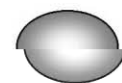
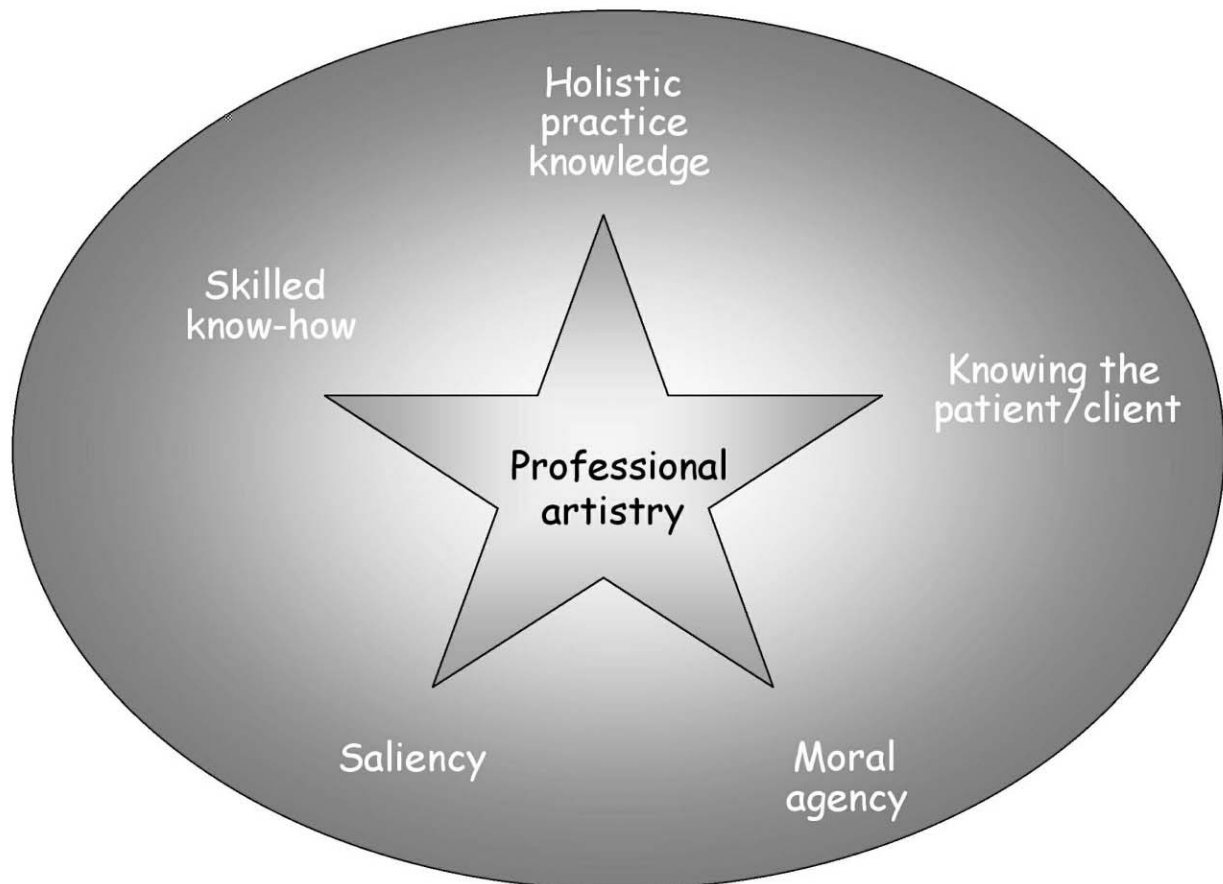


Changing patients' worlds through nursing practice expertise

Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation.

**A Royal College of Nursing
Research Report, 1998 - 2004**

A conceptual framework for nursing expertise in the UK



Enabling factors

- Reflective ability (reflexivity)
- Organisation of practice
- Autonomy and authority
- Interpersonal relationships
- Recognition from others

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Changing patients' worlds through nursing practice expertise: Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation

A Royal College of Nursing Research Report, 1998 - 2004

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Executive summary

The RCN Expertise in Practice Project

The project

The Royal College of Nursing (RCN) knows the importance of investing in exploring nursing practice expertise, across the UK and in all clinical specialisms.

The RCN accepted this challenge through supporting a team of researchers, drawn from the RCN Institute's practice development team, to undertake an ambitious research project: to test empirically a conceptual framework for expertise which arose from Manley and McCormack's (1997) Master's module, *Exploring Expert Practice* (NUM65U).

The Expertise in Practice Project began in May 1998 and continued into 2004 – a major undertaking. The project makes a significant contribution to contemporary understanding of what constitutes expertise in the practice of nursing. It provides insight into what occurs between expert practitioners and their service users.

Significance

The Expertise in Practice project predated governmental directives that high quality care should be centred on the patient (DH, 1999a, 2000). Its findings support all practising nurses as they implement *Agenda for Change* (DH, 1999a) by offering a practical framework for identifying practice expertise, and in pioneering a recognition process for the accreditation of practice expertise through peer review and self regulation. The report findings offer a theoretical framework to facilitate and enable practising nurses to work towards achieving person-centred, evidence-based and effective practice expertise – for example, through the use of critical companionship (Titchen, 2001a:2003) – a helping relationship. It also provides a framework which individuals and teams of health care providers can use to consider how their contribution, even with a single patient, can make a world of difference.

The process

Preparation for the project began in 1998 and involved working with UK-based practitioners, helping them, through the processes of clinical supervision and structured reflection, to explore the attributes of expertise in relation to their practice. This preparatory work showed that expert nurses needed facilitation to help them both articulate their expertise as well as develop evidence and a language to describe it. These findings influenced both the selection process for the main project and the project's processes. It is the project rather than the preparatory period that is the focus of this report.

During the project, the research team worked alongside six geographically based cohorts of nurse participants and their critical companions to investigate nursing practice expertise. Attributes and enabling factors of nursing expertise as derived from the literature (Manley & McCormack, 1997; Titchen, 1996) provided the selection criteria for participants in the project.

Each cohort met monthly throughout the project's formal phase and gathered evidence of practice expertise through action learning, observation of practice, qualitative 360 degree feedback and reflection in and on practice (Schon, 1983). This evidence was then amalgamated into a portfolio of evidence. A specified review panel (comprising a nominated clinical specialist, a non-clinical specialist reviewer and two members of the RCN Institute team) then reviewed the portfolio as an end point to the formal project phase. This critical review process provided the foundation both for developing practice standards for expertise and a formal professional accreditation process.

The findings

Guidance for achieving best practice

Gathering evidence of practice expertise in the workplace included considering the working relationships encountered in daily practice (e.g. between the nurse participant and their critical companion, the nurse participant and a nominated role set of colleagues and fellow professionals, plus inclusion of the perspectives of service users). The complexity of such an inclusive approach to data collection produced a number of protocols and guidelines, derived through stakeholder participation, to guide practitioners

through the ethical, practical and emotional quagmire of doing such work in practice. As a result, what has emerged from the project is a rich source of educational and practice-based material. This material can be used as part of programmes of learning and development that focus on achieving best practice, enhanced by greater insight into the methodological and ethical implications. These issues are outlined in this report, but further theoretical development is ongoing and will be disseminated in forthcoming publications.

The importance of the nursing voice

Personal integrity as part of individual nurses' professional values, and expressed through their professional relationships, was paramount in revealing key attributes of clinical expertise. The project also showed how nursing discourse has remained rooted in dominant theoretical frames that have potentially hindered the development and progression of a distinct nursing 'voice' – a voice that is able to express coherently the complexity of clinical nursing expertise. Through identifying and testing the attributes and enabling factors of practice expertise, the Expertise in Practice Project has uncovered a language that nurses can use to capture and articulate their clinical impact.

The power of expert practice

The project enabled participants to work as practitioner-researchers, and the evidence they captured gave great insight into the impact of nursing practice expertise on patients, work colleagues and organisations. Expertise has influence that spreads as far as implementing and instigating change at an organisational level, such as service developments. Also revealed are the 'unseen' implications of how expertise helps to prevent untoward incidents: for example, sharing specialist knowledge through education and training programmes; reducing risk of accidents and clinical incidents through keen observation of less confident staff and; identification of key expert practitioners to defuse potential disruptions or violent outbursts from anxious or angry patients. Expert practitioners should be recognised for the significant contribution they make to a health service that meets patients' needs.

Recognition

The project has shown that a national recognition process for nursing expertise has an important role in achieving the current government vision for a modern and effective health service. Policy makers must consider how they can make explicit the need to value, develop and recognise expertise in the workplace, as well as endorsing all those systems that currently strive to achieve this.

Acknowledgement

The Expertise in Practice Project research team acknowledge all those who contributed to the project as practitioner-researchers, critical companions, critical reviewers, expert reviewers, action learning set facilitators and also those involved in the preparatory phase of the project (a full list of participants appears in the Appendix). Your willingness to share experiences, offer your time, work and effort, as well as sharing personal values and beliefs, has been a privilege and pleasure to experience. Without the critical dialogue, critical thinking and attention to process detail the project would not have lived its values of participation and emancipation.

*RCN Expertise in Practice Project Research Team,
January, 2005*

For **further information** please contact:

Jo Odetola, RCN Institute Practice Development Team
20 Cavendish Square, London, W1G 0RN

Tel: + 44 (0) 20 7647 3673

www.rcn.org.uk/resources/practicedevelopment

1. The context for developing practice expertise

1.1 This report

This research publication reports on the RCN's Expertise in Practice Project (EPP). It presents the background, experiences and findings of an innovative six-year project that explores the nature of nursing practice expertise throughout the United Kingdom (UK). The project also set out to develop a pilot process for recognising, through professional accreditation, expertise in UK nursing practice. The project was made possible by funding from the Research Assessment Exercise and through use of core, funded staff from the RCN Institute's Practice Development Team.

The project design was informed by research approaches suited to practice-based research, co-operative inquiry and practice change; specifically, emancipatory action research (Grundy 1982) and fourth generation evaluation (Guba & Lincoln 1989). These approaches not only foster collaborative and participatory inquiry, but also enable stakeholder involvement, and the development of high levels of reflection, with action in the workplace as a central focus.

1.2 Project background and context

At the inception of the Expertise in Practice Project, there were a growing number of specialist practitioner movements (e.g. UKCC, 1996; 1997; 1999). Today, this context remains extremely relevant to the project's focus, as there is a need to:

- ♦ emphasise how nursing expertise is relevant to providing high quality care for patients/service users
- ♦ understand expertise in relation to career progression, competency development and sustainability across healthcare contexts

- ♦ develop mechanisms for accrediting nursing practice expertise
- ♦ develop expertise within the context of lifelong learning and work-based learning.

1.2.1 The project's origins

The original impetus for the EPP were three sources of related RCN activity during 1996-7:

- ♦ RCN Academic Board deliberations concerning the nature and value of a RCN Professional Award
- ♦ emerging concepts of advanced practice linked to consultant nurse research (Manley 1997)
- ♦ conceptual understandings of expertise arising from an RCN Master's module developed in 1996, *Exploring Expertise in Practice* (Manley & McCormack, 1997)

In July 1998, Project Lead, Kim Manley, developed a proposal to take this work forward, integrating it with research exploring the nature of expertise in UK nursing and its outcomes, and developing a professional accreditation process for nursing practice expertise.

1.2.2 Project purpose

The purpose of the project was four-fold, to:

1. recognise and value expertise in nursing practice
2. develop a recognition process for expertise in practice
3. develop further understanding of the concept of expertise within UK nursing and its different specialisms
4. explore the links between expertise and outcomes for service users and health care providers.

1.2.3 The research questions

Three research questions linked to these objectives guided the project. Two are 'how' questions – as would be expected of an action research design, with its focus on 'action'. The other is concerned with developing a greater understanding of the concept of expertise:

- ◆ How do we develop a recognition process for expertise? (Purposes 1 and 2)
- ◆ What is the nature of expertise in UK nursing and its different specialisms? (Purpose 3)
- ◆ How do we go about demonstrating impact of expertise? (Purpose 4)

As the project progressed, a number of linked evaluation and developmental questions emerged in relation to the outcomes which arose from these action research questions. These are outlined in Box 1. The second research approach, fourth generation evaluation, influenced questions about stakeholders within the evaluation process (also shown in Box 1). Stakeholders are defined as those who have a stake in the project, its purpose and processes.

Box 1: Project's research questions and associated evaluation and developmental questions

- ◆ How do we develop a recognition process for expertise?
 - ◆ Evaluation questions:
 - ◆ Who are the stakeholders?
 - ◆ What are stakeholders' concerns, claims and issues about the pilot recognition process?
 - ◆ How useful is the pilot recognition process for helping stakeholders identify expertise in project participants' practice?
 - ◆ How useful is the pilot recognition process for enabling practitioners to develop evidence of expertise in their practice?
 - ◆ What has been the experience of stakeholders participating in the pilot recognition process?
 - ◆ What resources are necessary for the pilot recognition process to take place?
 - ◆ What processes and resources are necessary for corroboration and verification of the practitioner's evidence of expertise?
 - ◆ Developmental questions:
 - ◆ What constitutes the evidence for demonstrating expertise?
 - ◆ What are the tools for collecting evidence of expertise?
- ◆ What is the nature of expertise in UK nursing and its different specialisms?
 - ◆ Evaluation questions:
 - ◆ How does the evidence resulting from the pilot recognition process achieve further understanding of the concept of expertise in UK nursing and its specialisms?
 - ◆ Developmental questions:
- ◆ How do we go about demonstrating the impact of expertise?
 - ◆ Evaluation questions:
 - ◆ How useful is the evidence generated through the pilot recognition process for indicating the outcomes of expert nursing care?
 - ◆ Developmental questions:
 - ◆ What are the contextual factors that influence the development of expertise in practice?

1.2.4 The products

The project therefore expected to produce the following products:

- ◆ A recognition process for the professional accreditation of expertise in practice
- ◆ A refined concept analysis of expertise and its enabling factors relevant to UK nursing and its specialisms
- ◆ Identified strategies for helping practitioners develop their expertise
- ◆ Identified tools and methods for helping practitioners gather evidence of their expertise
- ◆ Tentative outcomes in relation to the impact of expertise

1.2.5 Project overview

The Project had three phases:

1. Project preparation (September 1998 – December 1998)
2. The project (January 1999- June 2002)
3. Project review, write up and dissemination (2002-2004).

During the preparation phase of the project, practitioners from a diverse range of practice specialisms nominated for their expertise by RCN practice forums were helped to work with the attributes of expertise arising from the concept analysis (Manley & McCormack 1997). The practitioners were supported using the processes of clinical supervision and structured reflection through a number of workshops. The preparation phase informed the project in three ways. It:

- ◆ identified that practitioners required skilled facilitation to help them both develop their expertise and their evidence from practice to demonstrate it
- ◆ identified the need to develop multiple sources of evidence that could be triangulated to demonstrate expertise
- ◆ began to develop language that practitioners could use to begin to describe their expertise.

The project itself – the focus of this report – achieved the project aims and developed and piloted a recognition process with input from an accreditation panel of academics and practitioners (see Appendix) who were used to inform the project's development in its early stages.

The recognition process which was developed through the EPP to enable professional accreditation of practice, includes:

- ◆ access to preliminary information
- ◆ an application and registration process against specific criteria
- ◆ access to a skilled facilitator or critical companion
- ◆ an approach to developing and collecting multiple sources of evidence from clinical practice
- ◆ a peer review process involving expert practitioners from the same disciplines as well as a practitioner from a different specialism
- ◆ a system for maintaining standards and parity across all areas/specialisms of practice in a consistent and fair way
- ◆ systems of appeal and quality assurance in terms of processes and structures needed.

The review phase has included individual and collaborative publications, conference papers, symposiums and workshops, a celebration event and formal presentation to nurse participants at the RCN Congress (2002), plus the completion of this final project report. A continuing dissemination strategy includes further publications concerning theoretical understanding of expertise, methodological issues, educational implications, and also a practical guide for practitioners to help them develop and demonstrate their expertise.

The recognition process and review phase are not described in this report.

1.2.6 The project's accountability

A steering group followed by a research advisory group were established in 1998 and 1999 respectively and included external nurse researchers of high standing in the profession (see Appendix).

The purpose of the advisory group included providing research support to the RCN's Faculty of Emergency

Nursing Pilot Phase I. This project was linked to the work of the EPP through its purpose of developing an integrated career and competency framework for emergency nurses, and its use of Guba & Lincoln's fourth generation evaluation approach (1989). Therefore the advisory group could link the development of both projects. After one year the steering group and research advisory group amalgamated to become the Research and Evaluation Advisory Group, chaired by Brendan McCormack.

2. Understanding practice expertise: the literature

Members of the EPP research team searched and reviewed the professional published literature, covering the period between 1996-2004. Different elements were searched at various stages of the project development: the 'expert' literature was largely covered before the project started as part of the concept analysis of expertise, whilst the 'caring' literature was reviewed at a later stage following discussion and debate from the Research Advisory Group about its potential significance. Work continued throughout the project, to ensure the literature covered was up to date.

Manley and McCormack (1997) had previously analysed the literature on practice expertise to undertake a concept analysis of expertise (Manley & McCormack, 1997). This identified the:

- ♦ **five attributes of expertise:** holistic practice knowledge, knowing the patient, saliency, moral agency, skilled know-how
- ♦ **enabling factors** for developing expertise: reflective ability, organisation of practice, interpersonal relationships, autonomy and authority, recognition by others.

Aspects of **intuition, caring and empathy** were also reviewed to identify and capture aspects of practice expertise.

The literature about expertise is extensive and complex, and within the confines of this short report can not be coherently and critically presented here as a summary. Instead, a critical review of the literature related to expertise is the focus of a forthcoming publication.

3. Research approach and methodology

3.1 Research approach

Emancipatory action research (Grundy 1982) and fourth generation evaluation (Guba & Lincoln 1989) provided the project's philosophical framework. Emancipatory action research (EAR) (Grundy 1982) was selected because of its focus on collaborative inquiry and its integration of practice and practitioner development with refinement of theory through evaluation (Manley 2001). Fourth generation evaluation was chosen because of its focus on stakeholders, process, context and its empowering principles, consistent with EAR (Guba & Lincoln 1989).

3.1.1 Emancipatory action research (EAR)

Action research has three purposes: to develop practice, to develop practitioners and to develop and refine theory (Manley and McCormack, 2003). It integrates evaluation. In this study, the theory being generated and refined relates to the concept of expertise and the processes necessary to both develop and recognise expertise. The study will enable the evidence already in the public domain to be further tested and refined.

In this investigation, EAR specifically focused on the:

- ♦ barriers experienced and the strategies required to dismantle these barriers in developing practice
- ♦ critique – a concept linked with a school of thought known as *critical social science* – a theoretical underpinning that is intended to bring about:
 - ♦ enlightenment: developing self knowledge about how we act and why
 - ♦ empowerment: developing approaches and strategies to bring about better ways of behaving and working

- ♦ emancipation: enabling people to put these strategies into practice.

Action research findings were therefore implemented, following reflection and critique, as part of a series of continuous spirals of planning, acting, observing, and reflection (Grundy, 1982). All participants were able to help shape the project's development, engaging with the research team and negotiating how they wished to capture data, and gathering and analysing data as these emerged.

Participants in EAR are termed 'co-researchers', because they participate in and contribute to the study in some way. This differs from traditional research approaches where the researcher is considered an objective expert, gathering information from the research subject. Being a co-researcher encourages people to become involved and integral to all aspects of the research process. Any aspect of the research project provides an opportunity for joint reflection and reciprocal learning between all those involved. In the context of this study, co-researchers were partners who shared knowledge and power, so their views and perspectives were accorded equal status to others. The study's groups of co-researchers were:

- ♦ nurse participants, researching and investigating their own expertise as practitioner researchers
- ♦ critical companions, helping the nurse participants develop and understand their evidence
- ♦ users who provided feedback to the nurse participants. The term 'user' covers a broad range of people including patients, their preferred family and friends, individuals and communities who had contact with the nurse participants
- ♦ the accreditation panel, who contributed their expertise of accreditation processes to the recognition process
- ♦ other stakeholders, namely those who had a stake in the project or touched the project in some way
- ♦ the research team (Box 2)

Box 2: The research team's role as action researchers

The research team enabled the co-researchers to work, synergistically, within a set of explicit, shared values. These values included:

- ◆ making thoughts, decisions and actions transparent
- ◆ actively promoting ethical principles and moral agency
- ◆ promoting the use of negotiation as an integral process in all aspects of the project
- ◆ valuing the integration of all kinds of knowledge and experiences
- ◆ focusing on development of growth for all

Essentially, the research team were the action researchers in this project. They:

- ◆ helped nurse participants and critical companions to become practitioner-researchers (these co-researchers were not action researchers in the sense that they were setting out to change or improve their practices – even though this often occurred in practice). The research team enabled co-researchers to develop:
 - ◆ empirical and collaborative research skills
 - ◆ capacity to critique and engage in critical debate about their practice
 - ◆ a portfolio of evidence, accruing from the nurse participants and critical companions' empirical research and critique, for professional accreditation. This facilitation occurred through action learning (see 5.1) and critical review of draft portfolios
- ◆ developed, tested, refined and implemented an accreditation process for professional recognition.

The nurse participants and critical companions worked as co-researchers by engaging in critical debate about practice and by making their portfolios available to the research team to help generate themes about the nature of expertise.

The accreditation panel and other stakeholders, such as critical review groups for nurse participants' portfolios, were co-researchers with the research team, helping to develop, test, implement and evaluate the recognition process. They were co-researchers with the nurse participants by engaging in a critical dialogue about the participants' practice.

3.1.2 Fourth generation evaluation

Fourth Generation Evaluation (Guba & Lincoln 1989) is an evaluation approach which aims to empower different stakeholder groups and to share information between them. Stakeholders, those who have an interest in the project, cover those:

- ◆ producing, using and implementing the project
- ◆ who will benefit from the project
- ◆ who may be negatively affected by the project.

The concerns, claims and issues of stakeholders are central to this evaluation approach and this is why we used it to complement EAR.

'Concerns, claims and issues' is the name of the tool we used throughout the project with different co-researcher groups. 'Concerns' are unfavourable assertions identified about any aspect of the project; 'claims' are favourable assertions; 'issues' are framed as questions that any reasonable person would be asking about any aspect of the project.

The research team elicited concerns, claims, and issues and used them as the basis for continuing negotiation and refinement of ideas in action learning sets. This ongoing refinement and negotiation required a high level of commitment from co-researchers.

4. The nurse participants: selection and recruitment

The EPP research team's selection of nurse participants for this project drew on insights gained from the preparatory phase and previous studies on nursing expertise (e.g. Benner 1994; McLeod, 1994; Conway, 1996; Titchen, 1996).

We found participants in a number of ways:

- a) participants who had contributed to the preparatory phase
- b) members of specialist RCN forums who were nominated by their forums to become involved with the project
- c) self-selection
- d) recognition of a participant's expertise by colleagues.

We worked with the RCN practice forums across the four UK countries to access potential participants from a wide variety of nursing clinical specialisms. All potential participants were required to complete an application pack and recruitment process.

The recruitment process required participants to:

- ◆ complete a written self assessment against the attributes of expertise derived from the concept analysis (Manley & McCormack, 1997), and to outline their own rationale for consideration as a potential 'expert'
- ◆ identify and secure a critical companion to work with for the project's duration
- ◆ secure managerial support through a signed statement of support
- ◆ obtain two references in relation to the attributes of expertise, one from a registered nurse colleague and another from a colleague in a different health profession.

Of 61 potential applicants, 29 withdrew at this early stage of the project. The remaining 32 participants were invited to join the project. There were also 32 identified critical companions who worked with each of the nurse participants.

These dyads (groups of two) were divided into six geographically-based action learning sets across the four countries of the UK. During the life of the project, ten nurse participants withdrew for a variety of personal and professional reasons. Twenty-two dyads completed the project.

The gender distribution amongst the participants reflects that of nursing in the UK as a whole, 3 men and 19. The majority of the group are married (17/22), 9 have children. Nineteen participants describe themselves as 'White', 3 describe themselves as 'Irish' (two of whom live in Northern Ireland). None of the other participants involved in the project belong to any other ethnic category. Just over half the participants (12/22) are aged between 41 and 50, Eight are aged between 31 and 40, one participant is aged over 50 and one under 30.

Eighteen of the participants are qualified as general nurses, one of these had originally qualified as an enrolled nurse. Three of the remaining participants are RMN's, the other is an RSCN. Four of the general nurse participants have an additional registration; one is a midwife, one a children's nurse and two have district qualifications. Second qualifications were achieved within 2 or 3 years of initial registration in all but one case.

Participants have been qualified for an average of 19 years, the range being between five and 39 years.

The majority of this group are graduates (13/22), 12 of these having done nursing or health studies degrees, the remaining degree being in social sciences. Seven of the participants had completed a master's programme, four in nursing, two in counselling and one in health psychology. One participant is registered for a doctorate. One participant has not done any education at diploma or degree level but has undertaken a wide range of clinical (ENB) courses.

Of these 22 participants eight work in acute hospital settings, two in primary care settings, nine work in a variety of specialist roles that involve both working in hospitals and community settings, one works in occupational health and two work in mental health centres.

5. Processes (methods) for helping nurse-participants as practitioner-researchers to understand and develop evidence of their expertise

Two processes were used in the project's pilot recognition process to help nurse participants research their expertise as well as compile evidence of it: action learning (McGill and Beaty, 1992); and critical companionship (Titchen, 2001a). These enabling processes were used within the EAR framework, and in turn provided data-gathering opportunities using a number of methods (see Section 6). We chose these processes because they enabled the actions of stakeholders to remain central to the project.

5.1 Action learning

Action research is linked to action learning and structured reflection, which share the same processes of enlightenment, empowerment and emancipation (Fay 1987). They aim to help individuals and teams free themselves from oppressive structures, and the taken-for-granted assumptions in everyday practice.

An action learning set is a group of people who work together for a concentrated period of time in a continuous process of learning and reflection (McGill & Beaty, 1992). Originally the action learning sets were intended to help and support the critical companions, who in turn were helping the nurse participants.

Through insights developed from action research spirals, it became clear that the action learning sets needed to be for both nurse participants and their critical companions.

Action learning sets were facilitated by members of the research team (see appendix). Each set began with identifying concerns, claims and issues about how the project was progressing. These then guided the focus of the set in negotiation with participants, as greater understanding of the nurse participants and their critical companions' needs and self knowledge emerged.

For example, nurse participants would negotiate to present a piece of writing (narrative) about their practice, for their set to read and comment upon. This helped the presenter identify and make explicit the embedded practice expertise that the presenter might have overlooked or assumed to be a common experience that did not need further elaboration. All action set members were therefore actively engaged in critiquing and building on the exploration of evidence within these narratives. This group critique provided a joint internal review, in line with the process of action learning as a critical community (McTaggart, 1991). Through critique, nurse participants and critical companions were helped to look at, think about and evaluate their work, using both their own insights and the insights of others to learn about what they did well, and to develop ways of practising nursing and research differently.

Thirteen monthly action learning sets for each cohort were run during 2000-2001.

5.2 Critical companionship

Critical companionship is a metaphor for a person-centred, helping relationship. The critical companion helps others to develop expertise (in this study, in developing practitioner-researcher skills) by accompanying them on an experiential journey of learning and discovery. This relationship has parallel processes to skilled companionship, a patient-centred helping relationship between a practitioner and their patient/client (Titchen, 2001a,b; Titchen 2003; Wright & Titchen, 2003). Critical companions are partners who act as a resource on a journey of discovery – someone who can be trusted, a supporter who has a genuine interest in development and growth through providing high challenge and high support.

The critical companions, in this study, were selected by the nurse participants themselves and were a variety of nurse educators, practice developers, researchers and experienced clinicians.

Both critical companions and nurse participants were assisted in developing their critical companionship skills within action learning through using and experiencing key concepts from the critical companionship framework, such as:

- ◆ getting to know the person they were helping as a whole person, as well as, a colleague (particularity)
- ◆ developing reciprocal closeness, giving and receiving feedback, support or challenge in a mutually collaborative way (reciprocity)
- ◆ knowing what matters to the person and acting on this (saliency)
- ◆ using a variety of helping strategies (facilitation strategies).

6. Methods used by nurse-participants as practitioner-researchers to collect evidence of expertise for their portfolios

6.1 The methods (tools)

The EPP helped project participants use three broad practice development tools to gather evidence of their practice expertise for their portfolio of evidence. The tools nurse participants used (supported by their critical companions) were underpinned by the principle of stakeholder analysis (Guba & Lincoln, 1989):

- ◆ qualitative 360 degree feedback, including user narratives and staff interviews
- ◆ observation of practice
- ◆ reflection in and on practice (Schon, 1983).

The project obtained multi-centred research ethical committee clearance (MREC) and then local research ethical committee clearance (LREC) and research governance approval for the observation of each participant's practice and for the qualitative 360 degree feedback process which included interviewing users and staff. In this study, ethics related to the moral conduct and principles of the research team and all co-researchers. Our conduct and principles were influenced by Gilligan's (1982) ethics of care. Ethical considerations centred around human flourishing for all involved in the study, maintaining a person's privacy, not doing harm, dealing with sensitive issues and ensuring secure storage and maintenance of information and databases. Guidance offered in the *Code of Professional Conduct* (NMC, 2002) and the *Scope of Professional*

Practice (UKCC1992), *Guidelines for Professional Practice* (UKCC,1996) and *Research Ethics* (RCN, 2004) shaped our research practices.

All participants made considered decisions about how to use these practice development tools in the context of their own particular workplace.

6.1.1 Qualitative 360 degree feedback

360 degree feedback is based on the principle of ‘the systematic collection and feedback of performance data on an individual or group, derived from a number of the stakeholders in their performance’ (Ward 1997: p4). Qualitative 360 degree feedback was a tool developed with co-researchers to obtain qualitative feedback rather than numerical data from the nurse participant’s role set, which included colleagues and users. A specific research protocol was developed for involving users as co-researchers.

Approximately 40% (nine) of the 32 nurse participants were able to include at least one interview with a patient in the qualitative 360-degree feedback process. Not all participants, however, followed the project’s protocol for user narratives to the letter, but they were able to adapt the protocol as a framework to suit their particular clinical speciality and/or their patients’ individual situations.

Many of the nurses chose to centre their portfolios on case vignettes (i.e. the nurse’s account of the patient’s experience) rather than complete a user interview. They shared the writing process of these patient-orientated stories with their action learning sets and their critical companions, as a way of obtaining and extracting evidence of expertise.

6.1.2 Observation of practice

Observation of practice in the context of this study is a tool that enables evidence to be gathered directly about practice expertise, as well as providing a rich source of material for exploration and critique within action learning and critical companion relationships.

6.1.3 Reflection in and on practice

Formal and structured reflection in and on practice was a tool nurse participants and critical companions used individually, as well as within their action learning sets and critical companionships. Structured reflection aims to explore and elucidate tacit knowledge gathered through the person’s work experience that is difficult to articulate and explain (Schon 1983).

7. Methods used by the research team to gather evidence

In addition to the evidence gathered by the participants using methods outlined in Section 6, the EPP research team gathered further data through documenting action learning set notes, and the critical review panels constituting the pilot recognition process.

7.1 Action Learning

Each of six action learning sets across the UK were supported by one of two research associates (see appendix), who acted as participant observers, keeping field notes of each session which captured pertinent issues of discussion, action points, concerns, claims and issues raised by participants, and were a record of attendance. With the consent of co-researchers, each meeting was also audio-taped to provide an audit trail of each group's journey through the project and its complex methodology. Research associates wrote notes from the tape transcriptions and field notes, and sent them to all set members, clarifying and verifying the researchers' summary as well as keeping informed those who were unable to attend.

7.2 The critical review process

The research associates also acted as a participant observer documenting and recording the critical review process.

In this process, each nurse participant submitted their portfolio of evidence – a collation of their evidence of expertise – to a process of critique by peer review. The review panel consisted of:

- ♦ a nominated clinical expert in the nurse participants' specialist clinical field
- ♦ an external reviewer from a different specialism (nominated by the research team)
- ♦ two members of the research team (one to act as chair for the panel proceedings and one to observe, monitor and record)

- ♦ the critical companion and the nurse participant also participated in this panel process.

Terms of reference and guidelines for feedback were developed by the research team to help structure comments and to promote a critical discussion of aspects of expertise as exposed by the portfolios.

Twenty-two of the original 32 nurse participants (i.e. a 68% completion rate) submitted portfolios for review which were all received favourably by the critical review panels.

7.3 The data sets emerging for analysis by the research team

Several data sets were therefore available for a final, overall analysis by the research team:

- ♦ action learning set notes covering the nurse participants' and critical companions' journey in developing their expertise
- ♦ portfolios of evidence, produced as an end result of the nurse participant and critical companion's work in gathering evidence of practice expertise for submission to the review panel
- ♦ the critical review process and subsequent written reports on each participant's portfolio and critical dialogue with the panel.

8. Analysing and critiquing the evidence of expertise and the journey

This section describes how:

- ♦ evidence from the nurse-participants and critical companion's journey, captured from the action learning sets, was analysed
- ♦ evidence presented by the nurse participants was critiqued by the review panels
- ♦ the research team analysed the nurses' portfolio analyses, the critique that happened at the review meeting and the reviewers' report.

8.1 Analysis of the journey

The action learning set transcripts were analysed to capture the journey experienced by nurse participants and critical companions.

The written transcripts were initially used to identify themes, then NUDIST and INSPIRE (a pictorial computer program that produces mind maps) were used to validate these further. Each action learning set transcript was number coded and prepared for thematic analysis using NUDIST Version 4, a computer package that identifies and finds similar word patterning that can then be used as categories (nodes) to produce recurrent themes. The themes emerging were then constantly reframed and focused down through ongoing critical dialogue with co-researchers.

Three emerging themes described a journey of three phases, each associated with several categories not reported here:

- ♦ *Project processes* This theme dominated the first three months of each action learning set, when discussion centred on exploring the project methods and chosen processes, and each participant considered their own role in the project

- ♦ *Why are we here?* This phase centred on discussion of each individual participant's concerns, claims and issues, whilst also providing opportunity in the action learning sets for individuals to present material they were beginning to gather as part of the project for critique by the group
- ♦ *Participant change* This phase was associated with preparing evidence for portfolios and with nurse participants' personal journeys of support and challenge.

8.2 Analysis undertaken by the critical review panels of the nurse participants' evidence of expertise

The reviewers were asked to examine the portfolios submitted by the nurse participants against the attributes of expertise, as well as looking for evidence of:

- ♦ **quality:** whether the standard of material presented was of a consistently sufficient level
- ♦ **coverage:** whether the evidence provided represented adequate (>80%) coverage of the practitioner's sphere of practice and influence
- ♦ **trustworthiness:** whether the portfolio and material provided was authentic and produced by the practitioner
- ♦ **corroboration:** whether the evidence was embedded in sufficient material to support any claims.

The discussion in the review panel often revealed additional material about practitioners' expertise that were not explored in the portfolios. The critical review process culminated with a written report on the evidence provided by the nurse participant. When necessary, the panel made recommendations to the participant for refining the evidence presented. In most cases this was necessary to help participants clarify the processes they had used to construct new meaning from the evidence. For example, the panel might request a participant who produced a table of themes collated from the qualitative 360-degree process, to provide an explanation, through an audit trail, of how these themes were derived.

Nearly every review group was able to identify aspects of the portfolio that would benefit further dissemination through professional publications to illustrate expertise in practice

8.3 Research team's analysis of the nurses' portfolios, review meetings and reviewers' reports

The research team initially considered each portfolio of evidence as an individual case and inductively derived themes, using a grounded theory approach (Glaser & Strauss, 1967). The two research associates (Rob Garbett and Sally Hardy) acted as internal verifiers, with final categories and themes corroborated through a process of member checking with participants. All these stages were presented to, and critiqued by, a research evaluation and advisory group that met at key stages throughout the project.

Attributes and enabling factors of expertise, derived from a concept analysis of expertise (cf. Manley & McCormack, 1997; Titchen & Higgs, 2001) were then used, deductively, as a framework for categorising the inductively derived attributes of nursing practice expertise, providing an entry point to understanding, articulating and elucidating nurses' practice expertise. This deductive analysis was corroborated through member checking with approximately half of the nurse participants and critical companions.

The evidence from the peer review process and review report were used to challenge and embellish the themes arising in the resulting framework. Other themes emerging from the review process have informed the subsequent recognition process.

9. Outcomes of expertise for participants, colleagues, organisations and patients

The EPP findings cover four main areas:

- ◆ the experience and effect of exploring expertise on the individual nurse participants as a part of the project
- ◆ the effect the nurse participant had on their work colleagues
- ◆ evidence to corroborate the direct impact nurse participants had on organisational developments (incorporating both service and education)
- ◆ the effect the nurse participants had on patients' treatment pathways and patients' experience of health care.

9.1 Individual participants

The effect on individual nurse participants centered on their increased ability to reflect critically on their daily actions, and to articulate these more clearly to others. This increased ability to recognise and articulate actions and thought processes brought with it, however, an increased sense of frustration, as nurse participants became increasingly aware of a sense of feeling thwarted in the workplace.

The project showed that participating in the project processes (i.e. critical companionship and action learning) together with using data gathering methods (such as qualitative 360-degree feedback) was beneficial for both nurse participants and critical companions. These benefits were identified as:

- ◆ growth of confidence

- ◆ increased awareness of the expert nurse's role
- ◆ improved working relationships and the development of expertise in others
- ◆ integration of critical companionship (facilitation) and skilled companionship into daily work enabling and supporting others
- ◆ experiencing a culture of high support and high challenge within a critical companionship relationship and the action learning set
- ◆ enhanced ability for critical self reflection and appraisal, through experiencing the giving and receiving of structured feedback within the critical companionship relationship and action learning sets
- ◆ improved ability to link theory with practice (praxis) through reflective conversations
- ◆ ability to deconstruct and reconstruct experiences
- ◆ describing and articulating salient features of 'taken for granted' actions (e.g. decision making, saliency, reciprocity)
- ◆ a positive learning experience through a supported and facilitated, transformational journey of discovery.

An extract from one participant's portfolio offers an insight into the experience of undertaking the qualitative 360-degree process:

"The most significant experience ... was the 360-degree feedback exercise. It was at that point in my journey that I experienced what Freshwater (1998) describes as a 'difficult point of angst', the blackening (pg17) before my transformation. The feedback was in itself extremely positive. It was the analysis of the content of the feedback that really challenged my understanding and ability to use the conceptual frameworks of skilled and critical companionship..."

The effect of using the critical and skilled companionship frameworks (Titchen, 2001a;b; 2003) to enable participants to deconstruct their professional craft knowledge and artistry was shown clearly in extracts from project portfolios of evidence collected by the participants.

9.2 Work colleagues

Outcomes for work colleagues were complex, integrating the impact of nurses' practice expertise directly on colleagues with the additional impact on the whole working environment. Work colleagues used the nurse participant as a resource for both personal and professional issues. All staff (department or ward teams and associated professionals) were reassured by the nurse participant's presence in difficult, unusual or potentially hazardous situations.

Nurse participants showed an ability to identify and remedy their colleagues' shortfalls in a sensitive, diplomatic way. Participants helped improve colleagues' practice through processes such as obtaining extra resources and developing specific educational programmes, but largely through a process of role modelling.

One example, taken from an observation by a work colleague as part of the 360 degree feedback, encapsulates the complex impact of the expert practitioner on their work environment, patients and colleagues:

"He is caring for staff as well, he knows the rules and regulations, he's very professional in that way. He has empathy and that transfers to his staff. He is like a role model, well respected; I think the consultants respect him very much as well, the way he deals with everybody. Apart from all that staff go to him for personal and professional advice. He's confidential, he's a good all rounder. He supports the medical staff, he won't be critical, but if people are not performing properly he'll take over in a way that makes you feel relaxed. I think he is very brave to take on all this additional academic work as well, I admire him. He welcomes everybody into the department. If a patient is hostile, he's very calming. He doesn't shout, he's got a way with people. He could stop a volatile situation developing."

Nurse participants were recognised by their peers as able to adapt and alter standardised procedures to offer more flexible and responsive services for patients. Patients endorsed this in their own feedback, where they identified the importance of knowing that their health care was in the hands of someone who knew what their particular requirements were and what would be appropriate treatment or action to meet their individual needs.

9.3 Organisational change

The evidence revealed by the participants' portfolios showed that nurse participants had been influential in changing the face of service delivery for their patients and staff, for example, through improved workplace environment, access to specialist services for their patients, or developing training and educational opportunities for staff. The evidence also showed that nurse participants instigated dramatic changes in health care organisation through providing clinically-based educational programmes. One nurse, for instance, recognised a need and subsequently transformed what was a conventional ward-based environment into a purpose-built service providing 24-hour access to care.

For example, one nurse participant wrote:

"It was evident that although an extremely efficient inpatient area was in place, a downfall in the essential provision of adequate outpatients' facilities was sadly lacking. With my respective peers, the task of initiating a new purpose built area for day care was taken on board. I had a mammoth task ahead of me, to take this concept further to become a highly successful unit. This has revolutionised patient's already compromised lives."

Other nurse participants challenged their organisations to provide the necessary resources to prevent patient care from being compromised. The portfolios provided consistent levels of evidence revealing how nurse participants identified a shortfall in service provision, were central to initiating change, supporting changes through formalising developments and preparing staff for any necessary learning and skill requirements.

Nurse participants all revealed how they were committed to sharing their knowledge and practice expertise with others. If not suitably qualified to carry out any new procedures their service required, then the nurse participants were willing to travel huge distances to find suitable education and training. Once the participants had mastered a new skill they were then more than willing to share this new knowledge with colleagues, in order to provide the best care for patients.

A nurse wrote:

"I explored and produced a teaching package for trained nursing staff, which has dramatically reduced line sepsis."

Another writes, having completed some in-house training for staff:

"Chemotherapy incidents are now few and far between, the nursing staff have worth and an expansive knowledge of cytotoxic administration and handling of toxic substances."

9.4 Patients

Each nurse participant's central concern was providing care that produced maximum positive experience for patients/service users. This also impacted on families and carers.

As the portfolios show, the nurse participants offered patients (and carers) access to health care that was tailor-made and responsive to individual patient concerns. Patients recognised nurses with expertise as individuals who provide access to information and the ability to help with their current situation or problem. They also saw nursing expertise embodied by someone who was non-judgemental and offered a listening ear. Several patients reported their confidence in the nurse participant as making a difference to their care through the comments like "She's the first person we always phone."

In bringing together all the service user feedback and comments, the project found three characteristics that were consistently raised in all extracts presented in the portfolios. We propose that these characteristics are essential to providing expertise from service user perspectives. Each theme is supported by direct quotes taken from the nurse participants' portfolios and gathered through the 360 degree process from users (Box 3).

Box 3: Evidence from users presented in portfolios which support key characteristics of expertise

(All names are pseudonyms)

Approachable

- ◆ *"She is someone you can approach to talk to discuss anything."*
- ◆ *"I was very panicky, I thought how do I get out of this situation. At that point being able to contact Ann really mattered."*
- ◆ *"What I like about Sue is that she is interested in all members of the family. She made an effort to include my daughter in a conversation and that went a long way."*
- ◆ *"She makes you feel part of everything, she appreciates me."*
- ◆ *"When I first rang up I was in such a state, and she didn't say anything, but I knew she were still there. She stayed there long enough for me to gather myself."*
- ◆ *"She makes you feel important as a person, she'll sense you're down just from a conversation. Having someone to talk to like that boosted my morale, someone who understands. She is familiar with my home set up and my husband feels that when she's around things run smoothly."*
- ◆ *"They were the first person I ever told my story too, and they just sat and listened and didn't try to give me any magic solutions."*

Competent/trustworthy

- ◆ *"He is someone you can trust, someone I have total confidence in."*
- ◆ *"You can ask her questions and know you will get a straight answer."*
- ◆ *"She looks at the whole problem and picks up on things others miss because she knows me."*
- ◆ *"I know that she is someone to stick up for you with the doctors."*
- ◆ *"She knew what I meant straight away."*
- ◆ *"When she first came I was really ill, so I think that must be nice for her, to see that you are helping someone and their quality of life is improving. I cannot praise her enough, as she is the only one that has helped us."*
- ◆ *"Since Pat has come on board things have really changed. I mean we had a meeting here a few weeks ago with all the people involved, because Pat came on board she would phone the doctor, or the hospital and then all of a sudden people were becoming interested because she is so well respected, you can listen to her."*
- ◆ *"You don't feel so worried about going back to the hospital because you know she is going to be there."*
- ◆ *"I have confidence in her and she is so capable with all the situations we have found ourselves in."*
- ◆ *"There's no messing about, it's all quick, getting the equipment ready etc, its all done a lot more quickly when she's around."*
- ◆ *"I know she will sort it out so I don't get panicky".*
- ◆ *"She knew right away why this was happening and what to do about it."*

Knowledgeable

- ◆ *"I will go to her as someone who can answer questions, or seek advice, it is reassuring to know she is there for us."*
- ◆ *"I get an honest, to the point answer. She told me straight."*
- ◆ *"She is someone you can have confidence in. Someone who knows me, when I'm down, knows when I panic, what works for me, and what doesn't. She comes across as knowing their stuff"*
- ◆ *"I feel so relaxed and feel at ease to raise questions with her."*
- ◆ *"She made it clear in the first session and gave me the skills to deal with things on my own. I have a new outlook now and I'm reading more about my condition and things are really working."*
- ◆ *"She just seemed really knowledgeable, she just seemed to know how to do her job. She established the trust from day one."*
- ◆ *"She told me I would feel vulnerable for a while, both mentally and physically. She spoke about other forms of treatment, which I was pleased about. She obviously knew what she was talking about."*
- ◆ *"Someone else said that Kate can get to the heart of the matter quickly, she just seems able to hone in on the problem. Kate listens to you, a lot of the things that I have you don't notice, and a doctor wouldn't notice."*
- ◆ *"She's got a phenomenal memory, whenever you tell her about your home or family or what you do, next time you see her she'll say, 'well how did that go?'"*
- ◆ *"We turn to her for advice on all aspects, she's the best in the team for that."*
- ◆ *"You can see they know what they are talking about, and this goes a long way to help you deal with things."*

Nurses with expertise were therefore experienced by users as:

1. **approachable:** *someone you can approach to discuss anything. Someone who acts normally, treats everyone equally, makes you feel at home, at ease, friendly, welcoming. Someone you want to form a good relationship with, very, very kind and supportive. Treats you like a person, not a patient*
2. **trustworthy:** *someone you can trust, have confidence in, can ask questions and get answers, looks at the whole problem, deals with things as they arise, organised and efficient. Someone to stick up for you with the doctors. Knew what I meant straight away*
3. **knowledgeable:** *someone who can answer questions, seek advice, reassuring in their knowledge, honest, to the point, told me straight, would go back to them, didn't hurt when they did the procedure, someone you can have confidence in. Someone who knows me, when I'm down, knows*

when I panic, what works for me, and what doesn't. Comes across as knowing their stuff. Offers choices.

Nurse participants were identified as people who could 'heal a rift' and regain trust and confidence when patients had experienced negative incidents. Working to develop trust in the nurse-patient relationship was strongly evident from the portfolios, with patients identifying the nurse participants as someone in whom they had complete trust and confidence and for whom they had great respect. As a result of this relationship, patients felt more inclined to allow other professionals to care less efficiently for them.

Nurse participants revealed the ability to multi-task in an apparently effortless, seamless way that ensured patients' treatment and care remained unaffected by the chaos and uncertainty of hectic clinical environments.

In a critical review panel meeting, one nurse participant, when asked what evidence encapsulated her expertise, responded:

"I might have done everything or nothing for my patients, but for some I have changed their worlds."

Finally, there was evidence that nurses were experienced as skilled companions, as described by Titchen (2001b).

The following example shows this – a critical companion analysed the transcript of an interview with a carer (carer's words are in the left column). All names are pseudonyms (Box 4).

Box 4: An analysis of a carer's interview to demonstrate skilled companionship

Beth (nurse) is just so easy to talk to and I mean she wouldn't keep saying just ring me any time in work, I would be a bit reluctant to ring anybody. I feel happier, if I was going to have to ring anybody, Beth would be the first person I would go.

Really. Why's that?

Because she just makes herself so available you know, she makes you feel comfortable that, if you ring her, you don't feel like you're bothering her, and she's so busy and I'm aware that she is busy but she never gives that impression, she always gives you the impression that she's plenty of time for you, you know, she'll come in and see you.

Yes. So did that make you cared for at the time?

Yes, definitely.

Knowing the patient: Throughout the interview, Kate (carer) spoke of Beth like a 'family friend' and indeed in discussion with her, Beth also spoke of the family like her friends. Beth is the first point of contact for Kate and clearly she relies on Beth to clear a path through the complexities of the health and social care system that she has to cope with. Beth is clearly a skilled companion to Kate. She spoke passionately about Beth's caring approach to Joseph (patient), Beth's care of her, as a carer, and Beth's care of the whole situation.

10. Refining our understanding of expertise in UK nursing and its specialisms

10.1 The attributes of expertise

The evidence gathered through EPP supported the practical use of the concept analysis of expertise derived from the literature (Manley and McCormack, 1997), with its five attributes that characterize nursing expertise in the UK. We illustrate how the attributes have been refined through amalgamating discussion points from the action learning sets and from the final portfolios of evidence. Material presented here is a summary of what has been written or articulated by the project participants and enables the attributes to be described in a way that provides increased insight into their meaning.

10.1.1 Holistic practice knowledge

Holistic practice knowledge is concerned with:

- ♦ using all forms of knowledge in practice
- ♦ ongoing learning and evaluation from new situations
- ♦ drawing from the range of knowledge bases (alongside experiential learning) to assess situations and inform appropriate action with consideration of consequences
- ♦ embedding new knowledge and accessing this in similar situations as they occur.

10.1.2 Saliency

Saliency is related to:

- ♦ picking up cues (that can be missed or dismissed by others) to inform the situation
- ♦ observation of non-verbal cues to understand the person's individual situation
- ♦ listening and responding to verbal cues
- ♦ regarding the patient as a whole (i.e. recognising their uniqueness) to inform treatment process
- ♦ ability to recognise the needs of the patient, colleagues and others in the actions taken.

10.1.3 Knowing the patient

Knowing the patient is about:

- ♦ respect for people and their own view of the world (ontology)
- ♦ respecting patients' unique perspective on their illnesses/situation
- ♦ willingness to promote and maintain a person's dignity at all times
- ♦ conscious use of self to promote a helping relationship
- ♦ promoting the patient's own decision making
- ♦ willingness to relinquish 'control' to the patient
- ♦ recognising the patient's/other's expertise.

10.1.4 Moral agency

Moral agency is concerned with:

- ♦ providing information that will enhance people's ability to problem solve and make decisions for themselves
- ♦ working at a level of consciousness that promotes another person's dignity, respect and individuality
- ♦ a conscientious awareness in one's work of integrity and behaving impeccably
- ♦ working and living one's values and beliefs, whilst not enforcing them on others.

10.1.5 Skilled know-how

Skilled know-how refers to:

- ♦ enabling others through a willingness to share knowledge and skills
- ♦ adapting and responding with consideration to each individual situation
- ♦ mobilising and using all available resources
- ♦ envisioning a path through a problem/situation and inviting others on that journey.

10.2 Additional understanding of expertise

Through the EPP, Manley and McCormack's attributes (1997) were further tentatively expanded. Additional themes which emerged frequently in participants' evidence were the ideas of the expert nurse as:

- ♦ a catalyst for change (in their ability to alter situations and whole services)
- ♦ a 'risk taker' (a willingness to take informed decisions that were 'risky' but informed by ethical critique – that is, non-standardised but clearly informed by the consequences of such action, which enabled the best outcome for their patients to be achieved).

It is unclear without further research whether these two themes constitute new attributes of expertise or whether they are in fact explicit aspects of some of the original five attributes, such as skilled know-how and moral agency, for example. However, the five attributes of expertise with the insights provided by the two additional themes have created a foundation from which to develop the practice standards necessary for professional accreditation of practice expertise. The RCN Accreditation Unit now offers this accreditation.

10.3 Using the attributes in all specialisms

A key finding is that all the identified attributes of expertise (including those that additionally emerged) were found in every nursing specialism represented within the project. Each attribute is used in an

individual way which is relevant for each participant nurse's expertise and client group.

Despite the different ways in which the attributes of expertise are used in different settings, the enabling factors for developing expertise appear generic to nursing as a whole, and can be seen in every nursing situation, whatever the specialism.

10.4 The enabling factors

Each of the attributes of expertise outlined are linked in their development to specific enabling factors as originally identified in the concept analysis (Manley and McCormack 1997). Further insights into these enabling factors have been achieved through the amalgamation of evidence gathered throughout the project.

10.4.1 Reflective ability (reflexivity)

Reflection is not only important in the ability to uncover expertise, but also in a person's ability to further analyse and synthesise insightfulness to others, in a meaningful way. This was identified as something the nurse participants used in all aspects of their lives, both personally and professionally. Reflection requires both cognitive and metacognitive ability – that is, the capacity to think, and to think about that thinking (for example, to consider the different kinds of knowledge and reflection being used in a particular situation).

10.4.2 Organisation of practice

The effect of expertise on the organisation, as well as the intimacy of the nurse-patient interactions, were all identified as resultant of the nurse participants' ability to see the bigger picture. This ability to 'critically control' all of their interactions, with all persons involved in a patient's care provision, helps to identify the expert practitioner as different from their colleagues.

10.4.3 Autonomy and authority

Without exception, all project participants who submitted a portfolio of evidence were people who were making decisions, taking responsibility for any

consequences that might arise. They exuded a confidence that was recognised by those around them (patients and staff alike). Working autonomously goes beyond leadership and is recognised by a willingness to challenge whole teams and senior colleagues if patient care was compromised, as well as welcoming challenge about one's own actions. Despite this level of autonomy and authority, the expert practitioners were described as 'not working in a box' but were able to share their knowledge and skill for the benefit of others, which in turn increased respect for them.

10.4.4 Interpersonal relationships

Within the portfolios of evidence, all nurse participants were able to recognise their personal interest in, and the specific attention they paid to forming sound working relationships with patients and colleagues. These working relationships were identified as key to success in any situation. Some of the most significant pieces of evidence presented in the portfolios of evidence were from those nurses who had either undertaken or were particularly interested in the potential for therapeutic interactions.

10.4.5 Recognition from others

From the evidence gathered, it was clearly identified that the nurse participants were recognised by others as 'particular' and 'standing out from the crowd'. Many wrote of how they were inundated with requests to join committees, working groups and educational development groups, as their reputation and expertise was required by others.

10.5 Skilled companionship

There is evidence in the portfolios that the skilled companionship conceptual framework (Titchen, 2001b) provided the practitioner-researchers (nurse participants) with a useful tool for understanding essential elements of their practice expertise. The framework also helped them articulate the difficult-to-describe or invisible nature of experiences and intimate relationships with their patients, and to recognise this expertise, or its absence, in nursing colleagues, as a preparation for helping colleagues to become more effective.

A few used the framework in analysing their evidence, but did not describe the professional artistry (see Box 5, page 26) of skilled companionship expertise. This may have been because understanding the nature of professional artistry requires a firm grasp of practice epistemology (i.e., the nature of knowledge, its acquisition and use in professional practice). The framework was not used as often as the attributes of expertise, possibly because the practitioner-researchers were not only more familiar with the five attributes (they had used them in their application to the project), but may also have found the attributes provided a broader, simpler or more accessible framework.

Thus, we propose that the skilled companionship framework may be a useful adjunct to the attributes of expertise in the early articulation and development of expertise, especially in relation to how the attributes relate to each other and are used seamlessly in practice. As nurses become more sophisticated in articulating their expertise, the value of the framework appears to increase (see Titchen & McGinley, 2003, for example).

10.6 Definition of expertise

A previous definition of professional expertise in health care, developed by Titchen & Higgs (2001) is supported by the findings of the EPP. Building on previous empirical research (particularly in nursing) and scholarship (e.g., Schon, 1983; Benner, 1984; MacLeod, 1990; Titchen, 2000; Higgs et al, 2001), Titchen & Higgs (2001) define expertise as:

the professional artistry and practice wisdom inherent in professional practice

(See Boxes 5 and 6).

Box 5: Professional artistry defined

Professional artistry is the meaningful expression of a uniquely individual view within a shared tradition. It involves a blend of:

- ♦ *practitioner qualities* For example, connoisseurship, emotional, physical, existential and spiritual synchronicity and attunement to self, others and what is going on
- ♦ *practice skills* For example, expert critical appreciation, ability to disclose or express what has been observed, perceived and done, and metacognitive skills used to balance different domains of professional craft knowledge in the unique care of each patient, and to manage the fine interplay between intuition, practical reasoning and rational reasoning and between different kinds of practice knowledge
- ♦ *creative imagination processes* – imagining the outcomes of personalised, unique care interventions and creative strategies to achieve them.

By using cognitive, intuitive and sense modes of perception, professional artistry enables the practitioner to:

- ♦ mediate propositional, professional craft and personal knowledge in the use of applied science and technique in the messy world of practice through professional judgement
- ♦ realise practical principles
- ♦ use the whole self therapeutically to contact and work with the humanity of the patient.

(Adapted from Titchen & Higgs, 2001, p.274-5)

These qualities, skills and processes and their blending are built up through extensive introspective and critical

reflection upon, and review of, practice.

Box 6: Practice wisdom defined

Practice wisdom is the possession of practice experience and knowledge together with the ability to use them critically, intuitively and practically. Including characteristics of clarity, discernment and caring deeply from an objective stance, practice wisdom is a component of professional artistry.

(Titchen & Higgs, 2001, p. 275)

During critiques of their practice in action learning and in their portfolios, the practitioner-researchers exhibited, to varying degrees, a solid foundation of theoretical knowledge and an understanding of the nature of their professional practice. They also demonstrated a growing understanding of the types of knowledge that they used in practice and were becoming more aware of the ways in which they develop knowledge about their practice in, and from, practice. The portfolios showed that the practitioner-researchers understood that the different knowledges they use in practice constitute only one aspect of their expertise. There was an increasing awareness that the ways in which they used their knowledge and understanding also contributed to their expertise. There was abundant evidence that they used their creativity, imagination and

sensitivity to patients' needs in order to use their knowledge seamlessly, in appropriate ways, to tailor care for particular patients. For example, a critical companion in action learning said:

“Expertise is like a golf ball. The patient is at the centre, the core skills have to be there and it's all the other things wrapped around it that needs unpicking [through research] ... It [expertise] is not just one element, it's all of them.”

None of the portfolios explicitly presented expertise as practice wisdom and professional artistry, possibly because this wisdom and artistry are more deeply embedded in practice and less easily brought to the surface even than embodied, intuitive professional knowledge. However, the research team propose that

they can be discerned in the evidence, particularly in the practitioner-researchers' reflective accounts and their patients' narratives, for example:

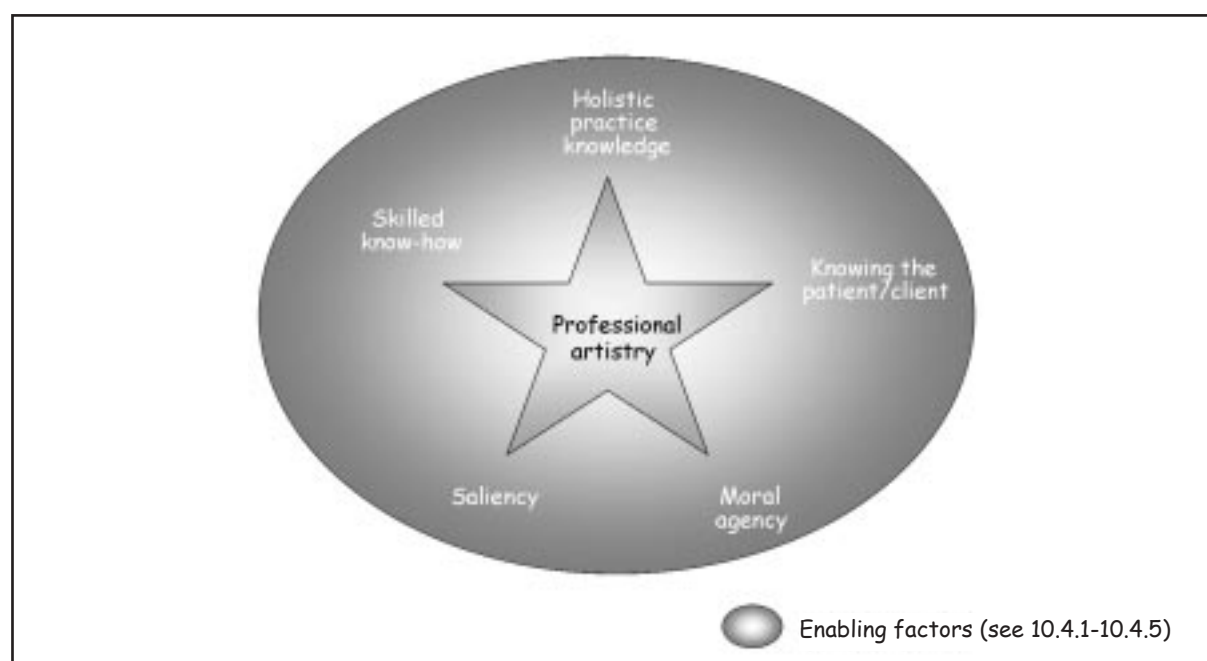
"During one of those defining moments with my critical companion, we recognised something in my daughter's old home-made painting pinned over my desk. It was an abstract wheel that threw out paint streaks as the paper had revolved around a turntable. It epitomised the nature of the nurse-patient expert interaction. Without movement there would still be a painting but only random dots and splashes although the very same actions had taken place. Movement had created cohesion, patterning and beauty. . . . The difference is in the heart of the action, the underpinning movement itself and at the moment of its creation (portfolio evidence)."

The research team identified in the evidence the blending of professional artistry to mediate science in nursing practice, i.e., applying propositional knowledge to make it useful to the particular situation and people. Blending and applying involve artistic processes, such as, appreciation, attunement, harmonisation, synthesis, and being able to see the whole and the parts of some

aspect of professional practice or experience and moving between them and getting the balance and form right. Glimpses of these processes can be seen in the evidence, but much deeper investigations of these processes, using artistic as well as cognitive research approaches, are necessary.

So what is the relationship between professional artistry and Manley & McCormack's (1997) attributes and enabling factors of expertise that have been verified, added to and elaborated within the EPP? We suggest a relationship, as outlined in Figure 1. If we re-visit the expertise star used within the project as a logo, professional artistry is the hallmark of expertise, i.e., the central attribute of expertise. The five attributes at the points of the star (surrounded by their enabling factors) refer either to the types of knowledge used in expert practice (i.e., holistic practice knowledge, knowing the patient/client, skilled know-how) or the ways in which the different knowledges or ways of being are used in practice (i.e., moral agency, saliency, being a catalyst for change and risk-taking). These knowledges and ways of being are related to each other and blended through professional artistry. In a way, it is professional artistry that brings the star to life; that makes it shine.

Figure 1: A conceptual framework for nursing expertise in the UK



Professional artistry brings to life the internal enabling factors of expertise, in that reflective ability is dependant on cognition, metacognition and creative imagination, whilst interpersonal relationships require

therapeutic use of whole self. It may be that professional artistry is also central to individuals, teams and organisations fostering the external enabling factors but that requires further investigation.

11. Reflections on the methodology, processes, methods and tools

11.1 Methodology

The swampy lowlands of practice are messy (Schon 1983), and this is also reflected in the world of practitioners whose challenge is to explicate their nursing expertise. To investigate such a world requires, therefore, practice-based methodologies and methods that can be used in day-to-day practice. It is fair to say, however, that such methodologies are complex and, for those unfamiliar with them, challenging to understand and assimilate – an observation that was endorsed by the project participants.

Throughout the project, it was the values and principles generated as part of the project process that guided the project team in their use of the methodology. These came together with the principles of critical social science which underpin EAR. These values and principles have kept us focused on enabling action in the workplace, in keeping with emancipatory practice development (Manley and McCormack 2003). This methodology, because of its focus on action and learning, and on reflection in and on action, has meant we could implement a number of changes in the project as we went along. For example, we reconfigured the action learning sets to include nurse participants as well as the critical companions.

In terms of the three purposes of action research, there is evidence that all three purposes have been achieved; our understanding about the nature of expertise across UK nursing, its different specialisms and its impact has been embellished; and there is clear evidence that both practitioners and practice have developed during the journey.

Fourth generation evaluation, with its underpinning principles concerned with mutual empowerment of different stakeholder groups, has augmented the emancipatory action research approach by making the

concerns, claims and issues of groups more explicit than would be evident through using EAR alone.

Good administrative support is essential to a research approach which is heavily dependent on large scale participation, through group and individual processes, and this was not achieved satisfactorily until late into the project.

Other challenges have included:

- ♦ the co-ordination of project processes involving a focus across the UK, particularly in keeping key stakeholders engaged
- ♦ being transparent with decision-trails arising from complex project processes such as action learning
- ♦ the need for consistent use of technology in the analysis of complex project data.

11.2 Processes used to support nurse participants and critical companions

From the preparatory phase, it was clear that even expert nurses needed help to develop evidence of their expertise. We therefore incorporated the concept of critical companionship into the project. Originally, we planned to give critical companions help with their role – this was the impetus for providing action learning sets. The action learning sets evolved to include the participants nurses too, following feedback from early cohorts. These later sets mirrored the collaborative values of an action research study, as well as the learning which arose from earlier action research cycles.

Both action learning and critical companionship, the key processes used to support the nurse participants, have been well evaluated by nurse participants and critical companions.

Action learning linked to tools that enable reflection in and on practice had perceived benefits which centred on the commitment shown by participants to the groups. This commitment persisted through difficult periods. Evidence supported the continued relevance and benefits to all participants of activities within the action learning sets, and critical companions used skills and strategies acquired through the project in other aspects of their work.

Increased reflective ability, according to the nurse

participants' evaluative feedback, was recognised as positive and part of the process of being engaged in the EPP. Working with action learning and a critical companionship framework in a practice research programme can clearly offer positive benefits for research participants, through advanced skills of reflection in and on their action. The following quotes about action learning, by a nurse participant and a critical companion demonstrate this:

Critical companion

"The action learning sets have been useful as in how it worked. It helped in formalising a way of doing it, you know, that process of continually bringing people back to the point and helping them in formulating questions. It's a good strategy."

Expert nurse participant

"It has helped me in numerous ways. It helped me to reflect differently on leadership and management issues, it helped me see how I work. Selfishly a spin off has been that I am being reviewed at the moment and this process has enabled me to show I have expertise and how to explain that to others."

From the action learning set notes, the experience of being a critical companion appears to have had a profound effect on both the critical companion and their nurse participant. Initially, the critical companions were concerned with understanding the model and coming to terms with the language used to describe and outline the process of facilitation and structured reflection. The first three months of the project was taken up with time spent setting out ways of working and re-establishing working relationships between the critical companion and their nurse participant. This process took place not just within the dyads (ie. critical companion and their nurse participant), but also within the action learning sets.

Both critical companions and participant nurses developed their knowledge, skills and understanding necessary for helping another through this relationship, be that another colleague, or within the parallel relationship with patients (termed skilled companionship). Two critical companions developed their own portfolios of evidence.

Being a critical companion within the EPP then was no easy task. The time and considerable effort people gave to the project was extraordinary. Mostly, the critical companions expressed great pleasure in being a part of

the journey of discovery in articulating and revealing practice expertise. What appears to be most important is the refocusing and facilitative ability of the critical companion in seeking out examples of the nurses' embedded understanding of their 'routine business' to expose practice expertise.

Within critical companionship relationships, nurse participants often presented for discussion an example of their practice they were unhappy with. These 'bad' experiences were then deconstructed to produce further insight into the nurses' embedded professional craft knowledge.

One example is drawn from a participant's portfolio. A nurse participant had asked a consultant for feedback on their working relationship. She felt the final taped interview with the consultant was worthless in providing evidence of her expertise. Only when the critical companion listened to the tape was the nurse's expertise unraveled. The companion pointed out examples of the nurse's ability to work in a complementary fashion with someone with an opposite interpretation of patient's presenting problems. The critical companion explains:

"This interview provided an excellent example of how she uses her expertise to enable a synergistic relationship. Reviewing the tape surprised her, as she had been unaware of the expertise she was demonstrating. It took someone else to identify how expertise was being demonstrated in what she saw as fairly routine business."

11.3 Methods (Tools) used to collect data by nurse participants

11.3.1 Qualitative 360 degree feedback

The evidence captured suggests that considered and context-sensitive application of the qualitative 360 degree feedback process provided the opportunity to gather useful, thought-provoking feedback on practice expertise.

Qualitative 360 degree feedback was a novel approach to gathering evidence for practice expertise and for the majority proved to be a worthwhile activity. Preparation and clarity of purpose in the use of this tool were

identified as influential in its success.

At the beginning of the project, we set out to contest the view that anonymity was a necessary pre-condition for obtaining feedback from colleagues. We proposed that with preparation and negotiation, an open approach to gathering feedback can be undertaken. This approach has the additional benefit of contributing to the development of a culture where the giving and receiving of open feedback can become the norm.

With regard to incorporating users within the qualitative 360 degree process, through the development of a specific protocol, our experience suggests that we need to refine approaches which will help practitioners to incorporate user narratives and feedback into their everyday practice. This is because although nurse participants wanted to gather feedback from their users and believed it was important to do so, they expressed initial concerns and an overwhelming sense of vulnerability at experiencing this 'raw' patient data. Yet, having taken the plunge with the support of their critical companions, the nurse participants largely agreed that this element of the project had been the most valuable. For example, one nurse wrote:

"A tense time being scrutinised by a patient. I felt vulnerable and quite uneasy at the prospect as this patient is known for having a frank approach. But an enlightening experience, to be valued by those people who in my eyes really matter. I was uncomfortable with the prospect of involving patients in this study but it has been invaluable to view me as others do. I express my gratitude for her keenness to be involved."

The nurse participants would not have been able to recount many patient-orientated stories in their portfolios if the research team had adhered rigidly to the qualitative 360-degree method for collecting user data. This is because practitioners found it difficult to reposition patients as co-researchers and the arduous ethics procedures tended to put them off. We recommend, therefore, that in future studies of this nature, more attention should be paid to helping practitioner-researchers and users of their services to co-construct user narratives.

The majority of the participants incorporated user narratives in their portfolios through reflective writing centred on individual case scenarios. Many centred their portfolios on case vignettes. They shared the writing process of these patient-orientated stories with their

action learning sets and critical companions to extract evidence of expertise. It is important for a research team and critical companions to help nurse participants appreciate that to rely on their reflective accounts alone as user evidence is to deny the voice and perspective of patients and carers.

Approaches need to be refined for enabling practitioners to incorporate user narratives and feedback into their everyday practice. The project obtained multi-centred research ethical clearance (MREC) and then proceeded to obtain local ethical clearance (LREC) and research governance approval for the observation of each nurse participant's practice and for the 360 degree feedback process to include service users. However, the incorporation of such evidence in professional portfolios using sound ethical principles needs to be carefully considered if future participants are to formally draw on valuable feedback from patients and users in their day-to-day work for accreditation purposes. There is a need, therefore, to:

- ◆ gain ethical clearance as early as possible in future research studies
- ◆ develop evidence-based tools that can be used in everyday practice and evidence-based protocol for gathering user feedback
- ◆ help practitioners achieve feedback from users, in everyday practice about their everyday work
- ◆ help practitioners examine their assumptions and fear that user feedback will damage therapeutic relationships with patients
- ◆ provide support to users who take responsibility for contributing as co-researchers in practice-based research.

Patient stories reaffirmed the need to remain sensitive in approaching patients and their carers for inclusion in research as co-researchers and data providers – their stories mean recounting and analysing highly sensitive and emotionally traumatic life events. User feedback consistently revealed how nurse participants' interventions with their patients acted as a catalyst for change.

11.3.2 Observations of practice

On the basis of the evidence contained in the portfolios, observation of practice was used rather less as a source

of evidence than other forms of data collection. The research team identified conceptual, practical and ethical reasons for this:

- ◆ *Conceptual:* whilst elaborate protocols for user narratives and qualitative 360 degree feedback were created by the research team for the nurse participants and their critical companions, a protocol for observation of care was not developed perhaps because observation of care had appeared less problematic
- ◆ *Practical:* barriers such as work commitments, organisational barriers and time restraints were identified as reasons influencing the use of this tool
- ◆ *Ethical:* observers (usually critical companions) would not normally have been involved in legitimately observing nurse participants in their workplaces and so delayed ethical approval negatively influenced the opportunity to use observations of practice until the end of the project.

Future researchers using observation to give new insight into nursing practice expertise need to address in their project design the practical, ethical and conceptual barriers to achieving results from observation of practice:

- ◆ developing observation protocols to guide researchers and practitioner-researchers
- ◆ obtaining prompt ethical clearance
- ◆ identifying practical implications for clinical areas (within the framework of Research Governance)
- ◆ providing practical and experiential opportunities for 'trying out' the process
- ◆ supporting the observer's role.

12. Conclusion and recommendations

12.1 A conceptual framework: the star of expertise

The five attributes together with their enabling factors can be represented as a five-sided star image centred around the concept of professional artistry (see Figure 1, p.27). We originally used the image of a star in a project newsletter in response to a request from participants for project material to help engage and inform potential role set members, and found the image helped explain the project and its processes. The bright star in the corner of the newsletter has come to represent the 'brilliance' of expert nursing practice.

12.2 Key project findings

Key findings of the Expertise in Practice Project include:

- ◆ an embellished understanding of the five attributes of expertise and their enabling factors, and the identification of two other themes: expert nurse practitioners as a catalyst for change, and 'risk-taking'. Whether these additional themes are attributes in their own right, or components of skilled know-how and moral agency, requires further investigation
- ◆ evidence that all the attributes of expertise and the two additional themes that emerged from the research, can be transferred to every nursing specialism represented within the project, although the nature of the use of each attribute depends on the specialism or client group
- ◆ evidence that the enabling factors for developing expertise are generic to the whole of nursing, and can be seen in every nursing situation, whatever the specialism
- ◆ evidence that skilled companionship (Titchen, 2001b) is transferable to diverse nursing specialisms
- ◆ evidence of both positive and negative impacts of the project and its processes on participants,

specifically for the nurse participants and the critical companions

- ◆ evidence of the positive impact of practice expertise on work colleagues, organisations and patients
- ◆ development of a detailed recognition process that can be used to accredit expertise. This process includes:
 - ◆ access to preliminary information
 - ◆ an application and registration process against specific criteria
 - ◆ access to a skilled facilitator or critical companion
 - ◆ an approach to developing and collecting multiple sources of evidence from clinical practice
 - ◆ a peer review process involving expert practitioners from the same discipline as the applicant, as well as a practitioner from a different specialism
 - ◆ a system for maintaining standards and parity across all areas/specialisms of practice in a consistent and fair way
 - ◆ systems of appeal and quality assurance in terms of processes and structures needed.

12.3 Project methodology, processes and methods

The associated purposes of EAR and fourth generation evaluation of developing practice, practitioners and the knowledge base (in relation to expertise), as well as achieving stakeholder involvement, have been demonstrated within this study. The complexities of using these methodologies have been recognised for the participants and the need for good administrative support to enable their complexity to be managed on a day-to-day basis has been identified.

The two research approaches complemented each other, but further work is required to outline their methodological relationship.

Action learning and critical companionship were the processes used to help nurse participants develop their

evidence of expertise and also the critical companions in their support of the nurse participants. Overall the experience of being a critical companion had a profound effect on both the critical companions and nurse participants. This was demonstrated in the participants' growing ability to deconstruct and reconstruct their own practice, to enable others to do the same, and in their subsequent confidence in articulating to others what constituted their expertise.

Action learning provided an influential forum for both supporting and challenging both nurse participants and critical companions as practitioner-researchers in actioning their growing insights into expertise and how to enable others.

The EPP aimed to help project participants to use practice development tools (methods) that would enable them to gather evidence of their practice expertise. Through, qualitative 360 degree feedback including user narratives, observation of practice, reflection in and on practice (Schon, 1983) and underpinned with fourth generation evaluation (Guba & Lincoln, 1989) the nurse participants and their critical companions gathered evidence of nursing practice expertise.

On the basis of the evidence available the **360 degree feedback** process, as tested out within the project, does provide a mechanism whereby colleagues can gather useful feedback on their practice. The evidence captured by the project suggests that considered and context-sensitive application of the 360 degree feedback process provided the opportunity to gather useful, thought-provoking feedback on practice expertise.

For a majority of the participants, user narratives were incorporated into portfolios through reflective writing centred on individual case scenarios. Approaches need to be refined, particularly for enabling practitioners, within sound ethical frameworks, to incorporate user narratives and feedback easily into their everyday practice.

Participants used observation of practice rather less as a source of evidence than other forms, due to conceptual, practical and ethical barriers. Further support and research is required to overcome some of the barriers necessary to achieve the potential this tool offers.

Reflection in and on practice (Schon, 1983) was a pivotal and integrated tool within the processes of action learning and critical companionship.

12.4 The implications of project findings

We have considered the implications of the Expertise in Practice Project's findings from a number of perspectives: nursing practice and practice development; organisations; higher education; future research; RCN; national policy.

12.4.1 Nursing practice and practice development

- ◆ The practice development processes and tools used within this project can make an important contribution in helping practitioners to develop their evidence for demonstrating not just their expertise, but also their competency and their readiness for career progression – as well as helping them to become more effective in the way they work.
- ◆ There is a need for skilled facilitators to help practitioners (even experts) with developing their evidence and their practice.
- ◆ There is the need for practitioners to gather ongoing quality evidence of development and achievement which can be used for multiple purposes; to learn how to construct portfolios, to be aware of issues of professional and academic accreditation and of the time needed to maintain one's own effectiveness.

12.4.2 Organisations

From an organisational perspective, the project identifies the benefits and costs of supporting professional accreditation. The EPP suggests processes that will assist organisations in not only the implementation of *Agenda for Change*, but also the achievement of a transformational culture of effectiveness (Manley 2004).

The need for health care providers to work with higher education institutes to enable academic as well as professional accreditation is highlighted.

12.4.3 Higher education

The implications for higher education include the need to consider how to marry the professional and academic accreditation agendas, so that equal value is given to the outcomes evidenced in practice. The project highlights the need to explore the potential for using practice portfolios to integrate all the agendas – such as demonstrating ongoing competence for registration, and achievement of the Knowledge and Skills framework (DH 2004) necessary for professional practice.

12.4.4 Future research

Future research should take into account:

- ◆ how practitioners are helped to use the tools developed within the project in their everyday practice
- ◆ helping practitioners to see and experience the benefits of including their own patients in their 360 degree feedback
- ◆ the need for greater public transparency and more consistent decision-making about the ethical issues of being a practitioner-researcher, particularly when using patient stories/narratives and other tools to develop one's practice.

Further research work is required in the area of the nature of expertise, particularly in relation to:

- ◆ the two additional themes identified and whether they are components of the five existing attributes rather than new attributes
- ◆ the role of the enabling factors
- ◆ the nature and role of professional artistry
- ◆ the inter-relationship between competency and expertise
- ◆ using the tools developed or refined within EPP s (i.e. qualitative 360 degree feedback and observation of practice) in other situations to enable other practitioners to explicate their evidence and further develop their practice
- ◆ the methodology, specifically the integration of Fourth Generation Evaluation with Emancipatory Action Research.

12.4.5 Royal College of Nursing

From an RCN perspective, with its UK-wide infrastructure of practice forums, there is an opportunity for the RCN to take the lead in the recognising nursing practice expertise across the UK, as well as providing a UK-wide and international role in professional accreditation. In addition, the processes developed through EPP will be valuable for demonstrating competency as well as career benchmarks as *Agenda for Change* (DH, 1999) is implemented.

The research team have since worked with the RCN Accreditation Unit to develop a national process for accreditation of practice expertise. This involves the submission of a portfolio of expertise for critical review against eight evidence-based standards, derived from the experiences of the EPP. This process is now up and running.

12.4.6 National policy

From the perspective of national organisations and policy, the project highlights a need to recognise the importance of both nursing expertise and the processes for developing practice as essential to achieving in reality the Government's vision of a modern and dependable NHS. Policy makers should consider how they can make explicit the need to value, develop and recognise expertise in the workplace, as well as endorsing all those systems in place that currently strive to do this.

12.5 Recommendations

12.5.1 Accreditation and development

To extend awareness of the impact of nursing practice expertise, and to develop this expertise further, the profession must develop an extensive programme for accrediting nursing expertise, across a wide range of specialisms and around the UK. Wide and effective dissemination of the EPP's findings to stakeholders such as the NHS University, the commissioners of education and professional development and the modernisation units within NHS Trusts will support this, focusing on how nursing expertise is developed

and recognised, and its impact on patient care and services. There is also a need to work with higher education institutions to integrate the needs of both professional and academic accreditation of expertise through educational programmes that can offer practitioners practical, evidence-based support, for the advancement of their practice expertise.

12.5.2 Further research

A programme of national and international research, to include university collaborators, should focus on refining further our understanding of the key attributes of expertise, and specifically the role of enabling factors in developing that expertise. There is also potential to initiate research to explore how academic outcomes can be discriminated from professional outcomes within professional portfolios of evidence.

12.6 Nursing practice expertise: a concluding statement

To bring this research report to a close, a quotation from one of the nurse participant's portfolios forms a concluding statement about how the project enhanced our understanding of nursing practice expertise:

"My confidence in actually highlighting my own expertise, within the evidence, grew significantly when I heard my role set panel's feedback. It was further assured through the content of my user's narrative. What I have found, through the experience of the project, is that I can still be very critical of my own and others' clinical practice, but in a very constructive way."

"In conclusion, I have been on a stimulating journey, a journey I needed to do if I am to be able to enable expertise to flourish."

To quote Thomas Beckett (1969),

"To be capable of helping others to become all they are capable of becoming we must first fulfil that commitment to ourselves."

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Glossary and abbreviations

Glossary

We present definitions of the terms used frequently within the report to describe the diverse and complex roles undertaken within the EPP. We also include explanation of commonly used abbreviations.

- ◆ **Co-researcher:** engaging project participants as co-researchers through collaboration aims toward a sharing of the researcher role, promoting a peer based partnership. More traditionally the researcher is considered an objective expert, gathering information from the research subject. Being a co-researcher encourages the person to become involved and integral to all aspects of the research process. Any aspect of the research project is seen to provide opportunity for joint reflection and reciprocal learning between all those involved. In the context of this research project this was achieved through promoting shared knowledge and power. Co-researcher was extended to include all project participants (including service users).
- ◆ **Critical companion:** a partner, a resource on a journey of discovery, someone who is reliable, can be trusted, a supporter who has a genuine interest in development and growth through high challenge balanced with high support. The critical companion role within the project was key to the facilitation of the nurse participant's investigation of their own practice.
- ◆ **Participant:** the people involved in the project who actively participated in the study of expertise in nursing practice. Participation looks for activity and involvement not often required from those involved in traditional research, where they are seen as subjects of the research rather than active participants. Participants in this project were considered partners, whose views and perspectives were accorded equal status to others. The term 'nurse participant' refers solely to the nurse gathering evidence of their own expertise for portfolio development.
- ◆ **Practitioner- researcher:** sometimes used to describe the role and purpose of the nurse participants within the project who were investigating their own practice
- ◆ **Project research team:** the research team employed by the Royal College of Nursing institute to co-ordinate the project.
- ◆ **Stakeholders:** those people who have an interest (or stake) in the project and how it affects them. These can be further defined as:
 1. those producing, using and implementing the project
 2. those who will gain in some way from the project, and
 3. those who might be negatively affected by the project.

Important stakeholders for this project were those people (ie patients, clients or service users) who came into contact with the nurse participant. Owing to the many different terms available and to the ethical and methodological issues we have decided to offer an explanation of why and who we consider by the term user.

- ◆ **User:** the term user was chosen for its broad and encompassing boundaries. It includes patients, their preferred family and friends, individuals and communities who had contact with the nurse participant engaged with the project.

However, the project research team were not comfortable with the term 'user' in that using labels can distract from individuality and celebrating difference. It also reflects the consumerisation of health care as a commodity, underpinned by managerial and business values, that disregard the recognition of vulnerability and varying levels of dependency within a caring and nurturing environment. In later work, the team refer to 'people who use the service'.

Abbreviations:

DH:	Department of Health
EPP:	Expertise in Practice Project
LREC	Local research ethics committee (now arranged through Central Office for Research Ethics Committees, or COREC)
MREC	Multi centred Research Ethics Committee (now accessed through COREC)
NHS:	National Health Service
RCN:	Royal College of Nursing
UKCC:	United Kingdom Central Council (now known as the General Nursing Council)

Appendix: Project participants

The RCN Institute Expertise in Practice project participants

Project Team (1998-2004)

Robert	Garbett	Research Associate	RCN Institute
Sally	Hardy	Research Associate	RCN Institute
Ann	Jackson †	Senior Fellow Practice Development Mental Health	RCN Institute
Kim	Manley *†	Head of Practice Development	RCN Institute
Brendan	McCormack †	Director of Education Research & Professor of Nursing Research	The Royal Hospitals Belfast University of Ulster
Angie	Titchen †	Senior Fellow, Research & Practice Development	RCN Institute

* Principle investigator/project lead

† Action learning set facilitators

Consideration needs to be made to the extensive administrative support required and provided for this complex national project.

EPP Project administrators

2000 *Nicky Blatch*

2000 -2001 *Julie Snell*

2001

Kelly Reeves

2001 – 2004 *Jo Odetola*

Research Advisory & Evaluation Group (1999-2004)

Loretta	Bellman	Writer/Researcher	RCN Institute
Veronica Ltd	Chapman	Director/Consultant	Nursing Systems Development
Robert	Garbett	Research Associate	RCN Institute
Sally	Hardy	Research Associate	RCN Institute
Sue	Hinchcliffe	Head of Accreditation	RCN Institute
Kim	Manley	Head of Practice Development	RCN Institute
Brendan	McCormack	Director of Education Research	The Royal Hospitals Belfast/University of Ulster
Lindsay	Mitchell	Director	Prime Research & Development Ltd, Harrogate
Susan	Read	Head, Acute & Critical Care Nursing	University of Sheffield
Sally	Redfern	Head of Nursing Research	King's College London
Sarah	Robinson	Senior Researcher, Nursing & Midwifery	King's College London
Rachael	Rowe	Project Leader, FEN	RCN Institute, London
Brian	Salter	Director of Research, Nursing & Midwifery	University of East Anglia
Cherill	Scott	Research Fellow	RCN Institute, London
Angie	Titchen	Senior Fellow, Practice Development	RCN Institute, London

Nurse participants/practitioner researchers

We also wish to acknowledge those who contributed to the project as nurse participants, critical companions, critical reviewers and expert reviewers. Your willingness to share experiences, offering your time /work and

sharing personal values and beliefs. The high level of openness and honesty has made the project a privilege and pleasure to experience, in revealing those hidden treasures of nursing expertise.

Victoria	Andrews-Rowley	Elizabeth Finn Trust, Worcestershire
Patricia	Bartley	Gwent Healthcare NHS Trust, South Wales
Eileen	Bayer	Llanbough Hospital, Glamorgan
Debbie	Boomer	Rampton Hospital, Nottingham
Sean	Collins	Bridge Centre, Omagh, Northern Ireland
Margaret	Conlon	Dept. of Child & Family Mental Health, Edinburgh
Beverley	Cornish	Clifford Chance, London
Sarah	Dodds	Royal Devon & Exeter NHS Trust, Exeter
Christopher	Earl	Royal Infirmary, Manchester
Carolyn	Fox	Victoria Hospital, Blackpool
Lewis	Garrett	Royal Bolton Hospital, Bolton
Niamh	Geoghegan	Chelsea & Westminster Hospital, London
Lorraine	Goacher	University Hospital of Wales , Cardiff
Jane	Hartwell	Portree Hospital, Isle of Skye
Janet	Hicks	Southport & Ormskirk NHS Trust
Vanessa	Hickson	Hope Hospital, Salford
Adrienne	Hoare	Rumney Medical Practice, Cardiff
Anne	Howard	Warrington Hospital, Cheshire
Ruth	Jenkins	University Hospital of Wales, Cardiff
Carol	King	Victoria Infirmary, Glasgow
David	Kingdon	The Woodlands Unit, Leicester
Jeanette	Laird-Measures	Portree Hospital, Isle of Skye
Kathy	Liddle	Western General Hospital, Edinburgh
Maura	McElligott	Addenbrookes Hospital, Cambridge
Maeve	McGinley	Foyle Health & Social Services , Londonderry
Shelley	Mehigan	Upton Hospital, Slough
Deirdre	Miller	Chelsea & Westminster Hospital, London
Dorothy-Anne	Price	The Ashgrove Surgery, Mid Glamorgan
Julie	Redman	Glenfield Hospital, Leicester
Janice	Richmond	Belfast City Hospital, Belfast
Deborah	Sandeman	Senior Health Resource Project, Edinburgh
Gill	Scott	St John's Hospice, Doncaster
Doreen	Snadden	Southern General Hospital, Glasgow
Karen	Spowart	Chelsea & Westminster Hospital, London
Elaine	Stevenson	Derby Chest Clinic, Derby
Julie	Stone	Princess Royal Hospital, Telford
Louise	Thompson	Blackpool Victoria Hospital
Margaret	Tipson	Farnborough Hospital , Kent
Rosemary	Turnbull	Chelsea & Westminster Hospital, London
Jane	Upward	Essex County Hospital, Colchester
Nicola	West	University Hospital of Wales, Cardiff

Critical companions/practitioner researchers

James	Barton	University of Wales, Swansea
Delyth	Bebb	University Hospital Wales, Cardiff
Martin	Bradley	Western Health & Social Services Board, Londonderry
Angela	Brown	Northern General Hospital, Sheffield
James	Carrigan	Tyrone & Fermanagh Hospital, County Tyrone
Annette	Chorley	RCN Institute, London
Kate	Cocozza	Southern General Hospital, Glasgow
Helen	Couth	Princess Royal Hospital, Telford
Karen	Crabbe	Towers Hospital, Leicester
Gill	Culloden	Royal Infirmary, Manchester
Sarah	Davidson	Chelsea & Westminster Hospital, London
Belinda	Dewar	Queen Margaret University College
Ann	Dolben	University Hospital of Wales, Cardiff
Jill	Down	Addenbrookes Hospital
Carole	Gore	Royal Bolton Hospital, Bolton
Alison	Goulbourne	Queen Margaret University College
Jean	Hankinson	University of Nottingham, Derby
Jane	Hartwell	Portree Hospital, Isle of Skye
Elizabeth	Henderson	Belfast City Hospital, Belfast
Majorie	Holden	Blackpool Victoria Hospital Turst
Kathryn	Jones	Chelsea & Westminster Hospital, London
John	Keast	Royal Devon & Exeter NHS Trust, Exeter
Jeanette	Laird-Measures	Portree Hospital, Isle of Skye
Nancy	Lee	University of Salford, Manchester
Johanne	Lickiss	Victoria Hospital, Blackpool
Collette	Major	Southport General Hospital
Brendan	McCormack	The Royal Hospitals Belfast
Audrey	Mears	Lynebank Hospital, Fife
Louise	Morton	Royal Free Hospital, London
Sally	Patrick	Upton Hospital, Slough
Bridget	Penney	Elizabeth Finn Trust, Worcestershire
Mary	Pitts	Essex Rivers Healthcare NHS Trust, Colchester
Martine	Price	University Hospital of Wales, Cardiff
Tony	Pritchard	Chelsea & Westminster Hospital, London
Janet	Sayer	Towers Hospital, Leicester
Vivienne	Simpson	Victoria Infirmary, Glasgow
David	Spooner	Rampton Hospital, Nottingham
Dr Winifred	Tadd	Academic Centre, Llandough Hospital
Renate	Thome	School of Health Science, Withybush Hospital, Pembrokeshire
Eileen	Turner	Kings College Hospital, London
Vicky	Warner	Gwent Healthcare NHS Trust, South Wales
Elaine	Williams	Warrington Hospital, Cheshire

Critical review panel members (2002)

Carol Bannister, Debbie Barber, Angela Brown, Margaret Brown, Jessica Corner, Angie Crewes, Jean Cummings, Sarah Davidson, Jill Down, Virginia Dunn, Maire Flannaghan, Kath French, Janet Hackin, Kathy Haigh, Karen Harrison, Mary Hinds, Neil Kitchner,

Alison McTavish, Audrey Mears, Stephen Morgan, Liz Morgan, Maria Noblet, Maria Noblet, Mary Pitts, Jean Robinson, Janet Sayer, Carol Shillabeer, Vivienne Simpson, Catriona Sutherland, Renate Thome, Eileen Turner, Mary Wadsworth, Rosemary Walker, Moira Walker, Christine Whitehead

Forums Phase 1 (Sept 1998 – Dec 1998)

Steering Group (1998)

Yvonne	Carter	Head of Dept General Practice and Primary Care	Chair of Royal College of General Practitioners, London
Dave	Dawes	Nursing Policy Committee	RCN
Sylvia	Denton	Deputy President	RCN
Rob	Garbett	Research Assistant	RCN Institute, London
Alison	Hill	King's Fund	
Kim	Manley (Project Leader)	Assistant Head of Practice Development	RCN Institute
Catherine	McClouglin	Chair, Bromley Health Authority	Co-Chair NHS Confederation
Robbi	Robson	Assistant Director, DNPP	RCN
Phil	Sanders	Chief Executive	Cornwall NHS Trust
Emma	Thompson	Project Co-ordinator	RCN Institute
Julie	Traynor	Assistant Director, Corporate Affairs	RCN
Paul	Wainwright	Senior Lecturer	University of Wales
Sarah	Waller	Director of Standards Promotion	UKCC
Mike	Walsh (Chair)	Professor of Nursing	Cumbria
Kathleen	Weeks	Chief Nursing & Healthcare Employment Consultant	Employment Service

Earlier Research & Evaluation Sub-Group (1998)

Howard	Catton	Senior Employment Advisor	RCN
David	Dawes	Development Manager & RCN Council member	Cheshire
Rob	Garbett	Research Assistant	RCN Institute, London
Steve	Griffin	Associate Member	RCN
Alison	Hill	Director of Effective Practice	King's Fund, London
Sue	Hinchliff	Head of Continuous Professional Development	RCN Institute, London
Kim	Manley	Acting Head, Practice Development	RCN Institute, London
Brendan	McCormack	(Chair) Co-Director Gerontological Programme	RCN
David	Moore	Assistant Chief Nursing Officer	NHS Executive, Leeds
Susan	Read	Head of Acute & Critical Care	Sheffield University
Sally	Redfern	Head of Nursing Research	King's College
Sarah	Robinson	Senior Researcher, Nursing and Midwifery	King's College London
Rachel	Rowe	Project Leader , FEN	RCN
Julie	Traynor	Assistant Director, Corporate Affairs	RCN
Ruth	Endacott	Project Evaluator/Facilitator	Eclipse Consultancy

Experts in Preparatory Phase (1998)

Michael	Graves	A&E Association
Anne	Asprey	School Nurses
Jennifer	Clark	Mental Health
Sylvia	Denton	Breast Care Forum
Christopher	Earl	Perioperative Forum
Philip	Hardman	Mental Health and Older People
Victoria	Heys	A&E Association
Rachel	Hollis	Paediatric Oncology
Katherine	Hopkins	Palliative Care
Wendy	Johnson	Nurse Practitioners
Peggy	Keating	Childrens Community Nursing
Diane	Kingston	Critical Care Forum
Kim	Manley	Project Leader
Leslie	McQueen	Ophthalmic
Shelley	Mehigan	Family Planning
Janice	Mooney	Rheumatology
Helen	Rush	A&E Association
Susan	Scott	DNPP Adviser
Beverley	Stoke	Health Visitor
Lesley	Styring	Learning Disability Nurses
Emma	Thompson	Project Co-ordinator
Margaret	Tipson	Diabetes

Expert Accreditation Panel membership (1999-2002)

Sue	Burt	Sister A & E	Norfolk and Norwich Hospital
Sylvia	Denton	Deputy President	RCN
Ruth	Endacott	Faculty Project Evaluator/Facilitator	RCN Institute, London
Steve	Ersser	Senior Lecturer	Oxford Brookes University
Di	Jackson	Senior Lecturer	St George's NHS Trust, London
Kim	Manley	Acting Head, Practice Development	RCN Institute, London
Hugh	McKenna	Professor of Nursing	University of Ulster
Shelley	Mehigan	Expert Representative, National Forums	Slough
Alan	Myles	Head of Education Development	RCN Institute, London
Julie	Scholes	Professor, Institute of Nursing & Midwifery	University of Brighton
Bernice	West	Robert Gordon University	Scotland

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