Year Three: - Dissertation (60 Credits)

Awarding Institution	Case A
Teaching and Learning Philosophy and Strategies	Teaching and learning strategies employed encourage student independence and learning from and through experience, using reflection, and the development of the skills required to practice at an advanced level; to ensure that the Advanced Nurse Practitioner award will meet the Standards and Criteria for RCN accreditation of Nurse Practitioner Programmes (2007). Paramount to the teaching and learning strategy will be the value placed on the student's own experience of practice and theoretical underpinnings of practice. The programme team and external experts will provide the main input on the taught sessions. The emphasis will be on student support and facilitation. Teaching and Learning strategies used, include: ▪ Keynote lectures and Seminars ▪ Enquiry based learning ▪ Group and individual tutorials and debates. ▪ Demonstration and replication by the student ▪ On line materials available on VLE ▪ Individual scholarly learning ▪ Reflective Learning Logs
Assessment Strategy	Assessment strategies are said to include both the assessment of theoretical knowledge and of practical knowledge Assessment methods used include: ▪ Reports ▪ Literature Review ▪ Portfolio ▪ Case study ▪ Reflective essays ▪ Business Plan ▪ Examination ▪ Integrated Care Pathways ▪ Essay ▪ Objective Structured Clinical Examination (OSCE) ▪ Dissertation The use of formative assessment is included within many of the modules. To achieve the award students must pass all the components of each module. The pass mark for written assessments is 40%. The pass mark for OSCE based assessment is 70%. Only two referral attempts are permitted.

Awarding Institution	Case A
Practice Component	Students are required to work in practice for a minimum of 15 hours per week. As part of the entry requirements students must submit a completed Clinical Site Evaluation Form (CSEF), which requires sign off by a qualified mentor in practice and their manager. The CSEF is an educational audit of the practice environment. Mentors provide formative feedback to students except for the Independent and Supplementary Prescribing module where they summatively assess and sign off specific competencies. A mentor handbook is issued at the start of the programme. Examination of clinical skills is through OSCE only.
Profile of Participants - Students	Participants (n = 16): Year 1 (n = 6); Year 2 (n = 3); Year 3 (n = 4) and Post Qualifying (n =3) Mean Age 41 years Age Range 27 – 52 years Length of professional service mean 19 years
Profile of Participants – Focus Groups	Participants (n = 14) Managers and advanced practice's in three Focus Groups. Focus Group 1 (n = 5); Focus Group 2 (n =7); and Focus Group 3 (n = 2). Mean Age 49 years Age Range 31 – 60 Length of professional service mean 5.5 years

Student Themes	
Awarding Institution	Case A
Student Status	Self motivated and self directed to study Students part or fully fund learning
Selection of HEI	Previous study Relevant content Location Preferred provider
Expected Outcomes from Programme of Study	Enhance career progression “Playing catch up” academically Competitive environment To remain clinical Development of assessment skills and knowledge
Factors Facilitating the Learning Process	Healthcare professionals Family Self Academic staff Organisational funding
Barriers to Learning Process	Lack of time – Workload Lack of understanding by organisation and Healthcare Professionals None Lack of support – Funding, study time Mangers perceived lack of academic qualifications
Facilitating Knowledge Transfer	Academic staff Organisational support – medical mentors, managers Trust and belief in student Self motivation - Proactive Use of assignments Research knowledge Knowledge to underpin practice
Programme Evaluation	Unprepared for workload Challenging modules Met expectations Use of more medical practitioners in teaching All modules are relevant

Awarding Institution	Case A
Effectiveness of Learning	Increased confidence Change in attitude – ability to challenge, improved communication with patients and peers Increased knowledge Improved consultation skills Improved clinical decision making Challenge tribalism
Benefits for Patients	Improved consultations Manage more complex patient presentations Reduce waiting times for patients Improved clarity with communications to patients Management based on knowledge rather than 'guesswork' Increased ability to anticipate problems More proactive in patient management More autonomous in decision making Provide linear journey for patients Increased use of evidence based practice
Role Change	Changing all of the time No change in grade or remuneration Clinical role change with increased responsibility Increased strategic responsibilities Increased recognition and use of advanced skills Increased autonomy More reflective practitioner

Awarding Institution	Case A
Focus Group Themes	
Expectations of Managers	- Contract by preferred providers for funding - Cost - Establish needs in department for advanced practice's - Fit in with organisational strategic plan - Selection and interview process used - Consider individual experience, benefits, PDP's - Shift to purchasing level 7 academic programmes - Expect student to initiate request for advanced practice study - Priority for Trust support offered for mandatory training and mentorship programmes
Factors Affecting Integration of learning in Practice	- Relevance of role - Relevance of programme of study - Teaching of others - Support from peers and other healthcare professionals - Difficult to get right - Tension between medical trainee's and advanced practice trainee's - Good support from HEI academic staff - Funding – time and fees - Vicarious liability - Lack of advanced practice mentors - advanced practice's work in isolation - Workload
Perceived Outcomes from the Programme of Study	- Improved practice - Improved health assessments - Increased confidence - Increased assertiveness - Greater confidence from others of students ability - Increased underpinning knowledge - Increased autonomy - Complete patient management - Junior doctors reliant upon them - Improved decision making 'Bridge' between junior nursing and medical staff - Increased use of evidence based practice - Increased strategic perspective - Increased use of prescribing

Awarding Institution	Case A
Evaluation of Learning	Appraisals
The Clarity of advanced practice Roles in Practice	Uncertainty of advanced practice role Lack of understanding of advanced practice role Lack of identity of advanced practice role Lack of uniformity of advanced practice role within organisations Resistance to advanced practice role by peers and medical professionals Different approach by advanced practice's to care – medical model with nursing philosophy

CHAPTER 5 CASE B FINDINGS

5.1 Introduction

This chapter presents the findings related to Case B and comprises the results from analysis of documentary evidence, student interviews, and Focus Groups. Case B is an advanced practice postgraduate programme delivered in North West England. Details of the organisation were previously provided in section 3.4.2

This chapter presents findings from the analysis of data from each of the methodological approaches used in the study and represents an exploration and evaluation of participants perceptions of the outcomes of the advanced practice programme of study in practice.

5.2 Documentary Evidence

Documentary evidence was collated from programme documents outlined in Section 3.8

5.2.1 Case B: The Programme of Study

At the point of data collection Case B was a postgraduate full-time advanced practice Programme that was validated in 2009 in its current format. Key characteristics of Case B include:

- The programme is normally delivered over two years full-time leading to a masters degree although students can exit with a Postgraduate award following completion of specific modules.
- The programme is benchmarked against the RCN Competencies for Advanced Nurse Practitioners (2007) despite not being an RCN accredited programme.
- Student fees are normally funded through an NHS contract, although employer or self-funding students can access the programme.
- The programme is modular and comprises core and optional modules that are followed in a set format, totalling 180 level 7 academic credits. Independent and

Supplementary Prescribing is not available within the programme. Module details are presented in Table 25 (Page 197).

- Admission criteria include; qualified registered professional, normally a graduate; currently working in practice that supports advanced practice working, written agreement of learning and financial support.
- The majority of students are employed in trainee advanced practitioner roles paid at their current grade, and on completion automatically move to Band 8a (DoH 2004a). Remaining students could be employed full or part-time, and undertake the study alongside this.
- The programme has a strong clinical focus and is assessed using a variety of methods both by the HEI and mentors in practice. Assessments include essays, portfolio, practice competence assessed in practice by the mentor and clinical facilitator and HEI based OSCEs.
- There is no final research based dissertation. Evidence based clinical competence is assessed via a portfolio of learning that facilitates work-based learning driven by client and service needs
- Protected learning time and support from practice-based mentors and assessors is inherent within the programme.
- Learning Facilitator support: Each student has access to a learning facilitator whose primary function is to liaise with the student and mentor ensuring effective support is provided, and to confirm that the learning environment for practice based assessments complies with quality assured mechanisms. The learning facilitator assists in the development of an individual student learning pathway throughout the programme of study.

Field notes recorded following an introductory meeting with a senior nurse manager captured my initial impression: *'This manager is telling me a different story, that of a Trust that values the role and is working towards implementing them throughout the Trust. She*

talks of innovation and implementing roles into clinical research, I have not heard of them working in this area before. She demonstrates such enthusiasm. This could be exciting'.

5.2.2 Participants: Students – Biographical Profile

Students were recruited from years one and two and following completion (PQ) of the programme of study, between December 2012 and February 2013. The students were employed in a variety of practice settings, and all students were trainee advanced practitioners studying full-time. Trainee advanced practitioner posts provide supernumerary status to the student during training.

Data were collected from eight students, six females and two males. The age range for the students was 33 - 56 years, with a mean of 42 years. Students had a mean of 16 years professional service. All students were nurses, six worked in either acute or critical care adult or paediatric clinical areas, and two students worked in a clinical research facility, sponsored by a drug company, based on the same site. Participants' profiles are presented in Table 21 (Page 168).

Table 21 Biographical Details - Case B

	Age Range (Mean)	Gender	Years Professionally Qualified Range (Mean)	Current Role	Current Clinical Specialty	Employment Status
Case B Year 1 Students (n = 2)	36 – 42 (39)	Female: 1 Male: 1	12 – 18 (15)	All Trainee Advanced Nurse Practitioners	A & E (n = 2)	All Supernumerary
Case B Year 2 Students (n = 3)	33 – 34 (33.5)	Female: 3 Male: 0	7 – 12 (9)	All Trainee Advanced Nurse Practitioners	• Acute Medicine (n = 1) • Clinical Research (n = 2) • Paediatric Clinical	All Supernumerary
	Age Range (Mean)	Gender	Years Professionally Qualified Range (Mean)	Current Role	Current Clinical Specialty	Employment Status
Case B Post-Qualifying Students (n = 3)	36 – 56 (46)	Female: 2 Male: 1	15 – 34 (24)	Advanced Nurse Practitioners	• General Medicine (n =1) • Respiratory/ Acute Medicine (n = 1) • Elderly Care / Stroke Medicine (n =1)	All Supernumerary

5.3 CASE B – STUDENT FINDINGS

The format of this chapter is consistent with the one used to present Case A data in Chapter Four. Themes aligned with those used for Case A are presented, with the addition of student support, a tripartite agreement, and supernumerary status themes.

5.3.1 Expectations of Students

The students were questioned about their initial motivation to undertake the programme of study that included the selection of the HEI, and the application process in order to identify factors that influenced their professional and personal development. These are now discussed.

5.3.1.1 Initial Interest and Application to the Programme of Study

The motive for applying for trainee advanced practitioner roles for all students was described as wanting to enhance their knowledge and skills to improve care delivery. They also perceived the advanced practitioner role was an opportunity for change and professional development, for example: *'I wanted to return to clinical practice'* (S39); *'I wanted to learn, have knowledge and skills and research to assess patients'* (S51); *'I was a band 5 then 6 in the research facility because of the growth of the facility...I wanted to advance clinically, I needed the knowledge to do this, develop my anatomy and physiology'* (S52). Students demonstrated researching the role to prepare them with sufficient information from which they could make an informed decision., for example:

'I have a few colleagues who did the course. I'd read a lot of literature, ... I saw a lot of difference, they were robust, doing lots of discharges, making diagnoses...I went to work with them, observed them' (Y2, S47); *'One of my friends at a different hospital was one, I knew what the role was and I wanted to stay clinically focused'* (PQ, S36).

Four students (S47, S49, S51, S52) reported being encouraged by their managers to apply; *'I was continually being told to go for an advanced qualification, my manager said why don't you apply for this'* (FG51); *'My manager has been looking at introducing the role into the facility, there was an expectation I would apply'* (S52). Ultimately the decision to change their role was self initiated.

Students from all three years described a structured robust application and selection process that followed advertisements for trainee advanced practitioner posts within the Trust, reported as: *'I responded to an internal advert, an application form then an interview panel with representatives from the Trust and the HEI, and finally a presentation about the role of the advanced practitioner'* (S52). Following recruitment into the post, all students became supernumerary, which meant that the students worked in practice three days per week and

had two days per week to undertake academic or practice learning. Students reported this as *'an incentive to apply for the trainee role'* (S47).

When providing their rationale to become advanced practitioner trainees students described their perceptions of the role. This was explained as:

'I thought the advanced practitioner role would be ideal for me...I saw my colleagues, what they were doing, assessing patients, diagnosing them, prescribing and managing patients, I thought that would give me a lot of autonomy' (Y2, S39)

And,

'In depth knowledge, to critically analyse the work that I was doing, and to take it forward in two perspectives; contributing to the current team, assess clients, diagnose and treat and refer without them seeing a medic, and also to develop the service further' (Y2, S50).

Further outcomes included; *'Meeting targets, the four hour waiting time'* (S50); *increased throughput of patients in clinical areas* (S39); *'increased efficiency in the service, and innovating new ways of managing current patients'* (S50). Exemplars to support the latter were provided, and included: *'the introduction of a nurse led outpatient service to manage DVT ambulatory patients'* (S39); and *'a new initiative where advanced practitioners worked with major cases in accident and emergency'* (S50).

5.3.1.2 Which Higher Education Institution to choose?

Students from all three years indicated that there was no choice in selecting the HEI to undertake the programme of study. The Trust and HEI worked in partnership to deliver this training programme through an established concordant agreement; *'I think we had to do it at...'* (S49); *'It was the only university the Trust linked with...'* (S36). The students expressed satisfaction with this, for example: *'It means I can learn where I know...I know the people'* (S39).

5.3.1.3 Expected Outcomes From the Programme of Study

Enhancement of learning, specifically the development of existing knowledge to underpin practice was the perceived principal outcome for students. Examples provided included: *'New knowledge, clinically focused, knowledge about conditions'* (S36); *'the development of academic skills and a more structured approach to health assessments to improve care delivery'* (S36, S47, S49). Additional objectives of the learning identified included: *'development of clinical assessment and diagnostic skills'* (S36, S39, S47); *'development of decision-making skills facilitating selection of appropriate investigations and treatments for a wider and more complex range of patient presentations'* (S36, S39, S47, S49); and *'enhancement of anatomy, physiology and research skills'* (S50, S51).

One Y1 student (S47) described how the development of these skills in conjunction with her nursing experience could help address the feeling of frustration currently held as:

"In ED patients come here, and many things get missed... medics can't even pick up subtle things sometimes, because we haven't listened to the patients, spent time with the patients... we don't do that kind of nursing any more'. (Y1, S47)

Three, Y2 students (S47, S49, S52) reported that their trainee advanced practitioner roles were new and innovative to the Trust. They viewed this as a joint challenge for them and their senior managers to make the role a success, particularly as there had been opposition from medics, for example:

'At our hospital we don't have ANP's here in A&E.... so it's kind of me and my lead nurse. She had the vision, she wanted ANP's—I came up with ideas because I disagreed with the medical thing.... at the same time she was planning to have some in the department... the doctors weren't very happy about it.' (Y2, S47)

And,

'Within the research facility sometimes you wait ages for a clinical physician to do something for you, it would be great if nurses could take over those responsibilities to

save the patients waiting, we could have finished the appointment in 21/2 hours...we need to change policies and procedures to support this' (S49).

This development was seen to provide a more seamless journey for patients, enhance care delivery, and also provide trainees with clinical progression beyond Band 6 (DoH 2004a). Students believed that the learning from the programme would link theory with practice, and facilitate greater understanding of the *'what'* and *'why'* (S49) of symptom manifestations, for example: *'You would sometimes know the symptoms, but you wouldn't know actually how the signs happen'* (S49); and facilitate the development of *'wider thinking and improve the delivery of care'* (S52).

Post qualifying students (S36, S37, S39) described feeling unfulfilled in previous roles in education and management, and reported the desire to move back into clinical practice, for example: *'I have had many jobs, I worked as a ward nurse, then I worked as a lecturer, I worked my way up the ladder...I was a clinical dean in..., supposed to be a good job, good salary...but when I analysed everything, I wanted, practice had offered me the most fulfilment and satisfaction'* (S37).. One, PQ student (S39) also reported *'there was a financial incentive for their application, although this was not the primary driver'* (S39). The following quote describes how a student (S37) perceived that the programme of study relieved the burden of uncertainty: *'You weren't just going on some masters course that had no relation to whether you would get a job at the end, you were doing a masters course as part of a job'* (PQ, S37).

One student (S39) explained that it wasn't the qualification per se that was important, rather *'the learning that took place during the programme of study enabled me to lead a multi-professional team "uniting us"'* (S50). Three students (S47, S49, S50) reported that having a robust qualification to support the role was beneficial. All students perceived the learning would enable to them to work more independently or autonomously in the future.

5.3.2 Factors Affecting the Learning Process

The ability of students to transfer learning from the programme of study to practice can be assisted or hindered by a variety of factors that are now described.

5.3.2.1 Facilitating the Learning Process for Students

Students described a number of factors that enabled them to learn effectively and these included support from other professionals including medics and academic staff, supernumerary status, and the composition of the programme.

5.3.2.1.1 Student Support – A Tripartite Agreement

Lecturers and clinical facilitators from the university, Trust managers, and mentors who were medical consultants were the three groups of professionals who were identified by students as enabling them to learn. This agreement was termed a *‘Tripartite agreement’* (S37), and was observed to provide the following:

‘People were aware from day one that we are here for learning. It was structured. We were given an assessor.... a person who would look after me. From day one I was told what was expected from me’ (Y1, S51)

Each professional group equally provided a different type of support to students. However, what became apparent was that this support was coordinated and provided almost a seamless model of learning.

5.3.2.1.2 Student Support – The role of Healthcare Professionals

In contrast to Case A students (Section 4.3.2) all students described how managers supported them during the learning by providing them with time to manage their learning independently: *‘My manager never put any pressure on me, he let us get on with it – this is the structure of the course, you’re supernumerary on two days and you go off and you get*

this and the other' (S36). Managers were reported to be enthusiastic, motivating, innovative and completely supportive of the learning, for example:

'I felt secure in what I was doing and I had access to help here at work.' (Y2, S39)

Managers placed no expectation on students to undertake their previous 'normal' role. Two Y2 students (S49, S52) did however describe difficulties relinquishing previous responsibilities, for example: *'It is difficult to switch over roles, you do the normal of what you've been doing and I have two uniforms, it is confusing'* (S49).

Medics acting as clinical mentors were also perceived as supportive even in clinical areas where they had initially opposed the introduction of the advanced practitioner. Four students (S36, S37, S39, S50) reported that medics were available daily to help with practice learning, for example: *'If I needed help with assessments and clinical practice, then I would go to him anytime'* (S36); *'He is one of the consultants, an ED consultant, and he is happy to offer time or anything'* (S47). In the clinical areas where resistance to the introduction of the advanced practitioner role had previously occurred, newly recruited consultants reportedly demonstrated greater support, for example: *'I approached Mr...instead he is new and has worked with APs before, he includes me with his team'* (S47). Six students (S39, S49, S51, S52) reported the effectiveness of medical mentors; by *'encouraging them to join medical ward rounds'* (S47); or by *'setting learning tasks related to real patients on a daily basis to reinforce learning'* (S50).

5.3.2.1.3 Student Support – The Role of Academic Staff

Support from academic staff was described as extremely beneficial. Clinical facilitators were described by students as pivotal to them completing the programme of study successfully, and the link between the student and their mentor, which facilitated them receiving effective and on-going feedback. Students described specific support provided, for example: *'Assessment support and practice'* (S36); *'Identification of learning needs'* (S37);

'Encouragement and pastoral support both individually and in small groups' (S47); and 'Provision of the facilitator's personal telephone number to aide communication' (S49).

5.3.2.1.4 Student Support – The Benefits of Supernumerary Status

Supernumerary status provided time for students to attend the HEI for formal teaching and for additional independent learning. All students felt advantaged because of the model used to deliver the programme of study, described as:

'Supernumerary status has been upheld.... We' are not expected to cover other areas. We are left to follow the work we need to do for the advanced practice programme.'(Y1, S50)

and

'I wasn't expected to do any, responsibilities. I was supernumerary for the whole time.' (PQ, S36)

Students reported that time spent on learning did not adversely impact on their personal lives, two students reported, *'Time wise we were well supported'* (S47, S51). The provision of time for two Y2 students (S49, S52) was beneficial because it specifically enabled them to access alternative placements, for example: *'I could access a children's skills module that was also running at the university....I went to North...for a placement, because I couldn't, there were no consultants here in the area that wanted to help me'* (S52). These placements were needed in order to meet clinical assessment module objectives. Furthermore, *'I had to do this...we are taught about the adult his is not relevant to my practice, I only look after children I need to know the specifics otherwise it is teach yourself'* (S52). Without supernumerary status these students considered that it was unlikely they would have been able to achieve the expected learning, for example:

'Having extra study days was very helpful... to go and see different things, and to write assignments. If I didn't have that time, it would have been a struggle.' (S39)

Managers appeared to trust the trainees completely to manage their time, which students viewed positively:

'The best thing is being able to be trusted to do things that were expected of us. It gave me opportunity to learn without too much restriction.' (S39)

The positivity generated from being a supernumerary student contrasted significantly with Case A self or part funded students, who reported many challenges.

5.3.2.2 Barriers to Learning

The participants were asked to describe any barriers to learning transfer they had experienced, and *'were minimal'* for four students (S36, S37, S39, S50), three of which were PQ students (S36, S37, S39). They described the programme of study, as *'structured'*, and providing sufficient time and resources to learn and support consolidation of learning in practice. Two PQ students, however reported difficulties in the setting of individual objectives, which were described as tedious yet useful, describing these as, *'a Blueprint'* (S39) or *'Road mapped'* (S37) for their learning.

5.3.2.2.1 Perceptions of Healthcare Professionals

Where the advanced practitioner role was being introduced for the first time in a clinical area, one Y1 (S47), and two Y2 students (S49, S52) reported that medics who had previously opposed the implementation of the advanced practitioner role now demonstrated less resistance. Students described:

'The doctor's weren't happy about having nurse practitioners in the department they don't want or like change –a few of our doctors are quite well known people, and I think they are quite old fashioned.... They think the nurse can't do this...how can a nurse do something in two years what the doctor did in five years.' (Y2, S47)

Three students (S47, S49, S52) reported an initial lack of clarity of the advanced practitioner role by other staff and role confusion, arising from having previously worked with them in the same clinical area. Students reported having to change these expectations which took time and was referred to as '*Stepping out of trainee role*' (S47). Another student reported:

'It's difficult they see me as a research nurse I have a slightly odd role now, because my days are blurred at the moment. I might be a sort of research 'nurse' in the morning and in the afternoon, they say 'This is what you need to be doing'... quite confusing.'

(Y2, S52)

The extra time provided by the trainee role was described as useful, yet insufficient because of the time to organise alternative placements away from their normal clinical area.

5.3.2.2.2 Legislative Issues

A further barrier reported by two students (S49, S52) and unique to this Case was related to existing legislative protocols and guidelines that support research roles in practice. Currently, a Principal Investigator is responsible for managing all aspects of clinical trials that were described as problematic:

'A main barrier is we don't have any laws and guidelines... I do a physical examination on a patient and have to be supervised, even if they say I am competent, I cannot sign off and authorise...it has to be countersigned, because it has to be a physician.'

(Y2, S49)

The future intention is for the advanced practitioners to take over these responsibilities. However, until or if legislation changes, students incurred issues in their daily practice.

5.3.2.2.3 Time as a Barrier to Learning

A lack of access to appropriate patients to meet programme objectives was problematic because of a lack of time to organise alternative placements; *'All OSCEs were adult focused, and I had to arrange a day to do paediatric training, in my own time'* (S52); and there was uncertainty of the depth of academic learning required in relation to paediatrics because this learning was self-directed *'I taught myself'* (S52). Conversely, they acknowledged the need for an advanced practitioner to be an *'all rounder'* (S52). The student (S52) had wanted support; *'I would have liked a bit more support, more consistent support from the lecturers to help me relate the adult stuff to the child'*. Another student found it time consuming to find patients to examine; *'Our patients are healthy... they are not ill, and you won't find acute symptoms. So we sort of try other areas, our patients, they don't know when to fit me in, I don't always have the opportunity to go'* (S49).

5.3.3 Programme Evaluation

Interview questions sought student evaluations of the programme of study. They were asked to identify the most beneficial aspects of the programme of study, the rationale for this, and to identify any areas that could be improved. Students were also asked about their overall satisfaction with the programme of study.

5.3.3.1 Beneficial Aspects of Learning

The most beneficial aspect of the programme of study identified by students was that it prepared them to become an advanced practitioner. All students reported that learning had promoted their development, for example: *'development of new skills and knowledge, which I am now using in practice'* (S47); *'Loads of new knowledge, basic to complex, and it gives you an opportunity to apply it to assessments'* (S51); *'I expect to learn new ways of learning, the portfolio and reflection that will be new to me'* (S50). First and second year students (S47, S49, S51, S52) reported that group work facilitated team working; *'We were all given*

different information about a patient, we had to work as a team to do trigger work, we had a clinical case and we had to develop trust, and increased knowledge regarding unfamiliar clinical problems and learn to share, and time manage' (S51). Medics supervised assessments in practice and provided feedback regarding the students' capability to provide positive patient outcomes. Two Y2 (S47, S49) and two PQ students (S36, S37) identified the clinical facilitator as particularly beneficial, for example; *'she would meet us frequently, at the university, and met a group of us in practice...and might say "you need to be looking at, you need to get experience in this" and we would do this'* (S36) They were also reported to *'help with finding placements'* (S49).

One student (S37) commented that learning was applied to practice by way of *'Symbiosis'* (S37) that was qualified as:

'I did learn something in the classroom, but just enough to get by in practice... the real learning comes when you are listening to a real patient's chest and thinking 'Well what was that?' 'And what does it mean?'... But you know you couldn't do it in practice without that grounding.' (PQ, S37)

Students (S51, S52) described how the programme helped them to think differently and to develop the self-belief to use this, for example:

'You approach things differently. When you have confidence to go ahead... you're sure of what you're doing, knowing you're doing the right thing.' (Y1, S51)

Second year and PQ students (S36, S37, S39, S47, S49) viewed peer support positively, *'practicing together assisted classroom learning by providing additional encouragement and understanding of each other's needs'*. Students identified that the learning from the programme of study facilitated new ways of delivering care, for example, *'the development of new clinical pathways in stroke management'* (S39); and, *'improved clinical leadership skills leading to the development and integration of nursing and medical teams'* (S37).

First year students (S50, S51) reported the academic level of the taught content of the programme of study was high in both content and delivery. A small number of sessions were reported by all students as less relevant or poorly delivered. However, these were reportedly linked to the relevance of individuals' practice. Academic staff that had *'previously held advanced practitioner roles were more credible and more able to relate theory to practice, consistently and accurately'* (S37).

5.3.3.2 Satisfaction with the Programme of Study

All participants provided positive responses when asked to describe their satisfaction with the programme of study. The structure of the programme was reported by a majority of students as aiding completion. Three students (S39, S49, S52) however commented that, *'there is a long gap in year two where you get no clinical teaching; it is all research and leadership. I have forgotten what I learned when we come back to it'* (S49).

Six students (S37, S39, S47, S49, S50, S51) described problem-based learning used within modules as very beneficial. Three students (S47, S50, S51) reported that this teaching strategy enhanced group work, team building skills, and research knowledge which provided them with; *'a greater appreciation and understanding of clinical conditions because it allowed us to discuss related issues that I may otherwise not have considered'* (S51). For example: a PQ student (S37) described how the management of patients with Parkinson's disease who presented with difficulty in swallowing made them consider the ethical dilemmas of end of life care in dementia patients, the results of which were subsequently implemented in practice to enhance care delivery.

5.3.4 Evaluating the Effectiveness of Learning and its Application to Practice

The effective transfer of learning from the programme of study to practice was an identified objective of this study. In an attempt to meet this, students were asked to identify the

perceived benefits to patients and to their organisational role. Themes again emerged in relation to appropriateness of learning, increased knowledge, behavioural changes, and benefits to patients.

5.3.4.1 Appropriateness of the Learning

All students, except one Y2 student (S52), reported that the learning had met or exceeded their expectations, providing relevant and structured content. One student reported that; *'the programme of study had fully prepared me for the advanced practitioner role and added on'* (S37). All students identified the need to supplement classroom learning with on going independent study and research and used the time associated with supernumerary status to do this (Section 5.3.5). Learning facilitated innovation and influenced the development of advanced practitioner roles in new areas. Despite this, in some situations, students (S49, S52) described *'I feel frustrated as I probably wont be able to fully implement the role because of legislative issues, although my manager is trying to address this issue'* (S49). They reported feeling supported during the transition.

5.3.4.2 Increased Knowledge and its Application to Practice

Students were asked to describe how they used the knowledge from the programme of study in their practice. PQ students (S36, S37, S39) perceived that they now *'applied a more holistic model of care that included consideration of physical, social and psychological management of the patient'*. The assessment, management and treatment of patients together with the ability to recognise abnormalities, was also perceived to have improved; *'New knowledge has added depth and breadth to my existing knowledge that has helped my development as an advanced practitioner'* (S36). Learning associated with history taking was identified as enabling the students to becoming more questioning, for example: *'Why is this patient in front of me?'* and *'What am I going to find?'* (S36).

Students reported being involved in all stages of a patient consultation and reported the outcomes of this as: *'Reduced patient waiting times'* (S47, S50); *'Greater continuity of care for patients by nurses who are current in their practice in contrast to medics who frequently rotate through, and the presentation of a familiar face'* (S49, S52); and *'Learning is the key to facilitating deeper knowledge and understanding, allowing us to build a 'bigger picture' in clinical presentations that previously I had been unable to do'* (S49).

5.3.4.3 Behavioural and Attitudinal Changes and Application to Practice

All students reported increased confidence as a result of the programme of study leading them to use more considered decision making *'I take a step back'* (S47) and to become more independent and autonomous in their practice. Additionally, confidence encouraged them to *'challenge medics more frequently and improve communication within the clinical team'* (S37). One Y1 student described *'Role reversal'* (S50) with junior medics in that, as their confidence and knowledge grew the medics became more reliant on them. Two students (S47, S51) reported initially feeling scared and anxious; *'at first it was a little overwhelming, the amount of knowledge I needed to learn, however as my confidence grew, I questioned more and I was able to review patients more thoroughly'* (S49).

5.3.5 Outcomes of the Learning on Practice - Patient Benefits

Students were asked to identify situations from practice to describe the outcomes of their learning on practice. PQ students perceived that *'patients received care from a competent practitioner who was able to manage my own caseload and any shortfall resulting from the medical rota'* (S39); *'worked within a designated clinical speciality'* (S36); *'made a difference to the patient'* (S37); and *'were appreciated by the family'* (S37). Five students (S36, S37, S39, S47, S52) described the advanced practitioner role as *'a bridge'* (S39) between medical and nursing teams particularly for junior nurses and medics. Furthermore, they reported feeling part of, and respected by, both teams.

Students provided exemplars of changes they had made to care delivery as a result of the programme of study that demonstrated how they had proactively managed a situation of which they would have previously not been capable. Additionally, they successfully identified and managed patients found to have been previously misdiagnosed. The following vignettes 3,4 and 5 provide examples of these:

'It has highlighted areas where the initial management plan and diagnosis may have been inadequate, and, after further investigation, it has highlighted further problems or areas that need further management, which has been a bit of an eye opener.... to actually realise that it does drive you to actually think deeper into cases. (S50)

Vignette 3

'I think patients get a better service...I go to A&E to see a patient, clerking them, and bring them here without me the patient would see a non-stroke specialist. Their admission route would be different...they would probably go through a number of ward moves before they got to the ward here. So I can do everything they need and get them here, so that benefits them.'
(S39)

Vignette 4

'One of my registrars sent me to see a patient... they were thinking she had a DVT, for three days. The first time I met her... it was completely shocking, they completely missed out that this lady had a fall. There was nothing in the papers to say she had a fall.... she definitely looked like a clinical neck of femur fracture. It was ignored.... No one put her on the bed to examine her properly, and that's what I did.'
(S47)

Vignette 5

One Y2 (S47) and two PQ students (S37, S39) now described themselves as *'Critical thinkers'* (S47) because they could identify the most effective management for individual patients. Furthermore, they perceived increased patient satisfaction as a consequence of *'listening, educating and questioning patients more thoroughly, and by taking more time to do this, for*

example, when I am explaining drug therapy to patients I see this as providing more continuous care (S39).

5.3.6 Role Change as a Result of the Programme of Study

Second year and PQ students described many changes in their role as a result of the programme of study. Students described examples of change, for example: *'More clinical in my role' (S39, S47); 'Performing more robust assessment, management and treatment as a result of my increased knowledge' (S36, S37, S39); 'Increased efficiency and effectiveness in managing patient consultations' (S47; S49); 'Increased patient satisfaction' (S36, S37, S39); 'Challenged clinicians more accurately' (S36, S39, S47, S52); 'Undertook more advanced investigations, for example, biopsies' (S49); and 'Manage patients with an increased acuity or more complex clinical presentation' (S36, S37, S39, S47, S52).*

For two students (S49, S52) the advanced practitioner role in their clinical areas was said to be *'evolving'* (S52), and creating *'uncertainty'* regarding what the future advanced practitioner role would encompass, specifically the amount of clinical *versus* management time the role would require. Students described needing to *'battle it out'* (S52) to gain a predominantly clinical role. For remaining students, greater role certainty was appreciated and supported by managers and medics. Three Y2 (S47, S49, S52) and PQ students (S36, S37, S39), reported that they were now innovating practice in the development of specific services, described as:

'I collaborated on the development of the stroke care pathway in many ways. I wrote a protocol for giving aspirin within 24 hours to patients. I'm currently working as part of a small development team to improve MDT meetings.... Improving the information we give to patients.' (PQ, S39)

One PQ student (S37) also reported that the Trust, in trying to maintain a research focus within the advanced practitioner role, was now allowing qualified advanced practitioners to

take one day per week as a research and development day. The aim of this day was described as enabling advanced practitioners to undertake and publish research and use it to inform and implement evidence based change within specialist clinical areas. Overall students presented a positive picture of the advanced practitioner role.

5.3.7 Summary

Eight student interviews were held between December 2012 and February 2013 and represented students from across years and post-qualification. All students were very positive that the programme of study had met their expectations in preparing them to work in the role of an autonomous advanced practitioner. The ability to effectively make clinical decisions and problem solve was seen as an important component of this role. Supernumerary status provided sufficient time for their learning and meant the impact on their personal lives was minimal. This is in direct contrast to Case A students. Students in Case B like those in Case A appeared self motivated, however Case B students were additionally incentivised by both an improved clinical career framework and an improved financial outcome. There was a sense that the concordant agreement between the Trust and the HEI had been well thought through and provided a robust training programme for Advanced Practitioners. *Field notes made during data analysis described, 'a well thought through approach and one that recognised the contribution of advanced practitioners. I also questioned why it had not been more widely promoted as a case of best practice'.* Table 22 overleaf provides a summary of the student findings described.

Table 22 Summary of Student Findings Case B.

Theme	Findings
Expectation of Students	▪ Self-motivated and self-directed in seeking the opportunity to undertake the programme of study ▪ All students applied for a trainee advanced practitioner post prior to the advanced practice programme of study, and underwent a rigorous application process
Factors affecting the learning process	▪ All students were awarded supernumerary status that provided sufficient time to learn ▪ All students felt fully supported by their managers, clinicians, university lecturers & clinical facilitators and consequently felt valued and trusted ▪ Clinicians initially opposed to the introduction of the advanced practitioner post were supportive of the student during the programme, providing time, learning and assessment ▪ The Trust was innovating the development of advanced practitioner roles in new clinical areas, for example, the clinical research facility
Facilitating the learning process for students	▪ Time ▪ Support from medics, academic staff & a clinical facilitator as a tripartite agreement
Barriers to Learning	▪ Students identified minimal barriers regarding their programme of study. ▪ Difficulties within specific specialities, for example: In paediatrics students experienced difficulties in the application of generic learning to their speciality ▪ Difficult in gaining experience with a variety of patient presentations in their normal clinical area in order to meet their learning objectives. ▪ Blurring of past and student roles during the programme of study
Programme evaluation	▪ All students were very positive regarding the benefits of their education
Evaluation of the effectiveness of learning and its application to practice	▪ The programme of study fully met student expectations ▪ The portfolio assessment allowed students to tailor learning to meet individual objectives; Increased self-confidence, & improved communication skills ▪ An increased ability to challenge other professionals, improved clinical outcomes, and patient satisfaction ▪ Increased knowledge and understanding of clinical assessments, diagnoses, treatment and management of increased acuity, improved clinical decision making and problem solving skills ▪ Examples of improved outcomes as a direct result of the programme of study, including the identification of misdiagnosed conditions ▪ Improved clinical leadership skills used to develop inter-professional teams by acting as a conduit between nursing and medical professionals.
Role change as an outcome of the programme of study	▪ Participants worked in designated advanced practitioner roles and were awarded a band 8a. ▪ Participants worked autonomously and were seen as key personnel within the multidisciplinary team

5.4 CASE B – FOCUS GROUP FINDINGS

The following findings reflect the data from a focus group held in April 2013 at one NHS Trust in the North West and data received via email to questions sent to two other managers who were unable to take part on the day but still wanted to contribute. Despite agreement

by senior management to be involved in the research, organising and recruitment to the focus group proved very challenging, and resulted in the small number of participants providing data from this Trust.

5.5 Participants: Focus Groups – Biographical Profile

The Trust staff recruited to the focus group currently had trainees undertaking the programme of study within the clinical areas for which they were responsible. The focus group was planned for April 2013, but this had to be cancelled due to withdrawals of expected participants on the day. The one manager who did present on the day was interviewed. Three further participants, who were unable to attend but keen to be involved, provided data using email. The decision to include this as evidence was in response to the difficulty in engaging managers to attend focus groups, two previous meetings having been cancelled at short notice.

All participants were nurses and included two females and one male. Their mean ages were forty-nine, with a mean length of professional service of sixteen years. Further characteristics of the participants' profiles are presented in Table 23 (Page 188). Their responsibilities and remit included identifying the educational needs of staff for professional development, purchasing the required education, and supporting staff during their education. The interview used the same focus group schedule to collect data as per Case A, and the same framework to analyse the data that was used in Case A.

Table 23 Biographical Details - Trust Managers and Advanced Practitioners Case B.

	Age Range	Gender	Years Professionally Qualified	Length of Time in Current Role	Current Role	Current Clinical Specialty
Individual Interview 1	49	Female:(n=1)	16 years	5 years	Matron	Acute Medicine
Case B Email respondents	53 - 54	Female: (n = 1) Male: (n =1)	Data Missing	Data Missing	Head of Nursing (n=1) Lead Nurse (n =1)	Paediatrics (n = 1) Research & Innovation (n = 1)

5.5.1 Expectations of Managers Supporting Staff to Undertake Postgraduate Advanced practice Programmes of Study

Managers described a unified approach to supporting trainee advanced practitioners in practice similar to that of students. Managers described the initial set up of the scheme: *‘...had a scheme for advanced practitioners, which the Trust has supported for a number of years. Previously I was a champion for the role and workforce, I have a vested interest, a passion for supporting the development of the staff’* (I1); *‘The agreement has been in place for six years between the SHA to fund advanced practitioner training, a partnership’* (Email2). Furthermore, the partnership allowed Trusts to formally commission annual funding to support the development of advanced practitioner posts. The Trust *‘aims to recruit at least one advanced practitioner to each clinical area’* (Field notes). Two HEI’s are used as preferred providers to deliver the educational component of the advanced practitioner training.

5.5.1.1 Factors Considered when Purchasing Programmes of Study

The multifaceted nature of the advanced practitioner role described by managers led them to conclude that the introduction of this role needed to be fully supported. Managers referred to an evaluation study undertaken previously by NHS North West (2009) that demonstrated this, from which recommendations were implemented (Section 3.4.2).

Field notes reported managers in Case B describing *'the success of advanced practitioners currently working in the Trust is the driver for continued and sustained recruitment'*. Managers believed advanced practitioners were valuable because they possessed clinical assessment skills, which together with their nursing experience, meant they were more knowledgeable than junior medical staff:

'High clinical skills, working alongside medics, we do have a high turnover of junior medical staff that possibly don't have the same skills. From a nursing perspective it's like 'we don't really want to be doctors, but we do like clinical assessment of patients.'

(Interview 1)

One manager (1) perceived the innovation of advanced practitioners into the research facility as *'a unique workforce planning initiative in response to the increasing demands of research trials'*, and the need to develop a clinical career pathway for research nurses.

5.5.1.2 Selection Process of Students Within Trusts

Field notes captured overall impressions as, *'a senior manager described a consistent approach to the selection and recruitment of trainee advanced practitioners that mirrored the descriptions provided by students'* (Section 5.3.1.1). Interest for the roles was reported to be competitive. Prospective students were required to demonstrate certain attributes through this process that managers believed were required to achieve the outcomes of the programme. These included:

'A keen interest in the role; Recent experience of professional education commensurate to postgraduate academic learning; Evidence of self-motivation; Evidence of working autonomously; and, Confidence in being able to manage and challenge opposition from difficult medics. (I1)

5.5.1.3 Multi-factorial Support of Students Undertaking the Programme of Study

Managers acknowledged that support from new and some existing medics had reduced the level of opposition towards the introduction of advanced practitioner roles in new clinical areas. However, managers identified a *'need for students not to be complacent, and a need to be proactive in positively demonstrating the strengths of the advanced practitioner role'* (I1). Managers believed that by shadowing and spending time with consultants; *'go in and do clinical assessments on new patients coming in, and also to do this on a couple of days per week will increase their visibility, its really helpful and useful'* (I1).

Managers recognised that the support of students was the responsibility of many individuals; *'It is a combined role between HEIs, the Trust and the local clinical area that the advanced practitioner is working in, supported by a clinical mentor (usually a consultant)'* (Email2). Similarly to student findings, managers (Email respondents) identified that support was multifaceted with individual professionals providing unique contributions, for example: *'medics specifically facilitate the acquisition of practical skills' (!3), and coordinated by a facilitator: 'We take a tripartite approach here-university based assessors and a Trust based mentor, that I fulfil' (Email2). 'The system provides an effective communication network and has resulted in students being well supported in their own clinical areas'* (Email3).

5.5.2 Factors Affecting the Integration of Learning to Practice

Managers and advanced practitioners were asked to identify factors that they perceived both facilitated and hindered students to transfer their learning from the programme of study to practice.

5.5.2.1 Factors Facilitating the Learning Process

Factors identified by managers that facilitated student learning included *'Support from placements, active involvement of mentors and assessors and time to learn'* (Email3). Relevance of the theory learned from the programme to practice, and *'previous experience within the speciality as well as support from the mentor'* (I2). Additionally, *'Reflective practice also assists this'* (Email2); and, *'Students are very practical hands on.... the theory and the background, evidence based stuff that they're doing must be useful.'* (I1)

5.5.2.2 Barriers to Learning Transfer

Two managers (Individual 1, Email respondent) identified no barriers for students in transferring their learning to practice because they were given time, support and access to appropriate resources to facilitate this during the programme of study. One manager (Email respondent) did identify some difficulties; *'Whilst the programme professes to be generic and flexible it has been difficult to identify learning opportunities that fit the curriculum within the research facility, which has meant that students have had to find placements outside in order to pass assessments... these are not skills they will utilise long term, for example our paediatric student has had to learn adult systems'* (Email3).

Managers reported opposition from medics: *'We had many meetings, we were driving it forward, and keen to recruit. The message we got back was 'we don't need them its doctors we need, senior doctors', and we have enough junior doctors. Managers in supporting advanced practitioner implementation claimed there were currently too many junior doctors. They couldn't understand that new junior doctors in an area, they can't function, they don't know the area, they are not very skilled, whereas nurse practitioners know the area, would be able to work autonomously'* (I1). In these situations, managers described advanced practitioner trainees as *'Trailblazers'* (Interview 1), who had the task of being able to demonstrate the strengths of the role. An attitude demonstrated by one *'trailblazing'* student was reported by a manager as, *'I am here in spite of you or despite you'* (Interview 1).

Managers perceived opposition was reducing within the Trust due to recruitment of new medical consultants who believed in the role, and who were described as *'taking over'* responsibility to support advanced practitioners.

In addition to this, access to mentors was reportedly sometimes difficult, *'It is sometimes difficult to determine who the mentor will be in the research facility, and paediatrics'* (I1) Lack of availability of medics to act in this way meant that occasionally students would be unfamiliar with selected mentors, causing difficulties for the student.

5.5.3 Managers Perceptions of the Outcomes of the Programme of Study

Managers reported changes in behaviour; *'Increase in confidence, absolutely. One of the girls in A&E had no previous background and was anxious when we first met. If you speak to her now, it's like a different person, she knows how to seek out answers'* (I1). Advanced clinical skills and decision-making, and increased knowledge as a positive outcome of the programme; *'They go off on a ward round the big thing I have noticed is if the patients are clerked in A&E by junior doctors and they decide to keep them in and transfer them to us, they review them, they actually find its really quite different, and the doctor has not really listened to the patient, or done a full history. They redo the whole thing using the skills they have learned'* (I1). This confirmed student findings (Section 5.3.5).

Managers also perceived that students were keen to be seen as clinical leaders Managers provided examples of how learning positively changed their practice that included: *'Increased involvement in post take medical rounds'* (Interview 1); *'Improved patient assessments and undertaking investigations'* (I1, Email 2&3); *'Acting in a dual role, that of an advanced practitioner and emergency nurse practitioner in the A&E department'* (I1, Emails2&3); *'Becoming safeguarding 'champions' for patients'* (I 1).

Increased knowledge and behavioural changes were the two most predominant themes identified.

5.5.3.1 Increased Knowledge

Managers described how new knowledge acquired by students effectively enhanced care delivery. *'Students review patients, identify investigations required, and collate and interpret results in order to work alongside consultants on daily ward rounds'* (I1). The thoroughness of the students in taking comprehensive histories from patients was reported *'as a very positive outcome of the learning'* (I1). Students were said *'to improve their knowledge of disease processes, were more able to signpost effectively according to assessed need, and demonstrate high levels of decision making in complex and demanding situations'* (I1). One manager felt this resulted from both previous nursing experience and the new medical skills they had acquired.

5.5.3.2 Behavioural Changes

All managers reported behavioural changes in students that included, increased confidence as the principal outcome of the programme of study. A testimonial for a student who was nearing completion of the programme provides a positive account of the students learning from the programme and is presented in Vignette 6.

'She presents self-direction and is skilled at problem solving. She presents high levels of decision making, performing effectively in complex and demanding situations. She demonstrates an understanding of critical situations and can perceive possibilities that may arise....she disseminates evidence-based knowledge to her colleagues and is an excellent role model to other ANP trainee's, nursing and medical staff.

She works in a client centred role, promoting patient focussed care and delivering measurable patient outcomes, coordinating, managing and signposting patients according to assessed need. She demonstrates clinical reasoning and decision making to determine and instigate further investigations for patients... She is confident in her role and is fully aware of her professional boundaries.

Always ensuring effective communication systems, written, verbal and the use of information technology is embedded in her everyday practice... She is always ensuring interventions are undertaken in line with best practice and continually reviews and evaluates her own role and clinical ...The feedback from senior members of the medical teams is very positive and they value her as a member of the team'. (Interview 1)

Vignette 6

Managers believed advanced practitioner students who possessed this confidence became 'autonomous practitioners' (I1) as an outcome of the programme, and were aware of their scope of practice described as *'knowing when to act and when to seek additional help in managing patients successfully'* (Interview 1). This led to service developments and provided a nursing contribution that challenged the medical approach. Managers reported that *'students became more self-managing, increasingly share information with others, and as a result they have developed greater team cohesiveness because staff have increased confidence in them'* (Email2).

5.5.4 Outcomes of the Learning on Practice

Identified benefits were reported to arise from the Trust's vision and support in using advanced practitioner roles consistently and in greater numbers within the Trust. The implementation of advanced practitioner roles was viewed very positively, for example; by *'improving career development and progression within a clinical remit for those experienced*

nurses who did not want to move into management the Trust would increase the retention of experienced clinical nurses; improved patient outcomes; improved patient experience; and increased continuity for patients and their families by caregivers. A more effective and timely service has also identified as an anticipated outcome for the two students currently implementing the role in new clinical areas' (Email 2).

The advanced practice programme, and subsequent advanced practitioner role, was described as *'providing a platform for future career choices'* (Interview 1), although clinical progression beyond this was recognised as limited because of a reduction in the number of nurse consultant roles currently being implemented. *'An advanced practitioner forum within the Trust provided an opportunity to discuss issues, provide peer support and offer a collective voice when required'*. (I1) Managers perceived that currently advanced practitioners within the Trust were well respected and listened to by medics and, because of the numbers within the Trust, could act as a strong and unified body to instigate change.

5.5.5 Summary

The concordant agreement established in 2009 by NHS Trusts in the North West and the then Strategic Health Authority has positively influenced the recruitment, development and implementation of advanced practitioner roles in most clinical areas within the Trust. The benefits of this are both to the nurses, in providing them with a clinical career structure, to the patients who receive more timely and in some reported instances, more accurate diagnosis, and to professional colleagues. The programme of study is one, which is practice focussed and supported by an infrastructure of medical, nursing and academic staff, who facilitate the student to integrate learning into practice through the provision of supervision, teaching, assessment and pastoral support. Qualified advanced practitioners act as advocates for the role by becoming clinical leaders and working alongside clinicians daily. A summary of findings from Case B managers is presented in Table 24.

Table 24 Summary of Findings - Case B Managers and Advanced Practitioners.

Key Theme	Finding
Expectations of Managers to support Staff	▪ A robust selection process operated within the Trust to ensure high calibre individuals were recruited to undertake the programme ▪ There was an annual recruitment of trainee advanced practice's in an attempt to provide every clinical area with an advanced practice ▪ Motivated practitioners, assertive, confident, trailblazers.
Factors affecting the integration of learning into practice	▪ Supernumerary status for students enabled them to learn successfully and involved time to achieve the programme outcomes ▪ Good support by ward staff including peers and ward managers, consultants and academic staff during the programme ▪ Opposition from medical professionals to the implementation of the advanced practice role in some clinical areas was overcome by students during the programme of study ▪ Advanced practice roles were positively viewed within the Trust
Outcomes of the learning from the programme of study	▪ Increased opportunity for clinical career progression was seen as a result of the learning
Outcomes of the learning on practice	▪ Managers perceived the advanced practitioner role positively. ▪ Increased autonomy, improved decision making and problem solving were reported as changes arising from the programme of study ▪ Increased confidence, increased knowledge and understanding led to more effective and timely patient management and increased patient satisfaction ▪ Improved patient consultations ▪ Identification of misdiagnosis
The current role of the advanced practitioner in Practice	▪ Aim to implement advanced practitioners in all clinical areas ▪ Established role, well perceived by other professionals ▪ Future clinical leaders

An overview of the results from Case A and Case B, including findings from the analysis of the documentation, the students and focus group interviews is presented in Table 25, and allows cross comparison of the key themes and their findings.

Table 25 Summary of Results: Comparison Table.

Awarding Institution	Case A	Case B
Year of Programme Validation	2008	2011
Links with Partner Institutions/Drivers	Multiple purchasers within South East England	Northwest NHS Workforce Modernisation Group
Programme Accreditation	RCN	None
Final Award	MSc Advanced practice with pathways in: ▪ Nurse Practitioner ▪ Nursing ▪ Critical Care ▪ Respiratory Care Cancer and Palliative Care ▪ Gastro-Intestinal Care May exit with Postgraduate Diploma level (120 Credits)	MSc Advanced practice (Health and Social Care) May exit with Postgraduate Certificate (60 credits) May exit with Postgraduate Diploma level (120 Credits)
Level of Qualification	Level 7 (masters) 180 Credits	Level 7 (masters) 180 Credits
Length of Programme	Part time mode 3 years normally maximum term 5 years	Full time mode 2 years normally maximum term 5 years
Mode of Attendance and Support	Part time mode day release over two academic semesters per year. Normal attendance one day per week Days are pre set and students are supported in clinical practice by a work based mentor (Normally a Medical Practitioner) and a clinical link tutor employed by the university.	Full time modular programme; teaching arranged to facilitate release by employers. Study can be block release or day release as the market dictates to meet the needs of the students on a pathway. Teaching is further supported by work-based study and supported in clinical practice by a clinical facilitator employed in a joint post to work at University and Trust.
Funding	NHS London, Employer and Individuals.	NHS Northwest, Individuals and NHS Trusts
Cost of Programme	Year 1 £3480; Year 2 £3480; Year 3 £2270. Total Cost £9230	Year 1 £2625; Year 2 £2625; Year 3 £2100. Total cost £7350

Awarding Institution	Case A	Case B
Entry requirements	- Registered Practitioner, currently in practice - Normally hold a first degree or minimum of 60 credits at level 6 - Working in a practice arena that will support and facilitate the development of advanced practice. Have written agreement of support from their employer for practice and financial support - Working in clinical speciality for a minimum of two years - Minimum employment in practice 15 hours per week	- Registered Practitioner, currently in practice - Normally be graduates in health and/or social care - Working in a practice arena that will support and facilitate the development of advanced practice - Have written agreement of support from their employer for minimum learning and financial support - Working in their clinical speciality for a minimum of two years
Relevant Subject Benchmarking	- Framework for Higher Education Qualifications (FHEQ) (QAA 2008). - Descriptor for a higher level qualification at level 7 - NHS Knowledge and Skills Framework (DoH 2004b) RCN Competencies for Advanced Nurse Practitioners (RCN 2007).	- Framework for Higher Education Qualifications (FHEQ) (QAA 2008). Descriptor for a higher level qualification at level 7 - NHS Knowledge and Skills Framework (DoH 2004b) - RCN Competencies for Advanced Nurse Practitioners (RCN 2007) - NHS Northwest Concordant for Advanced practice (2009).
Aims of Programme	- To promote an advanced level of scholarship; develop skills of interpretation and effective synthesis of knowledge within a specified field, to inform practice and develop healthcare practice and policy at both operational and strategic level. - Foster refined levels of clinical judgement and autonomy concerning the full range of healthcare interventions, equipping the student to support the development of advanced practice and practitioners and operate collaboratively within a specified field of care.	- To provide an academic and practice framework in which students can proactively and collaboratively develop professional expertise and academic values of advanced practitioners. - To enable those working in health and social care to meet the challenge of advanced practitioner status through appropriation of higher-level practice skills and knowledge in the context of service redesign and service needs.
Programme Structure and Content	All students are required to follow the programme in the sequence outlined within the programme specification for a given pathway. APL may be obtained with appropriate evidence. There are four core modules. Year one Modules: - Assessing Needs and Outcomes: methods and Measurement (15 Credits) Core - Scope of Professional Practice (15 Credits) Core Pathophysiology and Assessment of Illness and Injury (30 Credits) Year Two Modules: - Clinical Judgement, Diagnostic Reasoning and Pharmacology (30 Credits) or Independent and Supplementary Prescribing (60 Credits)	All students are required to follow the programme in the sequence outlined within the programme specification. APL may be obtained in exceptional circumstances. All modules are core. Year one Modules: - Principles of Advanced practice (30 Credits) - Advanced practice application of Life Sciences (30 Credits) - Contextualising Advanced practice (30 Credits) - Individual Learning Pathway; Tripartite agreement core and bespoke skills – Developing Portfolio & Advanced practice of evidence

Awarding Institution	Case A	Case B
Programme Structure and Content (Cont)	- Generating knowledge for Practice (15 Credits) Core - Leadership and Management (15 Credits) Core Year Three: - Dissertation (60 Credits)	Year Two Modules: - Research Methods (30 Credits) - Advanced Practitioner 1: Competence (30 Credits) - Advanced Practitioner 2: Clinical Reasoning (30 Credits)
Teaching and Learning Philosophy and Strategies	Teaching and learning strategies employed encourage student independence and learning from and through experience, using reflection, and the development of the skills required to practice at an advanced level; to ensure that the Advanced Nurse Practitioner award will meet the Standards and Criteria for RCN accreditation of Nurse Practitioner Programmes (2007). Paramount to the teaching and learning strategy will be the value placed on the student's own experience of practice and theoretical underpinnings of practice. The programme team and external experts will provide the main input on the taught sessions. The emphasis will be on student support and facilitation. Teaching and Learning strategies used, include: - Keynote lectures and Seminars - Enquiry based learning Group and individual tutorials and debates. - Demonstration and replication by the student - On line materials available on VLE - Individual scholarly learning - Reflective Learning Logs	The facilitation strategies within the programme prepare students for the development of generic and specific practice at advanced level. The programme embraces the concept of learning at work to develop new ways of working as outlined by Sargent (2003) and Manley (1997) and the NHS Northwest Concordat for Advanced practice (2009). The practice context is at the centre of the learning experience. Students engage in critical self-assessment of knowledge and skills against advanced practiceappropriate competency frameworks in order to identify, in negotiation with their employer and academic supervisor, an individual learning pathway within the programme. Teaching and learning strategies used, include: - Workshops and Master Class: - Learning Sets - Personal Tutor, Practice Mentor Support, Clinical Assessor and Learning Facilitator - Individual Scholarly Activity - On-line Learning Resources and Processes - Postgraduate and Research Seminar Series
Assessment Strategy	Assessment strategies are said to include both the assessment of theoretical knowledge and of practical knowledge. Assessment methods used include: - Reports - Literature Review - Portfolio - Case study - Reflective essays - Business Plan - Examination Integrated Care Pathways - Essay	Assessment strategies are developed to reflect the ethos and learning aims and objectives of individual modules. Assessment methods used include: - Self assessment - Peer assessment - Practice based assessments - Critical Reflective commentaries - Portfolio of evidence - Viva Voce - Objective Structured Clinical Assessment (OSCA) - Poster presentations

Awarding Institution	Case A	Case B
Assessment Strategy (Cont)	- Objective Structured Clinical Examination (OSCE) - Dissertation The use of formative assessment is included within many of the modules. To achieve the award students must pass all the components of each module. The pass mark for written assessments is 40%. The pass mark for OSCE based assessment is 70%.	- Service delivery and organisational assessment and redesign - Essays - Client management plans - Written reports - Unseen examinations The use of formative assessment has been included within many of the modules. To achieve the award students must pass all the components of each module. Pass mark 50% for all assessments
Practice Component	Students are required to work in practice for a minimum of 15 hours per week. As part of the entry requirements students must submit a completed Clinical Site Evaluation Form (CSEF), which requires sign off by a qualified mentor in practice and their manager. The CSEF is an educational audit of the practice environment. Mentors provide formative feedback to students except for the Independent and Supplementary Prescribing module where they summatively assess and sign off specific competencies. A mentor handbook is issued at the start of the programme. Examination of clinical skills is through OSCE only.	Sponsored students have guaranteed 2 full learning days per week and a practice based mentor to facilitate work-based learning. Clinical practice assessors undertake clinical assessment of clinical skills Each student will have a learning facilitator allocated with a specific remit to work with practice based assessors and mentors to ensure consistency in approach and standards as a quality measure. The portfolio assessment demonstrates evidence of all elements of advanced practice and requires sign of: 15 assessed client cases; 40 pieces of evidence of patient contact over the duration of the programme; audit of practice; and completion of core and bespoke clinical skills log. Students present and have assessed by their consultant in practice five clinical cases.
Profile of Participants - Students	Participants (n = 16): Year 1 (n = 6); Year 2 (n = 3); Year 3 (n = 4) and Post Qualifying (n = 3) Mean Age 41 years Age Range 27 – 52 years Length of professional service mean 19 years	Participants (n = 8): Year 1 (n = 2); Year 2 (n = 3); Post Qualifying (n = 3) Mean Age 42 years Age Range 33 – 56 years Length of professional service mean 1 years
Profile of Participants – Focus Groups	Participants (n = 14) Managers and advanced practice's in three Focus Groups. Focus Group 1 (n = 5); Focus Group 2 (n = 7) and Focus Group 3 (n = 2). Mean Age, 49 years Age Range, 31 – 60 Length of professional service mean, 5.5 years	Participants (n = 3) Mean age, 49 years Age Range, 33 – 56 years Length of professional service mean 16 years

Student Themes		
Awarding Institution	Case A	Case B
Student Status	Self motivated and self directed Students part or fully fund learning	Supernumerary status
Selection of HEI	Previous study Relevant content Location Preferred provider	No choice – Part of trainee post
Expected Outcomes from Programme of Study	Enhance career progression “Playing catch up” academically Competitive environment To remain clinical Develop of clinical assessment skills and knowledge	Career progression Development of clinical assessment skills and knowledge To support advanced practice practice To develop new practice protocols To prevent stagnation in their current role
Factors Facilitating the Learning Process	Healthcare professionals Family Self Academic staff Organisational funding	Tripartite support from mentors, academic staff and managers Supernumerary status
Barriers to Learning Process	Lack of time – Workload Lack of understanding by organisation and Healthcare Professionals None Lack of support – Funding, study time Mangers perceived lack of academic qualifications	Some students reported no barriers to learning Insufficient variety of patient presentations to support achievement of programme objectives Generic adult based programme of study not easily transferable to paediatric setting Expectations of medical consultants
Facilitating Knowledge Transfer	Academic staff Organisational support – medical mentors, managers Trust and belief in student Self motivation – Proactive Use of assignments Research knowledge Knowledge to underpin practice	Development of new knowledge and skills advanced practice forum within the Trust Use of the portfolio Research knowledge
Programme Evaluation	Unprepared for workload Challenging modules Met expectations Use of more medical practitioners in teaching All modules are relevant	High level of appreciation for the delivery and content of the programme of study Adult focus challenging for paediatric nurses Met student expectations mostly

Awarding Institution	Case A	Case B
Effectiveness of Learning	Increased confidence Change in attitude – ability to challenge, improved communication with patients and peers Increased knowledge Improved consultation skills Improved clinical decision making Challenge tribalism	Relevant content and well structured Learning initiated innovation Middle part of the programme insufficiently clinically focussed Increased knowledge and skills facilitated more holistic care delivery Improved patient consultations Increased confidence Increased ability to challenge medical professionals
Perceived Benefits for Patients	Improved consultations Manage more complex patient presentations Reduce waiting times for patients Improved clarity with communications to patients Management based on knowledge rather than 'guesswork' Increased ability to anticipate problems More proactive in patient management More autonomous in decision making Provide linear journey for patients Increased use of evidence based practice	More competent practitioner A '<i>bridge</i>' between nursing and medical professionals Increased respect received from other healthcare professionals Identification and successful management of misdiagnosed or incorrectly diagnosed patient presentations following medical admission Increased autonomy Increased use of evidence based care Increased use of thorough health assessments
Role Change	Changing all of the time No change in grade or remuneration Clinical role change with increased responsibility Increased strategic responsibilities Increased recognition and use of advanced skills Increased autonomy More reflective practitioner	More clinical role, performing more robust clinical assessments Greater efficiency and effectiveness of patient consultations Increased appreciation by patients in doing their job well Ability to challenge medical professionals more successfully Advanced practice role on qualification Uncertainty within future advanced practice role within clinical settings where the role is innovative
Expectations of Managers	Contract by preferred providers for funding Cost Establish needs in department for advanced practice's Fit in with organisational strategic plan Selection and interview process used Consider individual experience, benefits, PDP's Shift to purchasing level 7 academic programmes Expect student to initiate request for advanced practice study	Preferred provider established Presentation and agreement of business case for the introduction of advanced practice role Clear recruitment strategy Some opposition from medical professionals were overcome Students become trailblazers for advanced practice roles in new clinical areas

Awarding Institution	Case A	Case B
Factors Affecting Integration of learning in Practice	Relevance of role Relevance of programme of study Teaching of others Support from peers and other healthcare professionals Difficult to get right Tension between medical trainee's and advanced practice trainee's Good support from HEI academic staff Funding – time and fees Vicarious liability Lack of advanced practice mentors Advanced practitioners work in isolation Workload	Multifactorial support from managers, healthcare professionals and academic staff to support learning and finding placements Clinical areas where variety of patient presentations are limited Generic adult focus of the programme of study limiting for paediatric nurses
Perceived Outcomes from the Programme of Study	Improved practice Improved health assessments Increased confidence Increased assertiveness Greater confidence from others of students ability Increased underpinning knowledge Increased autonomy Complete patient management Junior doctors reliant upon them Improved decision making 'Bridge' between junior nursing and medical staff Increased use of evidence based practice Increased strategic perspective Increased use of prescribing	Increased confidence Greater initiative in problem solving Improved autonomy More self-managing Improved communication with other healthcare professionals Increased knowledge used to enhance effectiveness of care delivery Identification of misdiagnosed patient presentations Provides a clinical career ladder for nurses
Evaluation of Learning	Appraisals	Graduation from the programme of study
The Clarity of advanced practice Roles in Practice	Uncertainty of advanced practice role Lack of understanding of advanced practice role Lack of identity of advanced practice role Lack of uniformity of advanced practice role within organisations Resistance to advanced practice role by peers and medical professionals Different approaches by advanced practitioners to care – medical model with nursing philosophy	NA

CHAPTER 6 CASE C FINDINGS

6.1 Introduction

This chapter presents the findings related to Case C and comprises the results from analysis of documentary evidence, student interviews, and Focus Groups. Case C is an advanced practice postgraduate programme in Central England. Details of the organisation were previously provided in section 3.4.3.

This chapter presents findings in the same format used in chapters four and five. Findings from the analysis of data from each of the methodological approaches used in the study are presented.

6.2 Documentary Evidence

Documentary evidence was collated from programme documents identified in section 3.4.3, and provided contextual information.

6.2.1 The Programme of Study

Case C is an advanced practice Programme that was initially validated in 1996 with the current programme validated in 2011. Programme characteristics include:

- The programme of study is normally delivered over two and a half years part-time and leads to a masters award. Students can exit with a postgraduate award after completion of specific modules and a total of 120 academic level 7 credits.
- Student fees are funded either through an NHS contract, employer funded or self-funding
- The programme is modular and comprises core and option modules organised and selected around three pathways, totalling 180 level 7 academic credits. Module details are presented in Table 30 (Page 236). Modules must be taken in a specific

order. Independent and Supplementary Prescribing is available as an option module.

- The programme is benchmarked against the DoH (2010b) Advanced Level Nursing: A position statement.
- Admission criteria: a registered practitioner, currently in practice; with three to five years professional experience, first degree or evidence of recent professionally related study at diploma or degree level, undertaken Research Methods (degree level) or Physiology (diploma level) or Prescribing (level 6). Alternatively, students may need to undertake pre-course written work.
- Students are either employed in trainee advanced practitioner roles paid at their current grade and on completion automatically move to Band 8a (DoH 2004a), or are employed full or part-time in clinical practice and undertake the study while employed.
- The programme has a strong clinical focus and is assessed using a variety of methods, some of which are undertaken in practice.
- There is a final research based dissertation.

6.2.2 Participants: Students – Biographical Profile

Student participants were drawn from acute, primary care and community Trusts. Participants were recruited from years one, two and three of the programme, between December 2012 and April 2013 and were employed in a variety of practice settings. Students (n = 3) were recruited by their Trust as trainee advanced practitioners; *'Trainee advanced practitioner posts reportedly provided student supernumerary status in critical care areas only, throughout the programme and provided study time and days off to work on assessments, a negotiated number of hours in the clinical area in which they worked to consolidate learning, and study fees paid'* (Field notes made during a discussion with a senior manager prior to data collection). Two students (S43, S53) attended the programme

of study on their day off, two students (S41, S53) had their fees fully paid by the employer, two students (S58 and S59) had their fees partially paid, and one student (S43) was self-funding

Participants comprised six females and two males. All students were nurses. Ages ranged from 28 – 52 years with a mean age of 41 years. The mean length of professional qualification was 19 years. Participant characteristics are presented in Table 24.

Table 26 Biographical Details - Students Case C.

	Age Range (Mean)	Gender	Years Professionally Qualified (Mean)	Current Role	Current Clinical Specialty	Employment Status
Case C Year 1 Students (n = 2)	32 – 45 (38.5)	Female: (n = 1) Male: (n = 1)	11 – 24 (18)	• Trainee ANP • Practice Nurse	• Paediatric ITU • Primary Care	• Supernumerary year (n = 1) • Part-time (3.5 days in practice)
Case C Year 2 Students (n = 5)	28- 52 (38)	Female: (n = 4) Male: (n = 1)	6 -29 (15)	• Trainee ANP (n = 2) • Practice Nurse / Respiratory Nurse (n = 1) • Specialist / Practice Nurse (n = 1) • Nurse Practitioner - Primary Care (n = 1)	• Paediatric ITU (n = 2) • Respiratory Nurse (n = 1) • Primary Care (n = 2)	• Supernumerary (n = 2) • Full Time (n = 3)
Case C Year 3 Students (n = 1)	46	Female: (n = 1)	25	• Advanced Nurse Practitioner	• Primary Care / Diabetes	• Full Time

6.3 CASE C - STUDENT FINDINGS

Findings presented represent the data sets for students in Y1, Y2 and Y3. The format of this chapter is consistent with that used for Cases A and B. Themes consistent with those used previously in Case A are now presented.

6.3.1 Expectations of Students

Students in Case C were questioned regarding their initial interest in the programme of study, the application process, their rationale for selecting the programme and their expectations of learning from the programme of study.

6.3.1.1 Initial Interest and Application to the Programme of Study

Students described similar motivations to those students in Cases A and B in that they were all self-motivated and initiated application for the programme of study, for example:

‘ I was working at a private practice, they were happy with me to stay as I was, because they didn’t want to increase my pay, they didn’t need an advanced practitioner...I was working at a senior level, it was my decision to progress’

(Y2, S43).

Students also reported that their reasons for applying for the programme included; *‘I was a bit frustrated in my role’* (S58); *‘a need to integrate previous specialist courses with new knowledge in order to manage patients with complex chronic diseases, previous learning had not been brought together’* (S57); and, *‘to underpin and develop my current practice with theoretical knowledge in order to gain greater fulfilment’* (S57, S58). Two students perceived the programme would provide *‘a better balance to my role, and will widen my scope of practice by letting me manage more acute patient presentations in addition to patients with chronic conditions’* (S41).

Students described a lack of conviction in being able to persuade managers to support their CPE describing their arguments as *‘laughed at’*, and *‘wishy washy in wanting to be a better nurse’* (S58). Despite this perception, they gained support for their study. Additional reasons described by the remaining students included: *‘Clinical career development’* (S41, S57); *‘Extending the assessment, diagnostic and research aspects of the role’* (S40, S42); *‘To challenge poor practice and to perform more effectively in the advanced practice role’*

(S53); and *'Following an application for the nurse prescribing programme I opted to undertake the advanced practice programme instead'* (S43, S59).

6.3.1.2 Which Higher Education Institution to Choose?

The rationale for students selecting Case C was determined principally by how they were supported on the programme. Field notes made during discussion with a senior manager at Trust 2 indicated that supernumerary student support differed from Case B; *'students during year two have to re-negotiate study time with their manager and mentor in order to fulfil the expectation placed on them, of managing an increased number of patients in practice'*. For these students (S40, S42, S57) the choice of university was linked to the trainee role, *'the Trust were locked into a contract with.'* (S40). S42 reported *'I could have undertaken the advanced practice programme at an alternative uni that offered a specific pathway relevant to their job but the location of these, and funding made this difficult for me.'*

The remaining five students (S41, S43, S53, S57, S58) worked in their current roles while undertaking the advanced practice programme and selected the HEI because: *'The content was appropriate to meet their professional needs'* (S41, S43); *'The was in a close location to me'* (S43, S53); *'I had previously studied at the uni'* (S53, S58); and *'The programme was delivered on one day rather than two days per week'* (S59).

These quotes demonstrate that students generally made pragmatic decisions.

6.3.1.3 Expected Outcomes from the Programme of Study

Students reported anticipating a variety of benefits from the programme of study. Three Y2 students (S42, S43, S53) believed the learning would enhance career development through the acquisition of skills and knowledge and enable them to work more independently, for example: *' I think more in depth knowledge, sort of confidently, not just "I think I know it...I wanted to be reassured...I like the idea of me being able to assess patients, not just verbally*

but physically'. A Y2 student (S53) reported; *'I'd taken on a new role, to extend my role as a practice nurse looking at more diagnostic and assessment ...recognition of skills that is equitable to a doctor'*. Remaining students described the following expected outcomes: *'Increased knowledge would provide the theory to support decision making, rather than previously thinking, 'I think I know' (S41, S43); 'Facilitation of total patient care' (S59); 'The development of leadership skills through increased awareness of alternative perspectives and being positive' (S40); 'Development of existing knowledge' (S41); 'To underpin practice with research' (S42); and 'To remain in clinical practice' (S58).*

One student (S42) perceived the role as *'interfacing between nursing and medicine'* and considered the learning important to be able to teach and support all junior members of the team. Four students (S42, S43, S53, S59) reported that the programme of study would not impact on their pay or conditions on completion and were undertaking the programme of study for developmental reasons rather than financial gain, for example: *'I would have to fund myself, and sign an agreement I would work for two years after I had completed the course...there would be no salary increase either at the end' (S59)*. They also described; *'I have a lot of experience, things changed. I felt I could do more for patients...I felt I could do more total patient care'*.

6.3.2 Factors Affecting the Learning Process

Case C students described factors facilitating and hindering the learning process, which proved similar to those previously described by students in Cases A and B.

6.3.2.1 Facilitating the Learning Process for Students

Students described support from healthcare professionals and academic staff, family and significant others, and attitudes and motivation, as the issues that most affected their learning. These are now presented.

6.3.2.1.1 Student Support – The Role of Healthcare Professionals

All students saw medical mentors as pivotal to their learning, specifically in relation to the translation of theory to support patient assessment, history taking and making differential diagnoses. *'My GP mentor is fabulous...I observed him and then after a while then I started to see my own patients'* (S41); *'My medical mentor is a lovely chap, he's helped me articulate critical information at the bedside, in ITU...conditions change quickly and he has taught me how to assess and articulate this information quickly'* (S57). Positive encouragement and reinforcement of learning was identified, *'The GP is very good, he'll call me often and ask what it is, they want me to do well, he is encouraging and supportive'* (S58). Medical mentors also provided: *'new opportunities for learning'* (S59); *'specific knowledge regarding prescribing issues'* (S58); and, *'facilitated attendance at medical lectures and provided preparation for practical examinations, for example OSCEs'* (S41). Increased knowledge also enabled this student to improve critical thinking and subsequently adopt a calmer approach in managing sick children. Furthermore, a Y2 student (S53) identified that *'mentors increasingly trusted my ability to work as a future advanced practitioner'*.

Support gained from colleagues they worked with, for example, *'registrars'* (S40, S42), and qualified advanced practitioners (S41, S53) was described as beneficial, for example, *'Being taken under their wings really helped'* (S40), and provided an awareness that the learning could be situated within a nursing philosophy:

'The advanced practitioner was essential; she gave the nursing perspective, which is different from the medical one. We use a medical model, grounded in nursing advanced practitioner skills...She provided reassurance that I'm on the right track... my twenty years experience will fit together with this....' (Y2, S53)

Indirect support from managers recognising the importance of the study was also described: *'She provided help with administration to release time for me to practice'* (S41).

6.3.2.1.2 Student Support – The Role of Academic Staff

Academic staff liaised directly with practice mentors to ensure students were supported appropriately in practice and provided pastoral support that was deemed very helpful (S59). Second year students (S41, S42, S59) described academic staff as accessible. Students overall reported support and teaching delivered by academic staff as positive.

6.3.2.1.3 Student Support – The Role of Family and Significant Others

Half of the participants described how family support during the advanced practice programme facilitated them to complete the learning successfully: *'My husband and I, we have a deal, we take it in turns to study...he's take on much more of a role with our daughter, and grandparents have come in as well'* (S41). Additional help was also employed in more pragmatic ways, for example, *'a dog walker to free up time for study'* (S41). Similarly to Case A (S30), a Y2 student (S53) perceived the advanced practice programme promoted them as a good role model for their children, *'I carried on for the sake of the children to show them I could do it'*.

6.3.2.1.4 Attitudes and Motivation to Complete the Programme of Study

All students appeared motivated and enthusiastic about their programme of study and expressed increased confidence as an outcome of their learning. *Field notes captured this; 'the students I met today were so welcoming and wanted to share their stories. Some spoke of real hardships yet they were passionate that they would complete the course (body language was open, and their voices became elevated when describing this)'*. The realisation of the actual scope and level of responsibility and accountability of the advanced practitioner role scared students (S42, S59) and led *'initially I lost my confidence. I did overcome this by changing the way I communicated, I learned this on the programme. It has helped me to inspire patients and families confidence'* (S59). The ability to self manage time and be proactive in their learning and assessment preparation were reported as conducive and essential throughout the programme (S41, S53).

6.3.2.2 Barriers to Learning

Barriers that impeded student learning were described and were related to the support obtained from healthcare professionals and academic staff and a lack of time.

6.3.2.2.1 Perceptions of Health Care Professionals

Students described opposing levels of support from healthcare practitioners. Whilst some actively supported them, others were unhelpful or obstructive. One Y1 student (S58) described; *'My mentor. I put it to the three partners, one was very keen, two were quite keen, and then they told me it was the GP who shows least interest in what's going on, and gets more stressed...I almost didn't start the course because of this'*. The student described how the GP despite being aware of programme outcomes refused to supervise their practice and instead instructed them to undertake basic tasks: *'You are not ready for this, you can greet the patient and explain procedures'* (S58).

Similarly, one Y2 student (S53) described only one of five GPs in their practice as supportive and helpful. As a consequence the student sought alternative help externally; *'I have to fling myself on their mercies... they see it as easier to do it themselves, it is ignorance by them'* (Y2, S53).

Three students (S41, S53, S58) described having high expectations of the programme; the depth and amount of learning exacerbated their own stress and necessitated reassurance from colleagues that they could not know everything, for example:

'I am expecting too much of what they know, when they too don't know everything and still have to look things up'. (Y2, S58)

and

'I have a false image in my head of what I need to learn'. (Y2, S53)

One-off barriers described by Y1 students' included the following: *'Reduced support from peers in response to my own workload increasing'* (S58); *'GP's trying to get me to manage increasingly complex patients before feeling competent'* (S42); and *'I felt guilty I was managing less patients because of my study commitments, this was very stressful'* (S41).

6.3.2.2.2 Student Support – The role of Academic Staff

Despite general satisfaction by participants of academic staff, two Y2 students (S42, S43) reported that academic staff were not always appreciative of the hardships faced by students and increased workloads. The receipt of conflicting advice regarding assessments was described as adding to this burden and prompted the idea that *'students with families should be given more help, and more specific advice with assessment completion'* (S42, S43).

6.3.2.2.3 Time as a Barrier to Learning

The ability to find sufficient time to study in addition to their normal roles and responsibilities was difficult for students who were not supernumerary, *'Time, but is that a real factor'* (S58). (S42, S43, S59). These students reported that year one of the programme of study was particularly difficult due to the number of modules studied, working simultaneously, and personal issues experienced during this time. Students reported having unsuccessfully anticipated the workload that resulted in *'sacrifices'* (S43) having to be made, reflective of Case A students. *'Its been really difficult even though I had a free afternoon, with two kids, even though you think Sundays are free, they're not. I don't think I anticipated on how difficult it was going to be'* (S43). For two students (S41, S53) this consequently led them to developing stress related illnesses, manifesting as, *'clinical depression'* (S53), and *'alopecia'* (S41).

A Y3 student (S59) reported difficulties in year three of the programme because of problems with securing study leave because there were no taught days held in the HEI; *'I found this*

year difficult to manage, struggling to do my dissertation because of reduced time. They know I'm not at uni so if there's a business meeting I'm expected to attend'. Working practices, specifically the management of appointments, also restricted the students' ability to work independently due to resourcing issues, and described as:

'I have to revert back to practice nurse working if GP is off, trying to get advanced practitioner role out there is difficult not all are open minded in me working independently.... they don't grasp it and they don't want it'. (Y3, S59)

Self-motivation and tenacity to complete the programme allowed the student to overcome these difficulties.

6.3.3 Programme Evaluation

The effectiveness of the programme of study in meeting students' expectations was explored. Beneficial and negative aspects of the programme were examined.

6.3.3.1 Beneficial Aspects of Learning

Students reported that the learning was important in the development of both personal and professional knowledge and skills. *'Fantastic, I can't fault it'* (S41). While undertaking the programme, two students (S41, S53) reported the learning made them *'Think outside the box'* (S41) and were surprised at how much they didn't know reflecting findings from Case A. Several students described some modules as more useful than others, for example; *'differential diagnosis, examination skills and history taking skills facilitated me to be more confident in managing patient consultations'* (S42); *'leadership and management was helpful, yet it has not changed my practice'* (S43). Two Y2 students (S42, S53) found the research modules very beneficial though *'laborious at times'* (S42) reporting it helped to underpin and support their decision-making with evidence: *'This is why I have made this decision for this patient'* (Y2, S42). The Prescribing module was described as 'Informative' by three students (S41, S42, S43), and described by one as:

'Revision, allowing us to take prescribing to the next level with drug therapy' (S42).

Four students (S40, S41, S42, S59) reported that the programme of study provided up to date knowledge, *'It gave me confidence in the assessment, history taking particularly what is based on best evidence now' (S53)*. Consequently, increased confidence and knowledge led them to become more self assured and autonomous:

'It makes me feel more secure, I was less likely to miss clues from patients' (Y2, S42).

Learning benefited decision-making by demonstrating the need to consider multiple factors in order to manage clinical presentations effectively, and was described as, *'Sieving and sifting information' (S53)*. *'My decision-making has improved and I have more...increased knowledge from the course, and this has meant, I can now manage my own caseload independently. Patients wait less because they don't have to wait for a doctor to sign drug prescriptions (S41, S53).*

6.3.3.2 Satisfaction with the Programme of Study

Students described how the programme of study met their expectations, by presenting *'the whole picture' (S58)*, and *'reinforced what I do' (S57)*. *'The lecturers are honest and genuine' (S57)*. A Y1 student (S40) described how the teaching and learning changed their behaviour and improved communication skills. Presentations to peers and essays assisted in this development. All students agreed that modules were appropriate and relevant. Two students working in paediatrics (S40, S58) stated *'I would have preferred an advanced programme that was more paediatric orientated. They made adaptations for the paediatric nurses in the group, but we still feel we're muddling along' (S40)*; this reflects findings expressed by students in Case B who worked in similar areas. The programme of study content was reported to focus on the generic adult patient and related clinical conditions, and *'I just didn't feel it was always relevant to my practice' (S53)*; and, *'I had to apply the learning to my own area of practice that I found hard at times' (S57, S58)*. For some, and

comparable to students working in similar clinical areas in Case B, this was described as confusing because the theory presented (e.g. anatomy and physiology) could not be directly related to children because of physiological differences (S42, S57). One student (S40) disagreed, *'I think all the learning was useful... it gave me a wider knowledge base, and I think others are naïve in thinking that specific programmes of study can be developed to meet our own personal needs'*.

Academic staff were reported to vary in their ability to relate theory to practice: *'the use of specific cases to support application of theory to practice was effective while the use of generic examples were not as less useful'* (S41); *'assessments were relevant and helpful to the my current role (S40); 'the population study was really useful I used it in practice to get men over 50 to attend for heart checks' (S59).*

Two students (S43, S59) described how the programme had been overwhelming at times, and had led them to question their ability: *'The workload made me question my own intelligence at times'* (S43). Furthermore, one student (S41) reported *'if I had fully understood the workload when I enrolled, I would have studied full-time...it would have allowed me to fully focus'*. Discrepancies in opinions between academic staff and mentors towards assessments, particularly regarding practical assessments, led to the suggestion of practice based OSCEs as an improvement (S41).

6.3.4 Evaluating the Effects of Learning and its Application to Practice

Students were asked to identify the perceived benefits to patients and to their role within the organisation as an outcome of the programme of study. Outcomes were identified in relation to increased knowledge, behavioural changes including a change in attitude, benefits to patients, and role change.

6.3.4.1 Increased Knowledge and its Application to Practice

All students reported that they were able to develop existing knowledge and skills, specifically communication assessment and management skills, that resulted in positive changes in their practice. I now work more autonomously; *'I manage patients I couldn't manage before, sicker patients, patients who are more complex'* (S42); *'I provide more complete care'* (S59); *'I order more investigations, prescribe more and different medications, and provide patients with evidence based care, and continuity of care'* (S53). Second year students (S43, S53) reported, *'We are more accessible than medics to both other staff and patients and we improve the care we give to patients'* (S41). One Y2 student perceived that her colleagues believed she had changed and was *'no longer one of them'* (S42). However, she believed that whilst she now used more of a medical model in her practice she had not lost *'her nursing roots and would be devastated if she thought others thought she had'* (S42).

6.3.4.2 Behavioural and Attitudinal Changes and Application to Practice

All students (S40, S41, S42, S43, S53, S57, S58, S59) reported increased confidence as they progressed on the programme of study, even those who initially reported a loss of confidence (S42, S53). Additional benefits reported by students included: *'Increased confidence allowed me to challenge poor practice more effectively'* (S41); *'It gave me the ability to discuss cases more effectively and thoroughly with medics'* (S40, S53, S57); *'Offered alternative perspectives that I would have previously dismissed'* (S40); *'Gaining increased trust from colleagues in decision making'* (S40, S41, S53); *'Increased responsibility and self-awareness of my actions, strengths and limitations'* (S43, S53); and *'The increased use of evidence based practice'* (S42).

Two students (S41, S59) reported they were now more involved in strategic decision making, related to commissioning patient services and audits. They also believed they were progressing their career clinically in nursing as a result of the programme (S41, S59).

6.3.5 Benefits to Patients

Students described the outcomes in practice arising as a consequence of the learning from the programme of study that included: an increase in evidence-based knowledge now underpinned their practice (S40, S41, S42, S53); *'Increased confidence, definitely. I can challenge others more now'* (S43, S53); S57, S58); and, *'having that ability to have that personal nurse as well as providing medical intervention...the way the nurses develop within a couple of years time, how the advanced practitioner model will be'* (S57) (S40, S53, S57). Furthermore, *'improved communication skills led me to feel less nervous and more able to clearly and concisely articulate patient related information'* (S41, S43); and improved interpersonal skills, enabled them to build an improved rapport with patients and families (S58).

Specific examples of benefits included: *'Increased availability of appointments for Asian women in primary care'* (S43); *'more patients requesting to see the advanced practitioner rather than the doctor in primary care'* (S59); and *'an increased ability to manage patients with mental health issues'* (S53). Practice exemplars demonstrating the benefits to practice are presented in vignettes 7 and 8.

'Somebody who was very low in mood – actually came in for memory assessment, and was only fifty. I felt there was no cognitive impairment it was intact. I felt the memory loss was more related to mood... the GP said 'Book him in with the GP' and I said No, I don't want to do that. I have assessed this man, I'm in the best place to follow through with him, I just needed support that I was on the right track. I need someone to speak to and reflect, that I'm doing the right thing'.

(Y2, S53)

Vignette 7

'I think the benefits are providing complete care... get to know your patients, they open up, other things. I had a patient with a breast lump, she'd had it for a long time, and after getting to know her, she said, "Actually I've got this lump, would you have a look at it?" Well normally I'd be like, "that's the GP, I'm not touching you". It was good to be able to examine her and then refer her appropriately' (Y2, S41)

Vignette 8

One student was unable to provide examples when asked, for example:

'I can't think of anybody off the top of my head'. (Y3, S59)

Although all students were positive that the programme of study had developed them personally and professionally, their ability to recall and articulate specific exemplars from practice in support of this was limited or described in more abstract terms, for example:

'I have been told... patients feel more comfortable... they've seen my transition over the past two years, when you're listening to the patient, it takes half their worries away...when you're assessing the patient, that takes 80% of their worries away'.

(Y2, S43)

Two students also described benefits as *'providing more holistic care'* (S58, S59) and an alternative to medical care, which they perceived as advantageous.

6.3.6 Role Change as an Outcome of the Programme of Study

Students were asked to describe any role changes as a consequence of the programme of study. Second year students (S42, S53), who had not completed the programme at the time of data collection, anticipated that they would change, for example: *'I am more reflective in my practice'* (S41); *'I use advanced assessment skills more frequently and more expertly'* (S53); *'I see more patients with undiagnosed problems and needs'* (S42); and, *'I have become more autonomous'* (S57). Remaining students reported immediate role change on commencement of the programme of study, describing transition as a *'Journey'* (42); *'I have*

become more assertive in challenging practice in order to improve the quality of care' (S41); and, 'I have used the learning to raise the profile of advanced practice nursing and its importance within their Trust' (S40).

A Y3 student (S59) described how the primary care workforce was changing with an expected shortfall in practice nurses; *'From my learning I have become more confident that has enabled me to take on a more strategic role that I am using to influence future workforce planning, and support other practice nurses to deal with these challenges'*. This student also reported; *'developing business management skills within the practice, for example I have been involved in audits, budgetary management and the procurement of external services'* (S59), but no financial benefits or changes in role title had occurred as a consequence of these additional responsibilities. Another student (S53) described; *'my work terms and conditions won't change on completion of the course, they will only improve if I moved jobs, which I may consider'*. Only one student (S41) reported having been provided with a new job description, because they now managed more complex patients.

6.3.7 Summary

Students in Case C worked predominantly in critical care or primary care practice areas. Similarly to Cases A and C their biographical profile demonstrated that students accessing the programme of study were experienced professionals. All students were nurses and predominantly female. All students expressed self-motivation and determination to complete the programme of study even when conflicting organisational, personal and family issues challenged them. This was despite being aware that their current role may not change at the end of the programme unless they moved to a different organisation.

Students who were not supernumerary reported excessive workloads as problematic. Employers expecting the same level of work activity from the individual, together with balancing academic study and personal commitments, contributed to this. Some medics

actively supported individuals in a variety of ways, while other health care professionals did not appear to understand the outcomes from the programme of study and offered limited support. All students viewed the programme of study positively, especially at a personal level, describing how it made them think and behave differently within their current roles that led to more effective and efficient care delivery. Findings reported were more aligned to those identified in Case A for those students who were not supernumerary, and to Case B for those students who were supernumerary. A summary of the findings is presented in Table 27.

Table 27 Summary of Student Findings.

Theme	Findings
Expectation of Students	Self-motivated and self-directed in seeking the opportunity to undertake the programme of study
Factors affecting the learning process	- Three students were supernumerary whilst undertaking the programme of study. The remaining five students were expected to contribute some of their own time and money when full study leave was unavailable. - Support from healthcare professionals was variable. Some doctors actively supported students, whilst others offered none or only limited support
Facilitating the learning process for students	- Medics supported student learning in a variety of ways that included: observing their practice; providing effective communication strategies; help with assessments - Peers valuing their contributions - Family and significant others
Barriers to Learning	- There was a perceived lack of understanding by healthcare professionals regarding the purpose of the programme of study and it's benefits both to the individual and to the service - Some students described being overwhelmed by the workload during the programme of study, with two students reporting stress related illnesses - Time - Students placed high expectations on the amount of independent learning they should undertake, which had to be moderated with help from other healthcare professionals
Programme evaluation	- Academic staff were supportive, especially in a link role between the HEI and practice - Generic content, was perceived as appropriate by most students
Evaluation of the effectiveness of learning and its application to practice	- Participants frequently described Increased knowledge of anatomy, physiology, assessment skills and research as benefits resulting from the programme of study - Learning was perceived as positive - Students felt they were more articulate communicating with both colleagues and patients although evidence only moderately supports this

Theme	Findings
Role change as an outcome of the programme of study	▪ All students demonstrated increased confidence, exemplified by a reported improved ability to challenge other healthcare professionals using appropriate language with an underpinning knowledge base and understanding; improved patient consultations by providing more extensive assessments and diagnoses, reducing waiting times and reducing the need for increased medical resources ▪ Students perceived that increased knowledge supported their ability to make more complex clinical decisions accurately ▪ Students provided limited exemplars from practice of how the programme of study had enhanced their role

6.4 CASE C – FOCUS GROUP FINDINGS

The findings presented reflect the data from two focus groups and two interviews held between February and June 2013 in two separate Trusts, an acute speciality Trust, and a Community Trust. Despite agreement by senior management to be involved in the research, organising and recruitment to the focus groups in one Trust again proved challenging. This resulted in two individual interviews being held in the community Trust (Trust A) with a Trust education lead (I.1), and a team leader (I.2) rather than focus groups. The speciality Trust (Trust B) was very successful in recruiting participants to the remaining two focus groups with representation from senior and middle management, and advanced practitioners.

6.4.1 Trust Managers and Advanced Practitioners – Biographical Profile

The Trusts selected for recruitment had students on the advanced practice programme of study. Participants interviewed represented nursing and allied health professional groups and included nurses, physiotherapists and occupational therapists from a variety of clinical practice areas, and sub-specialities within acute paediatrics and adult community. The characteristics of participant profiles are presented in Table 28 (Page 223). The age range of the participants was 28 – 54 years with a mean age of 45.5 years. The mean professional length of service was 6 years. Their responsibilities and remit included identifying the educational needs of staff, purchasing education, and supporting staff during education.

Table 28 Biographical details - Trust Managers and Advanced Practitioners.

	Age Range (Mean)	Gender	Years Professionally Qualified (Mean)	Length of Time in Current Role (Mean)	Current Role	Current Clinical Specialty
Interview 1 Case C Trust 1 (n = 1)	40	Female: (n = 1)	18	3.5	Head of Clinical Education	Education Lead
Interview 2 Case C Trust 1 (n = 1)	57	Female: (n = 1)	37	10	Lead Urgent Care ANP	ANP Community
Focus Group 1 Case C Trust 2 (n = 8)	28 – 54 (43)	Female: (n = 8)	Data not completed accurately (Missing)	1 – 11 (4.5)	- Education lead nurse (n = 2) - Head of therapy services (n=1) - Consultant Nurse (n = 1) - Head of Nursing (n = 1) - Trainee advanced practitioner (n = 1) - Lead nurse-IMD (n = 1) - Lead nurse burns (n = 1)	- Paediatric education (n = 1) - Physio/OT/SLT/ Orthotics (n = 1) - Medical (n = 1) - Paediatric A&E (n= 2) - Paediatric medicine (n = 1) - IMD (n = 1) - Burns (n = 1) - Emergency Medicine (n = 1)
Focus Group 2 Case C Trust 2 (n = 10)	31 -52 (42)	Female: (n = 10)	Data not completed accurately (Missing)	10 months – 14 Years (5.5)	- Advanced Nurse Practitioner (n = 7) - Clinical Nurse Specialist (n = 1) - Associate Director of Nursing (n = 1) - Ward Sister (n = 1).	- Oncology / Haematology (n = 1) - Haemoglobinopathy (n = 1) - Paediatric ITU (n = 1) - Cardiology (n = 1) - Clinical IMD (n = 1) - Manager (n = 1) - Nephrology (n = 1) - ENT (n = 1) - Gastroenterology (n = 1)

The data from managers and advanced practitioner participants in Case C were analysed using the same process previously described for Cases A and B.

6.4.2 Expectations of Managers and Advanced Practitioners Supporting Staff to Undertake Postgraduate Advanced practice Programme of Study

Managers in both interviews and focus groups described a lack of uniformity in the advanced practitioner role within clinical areas, which they perceived arose because of different clinical needs within different specialities. There was, however, common agreement that the advanced practitioner required key attributes to fulfil the role, described as:

'They require, advanced assessment skills, collaboration, advanced decision making, expertise, the synthesis of information, leadership, increased use of evidence based practice and increased autonomy'. (FG, 2)

Participants also agreed that the *'advanced practitioner role should be supported by postgraduate education'* (FG1), to facilitate professional development in clinical areas. A number of factors were considered when purchasing education for advanced practitioners that are now presented.

6.4.2.1 Factors Considered When Purchasing Advanced practice Programmes of Study

In Trust A, a manager reported that funding advanced practice programmes of study was agreed when the training *'supports and defines the role'* (1.2). Within Trust 1, (I1) the development of Rapid Response teams were described as, *'emerging as a consequence of service reorganisation in the community to manage patients more effectively, and include advanced practitioners'*. Managers described how this prompted some individuals to apply for the programme of study (1.1). Problems with this process arose, for example; *'some senior nurses who were redeployed into advanced practitioner roles in this service, were directed to undertake the course in preparation, this led to conflict when one of the managers failed the course but was allowed to continue in an advanced practitioner role regardless'* (I.1). Field notes recorded that the participant was quite angry with this, she

spoke about it before the recording quite passionately, saying that all advanced practitioners should be qualified otherwise *'it gave the wrong impression to others'*.

Factors influencing selection of staff In Trust 1 included; *'workforce plans help to define the role we need'* (I1; and, *'where the staff member is within that type of role, and if they have the academic knowledge to back up that post...we prioritise someone who can go to university and study at that level, or if they need the course for their role'* (I1). Managers also used *'feedback from individuals who had previously undertaken similar programmes'* (I1) to determine the quality and value for money. Managers in Trust 2 looked for programmes that provided *'specific paediatric content and flexibility in order to meet our needs'* (FG2). The motivation of individuals to complete the programme of study and opportunities to use the learning from the programme of study upon completion was also assessed by managers prior to supporting individuals.

Managers in Trust 2 were asked to qualify why they purchased generic adult based advanced practice programmes of study when the service delivered paediatric healthcare. Managers responded, *'there is limited availability of paediatric programmes within HEI providers to choose from, and so we have responded by developing additional in-house education (a paediatric physical assessment module) to supplement learning from the generic programme...the adult focus that is provided by the HEI is a generic and systematic process, which they can then apply to practice'* (FG2). This contradicts data reported (Section 6.3.2).

6.4.2.2 Organisational Support

Managers within both Trusts supported individuals undertaking advanced practice programmes of study by facilitating attendance at the HEI, and by providing practice support. Within Trust 2, managers described how some trainee advanced practitioners were awarded supernumerary status, which included a salary increase from a Band 7 (DoH 2004a) to a

Band 8A (DoH 2004a) on completion of study it was limited; *'this is currently only within critical care areas though'* (FG2). Supernumerary status described by managers, corroborated student descriptions (Section 6.3.2). In Trust 1, *'individuals have programme fees paid and are given time to attend the taught component either partially or in fully, if the programme support the workforce planning in the Trust I talked about earlier or where it was required as preparation for the advanced practitioner role'* (I1).

The interview (I.1) in Trust 1 and both focus groups in Trust 2 reported a forthcoming change in the recruitment strategy where all student advanced practitioners would be supernumerary during the programme of study. Managers described this as *'total immersion into the programme'*; and, *'it will provide time for the student to study in smaller cohorts, and on completion they can act as mentors to other new students and improve the service effectively'* (FG2).

6.4.2.3 Selection Process for Staff Within Trusts

Mandatory training was described as the priority for receiving full support from both the Trusts. In selecting an HEI for a programme of study, Trust 1 considered; *'the cost and quality of the programme were the main factors. We use a system of open commissioning where we, the Trusts have an opportunity to commission places for advanced practice programmes from any HEI. Despite this we have preferred providers who are Trusts where "Loyal relationships" have been developed and which we use more frequently'* (I.1). The freedom afforded to Trusts by having an open market approach was believed to have *'enhanced the quality of the education because the competition it provides forces higher standards of education'* (I.1). Regular contract meetings between Trusts and HEI representatives were used as a forum for discussing quality outcomes, issues relating to specific programmes, and the development of education programmes in response to identified NHS reforms. This process occurred annually.

Managers in Trust 2 described a future recruitment and selection process for advanced practice programmes of study (FG1) that mirrors the activity used in Case B. The new strategy proposed the recruitment of a *'cohort of advanced practitioner trainee's from different specialities within the Trust that would be educated using a tailored postgraduate advanced practice programme of study'*. The rationale for the change was due to a multiplicity of reasons that included:

'A lack of opportunity for current students to acquire advanced practitioner roles on completion of the programme of study; the need to workforce plan more effectively; a current overspend on locum cover due to medical shortfalls that could be reduced by using advanced practitioners as a viable and effective alternative service; and a preference for an HEI provider to offer a tailored programme of study for advanced practitioners.

(FG 2).

Furthermore, managers argued that the current programme of study did not meet its needs and needed to be replaced by one that they had ownership of.

6.4.2.4 Perceptions of Advanced practice Roles

Trust 2 described *'a lack of understanding of the advanced practitioner role'* (FG1). The participants reported; *'some medics are resistant to the development of advanced practitioners because they do not understand the role and are unaware of what the expanded roles nurses provide, for example prescribing'* (FG2). Despite negotiations within the Trust, some difficulties were reported, for example: *'we still have problems with radiological and blood tests being accepted for advanced practitioners, because medics assume they will be inundated by unnecessary requests'* (FG2). Advanced practitioners and managers described how they were currently challenging historical views of *'Traditional boundaries'* (FG2) held by consultants, by promoting the benefits of employing more advanced practitioners. FG2 described how some medics *'have not been exposed to or are cognisant with the effectiveness of advanced practitioners; these tend to be the older*

consultants, unlike the new ones.... We are using the newly employed consultants and registrars, who are more supportive of the role, to help us actively promote and support the development of advanced practitioners within the Trust' (FG2).

The employment of a high number of Clinical Nurse Specialists (CNS) within Trust 2 added to the uncertainty of the advanced practitioner role because of the ambiguity existing between the two roles. The following quote demonstrates how a focus group, in attempting to clarify the difference between the two roles, lacked specificity:

'Clinical Nurse Specialists were developed with consultant support over many years and are based around, more nursing guidance support, parental sort of nursing roles.... they are well respected and accepted and big numbers; ...a change to the advanced practitioner role has been challenging around the autonomy in practice – challenging traditional ways of thinking and uncertainty of who they belong to.... a nurse or a medic, this is tricky. (FG2)

Advanced practitioners were also described as being *'given different roles within different specialities'*, with *'different levels of autonomy that adds to the confusion'*, worked outside the traditional scope of practice, and had teaching and learning and service development within their remit (FG2). For example, *'I think it's the level of autonomy...I think the key difference, the CNS, it's a more team approach, it may be about families that are kind of within the speciality...whereas the ANP would be more autonomous, making independent decisions and the ability to prescribe'* (FG1). They further reported, *'some of the confusion is regarding medical staff, because there are so many CNSs, and they know their role, but there's a new role they don't understand it, I don't think, what the role is or can do'.*

6.4.3 Factors Affecting the Integration of Learning to Practice

Focus group members described how student advanced practitioners were facilitated or hindered to achieve the learning outcomes required by the programme of study and are now presented.

6.4.3.1 Factors Facilitating the Learning Transfer

The role of healthcare professionals and the role of HEI's were identified as factors that facilitated students to effectively transfer learning to practice. Managers also reported the need for *'individual students need to take responsibility for their own learning, and its application to practice'* (FG1). Managers in both Trusts reported that students needed supervised time and space to enable them to consolidate academic learning from the programme of study, for example:

'Students need time to learn, it can't be absorbed overnight, and they need to build into practice'. (FG2)

The role of healthcare professionals and peer support in facilitating the transfer of learning was described as essential by providing time, alternative placements, and learning opportunities and by promoting positivity and motivation. *'It's a partnership thing, the academics support the theoretical, the practice it's the supervisor assigned to them'* (I1, I2). Furthermore, they considered the need for additional help; *'a link lecturer is needed to act in liaison between the two organisations ensuring the student "stays on track"'* (I.2), and make correct decisions, especially when personal difficulties were experienced. An informal process was described, although seen as *'In need of polishing'* (I.2). Medics were identified as the most suitable group to act as mentors in practice because they had the requisite knowledge.

The impact on home life was identified as a factor that can militate against trainees being successful on the programme of study affecting attrition rates, *'It only takes one sick child...*

(FG1). Trust 1 participants believed, *'it is the managers responsibility to support students in being honest at the outset, managers and academics need to make explicit to students' the effects on individual workload and work-life balance, and to provide strategies to support their success'* (I. 1). Overall, managers and advanced practitioners recognised that providing student support was essential if advanced practitioner trainees were to transfer theoretical learning to practice successfully.

6.4.3.2 Barriers to Learning Transfer

A number of factors were identified that provided difficulties for students undertaking an advanced practice programme of study, particularly unexpected and unpreventable events. Tiredness, resulting from balancing a heavy workload in practice with university work, was described as common: *'There are bumps in the road...* (Trust 1, FG 2). Finding time to work with mentors was described as adding to the burden and the greatest barrier.

6.4.3.2.1 The Role of Peer Support

Managers and advanced practitioners in Trust 2 described the allocation of suitable mentors in practice as *'challenging'* (FG 2). Lack of role clarity and understanding of the role, meant that medics were not always willing to support students:

'They see it as nothing to do with them...and expect advanced practice's to develop as the full rounded ticket without any input from anybody else'. (FG 2)

Students were reported to need help in selecting an appropriate mentor since not all medics were supportive or helpful because of the workload and time associated with the role. One manager considered additional support from others within the wider community useful:

'Consultant Geriatricians for community advanced practice's to work with because they provide a different dimension to care but they are not always available'. (I 1).

Managers in Trust B described how they were intervening to ensure appropriate mentors were available to students on the programme of study, and that they *'were now turning the*

corner' (FG2) following open and honest discussions with medics. However, managers described this process of negotiation; *'we now have a shared goal for planning an effective future workforce'*. This was potentially challenging, described as:

'This isn't to replace your SHO's, this is a different role, there will be crossover and there can be cross cover, but actually these are two different people and they've got different skills... that's the bit they don't really get, isn't it? They are happy for all doctor's to substitute part for some of the things, skills, and tasks – but the actual whole kind of nature of the role, I think they pass by a little.... as senior people, we have to keep the pressure on...' (FG2)

Generally participants believed medics were increasingly supporting the introduction of advanced practitioners, although they acknowledged there were still many to be convinced of the merits of advanced practitioner roles.

6.4.3.2.2 The Role of the Higher Education Institution

HEIs provided support to Trusts through regular face-to-face meetings and through a relationship developed over time between academic staff and Trust managers. Participants described problems: *'poor communication has been a problem; they don't always let us know that a module is not running. We have planned for this, reorganised staff, it is then cancelled and is frustrating, and is a waste of resources...the students then have to wait to do the module next year'* (FG1). Managers argued that programmes, *'need to offer a flexible and applied approach to learning, and allow specialist modules to always be delivered when offered'* (FG2). They also described how the Trust also had an obligation to be transparent with the HEI regarding what learning was required.

One focus group (FG1) reported; *'the current course places too much emphasis on the clinical learning and I think there are other responsibilities for the advanced practitioner role and should be included'* (FG2). Clinical leadership was seen as integral to the advanced

practitioner role, yet was not always demonstrated by students following completion of a programme of study (I.1). One manager (I.2) reported that Trusts were *'lagging behind in how they applied evidence-based practice, this is hindering the Trust, we have just received some evidence that shows we are not using research in practice enough'*. Managers identified; *'we need more qualified advanced practitioners to act as role models particularly in leadership'* (FG1).

Discussion regarding the utility of including nurse-prescribing modules in the programme of study resulted in mixed opinions. *'prescribing is really useful although it is difficult to fit into the course, because it will mean something else has to be taken out'* (FG2). Alternatively, some described how nurse prescribing was not always supported by the Trust, for example; *'in some areas they don't, the medics don't agree to ANPs using it, and therefore it's a waste they could be learning something else that they can use'*.

6.4.4 Managers and Advanced Practitioners Perceptions of the Outcomes of the Programme of Study

All participants reported positive outcomes from the programme of study. Increased knowledge, behavioural changes, service enhancement and the need to place greater emphasis on the development of leadership skills were the predominant themes identified. Overall, students were described as *'Blossoming'* (FG 2).

6.4.4.1 Increased Knowledge

All participants reported that students disseminated their learning with team members more frequently by becoming more actively involved in teaching. Advanced practitioners were considered to be *'effective in clinical decision-making, they use a sound rationale to support their decisions more effectively after the course'* (FG1). The ability to more clearly articulate these decisions to other professionals and patients following the programme of study, was

described. Managers and advanced practitioners reported; *'recently there has been a more positive debate about organisational and clinical issues, and I think this is because we have more advanced practitioners who have done the course and research. They use this more to deliver evidence-based practice'* (FG2). The support by others within the healthcare team, especially the mentor, was seen as pivotal to the successful transference of the new knowledge gained into practice.

6.4.4.2 Behavioural Changes

All participants agreed that students changed their behaviour as a result of the programme of study. Behavioural changes included increased confidence enabling the advanced practitioner to challenge others' behaviour and decision-making, reported as; *'more questioning of self and others decision making'* (I2), and had *'greater involvement'* (FG2) in the introduction of new organisational policies.

6.4.4.3 Patient Satisfaction

All participants reported that the programme of study guided students to develop a greater awareness of patients' problems, enabled them to manage more complex and different conditions to those they previously managed, and provided greater continuity of care for their patients. *'Following the course I think they are more aware of governance issues...yes, they use it more...in things like research and policy, when we have been trying to develop things in the Trust'* (FG2). As a result of these changes, the quality of care delivery by the whole workforce was said to improve. Managers believed that the proposed course *'would lead to more advanced practitioners and would be good for the Trust... yes in my clinical area it is a specialist area and recruitment of junior medics has been difficult. We wont have to employ so many agency doctors, who are not always very useful anyway, it will save money too'* (FG2). Unfortunately, participants were not able to present specific examples to support these bold assertions; *'improved patient satisfaction'* (FG1); *'increased support from medics'*(FG1); and, *'patients and their families are supportive of the role because they*

appreciate us, what we do...we improve continuity of care to patients, they see us every time they visit and trust us' (FG1).

6.4.5 Summary

Two focus groups and two individual interviews were held in two Trusts. Participants shared their thoughts freely and appeared enthusiastic of the advanced practitioner role describing the need to train more advanced practitioners in order to respond effectively to current workforce planning issues. Managers reported that students were self-directed in applying for programmes of study. Trusts appeared to support the need for purchasing the programme of study especially when advanced practitioner roles were defined.

Similar facilitating factors and barriers to learning transfer were identified to those reported in Cases A and B. Both Focus Groups in Trust 2 were dissatisfied with the programme of study delivered by one HEI. Positive patient benefits included, improved continuity, increased quality of care, and more confident and challenging practitioners who used evidence based practice more frequently in their clinical decision-making. Unfortunately, no real examples to support these perceived changes were identified. A summary of findings is presented in Table 29 (Page 235).

Table 29 Summary of Findings - Managers and Advanced Practitioners Case C.

Key Theme	Finding
Expectations of Managers to support Staff	▪ A programme of selection and recruitment of trainee Advanced Practitioners is in operation ▪ Managers identified that most students were self motivated and initiated the application to the programme of study, though this was in response to performance review meetings in some cases ▪ Two forms of training support were identified namely: some students were fully supported (i.e. supernumerary status) or alternatively worked in practice while undertaking the programme of study
Factors affecting the integration of learning into practice	▪ The role of HEI's in not providing advanced practice appropriate content and flexibility in programme delivery ▪ Student support by healthcare professionals and academic staff were considered to be essential in meeting programme outcomes and transferring theoretical learning to practice. ▪ Issues of resistance to the role, lack of clarity and ambiguity of the advanced practitioner role within Trusts was apparent in some clinical areas ▪ One Trust employed a large number of CNS's in addition to Advanced Practitioners, which led to ambiguity between the two roles
Outcomes of the learning from the programme of study	▪ Satisfaction with the programme of study as preparation for the advanced practitioner role was mixed, with some managers satisfied and others reporting the programmes lacked flexibility and specificity. Trust (2) consequently changed the way they purchased advanced practice programmes, to a tendering process where HEI's would develop and deliver a tailored programme of study for a recruited cohort of trainees.
Outcomes of the learning on practice	▪ Benefits of the learning were identified by participants as: increased confidence; increased ability to challenge practice and others; improved patient interactions; increased use of evidence based practice; increased quality of care; and improved patient satisfaction
The current role of the advanced practitioner in Practice	▪ The ability to gain promotion or move into an identified advanced practitioner role was limited in both Trusts ▪ Advanced practitioner roles would become more prevalent in response to meeting current workforce issues

Findings from Case A, Case B and Case C demonstrated both similarities and differences following analysis of the documentation and student and focus group interviews. The presentation of the findings for each Case, initially individually, allowed assessment of the outcomes of learning on practice for each Case in its own right, prior to a cross comparison between Cases. Table 30 (Page 236) provides an overview of this comparison prior to exploration of these findings more comprehensively in Chapter Seven.

Table 30 Summary of Results: Comparison Table.

Awarding Institution	Case A	Case B	Case C
Year of Programme Validation	2008	2011	2011
Links with Partner Institutions/Drivers	Multiple purchasers within the South East	Northwest NHS Workforce Modernisation Group	Multiple purchasers within Central England
Programme Accreditation	RCN	None	None
Final Award	MSc Advanced practice with pathways in: ▪ Nurse Practitioner ▪ Nursing ▪ Critical Care ▪ Respiratory Care Cancer and Palliative Care ▪ Gastro-Intestinal Care May exit with Postgraduate Diploma level (120 Credits)	MSc Advanced practice (Health and Social Care) May exit with Postgraduate Certificate (60 credits) May exit with Postgraduate Diploma level (120 Credits)	MSc Advanced practice Nursing MSc Advanced practice Health MSc Advanced practice Midwifery May exit with Postgraduate Certificate level(60 credits) May exit with Postgraduate Diploma level (120 Credits)
Level of Qualification	Level 7 (masters) 180 Credits	Level 7 (masters) 180 Credits	Level 7 (masters) 180 Credits
Length of Programme	Part time mode 3 years normally, maximum term 5 years	Part time mode 2 years normally, maximum term 5 years	Part time mode 2 ½ years; Full time mode 18 months, maximum 5 years
Mode of Attendance and Support	Part time mode day release over two academic semesters per year. Normal attendance one day per week Days are pre set and students are supported in clinical practice by a work based mentor (Normally a Medical Practitioner) and a clinical link tutor employed by the university.	Part time modular programme; teaching arranged to facilitate release by employers. Study can be block release or day release as the market dictates to meet the needs of the students on a pathway. Teaching is further supported by work-based study and supported in clinical practice by a clinical facilitator employed in a joint post to work at University and Trust.	Part time mode day release over two academic semesters per year. Days are pre set and a consultant/GP mentor and senior practitioner mentor support students in practice. Normal attendance one day per week.
Funding	NHS London, Employer and Individuals.	NHS Northwest, Individuals and NHS Trusts	NHS West Midlands, employer or individuals.
Cost of Programme	Year 1 £3480; Year 2 £3480; Year 3 £2270. Total Cost £9230	Year 1 £2625; Year 2 £2625; Year 3 £2100. Total cost £7350	Year 1 £2400; Year 2 £2400; Year 3 2400. Total Cost £7200.

Awarding Institution	Case A	Case B	Case C
Entry requirements	- Registered Practitioner, currently in practice - Normally hold a first degree or minimum of 60 credits at level 6 - Working in a practice arena that will support and facilitate the development of advanced practice Have written agreement of support from their employer for practice and financial support - Working in clinical speciality for a minimum of two years - Minimum employment in practice 15 hours per week	- Registered Practitioner, currently in practice - Normally be graduates in health and/or social care - Working in a practice arena that will support and facilitate the development of advanced practice - Have written agreement of support from their employer for minimum learning and financial support - Working in their clinical speciality for a minimum of two years	- Registered practitioner, currently in practice. - Hold a first degree or evidence of recent professionally related study at diploma or degree level. - Students will have three to five years professional experience in their clinical specialty - Have studied Research Methods at level 6 (degree level) or Physiology at level 5 (diploma level) or Prescribing (level 6). Alternatively, may need to complete some pre-course written work. 150 study hours self-study required to complete the on-line research and physiology access reading and essay.
Relevant Subject Benchmarking	- Framework for Higher Education Qualifications (FHEQ) (QAA 2008). - Descriptor for a higher level qualification at level 7 - NHS Knowledge and Skills Framework (DoH 2004b) RCN Competencies for Advanced Nurse Practitioners (RCN 2007).	- Framework for Higher Education Qualifications (FHEQ) (QAA 2008). Descriptor for a higher level qualification at level 7 - NHS Knowledge and Skills Framework (DoH 2004b) - RCN Competencies for Advanced Nurse Practitioners (RCN 2007) - NHS Northwest Concordant for Advanced practice (2009).	- Framework for Higher Education Qualifications (FHEQ) (QAA 2008). Descriptor for a higher level qualification at level 7 - NHS Knowledge and Skills Framework (DoH 2004b). - DoH (2010b) Advanced Level Nursing: a position statement
Aims of Programme	To promote an advanced level of scholarship; develop skills of interpretation and effective synthesis of knowledge within a specified field, to inform practice and develop healthcare practice and policy at both operational and strategic level.	To provide an academic and practice framework in which students can proactively and collaboratively develop professional expertise and academic values of advanced practitioners.	To improve the quality of evidence-based care through critical reflection and deep theoretical knowledge and skills. The provision of a rigorous educational environment to promote the growth of regional leaders who will be an expert resource predicated on research, advanced clinical scholarship, skills, and leadership.

Awarding Institution	Case A	Case B	Case C
Aims of Programme (Cont)	Foster refined levels of clinical judgement and autonomy concerning the full range of healthcare interventions, equipping the student to support the development of advanced practice and practitioners and operate collaboratively within a specified field of care.	To enable those working in health and social care to meet the challenge of advanced practitioner status through appropriation of higher-level practice skills and knowledge in the context of service redesign and service needs.	Utilising a model of partnership and collaborating with practice mentor(s), knowledgeable and experienced professionals will meet the changing needs of patients by critically evaluating current developments in new accessible approaches to direct clinical care and service design
Programme Structure and Content	All students are required to follow the programme in the sequence outlined within the programme specification for a given pathway. APL may be obtained with appropriate evidence. There are four core modules. Year one Modules: - Assessing Needs and Outcomes: methods and Measurement (15 Credits) Core - Scope of Professional Practice (15 Credits) Core - Pathophysiology and Assessment of Illness and Injury (30 Credits) Year Two Modules: - Clinical Judgement, Diagnostic Reasoning and Pharmacology (30 Credits) or Independent and Supplementary Prescribing (60 Credits) - Generating knowledge for Practice (15 Credits) Core - Leadership and Management (15 Credits) Core Year Three: - Dissertation (60 Credits)	All students are required to follow the programme in the sequence outlined within the programme specification. APL may be obtained in exceptional circumstances. All modules are core. Year one Modules: - Principles of Advanced practice (30 Credits) - Application of Life Sciences (30 Credits) - Contextualising Advanced practice (30 Credits) - Individual Learning Pathway; Tripartite agreement core and bespoke skills – Developing Portfolio & Mapping of evidence Year Two Modules: - Research Methods (30 Credits) - Advanced Practitioner 1: Competence (30 Credits) - Advanced Practitioner 2: Clinical Reasoning (30 Credits)	All students are required to follow the programme in the sequence outlined within the programme specification. There are five core modules. Year One Modules: - Leadership for Advanced practice (15 Credits) Core - Advanced Health Assessments (30 Credits) Core - Advanced Practicum (15 Credits) Core - Research, Theory and Practice (15 Credits) Core - Differential Diagnosis and Clinical Decision Making (15 Credits) Core Year Two Modules: - Independent and Supplementary Prescribing (30 Credits) or two Optional modules from a list of 13 (30 Credits) - Research Workshops Research Project (60 Credits)

Awarding Institution	Case A	Case B	Case C
Teaching and Learning Philosophy and Strategies	Teaching and learning strategies employed encourage student independence and learning from and through experience, using reflection, and the development of the skills required to practice at an advanced level; to ensure that the Advanced Nurse Practitioner award will meet the Standards and Criteria for RCN accreditation of Nurse Practitioner Programmes (2007). Paramount to the teaching and learning strategy will be the value placed on the student's own experience of practice and theoretical underpinnings of practice. The programme team and external experts will provide the main input on the taught sessions. The emphasis will be on student support and facilitation. <i>Teaching and Learning strategies used, include:</i> ▪ keynote lectures and Seminars ▪ Enquiry based learning Group and individual tutorials and debates. ▪ Demonstration and replication by the student ▪ On line materials available on VLE ▪ Individual scholarly learning Reflective Learning Logs	The facilitation strategies within the programme prepare students for the development of generic and specific practice at advanced level. The programme embraces the concept of learning at work to develop new ways of working as outlined by Sargent (2003) and Manley (1997) and the NHS Northwest Concordat for Advanced practice (2009). The practice context is at the centre of the learning experience. Students engage in critical self-assessment of knowledge and skills against appropriate competency frameworks in order to identify, in negotiation with their employer and academic supervisor, an individual learning pathway within the programme. <i>Teaching and learning strategies used, include:</i> ▪ Workshops and Master Class: ▪ Learning Sets ▪ Personal Tutor, Practice Mentor Support, Clinical Assessor and Learning Facilitator ▪ Individual Scholarly Activity ▪ On-line Learning Resources and Processes Postgraduate and Research Seminar Series	The underpinning educational philosophy seeks to blend technical and practical knowledge. The approach takes into account the clinical expertise each student brings together with the new knowledge and skills required by the advanced practitioner. A variety of teaching and learning methods are used to link theory and practice When developing students' knowledge, skills and understanding.

Awarding Institution	Case A	Case B	Case C
Assessment Strategy	Assessment strategies are said to include both the assessment of theoretical knowledge and of practical knowledge. <i>Assessment methods</i> used include: ▪ Reports ▪ Literature Review ▪ Portfolio ▪ Case study ▪ Reflective essays ▪ Business Plan ▪ Examination Integrated Care Pathways ▪ Essay ▪ Objective Structured Clinical Examination (OSCE) ▪ Dissertation The use of formative assessment is included within many of the modules. To achieve the award students must pass all the components of each module. The pass mark for written assessments is 40%. The pass mark for OSCE based assessment is 70%. Only two referral attempts are permitted.	Assessment strategies are said to have been developed to reflect the ethos and learning aims and objectives of individual modules. <i>Assessment methods</i> used include: ▪ Self assessment ▪ Peer assessment ▪ Practice based assessments ▪ Critical Reflective commentaries ▪ Portfolio of evidence ▪ Viva Voce ▪ Objective Structured Clinical Assessment (OSCA) ▪ Poster presentations ▪ Service delivery and organisational assessment and redesign ▪ Essays ▪ Client management plans ▪ Written reports ▪ Unseen examinations The use of formative assessment has been included within many of the modules. To achieve the award students must pass all the components of each module. Pass mark 50% for all assessments	A wide range of continuous assessments is said to be used within the programme. <i>Assessment methods</i> used include: ▪ Completing reports ▪ An integrated physiological case study ▪ Presentations ▪ Essays ▪ Research proposal ▪ Practice competency documents \OSCEs Practice based learning experiences includes opportunities to develop and be assessed in advanced clinical skill by consultant/GP mentor/assessors and senior practitioners, in educationally led practice. The use of formative assessment is included within many of the modules. To achieve the award students must pass all the components of each module. Only two referral attempts are permitted.
Practice Component	Students are required to work in practice for a minimum of 15 hours per week. As part of the entry requirements students must submit a completed Clinical Site Evaluation Form (CSEF), which requires sign off by a qualified mentor in practice and their manager. The CSEF is an educational audit of the practice environment.	Sponsored students have guaranteed 2 full learning days per week and a practice based mentor to facilitate work-based learning. Clinical practice assessors undertake clinical assessment of clinical skills	Students have two practice mentors; a consultant or GP and an advanced practitioner or senior professional from their discipline.

Awarding Institution	Case A	Case B	Case C
Practice Component (Cont)	Mentors provide formative feedback to students except for the Independent and Supplementary Prescribing module where they summatively assess and sign off specific competencies. A mentor handbook is issued at the start of the programme. Examination of clinical skills is through OSCE only.	Each student will have a learning facilitator allocated with a specific remit to work with practice based assessors and mentors to ensure consistency in approach and standards as a quality measure. The portfolio assessment demonstrates evidence of all elements of advanced practice and requires: 15 assessed client cases; 40 pieces of evidence of patient contact over the duration of the programme; audit of practice; and completion of core and bespoke clinical skills log. Pass mark 50% for all assessments	A meeting between the education team and mentor occurs at an early stage to discuss the development of the student. A mentor handbook is issued at the start of the programme. The advanced practice practicum module promotes the development of skills and knowledge gained in the Advanced Health Assessment module. It is supported in practice by mentors and assessed through a practice profile and OSCE assessed by a mentor and a member of the education team.
Profile of Participants - Students	Participants (n = 16): Year 1 (n = 6); Year 2 (n = 3); Year 3 (n = 4) and Post Qualifying (n = 3) Age Range 27 – 52 years Mean Age 41 years Length of professional service mean 19 years	Participants (n = 8): Year 1 (n = 2); Year 2 (n = 3); Post Qualifying (n = 3) Age Range 33 – 56 years Mean Age 42 years Length of professional service mean 16 years	Participants (n = 8); Year 1 (n = 2); Year 2 (n = 5); Year 3 (n = 1) Age Range 28 -52 years Mean Age 41 years Length of professional service mean 19 years
Student Themes			
Students Status	Self motivated and self directed to study Students part or fully fund learning	Supernumerary status	Supernumerary status OR Self motivated and self directed Following appraisal
Selection of HEI	Previous study Relevant content Location Preferred provider	No choice – Part of trainee post	Previous study Relevant content Location Preferred provider
Factors Facilitating the Learning Process	Healthcare professionals support Support of Family and significant others Positive attitude and motivation to complete the programme of study Academic staff Organisational funding	Tripartite support from mentors, academic staff and manage Benefits of supernumerary status	Healthcare professionals support Academic staff Support of Family and significant others Benefits of supernumerary status Positive attitude and motivation to complete the programme of study

Awarding Institution	Case A	Case B	Case C
Programme Evaluation	Unprepared for workload Challenging modules Met expectations Use of more medical practitioners in teaching All modules are relevant	High level of appreciation for content and delivery of programme Adult focus challenging to paediatric nurses Met student expectations mostly	Development of knowledge and skills to support patient management Workload overwhelming Met expectations mostly, modules were relevant and appropriate Specific content missing eg. Gynaecology Adult focus challenging for paediatric nurses
Facilitating Knowledge Transfer	Academic staff Organisational support – medical mentors, managers Trust and belief in student Self motivation – Proactive Use of assignments Research knowledge Knowledge to underpin practice	Development of new knowledge and skills enhanced care delivery Advanced practice forum within the Trust Use of the portfolio Research knowledge	Development of new knowledge and skills enhanced care delivery Research knowledge Medical mentors Self motivation
Effectiveness of Learning	Increased confidence Change in attitude – ability to challenge, improved communication with patients and peers Increased knowledge Improved consultation skills Improved clinical decision making Challenge tribalism	Relevant content and well structured Learning initiated innovation Middle part of the programme insufficiently clinically focussed Increased knowledge and skills facilitated more holistic care delivery Improved patient consultations Increased confidence Increased ability to challenge medics	Relevant content and well structured Increased confidence Change in attitude – ability to challenge, improved communication with patients and peers Increased knowledge Improved consultation skills Improved clinical decision making Reinforced current role
Perceived Benefits for Patients	Improved and linear patient consultations Manage complex patient presentations Reduce waiting times for patients Improved communication – improved clarity and articulation of information to patients and colleagues, however this is not evidenced in the transcripts Management based on knowledge and evidence based practice not 'guesswork' Increased ability to anticipate problems More proactive in patient management More autonomous in decision making	More competent practitioner A 'bridge' between nursing and medical professionals Increased respect received from other healthcare professionals Identification and successful management of misdiagnosed or incorrectly diagnosed patient presentations following medical admission Increased autonomy Increased use of evidence based care Increased use of thorough health assessments	Improved consultations Ability to manage more complex patient presentations Care delivery using a nursing philosophy within a medical model Improved communication – improved clarity and articulation of information to patients and colleagues, however this is not evidenced in the transcripts

Awarding Institution	Case A	Case B	Case C
Role Change	Changing all of the time No change in grade or remuneration Clinical role change with increased responsibility Increased strategic responsibilities Increased recognition and use of advanced skills Increased autonomy More reflective practitioner	More clinical role, performing more robust clinical assessments Greater efficiency and effectiveness of patient consultations Increased appreciation by patients Ability to challenge medical professionals more successfully Advanced practice role on qualification Uncertainty within future advanced practice role within clinical settings where the role is innovative	Increased ability to support peers Increased strategic role Anticipated benefits: Improved practice using expert knowledge and skills; no perceived change in job description or terms and conditions of employment
Focus Group Themes			
Expectations of Managers	Contract by preferred providers for funding Cost Establish needs in department for advanced practice's Fit in with organisational strategic plan Selection and interview process used Consider individual experience, benefits, PDP's Shift to purchasing level 7 academic programmes Expect student to initiate request for advanced practice study Open market approach used to tender programme from HEI – Preferred providers	Preferred provider established Presentation and agreement of business case for the introduction of advanced practice role Clear recruitment strategy Some opposition from medical professionals were overcome Students become trailblazers for advanced practice roles in new clinical areas	Currently no uniformity in advanced practice role Support to staff applying for funding considered when: programme of study supports identified practice advanced practice roles; Introduction in response to policy initiative to introduce advanced practice roles Meet the needs of the Trust due to poor recruitment of medical staff Selection process used Open market approach used to tender programme from HEI – Preferred providers
Factors Affecting Integration of learning in Practice	Relevance of role Relevance of programme to current role Teaching of others Support from peers and other healthcare professionals Difficult to get right Tension between medical and advanced practice trainee's Good support from HEI academic staff Funding – time and fees	Multifactorial support from managers, healthcare professionals and academic staff to support learning and finding placements Clinical areas where variety of patient presentations are limited Generic adult focus of the programme of study limiting for paediatric nurses	Relevance of programme to current role A lack of understanding of advanced practice role by healthcare professionals Traditional ways of working–Nurse/doctor role Ambiguity of roles (CNS and advanced practice) Programme of study does not meet the required needs of managers within the Trust – as a result Trust changing strategy for purchasing programmes

Awarding Institution	Case A	Case B	Case C
Factors Affecting Integration of learning in Practice (Cont)	Vicarious liability Lack of advanced practice mentors Advanced practitioner's work in isolation Students workload		Support of medics as a mentor Sufficient time for independent learning Support from academic staff from the HEI Patient support Students workload
Perceived Outcomes from the Programme of Study	Improved practice Improved health assessments Increased confidence Increased assertiveness Increased underpinning knowledge Increased autonomy Complete patient management Junior doctors reliant upon them Improved decision making 'Bridge' between junior nursing and medical staff Increased use of evidence based practice Increased strategic perspective Increased use of prescribing	Increased confidence Greater initiative in problem solving Improved autonomy More self-managing Improved communication with other healthcare professionals Increased knowledge used to enhance effectiveness of care delivery Identification of misdiagnosed patient presentations Provides a clinical career ladder for nurses	Increased knowledge and skills More effective in clinical decision making Ability to clearly articulate decision making Greater use of evidence based practice Increased confidence Increased ability to challenge decisions made by other healthcare professionals More questioning in practice Improved patient satisfaction – manage more complex patient presentations; greater engagement with governance and policy developments; improved quality of care. Limited examples were provided
The Clarity of advanced practice Roles in Practice	Uncertainty of advanced practice role Lack of understanding of advanced practice role Lack of identity of advanced practice role Lack of uniformity of advanced practice role within organisations Resistance to advanced practice role by peers and medical professionals Care delivery using medical model with nursing philosophy	NA	Uncertainty of role Lack of understanding by some healthcare professionals regarding advanced practice role Lack of uniformity within the Trusts of the advanced practice role Resistance to advanced practice role by peers and medical professionals

CHAPTER 7 INTEGRATION OF FINDINGS

7.1 Introduction

In the absence of meaningful evidence to evaluate the effectiveness of postgraduate advanced practice education the objectives for the research study (Section 3.2) set out to determine students' managers' and advanced practitioners' perceptions of advanced practice programmes of study. Findings from the three discrete cases portrayed these participants' reactions, identified factors that facilitate and impede the transference of theory to practice, and recognised the outcomes of learning and behaviour on the organisation for which they worked.

The purpose of this chapter is to report the findings from a comparative analysis of the results from the three individual Cases A, B and C (presented in Chapters Four, Five and Six). Figure 6 presents a diagrammatic representation of this process. The Barr *et al* (2000) evaluation framework (Section 2.12) was used to structure the discussion of the comparison of these findings. Implicit within this framework are levels against which these findings were measured and include Level 1, Reaction, Level 2a, modification of attitudes and perceptions, Level 2b, acquisition of knowledge and skills, Level 3, changes in behaviour, Level 4a, change in organisational practice, Level 4b, and benefits to patients.

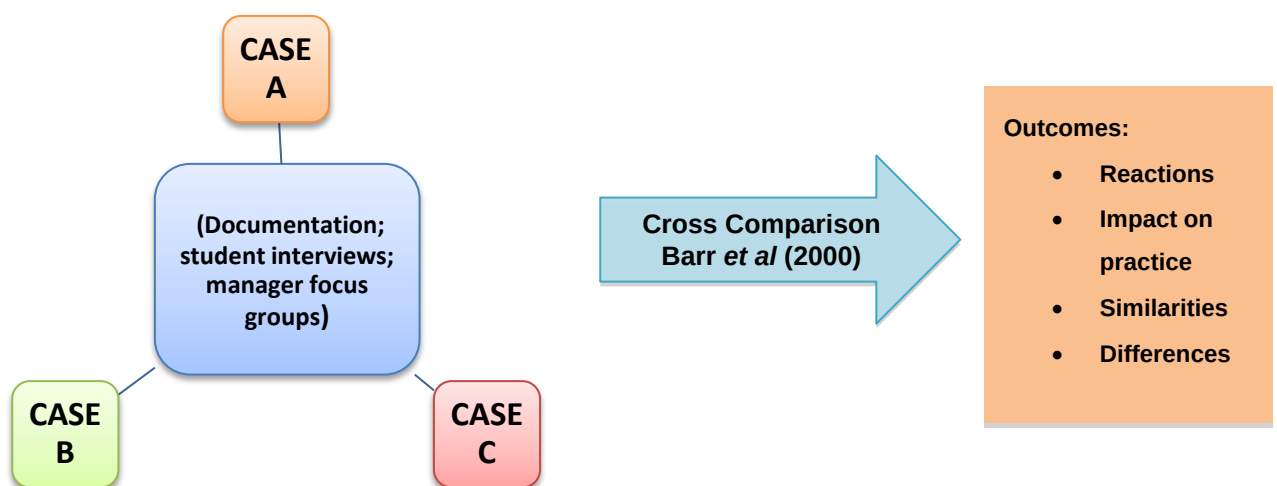


Figure 6 Diagrammatic Representation of the Integration of Findings.

This discussion also includes reflexive thoughts related to unanticipated participant responses that had to be examined when analysing and reporting the findings to minimise subjectivity and bias. This is consistent with the principles of qualitative research that assist the researcher in making sense of the phenomena, the meaning an individual brings to them (Ritchie & Lewis 2009), and adds credibility to this study.

7.2 Level 1: Reaction

Level one attempts to measure participants' reactions to and satisfaction with, the programme of study and the learning environment, and represents the satisfaction of the participant rather than the actual learning per se.

All students appeared to be self-motivated and self-directed when undertaking their programme of study, initiating the application to the HEI and seeking support from their workplace. In selecting an HEI to undertake a programme of study, students in Cases A and C favoured previous places of study, HEIs located in close proximity to their home and workplace, and/ or preferred providers. In Case B, where a concordant agreement between the Local Health Authority funding the training at the time, the Trust and the HEI was in place, the HEI was already stipulated and presented no real choice for the student.

Students in Case B were all satisfied with their programme of study, specifically in relation to the support that was provided. A major factor for this was that the students were granted supernumerary status, which provided study time for the taught components of the programme, autonomy to self-manage their remaining work-time independently in order to meet the programme learning outcomes, and provided designated mentorship support in practice. The majority of students in Case B were satisfied with the content and taught elements of the programme, reporting that it underpinned advanced practice and was appropriate in content and academic level. Conversely, a minority of students working

predominantly in speciality areas disagreed, reporting that while the content of the programme was beneficial it could not be directly applied to their related speciality and necessitated additional independent study to make it relevant. Similarly, students in Case C working in comparable clinical settings reported this as a weakness of their programme of study. Students in this situation would have preferred a tailored programme to meet their individual needs.

In Cases A and C, the majority of students worked full or part time while undertaking the programme of study. While the majority of students reported being satisfied with the programme content and delivery, they also reported difficulties in coping with the workload from the programme in addition to their normal job. Students underestimated the amount of academic learning required, and incurred hidden costs associated with this, for example: the use of unpaid and annual leave to attend the HEI; the inability to spend quality time with family or significant others; and in extreme cases, stress related illnesses. Students reported a lack of support from their managers and Trust as the principal reason for causing these difficulties. In response, students learned how to manage their time creatively, and accessed additional help to locate appropriate alternative mentors in practice. This subsequently assisted them to transfer their theoretical learning to practice, and complete the programme of study.

Managers in all cases appeared satisfied that the programme of study provided the students with increased knowledge and skills, which they perceived were valuable to the organisation. Managers in Cases A and C reported supporting staff to undertake an advanced practice programme only when they believed it contributed to the strategic aims of the organisation, which proved to be inconsistent, poorly defined, and sporadic within and across organisations. Reduced resources and managers working in isolation contributed to this variation in decision-making. Conversely, in Case B an organisational policy in place to implement advanced practitioner roles in all clinical areas led to a consistent level of support.

One organisation in Case C was however, was working towards implementing a similar model of training for advanced practitioners to that of Case B because of increased dissatisfaction with the generic approach taken by HEIs. Additionally, they considered the current training did not meet their organisational requirements. During data collection, when these perceptions were reported, I considered the managers were unaware of the difficulties in providing education to small numbers of students for speciality areas. Student findings from this Trust had demonstrated satisfaction with the current programme of study. However, managers appeared ignorant of this, and instead sought to change education providers (FG63) by instigating a tender process for the delivery of a specific advanced practice programme for an individual cohort without prior discussion with the HEI.

Reflecting on the interviews with these managers and listening to their comments, I remembered feeling the need to respond from an educationalists perspective, wanting them to realise the complex processes that faculties have to adhere to when developing curricula. I also wanted them to realise the resource implications of what they were asking for, and felt frustrated that I was unable to do this. From my own experience of similar fora I recognised that goodwill relationships between HEIs and healthcare providers could not be taken for granted, and were perhaps becoming more tenuous than I had realised.

The reality of the current financial climate and the impact of competition between education providers reinforced the need for greater collaboration and understanding of reciprocal needs. Healthcare providers need HEIs to offer greater flexibility and to be responsive and creative in meeting educational needs of their staff while maintaining quality. While the provider may acknowledge competing priorities, intentions or constraining factors impacting on the HEI, the competitive market dictates that they will seek and find alternative providers able to provide the exact education they require. Without a strategic partnership sharing a common understanding and responsibility for the vision of a credible advanced practice

model, there are unrealistic expectations of both stakeholders leading to a breakdown in communication and potentially under-prepared advanced practitioners.

In summary, the data suggests that students were self-motivated and initiated application to a programme of study. In Cases A and C, findings illustrated differences between managers and students regarding how personal and professional development needs were identified. Students perceived that it was the managers' lack of understanding of the advanced practitioner role, particularly at a strategic level, which contributed to this. The evidence from managers to support or refute this claim is, however, incomplete, although the knowledge demonstrated by managers of the advanced practitioner role in these two Cases would indicate that this is likely.

The concordant agreement in place in Case B that provided structure and support throughout the programme of study resulted in the majority of students reporting satisfaction. Findings indicated that the learning from it fully prepared them for an advanced practitioner role. Although students in Cases A and C reported elements of dissatisfaction, these were often personal to individual students, (S19, S43). Excessive workload for students in both cases most affected student satisfaction because this adversely affected their work life balance. Despite these nuances the findings from this evaluation have captured student reactions of the programme and demonstrate satisfaction with it that support level 1 of *Barr et al's* (2000) framework for all cases, and is represented in Figure 7.

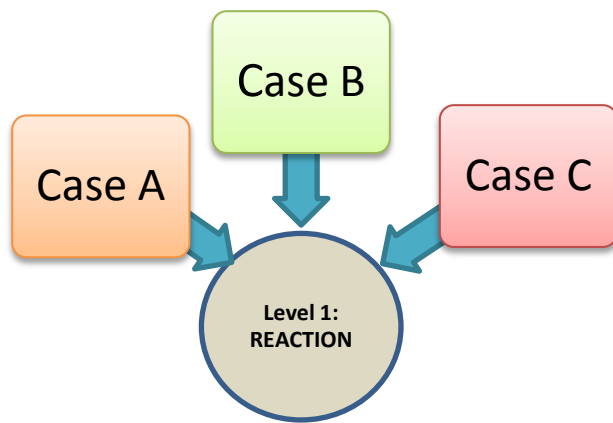


Figure 7 Realisation of Level 1 Barr *et al* (2000) Framework for Cases.

7.3 Level 2a: Modification of Attitudes and Perceptions

Level 2 of the framework evaluates the extent to which learning from the programme of study impacts on the 'job' that is represented by changes in attitudes or perceptions towards a shared intervention, for example care and treatment.

Students across all three Cases recognised that they were more confident in their interactions and communications with patients, peers and other members of the multi-disciplinary team as a consequence of the learning. Accuracy and clarity of communication were described; for example, students perceived they were more able to provide patients with enhanced health education and explanations of clinical conditions. Students in Case B reported developing increased autonomy when initiating care in the exemplars they provided, in comparison with students in Cases A and C. Managers in Case B also reported enhanced care episodes that were more effectively and comprehensively managed and, in support, provided exemplars comparable to those presented by students. Managers in Case A acknowledged that students had developed confidence as a result of their learning. However, this was only described in relation to nurse prescribing, which is an option module of the programme of study and not undertaken by all students.

A lack of role clarity and of advanced practitioner posts on completion of the programme, within organisations in Cases A and C, acted as barriers to wider implementation of the outcomes derived from the programme of study. In Case B, where advanced practitioner roles were more widely understood and implemented, students were more able to demonstrate how learning had enabled and facilitated them to improve consultations with patients.

In summary, the three cases demonstrated that learning from the programmes of study affected individual students by increasing students' confidence and assertiveness, which subsequently led to improved communication, patient interactions and consultations. In Case B, students provided exemplars to support these changes more frequently, more consistently and in greater detail (S37, S47), and were substantiated by managers (Interview 1). For Case B the findings therefore support attainment at level 2a of the Barr *et al* (2000) framework by demonstrating that learning has impacted on the job.

In Cases A and C, a smaller number of exemplars were identified and with less detail. Managers in some organisations in Case A (FG31) demonstrated a lack of understanding of the outcomes of the learning on practice and were seemingly unaware of the programme of study's content, despite agreeing to support the student on it. For many students the outcomes on practice were made within an existing role rather than that of an advanced practitioner role, ultimately limiting the scope of changes they could make. Articulation of examples to support these changes was less frequently reported. Despite these dissimilarities, the findings from Cases A and C also support realisation of level 2a of Barr *et al*'s (2000) framework. However evidence to support this is less tangible. These results are represented in Figure 8, where the thick arrow indicates full achievement of the level, and the thin arrow indicates partial achievement of the level.

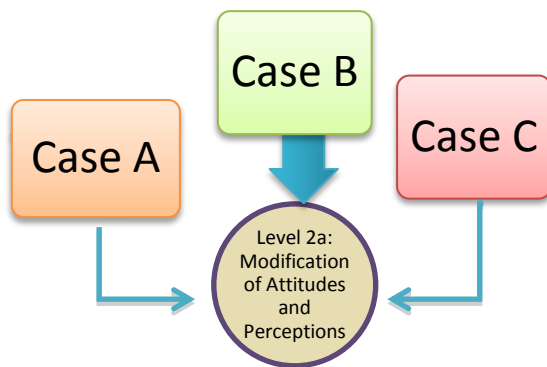


Figure 8 Realisation of Level 2a Barr et al (2000) Framework for all Cases.

7.4 Level 2b: Acquisition of Knowledge and Skills

Level 2b attempts to measure the knowledge acquired, skills developed, and attitudes changed due to the learning in relation to inter-professional collaboration.

Increased confidence facilitated students in all Cases to challenge decision making with greater assurance and accuracy. Findings indicate that increased assertive behaviour arose because students perceived they were more able to clearly articulate findings and use appropriate language when communicating with medics and were more questioning of their own practice as well as that of others. The identification of misdiagnosis (S37, S47) and the increased input on strategic committees in primary care (Case A) demonstrate wider acceptance of the learning as valuable, and increased trust of the student in practice.

Improved communication between peers was reported across Cases, although Case B students more commonly described greater acceptance by peers and were themselves described as '*a bridge*' (S37, S52) between nurses and medics. The acquisition of underpinning knowledge of anatomy and physiology; leadership and management, and research, led to students recognising they had developed improved problem solving and clinical decision-making skills that subsequently improved, for example, patient consultations, facilitated the management of more complex clinical presentations with a higher level of acuity, and increased the use of evidence-based care. Managers in all cases

concurrent by identifying similar outcomes. Commonly, improved assessment skills, history taking and consultation skills were identified as supporting the development of a more holistic approach to care that was aligned to a nursing philosophy to underpin the advanced practitioner role, rather than a medical philosophy described in current literature.

In Cases A and C, students and managers perceived that the learning and subsequent qualification provided legitimacy to the current role undertaken by the student rather than a future advanced practitioner role. Students described being surprised at the amount and significance of new knowledge they had gained from the programme that now underpinned their current role, and was regarded as compulsory.

In conclusion, students across all three cases reported that the knowledge acquired from a variety of subject areas provided them with increased self-confidence, which subsequently enabled them to manage more complex patient presentations. These changes helped students to challenge the medical management of patients with greater authority. Case B participants provided examples to support these assertions more frequently and in greater detail than students from Cases A and C. Managers in Case B confirmed these changes had occurred, reporting that students' practice improved as a consequence of the programme of study and challenged medical decisions accurately in the new role of a trainee advanced practitioner (Interview 1). In Cases A and C the extent to which the acquired knowledge and skills from the programme of study could be used was more limited, and often restricted to enhancing a pre-existing role.

Evidence from Case C students who were trainee advanced practitioners and similar to those in Case B indicates that learning acquired from the programme of study facilitated the students to demonstrate fulfilment of Level 2b of the Barr *et al* (2000) framework. The remaining students in Cases A and C reported outcomes indicating that the acquisition of new knowledge and skills to support perceived changes in practice was commensurate with

level 2b, albeit within the students current role ‘a *pseudo role*’ rather than that of an advanced practitioner role. Therefore the extent to which learning is utilised is inconsistent. This is represented in Figure 9.

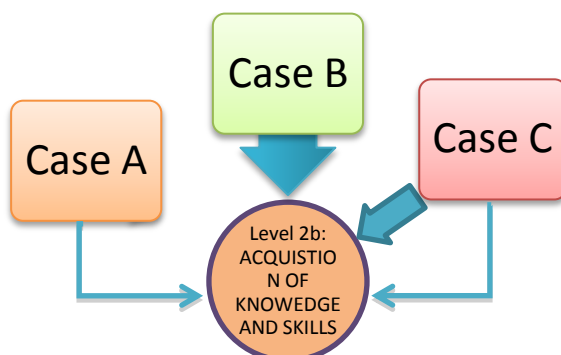


Figure 9 Realisation of Level 2b Barr et al (2000) Framework for all Cases.

7.5 Level 3: Changes in Behaviour

Level 3 of Barr *et al*'s (2000) framework seeks to capture the extent to which the participant's '**on-the-job**' behaviour changes as a result of the programme of study, and is linked to modifications in attitudes or perceptions, or the willingness of learners to apply this knowledge and/or skills in practice.

All students were motivated and enthusiastic to transfer their learning to practice in order to develop their role to that of an advanced practitioner. However, the type and amount of support received by the student from the Trust and relevant personnel affected their ability to integrate the learning in practice effectively. In Case B, '*on-the-job*' changes were more clearly articulated and presented than in the other Cases, largely because of the model adopted to recruit and educate advanced practitioners. The completion of the programme also culminated in an advanced practitioner role at band 8a (NHS England 2013) and was a strong incentive for students to complete their programme of study successfully. Learning was reported to be transferred to practice meaningfully with students directly applying new knowledge, skills and learning to improve patient care and develop inter-professional relationships as outlined by exemplars presented in Chapter five. A tripartite agreement

between the manager an HEI facilitator and an identified mentor (Section 3.4.2), enhanced this process and led students to report being well supported.

A speciality Trust within Case C used a similar model for students working in critical care, although there was no tripartite agreement in place. Here, students were supported in practice by mentors and given time to consolidate learning, and completion of the programme similarly led to employment as an advanced practitioner at Band 8a (NHS England 2013).

For the remaining students in Cases A and C, findings demonstrated self motivated and determined students whose desire was to complete the programme of study successfully. The level of support provided to these students was inconsistent across organisations and was commonly limited or none. The ability of managers to support staff with study time and fees was reportedly constrained by reduced education budgets and the prioritisation of mentorship and mandatory training within organisations. Furthermore, managers acknowledged that transference of learning was impeded because of the difficulties students faced in identifying mentors to support students, insufficient time for student learning due to workload demands, and the organisation's lack of understanding of the role. Students in these Cases were required to find their own mentor, which was reported as problematic. Limited time to work with mentors because of heavy workloads hindered students in transferring learning to practice.

On reflection of these accounts of student hardship I felt they were incongruent with what I had expected to find. As an experienced educationalist I am used to supporting students to try and achieve their potential. As a past and current student I too have faced challenges created by competing priorities associated with work, family and learning that have resulted in highs and lows, and doubts regarding my capability to complete my study. However I reasoned with myself that it was to be expected. Students in Cases A and C who were not

supernumerary described competing priorities that seriously impacted on their health and emotional well-being beyond my experience. I began to reflect on my previous management of these situations to question my level of caring, empathy, and ability to support my students in the best way. I carefully considered what the students in this study reported, examples of which are provided below in examples 2, 3 and 4 (Cases A and C) that relate to impacts on health, and the second more concerning to me, where the participant thought this was an extension of normal life and that no compromises were being made.

Example 2

'Last year I was really stressed out, I even lost my hair'. (S41 Y2)

Example 3

'It was very tough for me last year. Coming to university, the number of modules we has, then still working...it came to a head in August; I ended up going to my GP and was diagnosed with depression...it was related, you know it was related to both work and uni'. (S53, Y2).

Example 4

'I am a mother of two young children, I work full time. I've just finished night shifts, I've just come for this and I'm back on night shift tonight. So it's me having to create, my time, because I'm motivated and I want to get through it.... I have a child with special needs and so I am used to getting little sleep. (S23, Y1).

The quotes above and those of others demonstrate the importance of helping and caring for students in order to manage their expectations and workload effectively. Students reported minimal help from colleagues, managers or mentors, which reinforces current debates regarding nursing's lack of compassion and caring (DoH 2012b). While not being conversant with all of the facts of these cases, it is shocking that 'caring professionals' appear to fail their peers at a time of need, often adding to student burden by ostracising them in practice (S41).

On reflection I realised that I too needed to prepare students more thoroughly throughout their learning. Greater provision of information to assist students to manage their work life balance, promotion of pastoral care, and the provision of best support and advice have now been more fully recognised. I do not feel I am alone in my ignorance, and this study will help to promote to the wider educational community the need to be more observant, caring and compassionate. Additionally, it will provide a statement of motivation to try and change the preparation of advanced practitioners, and in so doing provide an equitable and effective strategy for advanced practitioner preparation and fulfil policy intent.

Despite these and other difficulties associated with a lack of financial support and study leave, students in Cases A and C demonstrated high levels of motivation and tenacity to complete the programme and transform their practice. Students' overarching desire to work as an advanced practitioner, and the development of requisite professional and practical knowledge and skills to underpin practice, reinforced their determination and strengthened their motivation to complete the programme of study. For those students unable to practice as an advanced practitioner on completion, they worked in '*psuedo roles*' (p244) and expressed a need to seek alternative employment in order to be able to practice as an advanced practitioner in the future (S23, S44, S41).

Reported behavioural changes and increased knowledge and skills indicated that as a consequence of the learning, students gained confidence, enabling them to manage different and more complex patient presentations and contribute more effectively to inter-professional discussions, albeit in the same role they held prior to commencing the programme of study.

In summary, despite differences between cases, all students in all Cases appeared to use the learning in their '*on-the-job*' roles. Case B and C students (from the speciality Trust only) used the learning from the programme of study to support their new advanced practitioner

role and acknowledged that they were well prepared to do this. Students and managers acknowledged that behavioural changes and new knowledge and skills helped them to manage patients, peers and other healthcare professionals more confidently and with greater authority (S39, S47, S49, interview 1).

All Cases therefore were able to demonstrate positive outcomes of the learning from the programme of study, consistent with level 3 of the Barr *et al* (2000) framework, which is represented by Figure 10. This was despite some inconsistencies in roles following programme completion in Cases A and C, which students found frustrating (S35, S44, S41, S43).

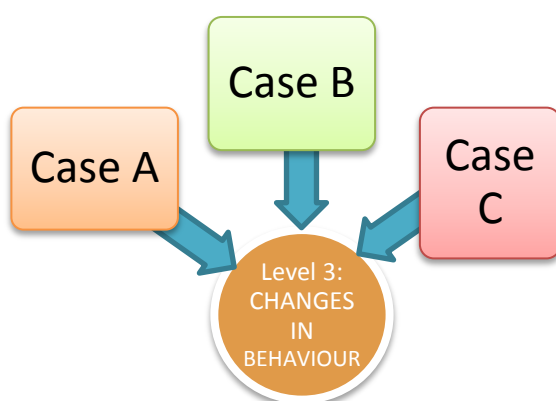


Figure 10 Realisation of Level 3 Barr *et al* (2000) Framework for all Cases.

7.6 Level 4a: Change in Organisational Practice

This level relates to the wider changes in organisational practice or care delivery, '*the bottom line*' (Barr *et al* 2000) that is attributable to the programme of study.

In Case B, the organisation supported the development of advanced practice training and roles within its workforce planning. Managers reported the use of an established and agreed model within this case for five to six years. The model is used for recruitment, training and subsequent employment of advanced practitioners in all clinical practice areas within the organisation that includes pioneering the implementation of advanced practitioner roles in

clinical areas where they previously have not been used, for example clinical research. As a result, managers are proactively involved in policy development to support and enable advanced practitioners to contribute to clinical trials in new and innovative ways. However, despite this students reported uncertainty working in these areas during this transition because of the lack of infrastructure in place. For example, they were only able to perform clinical assessment when fully supervised because of the current clinical research regulations.

Managers in Case B, having established the implementation of the advanced practitioner role, were further consolidating, enhancing, and transforming the role by building in professional development opportunities for advanced practitioners post qualification as part of their working practice. The realisation by managers that qualified advanced practitioners need to lead the effective involvement in research in order to develop and increase evidence based practice and research within the organisation drove this change. Case B's '*Bottom line*' therefore is one which demonstrates a commitment to the development and innovation of advanced practitioners within the organisation and in so doing meets level 4a of the Barr *et al* (2000) Framework.

In Cases A and C, a different picture emerges whereby students on completion of their study (with the exception of supernumerary students in one speciality Trust) continue in their current role. Managers within these organisations reported that the deployment of advanced practitioners was predominantly in isolated roles, which led to inconsistency in advanced practitioner role evolution within an organisation, and consequently reinforced a lack of clarity regarding the role and the learning requirements to support its development. The tentative nature of advanced practice within the organisations in Cases A and C exacerbated poor understanding of the advanced practitioner role by peers and other healthcare professionals. Furthermore, advanced practitioners crossing traditional boundaries were reported as a potential threat to medics that led to power and conflict

issues. Managers described how the ambiguous nature of the advanced practitioner role posed additional barriers for organisations that operate across more than one site because it resulted in inconsistencies and expectations of advanced practitioners by healthcare professionals. Students also perceived a lack of value of underpinning education for advanced practitioner roles by managers, despite impetus from policy documents to reconfigure the workforce by advocating new nursing roles.

Cases A and C allowed students to undertake the programme to improve their current role, by increasing their sphere of responsibility and independence. Students and managers reported that the underlying culture within their organisations currently did not support a consistent model for advanced practitioner role development and recruitment. Furthermore, these organisations did not provide any remuneration to the student following completion of the programme of study (except Case C students who were Trainees). As a consequence, some students believed the only way to achieve a change of title, and increase their grade and pay would be to change organisations, which they acknowledged as currently unlikely because of financial austerity within the NHS restricting the development of new roles.

Within the speciality organisation in Case C, a model, similar to that used in Case B, used in critical care areas to prepare and employ advanced practitioners, was to be extended and used unilaterally within the organisation from September 2013 on a trial basis. Managers in this organisation acknowledged that advanced practitioners provide commensurate care when trained appropriately, can be employed in clinical areas where recruitment of medics is difficult, and are more cost effective. This implies a transformational culture within this organisation by acknowledging and accepting the positive outcomes of learning from advanced practice programmes on practice.

In summary, Cases A and C partially demonstrate that students achieve the 'Bottom Line', identified in the original framework. Despite learning being reported by students and

managers as beneficial to care delivery, the current organisational culture appears unsupportive to the recruitment and development of advanced practitioners across or within these organisations, and arguably impedes students to successfully enable change. Managers identified that this reflected a lack of understanding of the benefits and clarity of the advanced practitioner role by senior managers and clinicians, and has resulted in the ad hoc and sporadic development and implementation of these roles within their organisations (FG60, FG61). For this reason, level 4a of the Barr *et al* (2000) framework is not achieved for Cases A and Case C with the exception of some areas within the speciality Trust, and is represented by Figure 11.

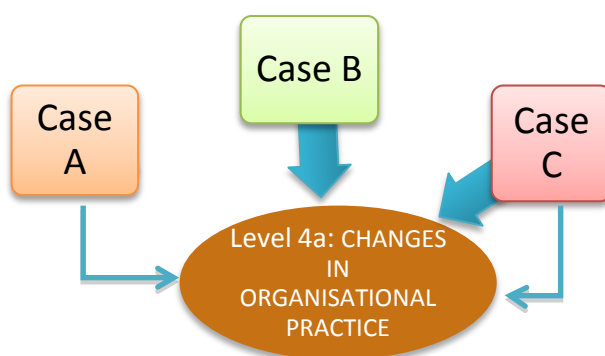


Figure 11 Realisation of Level 4a Barr *et al* (2000) Framework for all Cases.

7.7 Level 4b: Benefits to patients

Level 4b refers to any improved outcomes for patients as a direct result of student learning and was viewed in the framework by Barr *et al* (2000) as the consequential outcomes of the programme of study.

Managers and students consistently reported benefits to patients in all Cases as an outcome of the learning from the programmes of study. The ability to manage patients presenting with increased acuity and complexity via improved consultations, improved communication and reduced waiting times, were the benefits most frequently identified. Students in Case A

also reported that the programme enabled them to manage patients using knowledge rather than '*guesswork* (S19)'. Improved competence, proactive management of patients in a linear way, increased use of evidenced based practice, and the ability to communicate more clearly to patients and healthcare professionals were also reported.

Articulation of the outcomes of the learning to professional practice proved difficult for some students in this study. Students described their nursing practice rather than the process of nursing practice (the what, rather than the how and why) and this prevented them describing the richness and complexity of the experiences in which they were involved. My expectation was that there should be differences between students who were at different stages of their learning with those students nearing completion being more able to clearly articulate the expertise they had developed. This did not prove to be the case.

The vignettes presented by Case B participants were more profound and more comprehensive (section 5.3.5) providing detailed examples of how their practice had changed. Specifically how this had improved the quality of care delivered, for example, by the identification of patients misdiagnosed by junior doctors. Students in Cases A and C recognised they had changed their practice, but they used the explanation of acquiring new knowledge and skills in a generic way and could not always specifically explain how their practice had changed, for example '*to provide more holistic care*' (S59). The term '*holistic*' as a description of care delivery is, I believe, a nebulous and imprecise one, and can lead to multiple interpretations of meaning and intent which is unhelpful at a time when other health professionals are already struggling to understand the concept of advanced practice with any clarity.

The focus of examples provided by managers in Case A and some in Case C demonstrated a lack of awareness of how the learning was being used, for example, advanced practitioners being able to prescribe. One senior manager's embarrassment at her

managers' lack of knowledge was captured in field notes, and demonstrates that nurses can lack the language to adequately describe their expertise, and in so doing fail to get recognition for their significant contribution. Nurses report what they see and often lack specificity when explaining it: this results in explanations that are inappropriate or inadequate.

Managers articulated application of learning as medicine adapted for nursing, '*a type of medical knowledge and skills in a nursing way*' (FG 31). Similarly, student participants promoted the use of a nursing philosophy to support a medical model approach to undertaking patient consultations, and qualified this as nursing providing '*a holistic approach to care*' (S59). These findings support those reported in the literature review. While these findings imply a desire, passion and determination to situate advanced practice in the context of nursing, the descriptions used provide no indication of what the philosophical underpinnings of this are, or why this is the case. During these interviews, despite using probes to try and get participants to become more explicit in their explanations, I became concerned that they were unable to do this, and recognised through interpersonal cues two students becoming frustrated that they were using the same vocabulary to answer different questions. It is important to distinguish the advanced practice role from that of a medic if advanced practice is to be recognised. Students were keen for this to happen, for example:

'I think some senior doctors find it quite challenging... They think we want to undertake the role in the same way as them and get quite defensive at times' (S53).

The inability to clearly articulate learning hinders advanced practitioners from getting the recognition for the breadth and depth of knowledge that they possess, and is frustrating for all those involved in their preparation. The ability to communicate nursing knowledge and roles to others in inter-professional interactions requires nurses to use language to demonstrate the understanding of the experience of practice in order to make what is implicit explicit. If the advanced practitioner student could explicate their professional artistry it

would evidence the claim made by the participants in this study that they changed behaviour and subsequently changed people's lives.

While advanced practice education in England remains un-standardised, with differences attributed to location and ability and willingness of employers to facilitate education, variability in outcomes will follow. If advanced practitioners are to make a meaningful contribution to the development of cost effective, high quality, patient centred care, they must be able to articulate clearly their level of ability and purpose to nurses, allied health professionals and patients. Education must develop and examine tacit, procedural and propositional knowledge to ensure that graduates are able to do this.

Case B students and managers were able to report similar benefits to patients. Increased autonomy, increased ability to self-manage patients, greater initiative in problem solving and more effective care delivery in Advanced Practitioners as a consequence of undertaking the programme of study were identified. Furthermore, students described the benefits of using reflective practice to facilitate learning transfer. Vignettes in Chapter five provide evidence of the students' ability to assess, diagnose and manage patients accurately and, in some circumstances, correct misdiagnoses.

In conclusion, students and managers from all three Cases report that there is a positive outcome to patients as a consequence of the learning from the programme of study, consistent with level 4b of the Barr *et al* (2000) framework, which is represented in Figure 12. Using practice exemplars, students and managers illustrated the inclusion of new and enhanced knowledge and skills (related to, for example, anatomy and physiology, research, leadership, and professional development) to underpin and support improved clinical practice. While examples from the individual cases varied in specificity and frequency from students and managers, the perceived outcomes from the learning support the notion that there are benefits to practice in numerous ways. This appeared to occur even when the

students did not work in designated advanced practice roles during or post completion of the programme.

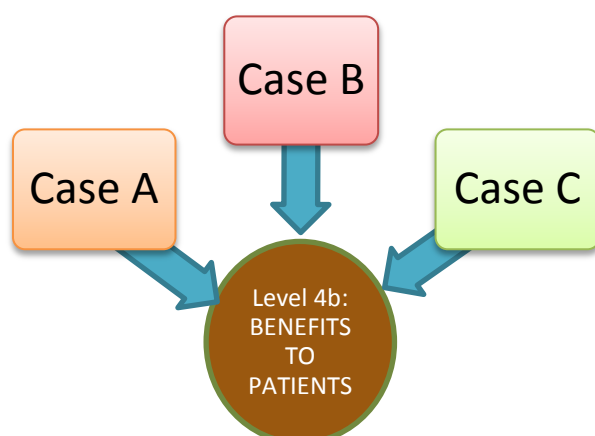


Figure 12 Realisation of Level 4b Barr *et al* (2000) Framework for all Cases

7.8 Conclusion

Evidence used in the integration of the results from the individual Cases was drawn from three sources of data, student interviews, manager's focus groups, and analysis of programme documentation. The comparison of findings demonstrated consistency of participant responses across cases in relation to issues that promote and hinder transference of learning from the programme of study to practice, motivations to undertake the programme, benefits to patients, and the level of students' and managers' satisfaction with the programme of study. Differences between programmes were evident regarding the model of recruitment and training in Case B and one Trust in Case C, to those used within other organisations.

The findings presented are strengthened because more than one source of data confirmed the issues reported. The Barr *et al* (2000) framework provided a structure to discuss these interpretations, and facilitated the presentation of nuances between and within individual cases and across cases.

Case B participants more consistently provided evidence to substantiate their perceptions of outcomes from the learning derived from the programme of study. Students from Cases A and C perceived the outcomes of learning from the programme of study on practice to be significant despite a more arduous and stressful journey. Furthermore, these students more frequently reported the need to be self-motivated and determined in order to succeed on the programme of study due to the increased workload generated by the programme of study in addition to existing work, and a lack of understanding by managers and colleagues.

Programme of study documentation identified similarity and consistency in programme aims and outcomes, teaching, learning and assessment strategies, and content across the three cases. The outcomes reported from the three programmes by both managers and students demonstrate varying degrees of attainment against the levels of the Barr *et al* (2000) framework for individual cases. Case B data demonstrated more consistent outcomes in practice arising from learning transfer from the programme of study to practice. There were many surprises during data collection (some of which were highlighted), and these indicate discrepancies in the outcomes of advanced practice programmes of study within geographical areas. Case B demonstrates a model of good practice that epitomises a model that could be interpreted as '*too good to be true*', or arguably one that has not been disseminated appropriately within the wider community.

The propositions these findings offer to the aim and objectives being considered in this study will now be discussed.

CHAPTER 8 DISCUSSION

In the quest to use NHS resources more effectively, while providing acceptable levels of healthcare to patients with increased complexity and acuity, redesigning service delivery has been a priority. Government mandates to offer a more complete and less fragmented service provide opportunities for autonomous advanced practice roles to fulfil this vision. Advanced practitioners working across disciplines possess the prerequisite knowledge and skills to deliver proactive and comprehensive care within newly proposed care models that are based on early intervention for patients (NHS NWL 2012; NHS Confederation 2014; NHS England 2014).

NHS England (2014), in promoting workforce changes endorses preparation of staff to fulfil this intent. Since the demise of the English National Board, UK HEIs working largely in isolation have assumed responsibility for the preparation of advanced practitioner roles using guidelines which describe the role and provide standards and an indication of content for curriculum development (RCN 2012; DoH 2010a). Currently there is inadequate research evidence evaluating the outcomes of advanced practice programmes of study, with only two small single centre studies identified by the literature review, Nicolson *et al* (2005) and Shearer & Adams (2012) and a local commissioned evaluation study (Acton Shapiro 2009a, 2009b, 2009c, 2009d). Additional evaluation studies reviewed here reflect a tendency for educational research to focus on short-term, retrospective evaluations (Crotty & Bignell 1988; Hughes 1990; Barriball *et al* 1992; Endacott *et al* 2000; Hogston 1995), and provide anecdotal evidence rather than recognised and accepted outcomes arising from rigorous research studies (Cooper *et al* 2001).

NHS England (2014) actively promotes the need for evidence to transform the service and recognises and accepts that this evidence may not come from RCTs because the populations under investigation are often too small. Fifteen million pounds is being made

available to commission through education, for examination of real clinical evidence in the absence of trials, and is anticipated to accelerate the adoption of cost effective innovation (NHS England 2014). If multi-professional CPE is to be championed, and high quality education and training that is responsive to the changing needs of patients and local communities promoted, then providing evidence to demonstrate the outcomes of advanced practice roles, is crucial (HEE 2012).

This study responds to these challenges, and contributes to the existing body of knowledge in a number of ways, namely:

- I. This study used three independent case studies to explore the perceived outcomes of postgraduate advanced practice education. This is important because it provides rigorous and valid evidence of outcomes from two perspectives that of the individual and that of the organisation.
- II. The use of vignettes to capture perceived benefits in practice for patients was present in this study. This approach has not previously been used within research in this field, and, while limiting in its rigour, was a complementary alternative to directly approaching patients, who may not recognise the advanced practitioner role and/or it's associated benefits.
- III. This study was comprehensive in that data were collected over a twelve-month period (rather than at the end of a programme) from participants who represented all stages of a programme (years 1, 2, 3 and PQ) and the organisations in which they worked. The use of an analytical framework in the study also addressed criticism from previous studies that comprehensive analyses of outcomes were lacking (Carpenter *et al* 2004).
- IV. This study is important because the findings provide evidence that recognises the need for strategic partnerships and fully supported education. The results demonstrate that when the provision of arrangements to enable staff to work across

organisation and sector boundaries are in place, retention and development of existing staff into advanced practitioner roles is more likely.

- V. A literature review, while identifying key components of advanced practice preparation, failed to retrieve a model that encompassed the multiplicity of elements, issues and relationships which is urgently required to consistently prepare advanced practitioners successfully. *This study is important because the study findings provide evidence which suggests that the successful transfer of learning from postgraduate programmes of study to practice requires active engagement and participation from all stakeholders.*
- VI. A proposed model of collaboration, implementation, and evaluation for advanced practitioner preparation is presented within this chapter.

The justification of these assertions is now discussed. Critical reflection of the research process acknowledging strengths and limitations that allowed the generation of this new evidence is also presented.

8.1 Strategic Alliances

Individual organisations develop strategic plans to set an agenda to meet current and future healthcare service and workforce needs. These plans in turn assist managers to identify the education required to prepare the workforce. If education budgets are to be used effectively by organisations to provide requisite professional staff development, the matching of staff to appropriate programmes of study is essential. Demonstration of the outcomes of advanced practice roles is crucial for role development and effective workforce planning to inform the educational preparation and support required for practitioners to take up these roles (Kennedy *et al* 2011). Preparation requires input and agreement from multiple stakeholders that is not always delivered (Gerrish *et al* 2011; Shearer & Adams 2012). Cotterill-Walker (2011) argues that discourses in the classroom contribute to confusion, in that theoretical

and an idealised vision of nursing conflict with the pragmatists in practice who are concerned with getting the work done. Communication within and between organisations can also be complex and further challenges collaboration with education providers to explore CPE effectively. Within this study relationships between students and members of the professional team was a predominant theme and is now explored.

8.1.1 Expectations – Managers and Students

Students and managers in this study demonstrated overall competing expectations. The catalyst for students entering advanced practice programmes of study focused on self-motivation to enhance their contribution and effectiveness in managing increasingly complex patients, and the need to respond to graduate nursing entry. In contrast, managers' expectations aligned with the organisation's strategic aims. Organisations expected managers to prioritise CPE in response to service need and policy directives. Competing priorities for resources to maintain current service provision, respond to quality standard requirements, and fulfil student expectations of CPE supporting the innovation of new roles, left managers' intentions compromised.

Education preparation for advanced practitioners was not always considered a priority by managers largely where there was no identified Trust strategy for the deployment of advanced practitioners, for which Cases A and C provide examples. Arguably, this demonstrates an underlying lack of understanding of the role despite policy outlining benefits of advanced practice (DoH1999; DoH 2000; DoH 2002; DoH 2004a; DoH 2005; Maben and Griffiths 2008; DoH 2008; DoH 2010a; DoH 2010b; DoH 2012a) and a failure by organisations to meet strategic intentions in response to policy. Where strategic intent in the Trust was to develop and implement advanced practice roles to meet service needs, managers and students expectations were more consistent (Case B). The indication of differing expectations in this study implies the need for a more extensive conceptualisation of

the purpose and outcomes of CPE, in which the corporate agenda is only one component (Nolan *et al* 2000).

8.1.2 Conflict between NHS Trusts and Higher Education Institutions

Continuous change within the NHS makes the planning of education challenging for managers particularly as they commission programmes from education providers twelve months in advance. Managers in this study described using preferred education providers, meaning they had a choice from a predetermined list prepared by commissioners. The number of education providers available as a result of open access generates competition between HEIs and presents an opportunity for increased choice and improved quality of education. Conversely for managers, it presents a dilemma if they have limited insight into what they are purchasing, a finding supported by Case A (FG 31).

Trusts currently hold the power in commissioning education, which can be problematic for education providers as historical alliances between Trusts and HEIs are challenged by the need for flexibility, quality and bespoke tailoring of programmes to fit service need. The necessity to provide mandatory training to all staff and provide mentorship to support pre qualifying nursing students is a priority, and substantially reduces the ability to provide and fully support relevant professional development for the remaining staff (Section 4.4.2). The generic nature of advanced practice programmes requires the student to apply learning to practice, which can add to their workload burden and to that of those supporting them. This appeared particularly problematic in speciality areas where additional theoretical input is required, for example, paediatrics.

The subsequent need for HEIs to respond to Trust needs often by developing bespoke education programmes is challenging because curriculum development can be a cumbersome process. The requirement for education providers to respond effectively to

meet individual service needs is, however imperative. Providing multiple and/or bespoke modules to meet purchaser demands for specialist practitioners may adversely compromise the learning experience of students, be difficult to resource, and not be cost effective. Reflection on the lack of compromise made by Case C managers demonstrates the presence of conflict, and an association with a lack of understanding, uncertainty and, based on some data, perhaps an emotional response to the problem.

The disparity between the pragmatist stance of preparing an individual to do a specific job/role within an organisation and the idealistic nature of education in promoting theoretical underpinnings to support role development is a problem that is not easily solved. It is also exacerbated by reduced education funding, and a shift to the purchasing of individual modules rather than whole programmes. In this study acceptance of a collaborative approach and communication networks (Case B) demonstrates willingness to share, common intent, and value of the advanced practice role in delivering effective patient centred healthcare. In so doing Case B promotes and provides effective preparation of these roles (Section 5.5.1), rather than divided interests that are reflective of historical hierarchies (Case A and C).

8.1.3 Power and Resistance – Students and Managers

This study supported the findings of Cotterill-Walker (2011) who identified that resistance from managers and colleagues limited the student's ability to apply knowledge to a practice setting, and over time negatively impacted on patient care. Students in this study reported organisational discord and resistance, a manifestation of power (Wood 1998), and perceived this to impact on their ability to transfer learning. Managers reported obstructive behaviour in not providing full support for postgraduate education, and a lack of academic preparedness for the roles managers held that challenged the manager's credibility (Cases A and C). Additionally, medics were reported to constrain the use of the advanced practice role

because they lacked understanding and were mistrustful and sceptical of its effectiveness. Resistance from peers, managers and medics created feelings of uncertainty, helplessness, and powerlessness for students, despite findings from all cases that demonstrated they increased their knowledge, confidence and assertiveness. Gerrish *et al* (2003) support these findings, identifying that a supposed lack of personal power, a lack of role models with power or vision in the workplace, and apathy and indifference from colleagues, prevent the application of theory to practice. Greater collaboration and understanding of the advanced practitioner role would assist the re-negotiation of relationships and in turn reduce resistance and conflict.

8.1.4 Power and Resistance – Doctors and Nurses

Historically, the sexual division of labour in society has promoted a marked power differential between medics and nurses (Sweet & Norman 1995). Education and employment of nurses traditionally promoted nurses as caregivers and equated this to the efficient fulfilment of doctor's orders (Sweet & Norman 1995). This power theme is an underlying issue within the literature and has been associated with the implementation of advanced practitioner roles (Bryant- Lukosius *et al* 2004; Gardner *et al* 2007; Ball & Cox 2004; Cox 2011). Findings from Cases A and C, appear to indicate that resistance from doctors remains and impedes access to experiential learning and support in practice.

Conflict from medics was perceived to occur as a result of nurses crossing traditional boundaries and of competition to practice skills also performed by junior medics. Despite students having the confidence and self-belief to challenge medics overtly, this did not reflect or change student perceptions of an unequal relationship. Findings indicated that while medics valued the contribution made by advanced practice students by delegating greater responsibilities to them, there remained an unspoken veneer of subservience to them by the student and qualified advanced practitioners (S49; S52). The presence of conflict within the

doctor nurse relationship does however indicate evolution in their historical relationship. Student participants described increased confidence and assertiveness that were associated with overt and active decision-making and reflect a shift from the traditional subservient and covert decision maker, characterised in previous feminist research (Campbell & Bunting 1991; Arunda 2006), towards autonomous practice. The subconscious need to inform medics of their decision-making (Case A) however represents them struggling to reconcile this traditional subordinate role with increased autonomy and independence indicating that the difficulty in making the change lies with the nurse.

8.1.5 Advanced Practice: Role Clarity and Utilisation in Practice

An important step for advanced practitioners in achieving a stable and meaningful vocabulary is the capacity to identify the service parameters that are common to these roles. Findings from this study support previous research evidence (Woods 1999; Carnwell & Daly 2003; Bryant-Lukosius *et al* 2004; Shearer & Adams 2012; Kilpatrick *et al* 2012), and provide a platform from which to continue the debate that argues the conceptualisation of advanced practice is problematic for healthcare professionals and patients (Section 2.2). Research evidence from these sources has established the complex processes that lie behind the preparation of advanced practice roles and the partnership required to support its development.

Uncertainty regarding the future of the role within Trusts was reported by students and advanced practitioners in this study, and appeared to arise from ambivalence amongst peers managers and allied health professionals regarding advanced practice role, function, and outcomes (Sections 4.3.2; 4.4.4; 6.3.2; 6.4.3.2). Identity of the role is a process of socialisation influenced by the relationship of the individual with their immediate professional communities and by allowing professionals space to define their place in the world (Andrew & Robb 2011; Stevenson *et al* 2011). Traditionally nurses have viewed the development of

the advanced practitioner role through a medical lens, but the findings from this study described the need to situate components of the learning normally acknowledged as medical knowledge and skills in a nursing paradigm. This indicates an intention to conceptualise the role as a nursing one to their immediate colleagues.

In this study where a strategic intention to implement advanced practitioners in a Trust was reported (Case B), managers supported the recruitment, training and employment of advanced practice roles. Where no strategic intent in Trusts existed, students and managers reported uncertainty regarding the advanced practice role for a number of reasons, namely a lack of identity, a lack of uniformity with advanced practitioners currently employed, and the need to remove bureaucratic barriers to facilitate the ground breaking nature of the advanced practice role to work in a complementary way within existing structures. These attitudes perpetuate the opinions previously identified in the literature regarding both the inconsistency in advanced practice role clarity and nomenclature (Daly & Carnwell 2003; Bryant-Lukosius *et al* 2004; Jones 2005; Gardner *et al* 2007), and recognised that, despite policy attempts to instigate these roles, it remains challenging to develop and prepare professionals to work in them. The provision of clarity around these roles would bring with it a sense of identity, ownership by the organisation, and an ability to provide consistent measurement of outcome for the role and, in so doing, support greater adoption of the role.

8.1.6 Recognition of Advanced Practice Roles

Inadequate remuneration can indicate a lack of value, acknowledgement and appreciation, and condones a stance by Trusts of not affording external legitimacy to advanced practice roles in practice, an issue raised in this study. The current period of financial austerity further threatens the support of advanced practice education programmes when roles are not viewed as essential. In contrast medics have historically had CPE resources identified and '*ring fenced*', which protects them in a poor financial climate (Tooke 2007). Reorganisation

of workforce commissioning and education in the NHS has seen delegation of responsibilities from a central office to Local Education Trust Boards (LETBs) and Clinical Commissioning Groups (CCGs). This move acknowledges that the workforce needs to be configured to recognise and meet the needs of localised populations that differ significantly across England (NHS England 2014).

The creation of these boards has seen recruitment to the majority of key posts within them awarded to medics in a similar way as the outgoing Deaneries. Medics therefore remain in control of education resources and may be less likely to support advanced practice roles in nursing where the role and purpose are unclear if they hold a traditional view of healthcare work and boundaries, or if they feel their role is threatened. However, nurses have managed to gain access to LETBs and CCGs in some localities and in the current context of commissioning money following the student, they must use their influence to ensure they gain a sufficient share of resources for nurse education (CFWI 2013). Findings from this study promote the effectiveness of nursing advanced practice roles and can be used as evidence by elected nurses on LETBs to influence allocation of funding in the training of advanced practitioners.

In summary, reduced education budgets and a lack of understanding of the advanced practice role inhibits the convictions of managers to endorse greater support of the role and its preparation within the organisation. Currently managers have limited understanding of the advanced practice role and how best to implement it, which compromises their decision making between choice of education provider and the effective use of education resources. Previous evaluations of CPE have failed to recognise which outcomes arise from the successful transfer of learning to practice, or the factors that support or hinder this process (Barriball & While 1996; Fleck & Fyffe 1997; Jordan 1998; Smith & Topping 2001; Pelletier *et al* 2003; Gijbels *et al* 2010). Without a comprehensive understanding of what is the outcome of postgraduate advanced practice education to service delivery, the future development of

advanced practice roles in England remains uncertain. The need to collect credible evidence that provides an indication of this is now essential in order to inform wider audiences.

This study indicates the need for effective and sustained communication between all parties via a strategic alliance to instigate and support the implementation of the advanced practice roles. Case B responding to the recommendations of an earlier evaluation study (Acton Shapiro 2009a; 2009b; 2009c; 2009d) demonstrates this can be achieved effectively. The following Figure 13, outlines the first stage of a proposed new model for the implementation of advanced practice roles in England, and represents the formation of a strategic alliance. Within the model, all stakeholders share values, vision and beliefs. Key professional groups would be represented within each stakeholder group.

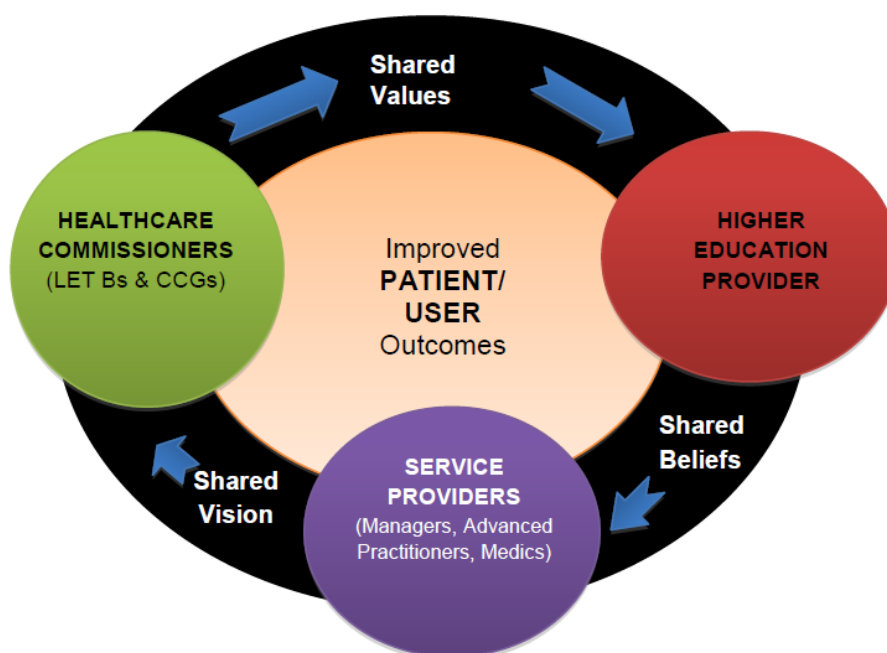


Figure 13 Strategic Alliances Required in the Implementation of Advanced practice Roles in England

8.2 Education Preparation

A discrepancy identified in the literature between what the student is taught, the theoretical perspective, and the resulting practice, is often termed the theory practice gap (Rolfe 1993; Corlet 2000; Billings & Kowalski 2006; Green 2010). Arguably, education and practice have competing priorities that influence against this practice needing change immediately while academics need to understand the theory underpinning the practice. Rolfe (1997) concurs, and argues that the DoH perceives research to be an elitist activity carried out mainly by academics, whose outcome is then passed onto practitioners to implement as evidence based practice. Rolfe (1997) contends that this research is subsequently identified as an exemplar by the nursing profession, and suggests a hierarchical relationship between theory and practice. Downward dissemination of research is normally through journal publications and conference papers; this suggests a straightforward introduction and acceptance of proposed changes arising from the evidence. Schön (1983) argues that such a unidirectional, hierarchical relationship results in a crisis in confidence in professional knowledge (Rolfe 1993). This is likely to continue without clear understanding of the theory required to support the implementation of advanced practice, and common agreement between all stakeholders involved in the process. Eraut (1994) supports this view arguing that the transfer of theory to practice requires partnership working if education is to be effective. This study supports these findings, in that where partnership working was in place there was improved understanding and implementation of the role.

8.2.1 Expectations of Learning - The Student Perspective

Clinical career progression for nurses in practice remains problematic (McCormack *et al* 2013). The maintenance of a clinical focus for nurses is challenging when policy continues to separate practice into components, for example clinical practice, leadership, education and research (DoH 2010b). Findings from this study supports those reported in the literature review (Griscti & Jacono 2006), which identified that individuals are motivated to participate

in CPE for a multiplicity of reasons that include meeting statutory requirements, advancing clinical practice by acquiring knowledge and theory to underpin the development of health assessment and prescribing skills; and to satisfy personal gratification, including the joy of learning. The need to 'play catch up', an expectation that learning would legitimise aspects of their current role (prescribing) rather than preparing them for a new one (Case A, section 4.3.4) enhanced career progression, and the development of leadership skills were also reported (Sections 4.3.4; 4.4.5; 5.3.4; 5.5.3; 6.3.4; 6.4.4). Few students at the outset of their study considered research or professional issues fundamental to their professional development; however, subsequent learning promoted realisation of their value and importance in relation to legal/ethical issues, autonomy and scope of practice.

Some student participants early in their learning, recognised they had underestimated the level, depth and breadth of knowledge, specifically critical thinking skills, required to function at an advanced level (Sections 4.3.2.2; 6.3.2.2). Learning prompted them to question their current practice and, in so doing, led them to recognise they were working outside their scope of practice and compelled them to change their practice. This finding supports the work of Woods (1999), who suggests the transitional process of moving from an experienced nurse to an advanced practitioner demands that individuals reconstruct their practice and frames of reference through personal and professional development. Conversely, some managers suggested that students were prepared to function at a higher level of practice prior to the programme of study. This implies either a level of ignorance regarding the requisite education needed to perform as an advanced practitioner and consequently the risks to patients and their staff, an unconscious acknowledgment of unsafe practice, or that these nurses did not need further education because they were already safe. These findings suggest that participants lack insight and understanding of the purpose and appropriateness of the advanced practice role and/or programme of study.

8.2.2 Expectations of Learning – Role Change

Many student participants held no or limited expectations that the outcome of the programme would influence or pre-empt a role change, a view more prevalent in Trusts where there were a limited number of advanced practitioners currently practising (Cases A and C). Students working in Trusts where the advanced practice role was established (Case B) had many role models and could clearly identify outcomes from the programme of study synonymous with working in an advanced practitioner role. Despite these differences the concept of becoming more autonomous or independent in working was commonly reported as an outcome of the learning in this study supporting findings from earlier research (Bryant-Lukosius *et al* 2004; Gardner *et al* 2007; Ball & Cox 2004; Cox 2011). In order to fulfil these aspirations students need supportive mechanisms in place to facilitate learning transfer. For some students there was a misplaced expectation that appropriate support was available.

8.2.3 The Effective Transfer of Learning to Practice – Mentor Support

Available evidence from programme evaluations in the literature identifies the influence of the organisation and managers as a hindrance to learning transfer, but does not recognise the importance of mentorship support (Gerrish *et al* 2001; Hardwick & Jordan 2002; Shearer & Adams 2012). In this study, mentorship was perceived as crucial in assisting the student to integrate propositional knowledge and practice theory. In circumstances where formal partnership working was in place to support students (Case B), transference of learning to practice was greatly increased and more effectively applied because it enabled effective feedback and the assimilation of theory and practice. It also facilitated the development and practice of clinical problem solving in a meaningful and constructive way. In developing these skills students fulfilled a prerequisite for advanced practice (ICN 2002).

The identification and subsequent ability to recruit other professionals to act as mentors was problematic for some students in Cases A and C because only informal arrangements

between the Trust and HEI to support student and mentorship collaborations were in place. Workload constraints for both the mentor and the student collectively limited and restricted learning opportunities for the student. Students in Cases A and C were more likely to use more than one medic as a mentor or seek alternative experiences in other clinical areas to meet programme outcomes. While the additional burden it created for student participants was perceived as a hindrance, as a learning strategy it is arguably positive in that learning gained from multiple perspectives can encourage and promote questioning and wider opportunities in which to gain experience, and concurs with previous findings (Gerrish *et al* 2011; Cotterill-Walker 2011; Shearer & Adams 2012).

The NMC (2008) governs the standards for nurse mentorship, fundamentally focusing on pre-qualification education, to ensure nurses are fit for purpose at the point of registration. This arrangement does not appropriately extend to advanced practitioners and arguably disadvantages post-qualifying students when developing and maintaining clinical skills. The NMC (2008) advocates that wherever possible, mentorship should be provided by professionals from the same group. In the field of advanced practice this is problematic, because many advanced practitioners work in speciality or remote practice areas that compromise accessibility. The lack of a postgraduate qualification may also preclude them from taking on this role because they lack an academic appreciation of the learning. These constraints were reported by student and advanced practitioner participants in Cases A and C, and resulted in them using predominantly medics to act in this role.

The use of medics comes at a cost to the student because the learning provided is not situated in the context of their practice discipline. Medics were also often reported to be unenthusiastic to act as a mentor because of a lack of remuneration and a lack of understanding of the advanced practice role (sections 4.3.2.2; 5.5.2.2; 6.6.2.2). Limited availability further compromised learning for students because of other competing priorities (S41, S43, S49, S52) and competition from trainee medics who needed to develop

comparable learning outcomes to advanced practice students and who were reportedly prioritised by consultants. This finding concurs with Shearer & Adams (2012), who identified an initial lack of co-operation by medics to mentor advanced practitioners.

Advanced practitioners continue to face challenges to content terms and conditions of work, despite attempts to challenge professional ways of working by adapting systems of authority, accountability and autonomy (DoH 2000; DoH 2002; Mackey 2007). Attempts at Inter-professional education to promote a greater understanding of respective roles and requirements have left the situation largely unchanged. The design of advanced practice curricula makes essential the need for a supervised practice component. The growth in numbers of accessible advanced practitioners for advanced practitioner students will, over time, ease the burden on medics to undertake this task. However, until then, the continued support of medics is paramount and only achieved consistently by obtaining their consent and co-operation, during the process of preparation and implementation of advanced practitioners.

8.2.4 Barriers to Learning Transfer

Graduates do not practice in isolation, and responsive behaviours are determined by constraints in the workplace, including time and peer pressures (Hardwick & Jordan 2002). The ability to be self-motivated was a significant factor identified by students in this study in being able to complete programmes of study even when faced with adverse circumstances, and concurs with previous findings (Shearer & Adams 2012).

Managers have considerable control over practitioners' conduct, delivery of care and personal advancement, particularly when faced with budgetary constraints. Expenditure on nurse education to support practitioner development must therefore be cost effective and provide value for money. Managers in this study demonstrated fiscal control of CPE by

prioritising resources to support compliance of quality standards and in so doing exacerbated conflict, because students perceived they were not supporting CPE (Section 4.3.2.2; 4.4.2.2). This combined with the perception that managers were ill placed to understand how useful learning from a programme of study could be to the Trust, because they did not possess the ability to make informed decisions. Additionally, they did not hold a postgraduate qualification, which led students to believe that practice change was hindered, and concurs with Woods (1998) and Griscti & Jacono's (2006) findings. A failure to identify accurately the content and contribution of other key aspects of the learning from the programme of study by managers in this study (Case A), for example the value of undertaking research modules, supports this notion.

The use of a model in Case B to recruit and prepare advanced practitioners presented a visible clinical career development framework for nurses to progress, clearly promoted a defined advanced practitioner role, and was based on service need. The model draws comparisons with similar structures identified within the literature and used within Scotland and Wales (NHS Scotland 2009; NHS Wales 2010). The allocation of study leave by managers to students to undertake educational programmes has documented resource implications for the NHS (Gould *et al* 2006), and requires the presentation of a sound business case to secure funding from NHS education commissioners. Without additional funding to secure advanced practitioner roles for trainee advanced practitioners on completion, the investment in advanced practice education and the benefits it brings can be unproductive or left unappreciated. Excessive workload, financial and time pressures, and lack of access to appropriate support hinder students in successfully transferring learning to practice when support to undertake programmes is unavailable. The identification and matching of CPE to students by managers is essential and requires a considered approach.

In conclusion, communication between all stakeholders involved in the preparation and employment of advanced practitioners needs to be continuous transparent and agreed

through collaboration. The use of on-going evaluation of the process would enable the provision of continuous stakeholder feedback and demonstrate a participatory approach to addressing the issues in CPE. It also provides an opportunity to enhance currency of programmes and promote understanding, development and implementation of new ways of working in line with policy directives. Increased investment in staff CPE needs to occur to ensure the effective translation of learning in practice. A radical change to the way NHS England currently plans and trains the advanced practice workforce needs to occur by fully funding training and roles for advanced practitioners on completion.

The second phase of a proposed model represents preparation of the advanced practitioner in a structured way, with involvement from all stakeholders. This is in line with models currently effectively used in Wales and Scotland, and will facilitate realisation of the future workforce challenges identified in concurrent policy documents (DoH1999; DoH 2000; DoH 2004a; Maben & Griffiths 2008; DoH 2008; DoH 2010a; DoH 2010b; 2014). The model promotes the need for collaboration between stakeholders throughout the implementation process to achieve shared goals. The model begins with the identification of need for an advanced practitioner in practice by the service provider. The proposal is then formulated into a business case that is presented to healthcare commissioners for funding of the post and the supportive education. Education providers then work with service providers and healthcare commissioners to provide theoretical components of the programme of education, and to ensure that appropriate support is provided consistently in practice to enable translation of theory to practice. Finally evaluation of the advanced practitioner education and outcomes on practice is undertaken to provide evidence of the effectiveness of the role and to develop future programmes in line with changing healthcare contexts. The model is presented in figure 14 overleaf.

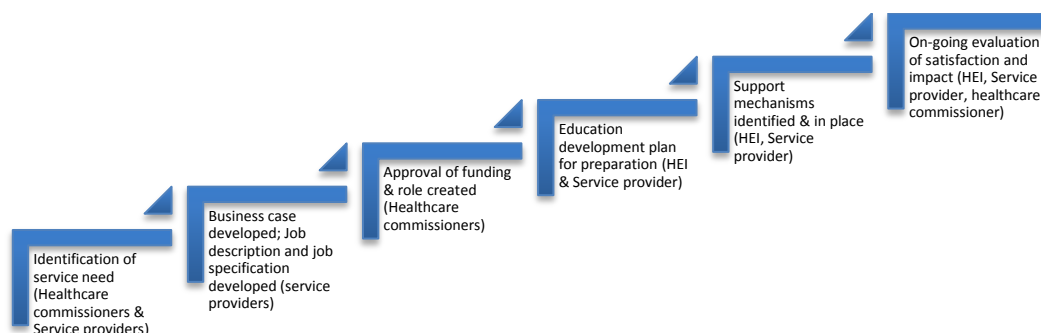


Figure 14 Stages of Preparation for Implementation of Advanced Practitioner roles.

8.3 The Outcomes of Education Preparation on Practice

Debate has surrounded the academic level to which advanced practitioners should be prepared. Until 2010, DOH (2010b) guidelines advocated master's level preparation, falling in line with the ICN guidelines (ICN 2002). Dilemmas of master's education have previously been reported in the literature and support this study's findings (Gerrish *et al* 2001; Watkins 2011). The influence of educational values, local stakeholders and policy change strongly influences the content, depth and breadth of postgraduate programmes (Gerrish *et al* 2001), and, further, leaves education providers to balance external expectations with academic and professional ones. Despite the tension this generates, the perception by students in all Cases in this study indicated satisfaction with the learning from the programme of study. Specifically, this related to the way it changed their thinking and decision making, and its potential to change practice by increasing their self-confidence and promoting personal growth; this concurs with findings from Whyte *et al* (2000).

8.3.1 Postgraduate Advanced Practice Education

The qualification of a master's degree was likewise perceived as essential to the level of practice attributed to the advanced practice role and clinical leadership in this study. Contrary to findings from Nolan *et al* (2000) and Hardwick & Jordan (2002) who reported no discernable academic and skills based outcomes relating to practice change, this study has

added to the existing evidence base by providing exemplars using vignettes, of perceived improved role changes that affected student and advanced practitioner performance.

The three Cases used in this study while individually dissimilar in size and focus, cited similar intentions for the advanced practice programme of study in line with policy guidelines (DoH 2010b) and in the context of service redesign and service needs within the documentation evaluated. Learning from a programme of study was considered relevant in all Cases and enabled students to positively enhance care delivery. Academic staff were considered highly accomplished because they clarified theory in the context of direct abstractions and situations taken from clinical practice, which subsequently facilitated the student to translate theory to practice.

Watkins (2011) and Shearer & Adams (2012) report that postgraduate education enhanced the development of critical thinking and appraisal skills that were translated into evidence based changes in practice, and specific clinical assessment skills made students more effective practitioners. Findings from this study coincide, but students also described how research and leadership theory were instrumental in modifying student thought processes and behaviours. Students supposed that learning from the programmes of study motivated them to promote the best outcome for the patients they managed. Furthermore, they described how the acquisition of knowledge and skills led to positive behavioural changes, and subsequent positive tangible changes to treatment outcomes, for example: decreased patient waiting times, increased patient satisfaction, and the management of more complex and acute patients by students (Sections 4.3.5; 4.4.6; 5.3.5; 5.5.4; 6.3.5; 6.4.4).

With no current research evidence available comparing and contrasting the content, design and outcomes of advanced practice postgraduate programmes, this study provides a unique contribution by providing valuable evidence from which generalisations can be made. This study demonstrates consistency in the preparation of advanced practitioners by three

geographically distinct programmes in England concerning content and underpinning theoretical concepts (Table 23). Key features of the content included a focus on practice-based assessment skills (commensurate to those used by medics), research and leadership. Interestingly, students clarified the use of assessment based skills as being used within a nursing philosophy of care, and in doing so confirm the findings of Shearer & Adams' (2012) evaluation of an advanced practice programme in the South East, and earlier literature (Carnwell & Daly 2003; Bryant-Lukosius *et al* 2004).

The programmes differed in length, in the use of designated mentors and facilitators and in the assessment for the final dissertation. Cases A and C used a traditional research-based theoretical assessment while Case B, alternatively, used a practice portfolio that students compiled over the duration of the programme; this required the student to use purposeful reflection. Findings from this study support the usefulness of the latter assessment because it demonstrated that students were enabled to rehearse arguments and underpin their practice with theoretical knowledge, which subsequently led to increased confidence and improved patient care (Schön 1983). This type of assessment is, however, more resource intensive to quality assure, and requires structures to be in place to ensure comparable, equitable and equivalent assessments for students being assessed in different practice areas.

8.3.2 Articulating the Outcomes of Programmes on Practice

Tacit knowledge (know-how) has been described as knowing more than we can tell (Kothari *et al* 2012). What we know is acquired through practice and experience rather than through language and can be difficult to communicate. Nursing can be highly complex both in pattern and delivery, with individual nurses working differently, carrying out nursing actions in a unique way with each patient. Advanced practice nursing draws on multiple forms of

knowledge and is influenced by many things such as practice context, culture, organisational structures, levels of education and experiential development.

During data collection students' and managers' described experiences from practice in order to demonstrate the outcomes of the learning on patients (level 4b, Barr *et al* 2000) from the programme of study, and these were presented as vignettes. Student and manager findings indicate that some individuals were unable to clearly articulate the level of expertise they had developed or witnessed.

Transitional change in individuals, teams and organisations requires the explicit and intentional use of knowledge and use of multiple intelligences if the intention of preparing advanced practitioners for practice is to be realised. Facilitation, construction of a shared reality and blending and balancing of individuals and teams within organisations are needed to support this (McCormack *et al* 2013). Education needs to play its part in this process by promoting awareness of what makes nursing, and specifically advanced practice nursing unique, and furthermore engaging students to question and be able to answer; who they are? What they do? and why? If advanced practitioners want other professionals to value and recognise the role, they must be able to confidently explicate the advanced practitioner role and use theory to answer the question of "how the discipline underpins the practice?" Piecemeal implementation has promoted an un-coordinated adoption of the role that constrains necessary understanding. The need for standardised preparation and evaluation of advanced practice to address this issue is supported by findings from this study.

8.3.3 The Acceptance of the Advanced Practice Role by Other Professional Groups

Findings from two of the Cases (A and C) in this study indicate the need for advanced practitioners to cross historical professional boundaries to deconstruct specialised divisions

of tasks, rules and practice, an undertaking requiring the re-negotiation of power relationships currently held, for example between nurses and medics. Organisational control imposed on students in determining their role and scope of practice in these cases support Woods' (1999) perspective of advanced nursing practice having a contingent nature, and being resigned to organisational governance. Bryant-Lukosius & DiCenso (2004) and Gardner *et al* (2007) concur, and reason that, while advanced practice has been accepted as an effective strategy to manage patient care, the speed of implementation and poor articulation and definition of the role, has led to confusion regarding scope of practice and ambiguity in practice.

In Case B there was encouragement to challenge professional hierarchies because of the organisation's innovative stance towards advanced practitioners and the value placed on the role. There was buy-in from medics in Case B that enabled inter professional and partnership working, illustrated by findings reporting direct clinical practice interventions demonstrating outcomes at level 4a and 4b (Section 5.5.4). Advanced practitioners were largely '*adopted*' as part of the medical team and this reinforced to peers the position of trust in which they were held by medics as a consequence of them expanding their knowledge and skills and increased autonomy.

The response by Case B contrasts with the frequently reported impetus for the implementation of advanced practice roles as a reaction to medical shortages. The Case B model includes involvement from multiple stakeholders to plan the preparation and implementation of advanced practice roles to improve healthcare delivery. Currently in an attempt to transform urgent and emergency care services, Health Education England (HEE) has convened a taskforce to address current problems of increased attendance and a shortage of appropriately trained specialist consultants. Recommendations of the taskforce include the expansion of supportive staff including Advanced Clinical Practitioners, Physicians Assistants, Pharmacists and Paramedics (HEE 2012) that will be defined using

agreed standards, scope of practice and competencies. This initiative perpetuates the need for nurses to fill a gap of medical shortages and potentially creates multiple varied roles leading to further confusion uncertainty and conflict with current advanced practice roles. Furthermore, it infers an un-coordinated approach between all major stakeholders. A failure of opportunities for nurses to take the initiative in these types of innovative developments leads to a lack of ownership and may contribute to feelings of being unvalued and disempowered. Although funding for these posts has yet to be determined the need to resource adequately this education using a designated budget is imperative and would provide additional opportunities for advanced practitioners.

8.3.4 Advanced Practice Nurses – Cost Benefits for Patient Care

In order for advanced practice roles to be utilised effectively they must be able to demonstrate value for money. Research evidence supporting economic cost effectiveness benefits of advanced practice outcomes is limited and mainly associated with NP substitution for GPs (Hollinghurst *et al* 2006; and Dierick-Van-Daele *et al* 2009). Results from these studies found that NPs provided comparable care to GPs, but were more expensive. Differences in costs in these studies were attributed to GP interventions in NP consultations, and were normally due to nurses being unable to prescribe. Estimating cost effectiveness is challenging because it requires access to commensurate data to measure discernable costs for the activities undertaken by individual practitioners. Costs and benefits are measured in different ways and this adds to the complexity of evaluating practitioner impact in monetary terms. Miller *et al* (2009) reported potential savings of £46,286 a year (assuming one advanced practice in post and using the most conservative potential benefit), and £709,714 (assuming three advanced practices in post using the most optimistic calculation) assuming the advanced practice was paid at Band 7 (DoH 2004a).

At a time of fiscal scrutiny within the NHS, education budgets for healthcare professionals, particularly non-medical professionals, are reduced and the scrutiny of the effectiveness of programmes increases (CFWI 2013). The costs of programmes of study for advanced practice preparation in this study were shown to be significant (Tables 18; 23; 28); however, in two of the Cases (Case A and Case C) the benefits from the learning to practice failed to be fully exploited in substantive ways. Findings from this study indicate that students, managers and advanced practitioners perceived advanced practitioner trainee's behaviours, skills and knowledge had improved. These changes, though not verified, were believed to improve care delivery, for example reduced length of stay, reduced patient waiting times, increased capacity by advanced practitioners freeing up medics' time, and demonstrating fitness for purpose.

Significantly, initial expectations by the student of changing role post qualification to work as an advanced practitioner were not always met in two Cases, A and C. In economic terms in Cases A and C, care quality, staff motivation, and staff retention resulting from this lack of support suggest that postgraduate advanced practice education may not be currently good value for money. If the intention to introduce more advanced practitioners into practice is to be realised, further analysis of cost benefit must be undertaken. Outcome indicators relating to diagnoses and prescription are a standard through which effective care provided by advanced practitioners can be assessed to demonstrate outcomes more tangibly, but this is limiting in its nature in defining advanced practice. The use of an analytical framework to identify indicators that reflect the use of research and leadership skills in the context of a nursing philosophy may be a way forward and also enhance recognition of the merits of the advanced practice role.

8.3.5 Theoretical Explanations of Programme Outcomes

Students and managers in this study reported that learning was transferred to practice and enhanced subsequent care delivery in many ways. Benefits to patients were reported indirectly in this study using vignettes (Sections 4.3.5; 5.3.5; 6.3.5) and this provided a valuable contribution to existing research evidence. The acquisition of knowledge and skills to develop practice was central to these reported benefits. The works of nursing theorists Benner (1984) and Carper (1978), outlined previously (Section 2.5), attempted to explain nursing knowledge in a linear way in the form of objective and subjective ways of knowing. Carper (1978) advocated that knowledge was based on the integration of various types of knowledge to produce the '*whole*', whereas Benner (1984), promoted a position of disintegration where each type of knowledge represented different levels of the novice to expert continuum.

Consideration of the outcomes of this study in the context of Carper (1978) and Benner (1984) demonstrate alignment with both theorists. Some student and manager findings indicate the efficacy of theoretical and practical concepts promoted throughout the learning that culminated in the student acquiring requisite skills. Students subsequently integrated these skills in practice to provide holistic care to patients (FG54; S43; S59). Evidence from this study partially fits with Carper's (1978) theory. Other students and managers reported attributes and enabling factors related to the concept of expert nursing (FG 46; S36, S33, S44; S45), and perceived a continuum or transition from student to qualified advanced practice. Benner's (1984) theory promotes the transition from novice to expert, where expert represents the ability of the individual to take information learned from formal education and the literature and apply it in the environment in which they work, and in this study was well represented in the findings of Case B (Chapter 5).

The definition of advanced practice (ICN 2002) advocates that prerequisites for advanced practice include, expert knowledge, complex decision-making skills, and clinical competence to enable development of autonomous practice, determined by the context in which the advanced practitioner practices. Manley *et al* (2005) describe three attributes of expertise, namely holistic practice knowledge, (knowing the patient and skilled '*know-how*'), saliency, (the ability to pick out important cues from the array of background information that surround individual patients), and moral agency or moral knowledge. While students and managers did not formally identify the advanced practice as an expert, they did recognise and report these concepts as outcomes from the learning, albeit articulated in a different way. For example, students reported tailoring health education and treatment information by considering the patient's social and cultural backgrounds in addition to healthcare needs: by taking comprehensive health histories students were able to make differential diagnoses effectively and independently. Student findings also support the development of interpersonal skills as an enabling factor in the development of expertise, rather than integral to it. Advanced practitioners in all cases reported the fundamental need of listening to the patient that is consistent with the novice and arguably indicates that learning is a continuous process rather than the continuum advocated in Benner's theory.

Variations exist regarding the outcomes of learning transfer between cases. Predominantly this was highlighted by the difficulties some participants faced in articulating and presenting evidence to support what advanced practitioners do and the outcomes of this role to patients and practice. Transference of learning to practice was not a straightforward process for all students. Participant findings did identify increased autonomy as a positive change and when combined with increased confidence and behavioural changes this enabled more independent management of more complex patients resulting in reduced waiting times for patients and increased patient satisfaction (sections 4.3.5; 5.3.5; 6.3.5).

The transference of learning to practice requires multiple and diverse personal and organisational factors to be in place in order to promote and influence positive and effective practice outcomes. Continuous feedback using a structured analytical framework also needs to be included in the process if advanced practice preparation is to maintain its currency within a changing NHS.

8.3.6 The Barr *et al* (2000) Analytical Framework in Evaluating the outcomes of Learning

The use of Barr *et al*'s (2000) framework enabled a comprehensive and coherent picture of the perceived outcomes arising from three individual Cases in practice. This in turn led to a cross-case comparison to determine common outcomes. The framework measures changes in multiple domains at the individual, organisational and patient level, although the latter was measured indirectly in this study. Barr *et al* (2000) interpreted Kirkpatrick's (1967) original framework as hierarchical and that levels 3 and 4 of the framework imply greater quality and trustworthiness of the evidence (Yardley & Dornan 2012). Findings from Case B illustrate the outcomes of learning in practice at all levels of the framework, and the acquisition of appropriate technical, interpersonal, professional, cognitive and academic knowledge and skills. In the remaining two Cases the outcomes of learning from programmes of study is incomplete in relation to the levels acquisition of knowledge and skills (2b) and changes in the organisation (4a) (Section 7.4; 7.6) and was intangible for some students and managers in relation to the modification of attitudes and perceptions (2a) (Section 7.3). A lack of a supportive organisational culture was evident from the participants' responses in Cases A and C, and responsible for the incomplete outcome at organisational change level (4a).

In summary, the NHS has to continue to respond to on-going financial crises and continually changing healthcare policy (DoH 2010a; DoH 2012a; NHS England 2014) leading to a more

complex clinical environment and work overload. Extraneous variables interact in the workplace to facilitate or thwart change. Despite the motivation to change, advanced practitioner students are restricted by reduced resources inertia and entrenched attitudes in the workplace. This was exemplified in data from Cases A and C. In these Cases, many students could not use their learning in defined advanced practice roles, and were hindered by managers and healthcare professional's negative attitudes. Conversely, Case B students were well supported, accepted by other healthcare professionals and able to work as qualified advanced practitioners on completion. The outcome of these conflicts for students in this study was that some were better equipped than others to integrate theory to practice, and some were powerless to engender change in practice. Figure 15 (Page 296) presents the final part of the proposed new model that characterises the evaluation of outcomes. In this model each level is awarded equal status albeit (a) and (b) are acknowledged as being more simplistic and easily demonstrated.

Evaluation Criteria	Outcome Indicators (Adapted from Barr <i>et al</i> 2000)
A. Learners Reaction	• Satisfaction with programme of study • Improved career opportunities
B. Changes in Attitude & Perceptions	• Increased confidence • Increased assertiveness • Improved communication (patient & other healthcare professionals)
C. Acquisition of Knowledge & Skills	• Use of evidence based practice • Increased use of theoretical & skills based knowledge • Increased competence
D. Changes in Behaviour	• Implementation of the learning • Practice change • Improved collaborative working
E. Changes in Organisational Practices	• Cost benefit; Cost effectiveness • Clinical nurse leadership • Service redesign
F. Benefits to Users/Clients	• Improved quality of care: timeliness of care; patient compliance • Patient satisfaction • Indicators: Length of stay, referrals. waiting times.

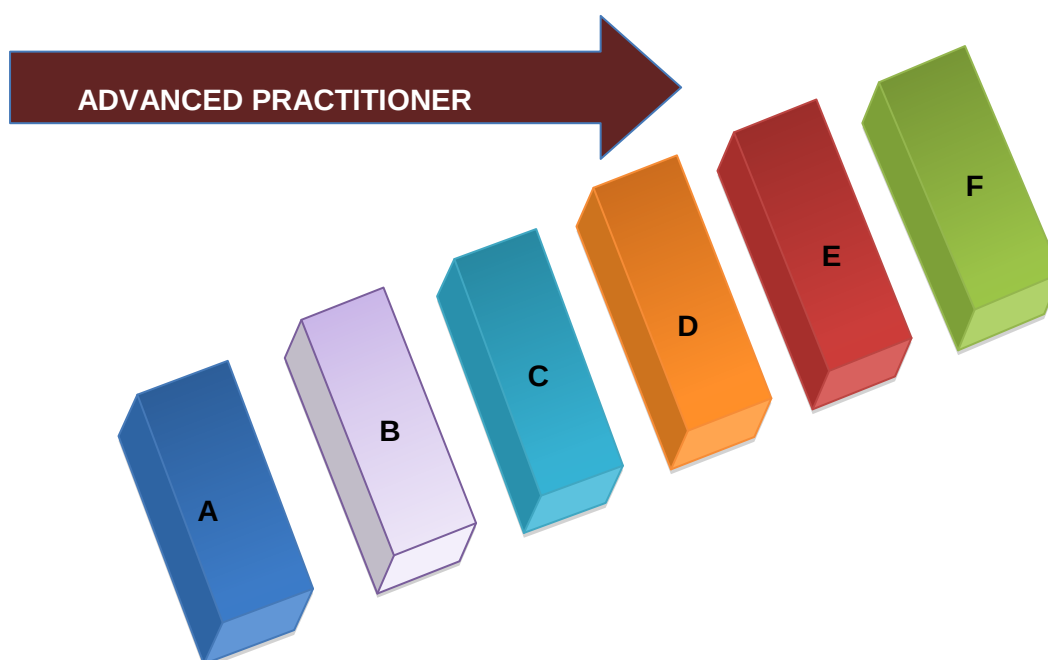


Figure 15 A Framework to Measure the Outcomes of Advanced Practitioner Roles in Practice

8.4 Conclusion

The findings from this study have been used to create and endorse a three-stage model that can be used in the effective preparation implementation and evaluation of the outcomes of advanced practice roles. This is characterised by, firstly, the development of strategic

alliances between HEIs, healthcare providers and healthcare commissioners in order to provide effective care to patients, secondly, a process that facilitates a supportive, coordinated and collaborative approach and recognises previous evidence (NHS Scotland 2009; NHS Wales 2010), and, thirdly, the need for continuous evaluation that provides feedback to allow modification of the process in response to the changing healthcare landscape

There were significant similarities and differences between the Cases used within this study. The three Cases were geographically spread throughout England to assess how unrelated organisations developed and delivered programmes of study in the absence of regulation. One Case, Case B, stood out from the three as a model of good practice, and was characterised by partnership working governing the introduction, preparation and implementation of advanced practice roles that was established under a concordant agreement. The advanced practice role in this case was perceived as valid, transparent and innovative, and in situations where opposition to the role from medics was received they expected to be able to change these attitudes by supporting advanced practice trainees to act as ‘*trailblazers*’ (Interview 1). Within Case B supernumerary status was awarded to trainee advanced practitioner students in critical care settings only that enabled them to gain more extensive practice experiences, completed mandatory practice competencies and supported classroom learning. In resourcing advanced practice development in this way healthcare providers and commissioners recognised the demands of the learning and support required for the role. In contrast, organisations in cases A and C implemented advanced practitioners more sporadically and had a less co-ordinated and consistent approach to recruitment and underpinning CPE.

The outcomes of the learning from the programmes of study on practice, specifically in relation to patient outcomes was reported as variable and associated with the support received during the students’ transition on the programme of study, the organisational

culture and consequential constraints placed on students in their work environments. A lack of understanding regarding role clarity remains evident and, until this is improved, the intentions of advanced practice programmes of study to prepare and increase the numbers of advanced practitioners in practice will not be realised.

Findings from this study demonstrate the need to make explicit the nursing philosophy and theoretical underpinnings of advanced practice to enhance clarity and transparency, particularly for other healthcare professionals. A consistent promotion of advanced practice as a complementary approach rather than competitive to medicine may decrease the perceived threat to other professionals. Greater clarity of the advanced practice role will strengthen its identity and facilitate the development and provision of consistent measures of outcomes for the various roles and scope of practice that current advanced practice roles embody. A positive organisational culture that values, promotes ownership, and understands the contribution advanced practice roles can make, will significantly influence their successful implementation. Subsequently, supportive professional relationships during the educational preparation of advanced practitioners may empower students to challenge and re-negotiate the current situation in practice.

The proposed model is one that can be translated for use internationally. The model is not context specific and is therefore adaptable to different healthcare delivery systems. The levels that provide the standards for evaluation are generic and meaningful for advanced practitioners because they measure outcomes commensurate to the ICN (2002) definition of advanced practice.

The newly proposed Advanced Practice Partnership, Implementation and Evaluation Model (APPIE) that is based on the findings of this study is presented in Figure 16 (Page 300). The model promotes continuous evaluation and in so doing demonstrates achievement of the aim and objectives of the study. The evaluation component of the model can be used

independently to evaluate education programmes because it provides a standard for each of the stakeholders to measure outcomes: For HEIs this is in relation to the effectiveness of student preparation to deliver more complex healthcare; for LETBs and CCGs it is a mechanism in which they can determine continued resourcing; for healthcare providers it allows measurement of patient outcomes.

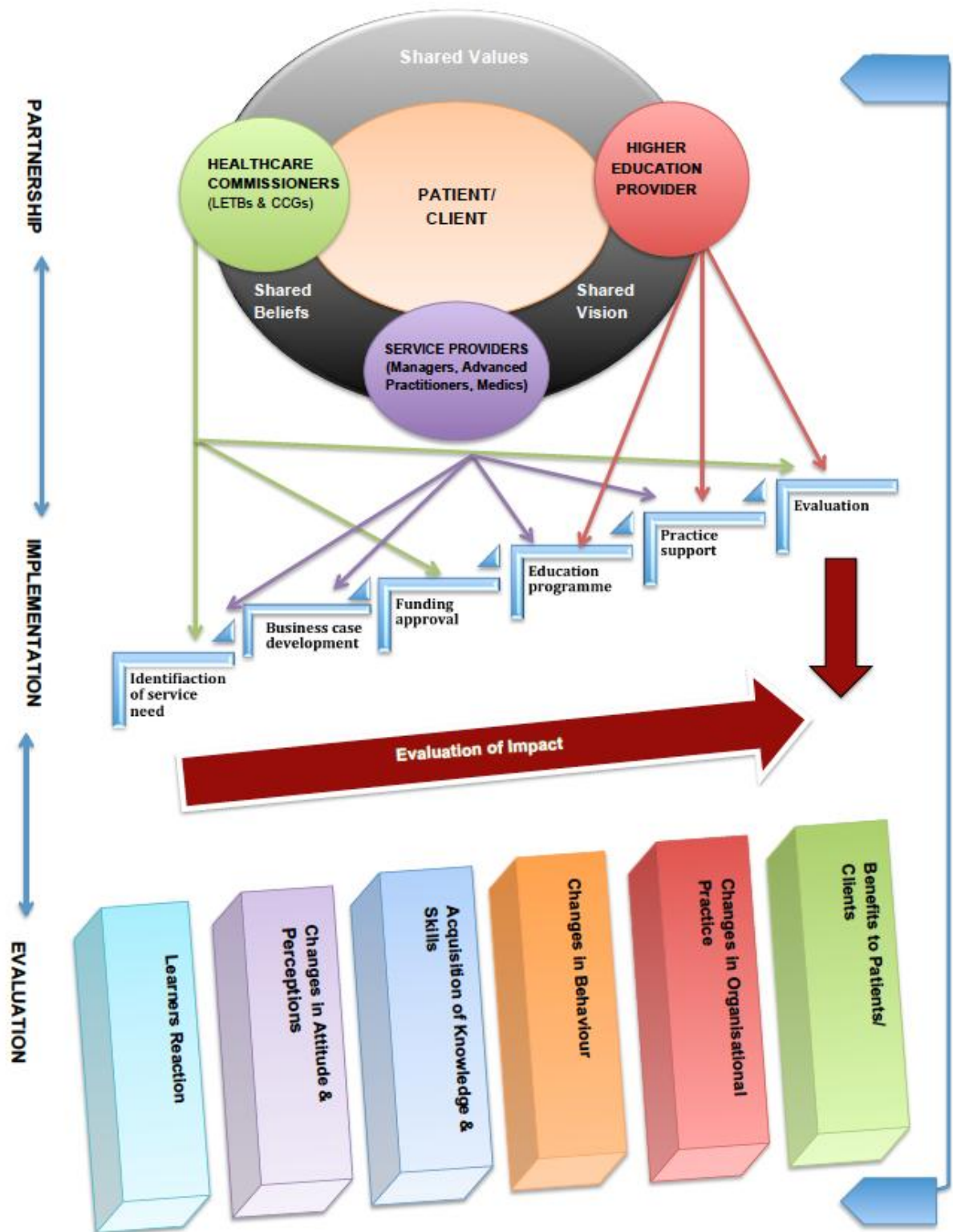


Figure 16 Advanced practice Partnership, Implementation and Evaluation Model (APPIE). (Adapted from Barr *et al* 2000; NHS Scotland 2010; NHS Wales 2010).

8.5 Strengths and Limitations of the Study

This study's aim was to explore the outcomes of advanced practice postgraduate programmes on practice and understand the reality of the participants within real-life contexts, and this was achieved. Consideration of the real life experiences and interpretations of those under study offered multiple interpretations that were crucial to answer the aims and objectives of this study. By valuing and accepting multiple perspectives as an outcome, the study aligned ontologically with the constructivist perspective rather than the assumption offered by the positivist paradigm.

A multiple case study design was used that enabled findings from students, Trust managers and qualified advanced practitioners to be considered and compared with and across cases. Documentary evidence was also used to provide context to the individual cases. Previous studies have used qualitative designs to investigate the outcomes of CPE programmes, although these have been predominantly retrospective, single centre studies using a small number of participants (Corlett 2000; Smith & Topping 2001; Hardwick & Jordan 2002; Sharples *et al* 2003; Gould *et al* 2004; Gould *et al* 2006; Nicolson *et al* 2005) or literature reviews (Barr *et al* 2000; Shaneyfelt *et al* 2006; Gijbels *et al* 2010).

This multiple case study design was effective in demonstrating examples of real people in real situations and reporting their experiences without manipulation. Patterns of concurrence, leading to an overall interpretation, offset potential weaknesses of using a single data collection tool criticised in earlier studies (Hughes 1990; Pelletier *et al* 1994; Jordan *et al* 1999; Hardacre & Keep 2003). The identification of similarities in all cases strengthens the likelihood that the findings are more representative of advanced practice programmes in England and may have a broader resonance.

Evaluation of advanced practice programme documentation facilitated presentation of the context of each case and the inclusion of elements that impinged upon it, an essential step in the provision of a thorough understanding of the phenomenon under investigation, the findings and their meanings (Hewitt-Taylor 2002). This study examined an advanced practice programme of study in the context in which it occurred, relationships between those involved in the real world of nurse education and practice, and the interface between groups enabling the construction of real life by those involved in the case. It identified cause and effects, the 'how' and 'why', for example how students identified education providers to meet their needs; why students were hindered in transferring learning to practice, and why conflict between students and professional colleagues arose. The richness of the descriptions provided by participants facilitated comparison across cases and portrayed current experiences at different stages of learning within a programme rather than retrospective analysis used in the majority of previous studies (Gijbels *et al* 2010). The findings from this study therefore allow other practitioners to understand and situate the circumstances in which the study was conducted in order to demonstrate insight into the suitability, effectiveness, consistency and outcomes of advanced practice programmes of study in England.

Data analysis examined cases independently prior to a cross case comparison. The intention of using a multiple case approach was to be able to generalise to the wider higher education community that provides advanced practice postgraduate programmes. Literature portrays the issue of generalisability from case study research as causing confusion and preventing the potential of its use in nursing to be fully met (Sharp 1998; Cohen *et al* 2011). The demonstration of trustworthiness represented by confirmability, credibility and transferability reinforces the generalisability of the study (Chapter Three). Confirmability in this study was demonstrated by prolonged engagement in the field (data were collected over a 12-month period), the use of multiple methods, and by sharing findings with participants

and allowing them to comment. Similarities in biographical details between the cases in this study (ages and length of professional experience) promote transferability.

Qualitative enquiry is not a neutral activity, and researchers are not neutral bringing to the research their interpretation of the social world (Cohen *et al* 2011). Participants interpret their reality in their own way and are influenced by the researcher's presence during data collection. As a researcher/practitioner I brought preconceived ideas, assumptions, values and opinions to the research that demanded suspension in order to maintain objectivity. Although this was challenging, the use of reflexivity that recognises the phenomenon that the social world is an already interpreted world, undermining the notion of objective reality (Cohen *et al* 2011) proved effective in facilitating clarity and transparency of the methodological processes; and ensured the research was conducted as rigorously and objectively as possible.

Maintaining objectivity during this research process was challenging, yet positive, in that it developed me personally and professionally in order to realise the aim and objectives of this study. The use of a diary to record feelings following interviews allowed me to monitor my reactions and interactions with participants and impressions, rather than depending on memory recall, and ensured accuracy in reporting them. The acknowledgement and disclosure of my own values and views when confronted with data that surprised me, and considered in Chapters Four, Five and Six, recognised rather than eliminated potential biases in an attempt to acknowledge and understand their influence. At the commencement of this study I believed that the articulation of outcomes would be difficult for some practitioners to qualify or quantify, and although I passionately believed in the effectiveness of advanced practitioners from previous discussions with other educationalists practitioners and students, I was sceptical that I would find a successful evaluative process in operation that considered both advanced practice education, and the outcomes of the learning on practice. I was, however, hopeful that there would be a greater appreciation and

implementation of advanced practitioners in practice than acknowledged within the current literature, following successive governments' advocating alternative ways of working to meet healthcare needs.

The findings from all Cases demonstrated no valid evaluations were consistently undertaken to measure outcomes of advanced practice practice, reinforcing my initial viewpoint. HEIs, in line with current literature and conforming to quality assurance standards, evaluated modules or programmes for perceived effectiveness, but not their outcomes in practice. Cases A and C reinforced my earlier opinions that advanced practitioner trainees overall found employment as an advanced practitioner post completion of education problematic or non-existent. Alternatively, Case B findings demonstrated a process of advanced practice training and implementation that was supportive, fluent and recognised by members of the multi-disciplinary team. Initially this challenged me because I considered the latter Case was too good to be true. The collection of more data that reinforced and corroborated the positive and innovative stance taken within Case B, and the consistency in which improved outcomes in response to education were reported, meant that I had to acknowledge this as a reality.

A key strength of this evaluation study was its foundation in the Barr *et al* (2000) theoretical framework. The use of the framework prompted the collection of data from multiple sources and demonstrated the effect and outcomes of educational interventions on participants' satisfaction and behaviour at multiple levels, the organisations in which they practice, and the patients to whom healthcare was provided. The theoretical framework guided the study design allowing the use of different qualitative methods and evaluation across multiple sites, supporting the conclusions drawn by Curran *et al* (2007), Burns & Grove (2007), Carter & Little (2007), and Cresswell (2009) regarding the constructive use of a framework in qualitative research. The use of a framework also had practical benefits in affording a structure for the analysis of the data, providing a clear trail when reducing themes, and

presentation of the findings in a meaningful way, promoting confirmability. Subsequent framework analysis used independent experts to confirm that the generation of themes had been extrapolated meaningfully. Ensuing discussion was linked to current research and linked to data also ensured credibility and confirmability.

Another key strength of this evaluation study was the large number of respondents recruited across the three case studies. Convenience sampling while described as opportunistic (Ritchie & Lewis 2012) enabled the recruitment of a total of thirty-two students representing all years of a programme of study. Similarly the recruitment of managers, though challenging, represented a diverse range of clinical practice areas in six focus groups and a range of perspectives and views regarding the need for advanced practice nurses and the development of advanced practitioner roles. The sample size in this study allows adequate depth, exploration and analysis of the findings, further promoting generalisability.

This study used self-report to assess the perceived outcomes of learning for the individual and on practice, using a theoretical framework. While this enables the participant data to be reported and can be seen as a strength, it is limited in that the outcomes from the learning on practice has not actually been observed and assessed. However, findings from this study were consistent across Cases and between groups, strengthening the trustworthiness of the results reported. Epistemologically the constructivist paradigm requires the researcher to interact with the participants in a collaborative way (Becker 1996; Cohen *et al* 2011) and this was achieved.

The process of gaining ethical consent in individual NHS organisations was time consuming and onerous and limited the number of Trusts included within the study. Despite this six Trusts reflective of different types of organisation structures and cultures were used within this study.

Unfortunately, this study did not capture data from mentors supporting students. Findings from this study indicate the crucial supportive role performed by mentors to assist students transferring learning from programmes of study to practice, and this needs to be explored more comprehensively. The need to examine the mentor/student relationship from both perspectives would enable a greater appreciation of how it enhances transfer of learning to practice and additionally gain an insight into the doctor/nurse relationship. Mentors' perceptions of the outcomes would also provide information regarding the direct effect of the learning on practice, because of their involvement in assessment both formatively and summatively. Overall the extent to which the methodology used in this study enables generalisability enhances the use of the findings to influence changes in policy and practice, and future research.

The overall findings from this study, indicate that there are positive outcomes in practice from advanced practice programmes of study. While variation in the outcomes between cases were found using the Barr *et al* (2000) theoretical framework, there remains sufficient evidence to support the value and purpose of the education. The lack of supportive infrastructures and understanding of advanced practitioner roles within organisations exacerbate a lack of recognition of the value of these roles in wider professional groups. Policies previously supporting the implementation of advanced practitioner roles have failed to inform other healthcare professionals of the benefits of the role and are a key goal for future workforce planning. A strategy needs to be formulated and introduced to promote strategic alliances between all major stakeholders if advanced practice development and implementation is to be effectively realised. The introduction of a framework to evaluate the outcomes generated by this study can then follow, and provide the necessary evidence to substantiate the claim that advanced practitioners provide commensurate complementary healthcare to medical professionals.

CHAPTER 9 CONCLUSION AND RECOMMENDATIONS

The effective preparation of advanced practitioners is complex, and determined by a multiplicity of variables. This study has demonstrated that the outcomes of learning from advanced practice programmes on patient care is affected by support structures. Organisational culture, role clarity and understanding of the advanced practice role by other healthcare professionals are influenced by variance in nomenclature, scope of practice, and remuneration of these roles within healthcare organisations. This study has demonstrated inconsistency in the implementation and role of advanced practitioners within and across healthcare organisations. This evidence suggests that successive NHS strategies to reconfigure the current workforce to address current shortfalls by using the advanced practice role in care delivery have been inadequate or ineffective. A lack of evidence to illustrate the economic comparability between advanced practitioners and doctors in performing similar and complementary management of patients aggravates the issue.

It is evident from this study and previous literature that nurses desire the advanced practitioner role, and policy makers recognise its usefulness. However, despite attempts to define the role clearly and identify the consequences of advanced practice education, confusion and ambiguity remain. Using Barr *et al's* (2000) theoretical framework to measure students', managers' and advanced practitioners' perceptions of outcomes, this study has explored the outcomes of learning from advanced practice programmes of study on practice. Changes identified by participants were said to include increased patient satisfaction, reduced waiting times, and prevention of misdiagnosis. These outcomes in practice were perceived to arise as a consequence of experiential and theoretical learning that resulted in the advanced practitioner working independently and crossing traditional boundaries to expedite care management. However, the autonomous advanced practitioner contrasts markedly with the ward nurse and potentially provides a threat to medics.

Political ideology and the policy process seem to govern the external healthcare agenda. A legacy of a power imbalance between medics and nurses has meant that the identification and implementation of advanced practice roles has predominantly been driven by a shortfall in medics and in so doing ensures that others dictate nursing practice developments. The Scope of Practice (NMC 2007) naively suggests that nurses will have the strength of character to define the boundaries for practice and have the vision to innovate practice and facilitate autonomy and creativity, an argument used by the NMC (2005) to not regulate the role. Case B in this study however, demonstrated that innovation in practice and autonomous working are achievable, if a supportive infrastructure is in place. The historical submissive stance taken by nurses to medics arising from a lack of status and power as a professional group and the current inadequate nurse involvement in policy development (reflected in the lack of nurses appointed on commissioning boards), appears to refute the idea that this document alone is sufficient in promoting nurse led innovations or contributions at a strategic level.

The introduction of the advanced practitioner role requires a change in thinking and behaviour. Change requires nurses to stop adopting a subservient role, stop trying to emulate doctors and instead be able to demonstrate attributes that are multifaceted, resource and care effective, and based on the need to implement autonomous nursing roles rather than replace medics. Changes in first level nurse education to graduate and postgraduate level have gained nurses an equal academic status with doctors on completion. Advanced practice programmes of study increase confidence and assertiveness of practitioners as this study has shown; nevertheless it can make them the target of professional jealousies by other healthcare professionals. As a result, there is the potential for doctors to feel threatened, leading to resentment because they perceive this as a challenge to their knowledge and competence. An inability of advanced practitioners to clearly articulate their role and scope of practice exacerbates this, and conceivably arises because they don't understand why they want to become an advanced practitioner.

Change away from the nurse stereotype can cause disruption, conflict and tension that many nurses do not have the energy or desire to fight. The challenge to nursing and education is the need to change the employability of postgraduate and doctoral qualified nurses by reporting the positive outcomes of their practice supported by evidence. The need to change nursing philosophy and stance by conceptualising advanced practice, making it recognisable and discernable to others remains crucial. A discrete advanced practitioner identity may however be difficult to achieve. Practitioners' understanding of the advanced practitioner identity is often context dependent with individuals presenting different characteristics for different groups constructed from previous experience, practice and learning. The use of a concept analysis to identify the underlying values and concepts of advanced practice roles could, facilitate improved understanding, clarity and articulation of the roles, and subsequently maximise its implementation in practice as outlined in healthcare policy.

Clinical leadership is at the heart of nursing's future, providing the influence, vision, strength of character, and resolve to successfully change the political landscape. Clinical leadership is commonly perceived as an outcome of a programme of advanced practice study. Policy documents (DoH 2010b) promote the development of leadership competencies as a key component of the advanced practitioner role and the need to be a leader not a follower. A reliance on other healthcare professionals to recognise advanced practitioners as a clinical leader and for advanced practitioners to actively exemplify the associated behaviours in their everyday practice is necessary if it is to become an improved reality in practice.

Demonstration of the economic benefits provided by advanced practitioners is also a necessity if the advanced practice role is to have longevity. In today's outcomes and value-driven NHS, it is imperative to highlight the financial benefits, as well as the quality-of-care justifications for investment in advanced practitioners. The type of care and timely interventions provided by advanced practitioners not only help to reduce patient morbidity,

they also potentially prevent costly care episodes, for example the reduction of waiting times for patients and earlier recognition of inaccurate diagnoses, which have clear ramifications for the NHS purse. The value for money of the advanced practice workforce can be maximised by ensuring that these specialists do not spend time on activities that can be performed equally well by lower band staff. The NHS is adapting and preparing for the challenges of modernisation and financial constraint by reconfiguring its workforce. The advanced practitioner role will need to deliver patient-focused care in a cost-effective way and help to meet many of the current demands for increasingly streamlined, but high-quality and safe, services if it is to survive. Advanced practitioners need to be able to demonstrate they are value for money.

The advanced practitioner role is important to improving patient outcomes. Despite the DoH (2010b) offering standards to promote the development of core advanced practice skills and to standardise practice, this study has demonstrated that the advanced practice resource is not being developed or used in a consistent way across England. Advanced practitioners were commonly thwarted in being given an opportunity to use post qualification what they had learned in an advanced practitioner role. Advanced practitioners need to be able to defend their services through the production of robust business plans demonstrating the benefits of their role in terms of national policy and NHS outcomes. A coherent and consistent evidence base demonstrating the outcomes of advanced practitioners have on practice, particularly in these times of increasing patient demand, the ageing demographic and organisational change, is also needed.

Previous evidence to support the cost effectiveness of advanced practitioners is limited, and has used retrospective data from other studies to collate the analysis. An economic evaluation using a cost benefit analysis would be appropriate for further investigation. Cost benefit analysis allows the measurement of costs and benefits in commensurate terms and could be used to assess whether the additional benefits of implementing an advanced

practitioner as a new intervention are greater than the loss in benefits from the reduction of medics, by comparing and contrasting patient outcomes using a randomised controlled trial (RCT). From literature, previous studies identified the use of RCTs to compare effectiveness successfully, but preparation for the advanced practitioner role has changed specifically in relation to the inclusion of non-medical prescribing and therefore re-evaluation in light of these alterations is now required.

9.1 The Importance of Education in Defining Advanced Practice

The importance of the evaluation of education programmes established in this study does not present the whole picture. The move towards master's level preparation for advanced practice roles is a recent change in the UK, occurring simultaneously to a move internationally to prepare advanced practitioners at doctoral level in recognition of the perceived level of education required for clinical practice and leadership. International discrepancy in the preparation of advanced practitioners is an established subject and is counterproductive in recognising and rationalising the education required for advanced practitioners' preparation in England today. In response, decisions need to be made as to whether doctoral or postgraduate education is required to prepare advanced practitioners. In order to do this nurses and educationalists need to appreciate how education levels differ by using the evidence from patient/service outcomes. Future research questions need to identify outcomes to determine how advanced practitioners understand and promote their specialist attributes.

This study demonstrated that advanced practitioners were poor in articulating what they do and the outcomes of their practice. Linked to this is the inability to express advanced practice expertise and nursing uniqueness. For example, many students in this study described the advanced practice role in a way that suggested they were a nurse with *'bolt*

ons', using a medical model and medical skills underpinned by a nursing philosophy, rather than nursing values complemented by medical philosophies and skills.

A difficulty in defining advanced practice arises from the diversity of education preparation. The fragmentation in approach by the four countries within the UK compounds this, and dilutes the powerbase from which nurses can be unified in gaining absolute recognition and clarity of the advanced practitioner role. Education enables students to recognise and use different types of knowledge to construct their practice in order to describe what they do. A debate highlighted in the literature by Mantzoukas & Watkinson (2007) suggests that scientific Vs intuitive knowledge grounds the use of knowledge in practice for advanced practitioners, and is said to essentially be '*knowing that*' (scientific knowledge) and '*knowing how*' (personal knowledge). Advanced practice is underpinned by theoretical knowledge, experiential knowledge and the clinical implementation of these types of knowledge. It is essential that educationalists assist students to identify these elements in their practice, and differentiate between expert and non-expert practice and the subsequent outcomes on patients, teams and organisations. The uptake of postgraduate programmes is certain to increase as a result of graduate preparation of first level nurses. Findings from this study indicate that many senior practitioners do not possess a postgraduate qualification and mentorship support is difficult for trainees partly for this reason. Doctoral level preparation would exacerbate this problem and the decision therefore to follow the international lead is questionable at the current time. The understanding of what constitutes doctoral level varies and is often lower in other countries than the UK (Ellis 2006) strengthening the argument to continue advanced practice education preparation at masters level.

The findings from this study illustrated the need for a partnership approach if advanced practice preparation is to be consistent and effective across England and commensurate with the remaining countries in the UK. Policy makers responsible for workforce redesign in England must acknowledge the need to provide a framework to assist organisations and

education providers to develop advanced practitioners in a unified way, following the lead taken by NHS Scotland (2010) and NHS Wales (2010). A policy would ensure advanced practitioners and consultant nurse roles are developed in a consistent and sustainable way by setting the processes through which these roles are to be established, and while allowing flexibility to align them within clinical and geographical contexts. Policy would also be responsible for determining where new posts are to be established, be based on service need, developed in accordance with detailed job specifications, and be appropriate to the competencies required for the job. The recommendation from this study is that policy in England should accept the Scottish and Welsh model in part, and in so doing establish a more unified UK approach. The proposed model developed from results of this study builds on the Scottish and Welsh model by recognising stakeholders in a partnership approach, and by adding evaluation of the outcomes of advanced practitioner preparation and implementation as an essential element.

This study has shown that currently the clinical career pathway for nurses in England is ineffective, with many nurses resuming the same role post education. This proposed model would provide the mechanism in which advanced practitioners as clinical leaders can be developed more uniformly. Equipping nurses with the knowledge and skills to operate successfully in practice is inadequate if they are unable to articulate the outcomes of the advanced practitioner role. Nurse academics need to facilitate students to be able to authenticate their knowledge base and nursing competence to others to enable them to connect their practice with others. This requires intentional attentiveness by the advanced practitioner and is synonymous with the ICN (2002) definition of advanced practice.

This study set out to explore the outcomes of postgraduate education programmes in practice using Barr *et al's* (2000) framework of outcomes. The outcomes of the programme of study was established for an individual personally and professionally, the organisation, and the patient through student and manager interviews. Findings were subsequently

evaluated against this framework. Education providers currently try and estimate the outcomes of learning from programmes of study principally to the individual learner, and through this, on practice. What is measured is perhaps not indicative or representative of reality because of the anecdotal and retrospective nature of some of the evidence. In this study measuring the outcomes of advanced practitioners care delivery behaviour was assessed using vignettes. There may be reluctance by some professional groups to recognise the indirect and direct benefits identified by this study on practice because the findings were based on self-reported perceptions. However, evidence collated from the three distinct cases prospectively, using students, managers and advanced practitioners to verify the data, strengthens the credibility of the findings.

Further research is required as a follow on to this study. The attitudes of medical mentors or medics working alongside student advanced practitioners were not assessed. This study has indicated that other healthcare professionals lacked a clear understanding of the advanced practice role and in some circumstances perceived them as a threat. In this study medics acting as mentors were often reported as problematic for both students and mentors, but data were limited. There is a need therefore to gain feedback from mentors regarding the efficacy, value and appropriateness of medics' involvement in advanced practitioner preparation. If advanced practice roles are to be fully integrated into practice, there is a need to establish from them exactly what is unclear about the role and gain their support in facilitating effective change.

The requirement to gain more direct evidence from patients regarding outcomes in practice is also imperative. Patients often lack a clear understanding of the advanced practice role and often need an explanation regarding the role prior to consultations. This infers that interviewing patients directly may be problematic, and findings inconclusive, because of the lack of awareness and comprehension of the advanced practice role. Ontologically the use of a constructivist approach used in this study is appropriate because it acknowledges that

reality is multiple and subjective, and constructed by individuals. As a follow up to this study examination of how reality is constructed would be useful in order to generate evidence of the lived experience of advanced practitioners. Existential phenomenology or ethnography as a methodological approach could be used to provide such evidence. An observational study could similarly provide detailed information of the advanced practitioner patient/medic relationship and provide evidence of direct impact of care delivery simultaneously.

The use of the Barr *et al* (2000) framework in this study provides an evaluation tool with which to underpin and evaluate outcomes. Without such evaluation in the context of diminishing resources, the sustainability of CPE by organisations in its current format is questionable. The desire and obligation to demonstrate discernable outcomes of education programmes on practice consistently provides the necessary evidence to counter balance this argument. The adoption of a policy for the development and implementation of advanced practitioner roles identified previously is now a priority; however, it requires adjustment to ensure evaluation and impact of the posts created by the policy are undertaken. The recommendation from this study is that evaluation should form part of the policy and be conducted continuously throughout the educational preparation of the advanced practitioner. The categories used within the Barr *et al* (2000) framework are appropriate in providing the range of outcomes that need to be evaluated and are comprehensive in acknowledging the outcomes on the individual, organisation and patient. The use of clinical indicators could also be incorporated into this, making the framework context specific.

9.2 Summary

In conclusion, evaluation relates to all aspects of the professional development process and can be used to inform planning and implementation of education programmes. The promotion of accountability and development of governance structures are a secondary outcome. The changing organisation of healthcare delivery provides opportunity for the introduction of

innovative advanced practitioner roles playing a central role in resolving service issues and providing improved patient outcomes. Policy driving the introduction of these advanced practice roles has largely been in response to doctor shortages, and perceived as a modified medical role. Within the context of continuously shifting role boundaries, advanced practitioners need to establish a discernable identity that is recognisable and measurable to provide evidence for direct impact on patient outcomes. An apparent need to compare the current outcomes of advanced practitioners and medics in the justification of the advanced practice role can be achieved through economic analysis, since the impact and appropriateness of the application of knowledge and skills by both groups are drawn from a similar theoretical and skills portfolio that facilitate effective comparison.

Economic evaluation alone will be insufficient in promoting and extending advanced practice. The need for nurses to identify, articulate and promote clarity of the role remains. Nursing leaders should address this need as a priority, and ensure that the advanced practice identity is unambiguous and centred around nursing practice if it is to create self worth. The development and preparation of advanced practitioners does not solely rest with education providers rather it is a symbiosis of experiential learning and formal education. Education providers, nevertheless play an instrumental role in enabling students to construct and promote the language and learning required to facilitate formulation of an advanced practice identity.

Evaluating the impact of education programmes, while considered essential, has to date failed to be recognisable, measurable or transparent and is largely perceived to be the responsibility of education providers. The outcomes of the learning from education programmes is determined by many variables and is context dependent and is therefore challenging to undertake. Evaluation studies of CPE have predominantly been limited to single centre programmes evaluations, usually undertaken at the end point of the learning. Effective evaluation is on-going and should involve all major stakeholders to identify both

strengths and weaknesses of the preparation and development of advanced practice roles, and subsequently be used to inform future developments.

In England there is a great opportunity to demonstrate the positive value of advanced practice roles to improve patient outcomes. At a time of radical change and uncertainty within healthcare, nurses need to rise to the challenge by demonstrating the added value these roles bring to progressing patient management and treatment. The measure of success needs to be consistently formally evaluated in order to demonstrate the impact advanced practitioners have in improving clinical outcomes if they are to be irrefutably recognised in their own right in the future.

9.2.1 Summary of Recommendations

This chapter has proposed a number of recommendations. To ensure clarity and increase the potential utility of the substantial arguments presented in this thesis, these will now be summarised.

9.2.1.1 Recommendations for Practice

- ❖ Adoption of a partnership approach between commissioners, healthcare organisations and education providers in the preparation, implementation and continuous evaluation of advanced practice roles.
- ❖ To endorse the requirement for organisations to educationally prepare advanced practitioners only to fulfil pre-identified and agreed roles within organisations.
- ❖ Development of a five-year workforce plan, demonstrating how healthcare organisations plan to react to concurrent policy documents in order to employ the advanced practice role to improve patient outcomes.
- ❖ To fully resource the preparation of advanced practitioners comparable with postgraduate medical education funding.

- ❖ Working with professional nursing bodies and LETBs and CCGs, provide greater clarity of advanced practice role characteristics, competencies, definition and intention in order to facilitate transparent articulation that promotes saliency and understanding by others, and improves dissemination and usage of the advanced practice role, as intended by policy.

9.2.1.2 Recommendations for Future Research

- ❖ A concept analysis to identify the values and concepts required in developing and extending models of nursing practice to maximise the advanced practice role and its impact on practice.
- ❖ An economic evaluation of the advanced practice role using a cost benefit analysis.
- ❖ The outcomes of the preparation of the advanced practice role on practice should be evaluated using heuristic phenomenology, ethnography and/or observation to evaluate the lived experiences of the advanced practitioner in order to consider the influences of the organisation, and mentors and allow the impact on patients to be measured more directly.
- ❖ An evaluation of how and what masters and doctoral level characteristics/education develop practitioners to use expansive language in order to explain their professional expertise post education.

9.2.1.3 Recommendations for Policy Development

- ❖ Promotion and utilisation of the proposed advanced APPIE model developed from this study in the implementation of advanced practitioner roles.

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APPENDIX I: Student Question Guides

REC Reference Number: [PNM/11/12-72]

General Introduction

- Introduce myself
- Welcome and thank you for participating in the study
- Emphasise confidentiality. Inform them that Identification within the study will be by numerical codes only
- Confirm that they are still happy to be interviewed
- Restate aim of the research - To evaluate the impact of postgraduate advanced practice education to students and stakeholders. The project will inform advanced practice policy and curriculum design
- Explain that the Interview will be audio taped and gain agreement to do this. Reaffirm that transcripts will be transcribed and stored encrypted on a password protected computer. It is important to record the interviews to capture their exact words
- Prompts will be given to topic questions if a silence prevails to stimulate some discussion as indicated

Field Notes

Collection of general details to assist in data analysis and presentation of findings

- Gender: Male / Female
- Age?
- Current role?
- Current area of clinical practice? (*Prompt if necessary Community/acute*)
- Length of time as a qualified practitioner?
- Start date on to the programme?
- Anticipated programme completion date?
- Length of time (if any) waiting to access the programme?
- Supernumerary status?

Topic Guide.

1. Can you describe the selection process you went through in applying and being accepted onto this postgraduate advanced practice programme within your Trust?

Probes:

- clarify if the student or the trust made the initial suggestion to undertake the programme

2. Why did you choose this particular University to undertake the programme?

Probes:

- *Reputation?*
- *Contracted place?*

3. Why did you want to undertake this advanced practice programme?

Probes:

- What do you hope to achieve by completing it?
- Career development?
- Increase your knowledge? Of what?
- You were asked to?

4. Have you experienced any barriers to your learning to date?

Probes:

- Time?
- Family/personal circumstances?
- Trust support in terms of providing time and payment of study fees?
- Why do you think that is?

5. Have you experienced any aspects that have facilitated your learning to date?

Probes:

- Time?
- Family/personal circumstances?
- Trust support in terms of providing time and payment of study fees?
- Why do you think that is?

6. How effective has your learning been so far? Can you provide some examples?

Probes:

- Examples of positive aspects of learning, e.g. new knowledge; new ways of thinking, Collaboration with peers

- Examples of any negative aspects of your learning..e.g. aspects you have not valued or found useful
- meeting your expectations?
- Too soon to make a judgement?

7. How have you been helped to transfer your learning into practice? Can you provide examples of what has helped you to transfer your learning

Probes:

- Help from lecturers/personal tutor
- Help from manager/ mentor
- Attitudes and motivation

8. What do you think are the benefits to your patients resulting from your learning?

Probes:

- Behavioural changes; attitude, confidence, increased knowledge
- Quality of care; Give examples of advanced practice demonstrated through....
- Please identify any specific scenarios which illustrate benefits

Thank you for your participation in this study, your input is highly valued.

Interview Schedule (Year 2 & 3 Students).

Topic Guide.

1. Can you describe the selection process you went through in applying and being accepted onto this postgraduate advanced practice programme within your Trust?

Probes:

- clarify if the student or the trust made the initial suggestion to undertake the programme

2. Why did you choose the particular University to undertake the programme?

Probes:

- *Reputation?*
- *Contracted place?*

3. Why did you want to undertake this advanced practice programme?

Probes:

- What do you hope to achieve by completing it?
- Career development?
- Increase your knowledge? Of what?
- You were asked to?

4. What aspects of your learning do you think will be the most beneficial in your practice and why? Please can you use examples to illustrate this?

Probes:

- Critical thinking / problem solving
- Acquisition of new skills, which are?
- knowledge

5. Can you describe any barriers you have experienced in transferring your learning into practice?

Probes:

- Time?
- Competing priorities - Family/personal circumstances?
- Other staff
- Organisational policies
- Trust support in terms of providing time and payment of study fees?

- Why do you think that is?

6. Can you describe any aspects you have experienced that have assisted you in transferring your learning into practice?

Probes:

- Time?
- Competing priorities - Family/personal circumstances?
- Other staff
- Organisational policies
- Trust support in terms of providing time and payment of study fees?

7. How have you been helped to transfer your learning into practice? Can you provide examples of what has helped you to transfer your learning

Probes:

- Help from lecturers/personal tutor
- Help from manager/ mentor
- Attitudes and motivation

9. What do you think are the benefits to your patients resulting from your learning?

Probes:

- Behavioural changes; attitude, confidence, increased knowledge
- Quality of care; Give examples of advanced practice demonstrated through....
- Please identify any specific scenarios which illustrate benefits

8. Is there anything you would have changed regarding learning from the postgraduate programme?

9. How Has/will your role change as a result of your learning?

Thank you for your participation in this study, your input is highly valued.

APPENDIX II: Recruitment Poster.

REC Reference Number: :[PNM/11/12-72]

You are invited to participate in a Research Study which aims to:

'Evaluate the impact of postgraduate advanced practice education on students and stakeholders'.

*You should only participate if you want to;
Choosing not to take part will not
disadvantage you in any way.*



Why are we doing this research?

Advanced practice education programmes have grown enormously over recent years yet their impact on you as students and your sponsors has not been well evaluated.

The project aims to compare and contrast three different advanced practice programmes using feedback from students like you and your sponsors to inform and enhance future advanced practice education.

By taking part you will be able to help us better understand if these Advanced Practice Programmes prepare you effectively for Advanced practice roles and to help determine how they enhance the care you give your patients

Participation will involve:



- Being interviewed about your studies, which will take approximately 1 hour of your time
- We will arrange the interviews at a time to suit you where you are studying
- All information will be treated confidentially, at no time will anyone be able to identify you
- You will be able to withdraw from the study at any time
- Information sheets are available for you to read before you make your decision to participate

If you are interested in taking part or would like to know more about the study please contact:

Lesley Bridges. 01494 522141 ext 5730 or

Lesley.bridges@bucks.ac.uk or your course leader.....

Thank you for your consideration

APPENDIX III: Student Information Sheet

INFORMATION SHEET FOR PARTICIPANTS (Students)



REC Reference Number: [PNM/11/12-72]

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of project: The impact of postgraduate advanced practice education for students and stakeholders: An evaluative project.

I would like to invite you to participate in this postgraduate research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the project about? Postgraduate advanced practice education programmes have grown enormously over recent years yet their impact on students and sponsoring organisations has not been well examined. The project aims to compare and contrast three different advanced practice programmes to find out more, including feedback from students and sponsors. By taking part you will be able to help us better understand how Trusts select staff onto these Advanced practice Programmes and determine if the programme prepares students effectively for advanced practice roles.

Aim of the project: To evaluate the impact of postgraduate advanced practice education on students and stakeholders. The project will inform advanced practice policy and curriculum design.

The objectives of the project are:

1. To determine the expectations of students undertaking postgraduate advanced practice educational programmes.
2. To determine the expectations of Trust Educational Leads supporting staff to undertake postgraduate advanced practice educational programmes.
3. To evaluate if postgraduate advanced practice education programmes facilitate theory to practice knowledge transfer.
4. To identify any enablers and inhibitors to the integration of learning to practice.
5. To explore Trust Educational Leads views of the performance of staff attending advanced practice programmes.
6. To examine similarities and differences between different postgraduate advanced practice educational programmes

Why have I been chosen? You have been chosen because you are a student undertaking a postgraduate advanced practice programme and I want to find out your views about the programme and how your learning has influenced your practice role.

Who is involved in the project? The project is led by a university lecturer from Buckinghamshire New University who is undertaking a Professional Doctorate at King's College, London with an interest in the development of advanced practice programmes. Postgraduate advanced practice students in addition to trust partners will be involved in the project. The project findings will be used to inform future programme development.

Do I have to take part? No, the project is entirely voluntary. Whether you choose to take part or not will be your decision and will not affect you as a student. If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form agreeing to take part. You do not have to give a reason if you decide not to take part.

What is involved? If you agree to take part you will be one of a small number of students asked to take part in the project. I will arrange to meet with you at a time and place of mutual convenience for a face-to-face interview. The interview will last approximately 30-60 minutes, and you will be asked some questions that we would like you to respond to. The interview will be audio-taped subject to your permission to allow all of your responses to be captured accurately.

What types of questions will I be asked?

Questions to be asked are to help the researcher to gain feedback from you about your experience regarding access to the programme of study you are undertaking and your learning. . Examples of questions that you are likely to be asked are;

Can you describe the selection process you went through in applying and being accepted onto this postgraduate advanced practice programme within your Trust?

Why did you choose this particular University to undertake the programme?

How effective has your learning been so far? Can you provide some examples?

What happens to the information? All of the information provided is confidential. No one will be able to identify you from the project. The audio-recordings will be coded and downloaded onto a password protected computer. The data will only be accessible to the researcher and the research supervisors who will be able to view the transcripts. Recordings will be erased once downloaded onto the computer. Transcripts will be transcribed by a third party audio typist who currently works for other researchers within the faculty and complies with the Data Protection Act 1988, deleting all files once sent onto the researcher. Transcripts will be kept until after the thesis is completed and thereafter destroyed. The researcher will ensure that views are not misrepresented by allowing access to the transcripts for verification if asked for. If however bad practice is disclosed or revealed a formal procedure will be followed.

What if I am worried that the content will affect my future studies? All information provided by you is confidential and will not be discussed with your lecturers. If you are worried at any time please speak to the researcher or personal tutor who will discuss your concerns with you. If you do not wish to take part but do not want to tell the researcher personally then please contact your programme leader who will inform the researcher. A decision to withdraw at any time, or a decision not to take part, will not affect your academic progress. You do not have to give a reason for not wanting to take part.

Contact for further information: If you would like any additional information about the project please contact Lesley Bridges on 01494 522141, Extension 5730 or Lesley.bridges@bucks.ac.uk.

What if I wish to complain? If this project has harmed you in any way you can contact King's College London for further advice and information. Please contact my supervisor Dr. Julia Roberts 020 7848 3017: or julia.roberts@kcl.ac.uk.

What will happen to the results of the project? The results will be collated and presented as part of my Thesis. Some data will be used in publications and conference presentations but these will be anonymised in any presentation materials and will not be traceable to you. The intention is to improve advanced practice policy and curriculum development for future students and trusts. A copy of the final report can be sent to you if you would like it.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason. It is up to you to decide whether to take part or not. In addition to withdrawing yourself from the project, you may also withdraw any data/information you have already provided up until it is transcribed for use in the final report July 2014

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Please contact Lesley Bridges contact details above to discuss future arrangements for the interview.

Thank you for taking the time to read this information sheet.

APPENDIX IV: Student Consent Form

CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Project: The impact of postgraduate advanced practice education for students and stakeholders:

An evaluative project.

King's College Research Ethics Committee Ref: _____ PNM/11/12-72 _____

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Advanced

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to July 2014 ☐
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998. ☐
- I understand that the information you have provided will be published within a report and you will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications. ☐
- I agree that the research team may use my data for future research and understand that any such use of identifiable data would be reviewed and approved by a research ethics committee. (In such cases, as with this project, data would not be identifiable in any report). ☐
- I consent to my interview being digitally recorded and transcribed. ☐

Participant's Statement

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the project. I have read both the notes written above and the Information Sheet about the project, and understand what the research project involves.

Signed

Date

APPENDIX V: Focus Group Question Guide

Focus Group Interview Schedule - Trust Partners. Topic Guide.

Topics:

1. Can you briefly describe your role in continuing professional development for staff within your trust?
2. What factors do you consider prior to purchasing postgraduate advanced practice educational programmes for your staff?

Probes:

- Was Cost an issue?
 - Reputation of the university
 - Proposed content and format (Mode of delivery)
 - Attrition /completion rates?
 - Location
 - Organisational need
3. Can you describe the process by which you selected staff to undertake the advanced practice programme at...?

Probes:

- Did the student or the trust made the initial request for application?
 - Did this include undertaking a training needs analysis – if so why is this useful?
 - Was it informed by personal development plans at appraisal?
 - Was it informed by Trust needs?
 - Was it informed by budgets?
4. Whose role do you think it is to support staff undertaking advanced practice postgraduate programmes in transferring their learning into practice and why?

Probes:

- University?
- Yours?
- The member of staff undertaking the programme of study?

- Joint responsibility?
 - Clinical area
5. How is this achieved in your trust?
 6. What do you think enables the staff to transfer learning from the advanced practice programme to practice?
 7. What do you think hinders staff to transfer learning from the advanced practice programme to practice?
 8. Can you provide any examples of changes in behaviour/role to staff as a result of the learning from a postgraduate advanced practice programme? Perhaps in relation to....

Probes:

- Professional development
 - Individual development
 - Organisational need
 - Educational development
 - Enhanced care
9. Please describe using examples or scenarios, the benefits you have seen to patients, other members of staff or to the organisation as a result of learning from a postgraduate advanced practice programme?

Thank you for your participation in this study, your input is highly valued.

APPENDIX VI: Information Sheet For Participants (Trust Partner)

REC Reference Number: [PNM/11/12-72]

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of project: The impact of postgraduate advanced practice education for students and stakeholders: An evaluative project.

I would like to invite you to participate in this postgraduate research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the project about? Postgraduate advanced practice education programmes have grown enormously over recent years yet their impact on learners and sponsoring organisations has not been well examined. The project aims to compare and contrast three different advanced practice programmes to find out more, including feedback from learners and sponsors. By taking part you will be able to help us better understand how Trusts select staff (learners) onto these Advanced practice Programmes and determine if the programme prepares students effectively for advanced practice roles.

Aim of the project: To evaluate the impact of postgraduate advanced practice education on students and stakeholders. The project will inform advanced practice policy and curriculum design.

The objectives of the project are:

1. To determine the expectations of students undertaking postgraduate advanced practice educational programmes.
2. To determine the expectations of Trust Educational Leads supporting staff to undertake postgraduate advanced practice educational programmes.
3. To evaluate if postgraduate advanced practice education programmes facilitate theory to practice knowledge transfer.
4. To identify any enablers and inhibitors to the integration of learning to practice.
5. To explore Trust Educational Leads views of the performance of staff attending advanced practice programmes.
6. To examine similarities and differences between different postgraduate advanced practice educational programmes

Why have I been chosen? You have been chosen because you are a trust partner who is involved with the selection of staff to undertake a postgraduate advanced practice programme and we want to find out your views about how the programme learning has been transferred by your staff into practice.

Who is involved in the project? The project is led by a university lecturer from Buckinghamshire New University who is undertaking a Professional Doctorate at King's College, London with an interest in the development of advanced practice programmes. Postgraduate advanced practice students in addition to trust partners will be involved in the project. Study findings will be used to inform future programme development.

Do I have to take part? No, the project is entirely voluntary. Whether you choose to take part or not will be your decision. If you decide to take part you will be given this information sheet to keep and will be asked to sign a consent form agreeing to take part. You do not have to give a reason if you decide not to take part.

What is involved? If you agree to take part you will be one of a 6-10 managers asked to attend a focus group within the trust in which you work. I will arrange to meet with you at a time and place of mutual convenience. The focus group will last approximately 30-60 minutes. The group will be asked some questions that I would like you to respond to. The focus group will be audio-ped subject to your permission to allow all of your responses to be captured accurately.

What happens to the information: Every effort will be made to ensure that information provided from the focus group discussions will be kept confidential, however, it is not possible to guarantee that these discussions will be kept strictly confidential. No one will be able to identify you from the project. The audio-recordings will be coded and downloaded onto a password protected computer. The data will be accessible to the researcher and the research supervisors who will be able to view the transcripts. Recordings will be erased once downloaded onto the computer. Transcripts will be transcribed by a third party audio typist who currently works for other researchers within the faculty and complies with the Data Protection Act 1988, deleting all files once sent onto the researcher. Transcripts will be kept until after the thesis is completed and thereafter destroyed. The researcher will ensure that views are not misrepresented by allowing access to the transcripts for verification if requested. If however bad practice is disclosed or revealed a formal procedure will be followed.

Contact for further information: If you would like any additional information about the project please contact Lesley Bridges on 01494 522141, Extension 5730 or Lesley.bridges@bucks.ac.uk.

What if I wish to complain? If this project has harmed you in any way you can contact King's College London for further advice and information. Please contact my supervisor Dr. Julia Roberts 020 7848 3017: or julia.roberts@kcl.ac.uk.

What will happen to the results of the project? The results will be collated and presented as part of my Thesis. Some data will be used in publications and conference presentations also. The intention is to improve advanced practice policy and curriculum development for future students and trusts. A copy of the final report can be sent to you if you would like it.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason. It will not however be possible to withdraw participants' data from the focus groups discussions as the meaning/content of the discussion may be lost.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Please contact Lesley Bridges contact details above to discuss future arrangements for the interview.

Thank you for taking the time to read this information sheet

APPENDIX VII: Trust Participants Consent Form

CONSENT FORM FOR TRUST PARTNER PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.



Title of Project: The impact of postgraduate advanced practice education for students and stakeholders:

An evaluative project.

King's College Research Ethics Committee Ref: _____ PNM/11/12-72 _____

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Advanced

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason up to July 2014. However, due to the interdependent nature of focus groups it will not be possible to remove your ideas and views expressed in the discussion of the study. ☐
- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998. ☐
- I understand that the information you have provided will be published within a report and I will be sent a copy. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications. ☐
- I agree that the research team may use my data for future research and understand that any such use of identifiable data would be reviewed and advanced practice approved by a research ethics committee. (In such cases, as with this project, data would not be identifiable in any report). ☐
- I consent to my interview being digitally recorded and transcribed. ☐
- I understand that discussions in the focus groups are confidential and this must be maintained by all participants ☐

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the project. I have read both the notes written above and the Information Sheet about the project, and understand what the research project involves.

Signed

Date

APPENDIX VIII: R&D Letters of Access

Lesley Bridges

20 March 2012

Dear Lesley

PNM/11/12-72 The impact of postgraduate advanced practice education on students and stakeholders: An evaluation study.

Review Outcome: Full APproval

Thank you for sending in the amendments/clarifications requested to the above project. I am pleased to inform you that these meet the requirements of the PNM RESC and therefore that full Approval is now granted with the following provisos:

1. Section 5.3: Submit a draft of the email you will send to students who have not been selected for the study to the Research Ethics Office for record.
2. Consent Form for students: State that participants can withdraw their data up to July 2014.
3. Consent Form for Trust Partners:
 - I. Please provide a Consent Form for the Trust Partners.
 - II. Add a bullet point and tick box stating that participants can withdraw from the study at any time, but due to the interdependent nature of focus groups it will not be possible to remove their ideas and views expressed in the discussion from the study.
 - III. Add a bullet point and tick box stating that discussions in the focus groups are confidential and this must be maintained by participants.
4. Information Sheet for Students: This states that two programmes will be compared and contrasted, rather than three, please amend.
5. Information Sheet for Trust Partners: State that whilst every effort has been made to ensure the confidentiality of the focus groups discussions, it is not possible to guarantee that these discussions will be kept strictly confidential.

Please ensure that you follow all relevant guidance as laid out in the Practice in Academic Research (<http://www.pnm.ac.uk/research-ethics/>)

Guidelines on Good
[/index.php?id=247](http://www.pnm.ac.uk/research-ethics/index.php?id=247)).

For your information ethical approval is granted until **14 February 2015**. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed).

You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

Ethical approval is required to cover the duration of the research study, up to the conclusion of the research. The conclusion of the research is defined as the final date or event detailed in the study description section of your approved application form (usually the end of data collection when all work with human participants will have been completed), not the completion of data analysis or publication of the results. For projects that only involve the further analysis of pre-existing data, approval must cover any period during which the researcher will be accessing or evaluating individual sensitive and/or un-anonymised records. Note that after the point at which ethical approval for your study is no longer required due to the study being complete (as per the above definitions), you will still need to ensure all research data/records management and storage procedures agreed to as part of your application are adhered to and carried out accordingly.

If you do not start the project within three months of this letter please contact the Research Ethics Office.

Should you wish to make a modification to the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications:

<http://research/support/ethics/applications/modifications.aspx>

The circumstances where modification requests are required include the addition/removal of participant groups, additions/removal/changes to research methods, asking for additional data from participants, extensions to the ethical approval period. Any proposed modifications should only be carried out once full approval for the modification request has been granted.

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chair of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (</support/ethics/contact.aspx>). We wish you every success with this work.

With best wishes

Yours sincerely

Senior Research Ethics Officer

Department Manager Advanced Practice

Monday, 18 June 2012

NHS PERMISSION FOR RESEARCH

NHS Permission for your research study has been granted by the NHS Research & G Consortium Office on behalf of the NHS Research & G Consortium Trusts. The Investigator named in this letter has permission to undertake the following research in the NHS Trust(s) and Research Site(s) identified below:

Original Date NHS Permission Issued: 18/06/2012

Updated Date NHS Permission Issued: N/A

Research Reference Numbers:	IRAS Code:	96940	
	Consortium Ref.:		
	Academic REC Ref:	PNM/11/12-72	
Project Title:	The impact of postgraduate advanced practice education for students and stakeholders: An evaluation project		
Date NHS Permission for Research Ends:	01/08/2015		
Chief Investigator/ PhD Student:	Mrs Lesley Bridges		
Chief Investigator Employer:			
Academic Supervisor:			
Sponsor:			
Funder & Funding amount:	No funding		

NHS Trust Registered:	Local Collaborator:	Date NHS Permission Issued for Site:	Date Research Ends at Site:
		18/06/2012	31/12/2014
Trust Directorate/Service:	All divisions		

HR Agreement:	Issued:	YES
	Total Letters of Access (LoA) for non-NHS Staff Issued:	01

Issued to:	HR Agreement:	Local Research Manager:	NHS Trust:	Date Issued:	Date Expires:
Mrs Lesley Bridges	Non-NHS LoA			18/06/2012	31/12/2014

Researcher(s) must abide by the governance arrangements specified by their NHS Local Research Manager and described in their LoA/HRC

Conditions of NHS Permission

NHS Permission is given provided that you comply with the conditions described in the attached document: **Standards Conditions of NHS Permission for Research**. You are advised to read

the conditions carefully as failure to comply with these conditions may invalidate your NHS Permission granted by the RM&G Consortium.

Research Investigators are required to share the learning from research and provide the RM&G Consortium with:

- The literature review from the research protocol.
- Interim findings from the research, when available.
- A final report or summary of the research, highlighting where appropriate any findings specific to RM&G Consortium Trusts.

Please email this information directly to the RM&G Consortium Office using the following address: consortium@rmg-trusts.nhs.uk

If you require any further assistance, please contact the RM&G Consortium Office stating your Consortium Ref: 0.96940.

We wish you success on completing your research.

Yours Sincerely,

RM&G Operational Manager (Consortium)
RM&G Consortium

Documents Enclosed:

1. NHS Permission Letter 06.2012
2. RM&G Consortium Standard Conditions of NHS Permission for Research
3. Non-NHS Letter of Access issued to Mrs Lesley Bridges 06.2012

Scanned Copy of Documents sent to:

Mrs Lesley Bridges - Chief Investigator/ PhD Student / Letter of Access Holder for
Local Collaborator & Local Research Manager
Sponsors Contact Point/ Academic Supervisor
Lead
Leads
PA

Mrs Lesley Bridges
Department Manager – Advanced Practice

Ref: R02021-Ltr 24a-Bridges

Dear Mrs Bridges,

PIN: R02021 (Please quote this number in all future correspondence)
Research Study: The impact of postgraduate advanced practice education for students and stakeholders: an evaluative project.

Further to the above study being registered with:
Trust, I can confirm that the study documentation received and listed in the table below, has now been reviewed and ethical approval is not required in accordance with the new GAfREC guidelines.

We acknowledge that the Sponsor for this study. as accepted the role of Research Governance

I am pleased to confirm that the Trust Director of Research & Innovation has given approval for the project to be undertaken.

The Trust aims for its research projects to recruit their first participant within 30 days of the recruitment start date. If you do not tell us your actual recruitment start date, we will use this approval date. This information is important for monitoring Trust recruitment performance for internal and external assessment. I would like to take this opportunity to wish you well with your research.

Yours sincerely

Research Operations Manager

Date: 16 May 2012

SMH.

Notification Form (PMKMR)

Trust Authorisation Sheet

Title of Research Project: The impact of postgraduate advanced practice education for students and stakeholders: An evaluative project.

Principal Investigator: Lesley Bridges (local liaison)

To be signed by the Clinical Director:

I am satisfied that this Directorate has the

- necessary local research environment, i.e. facilities and resources, to host the research
- that the researcher(s), specifically the local researchers, have the necessary expertise to conduct the research, and
- that the research is appropriate to the local population

Signed:

Print Name:

Date: 12.04.12

To be signed by the Research and Innovation Accountant (as part of approval process):
I have checked the financial details of this proposed research project. I am satisfied that the research costs detailed are appropriate and that the costs have been properly identified in accordance with Trust and NHS guidelines. I am satisfied there will be no unmet costs to the Trust, and any service support costs and/or excess treatment costs have been agreed (97/32).

Signed:

Print Name:

Date: 11/5/12

To be signed by the Divisional Director of Research and Innovation

Signed:

Print Name:

Date: 15/5/2012

*Research Ops.
Manager*

Ms Lesley Bridges

Dear Ms Bridges,

Re Research Project The impact of postgraduate advanced practice education for students and stakeholders: An evaluative project.

Thank you for your letter with details of the above project you are requesting to carry out at the

I have looked at the protocol and discussed the implications with others whose services the project may have an impact upon and am happy to give the project approval to be carried out at the Hospital subject to a favourable ethical opinion. This approval includes the site specific assessment.

Your project details will be passed onto [redacted] who will log them on our database and, if appropriate, include our participation in the study in any returns requested by the department of Health or one of its agents.

I would like to take this opportunity to remind you [redacted] ages all research in accordance with the requirements of the Research Governance Framework. As a researcher working in the Trust you must comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver Research Governance.

If the R&D Office can be of any further assistance please do not hesitate to contact myself on the above telephone number.

Yours faithfully,

[redacted]
R&D Director

Copy: Research &



13 December 2012

Lesley Bridges

Dear Lesley

Letter of access for research

This letter confirms your right of access to conduct research through [redacted] the purpose and on the terms and conditions set out below. This right of access commences on 07 January 2013 and ends on 31 July 2014 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor
You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] you will remain accountable to you. [redacted] but you are required to follow the reasonable instructions [redacted] NHS organisation or those given on her behalf in relation to the terms of this right of access.

claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust Occupational Health Department before commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

We will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

19/12/2012

Mrs Lesley Bridges
Department Manager Advanced Practi

Dear Mrs Bridges,

RE: JRCO Study Approval

Project Title: The impact of postgraduate advanced practice education for students and stakeholders. An evaluative project.

Short Title: The impact of postgraduate advanced practice education for students and stakeholders: An evaluative project.

Joint Research Compliance Office Reference number: JRCOSM0412

CSP Reference number: N/A

Ethics reference number: N/A

Principal Investigator: Mrs Lesley Bridges

I confirm that this project has now been approved by the Joint Research Compliance Office. The project may now start. Please note that the start date of the project is the date of this letter and the duration is the same as that provided in your application form.

The list of documents reviewed and approved by the Joint Research Compliance Office under requirements of the Research Governance Framework are as follows:

Document	Version	Date
NHS NRES (IRAS) R&D Application Form, version 3.4	96940/310822/14/800	
NHS NRES Site Specific Information (SSI) (IRAS) Form, version 3.4	96940/310708/6/761/138653/240227	02 nd April 2012
Response to further information request from Research Ethics Committee (University REC)	Full approval	20 th March 2012
Poster Advert "we are doing this research" and participant		

invitation leaflet		
Interview Question Guide		
Client Information Letter and Indemnity and Insurance certificate from Royal & Sun Alliance.		02 nd August 2011
Research Study Protocol		
Principal Investigators CV: Lesley Bridges		03 rd April 2012

Before you commence your research, please note that you must be aware of your obligations to comply with the minimum requirements for compliance with the Research Governance indicators 17 (Data Protection); 25 (Health and Safety) and 22 (Financial Probity). Details of the requirements to be met can be found in the Research Governance Framework available on www.dh.gov.uk.

Under the Research Governance regulations, Serious Adverse Event Reports, Adverse Reactions and amendments to the protocol or other supporting documents must be forwarded to the Joint Research Compliance Office and Ethics Committee.

In accordance with the Research Governance Framework, research projects carried out in the Trust will be randomly chosen by the Joint Research Compliance Office for auditing. Please see the attached checklist for documentation that will be required during the audit.

I wish you well in your research.

Yours sincerely

(authorised to sign on behalf of)

Research Governance Manager

13 December 2012

Lesley Bridges

Dear Lesley

Letter of access for research

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You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research, Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor.
You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through the NHS organisation you will remain accountable to your NHS organisation and you are required to follow the reasonable instructions or those given on her behalf in relation to the terms of this right of access.



claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while [redacted]. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust Occupational Health Department [redacted] to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

[redacted] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Lesley Bridge

03 April 2012

Dear: Lesley,

RE: R & D NOTIFICATION AND APPROVAL FOR: Ref: REC: PNM/11/12-72

Study Title: The Impact of Postgraduate advanced practice education on students and stakeholders: An evaluation study

I am pleased to inform you that I have given my approval for the above study to be carried out in the subject to the following conditions.

- The study must adhere to the requirements of the Department of Health's Research Governance Framework for Health and Social Care (2005).
- There will be no call upon resources other than those identified and agreed.

We would wish to receive a summary of your overall findings and will ask you to provide a brief progress report in December 2013.

If in the course of this study, you encounter any unexpected adverse event such as a health and safety problem, this should be reported according to Trust policy.

I would be grateful if you could keep Assistant Director of R&D, notified of your progress with this study. Please address any correspondence to the Risk and Governance department located in the telephone number.

Your study will be entered onto the National Research Register.

We wish you well with your study.

With kind regards

Assistant Director of R&D

Mrs L Bridges

Dear Mrs Bridges

Re: Letter of Access for Research

Project Title: The impact of postgraduate advanced practice education for students and stakeholders

This letter confirms your right of access to conduct research through the purpose and on the terms and conditions set out below. This right of access commences on the day of your focus group and ends on the day of the focus group (date to be arranged).

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Local Collaborator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through, you will remain accountable to your employer but you are required to follow the reasonable instructions NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

Cont/d...

13 December 2012

Lesley Bridges

Dear Lesley

Letter of access for research

This letter confirms your right of access to conduct research through [redacted] on the terms and conditions set out below. This right of access commences on 07 January 2013 and ends on 31 July 2014 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research [redacted] Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor [redacted] You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] I will remain accountable to you [redacted] required to follow the reasonable instructions [redacted] NHS organisation or those given on her behalf in relation to the terms of this right of access.

claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the policies, procedures, and the Research Governance Framework, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while in the Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust Occupational Health Department prior to commencing your research role at the Trust.

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We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

We will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Ms Leslie Bridges
Advanced Healthcare

Dear Lesley

Confirmation of Ethical approval: April 2012

I am writing to confirm that Ethical approval was granted by the Faculty of Society and Health Ethics Committee of meeting held on the 13th April 2012 for your project titled:

"The impact of postgraduate advanced practice education for students and stakeholders: an evaluation project."

Yours sincerely,

Dr
Secretary to the University Ethics Panel
Research Unit
Academic Quality Directorate

