

**An Investigation into the Effects of
Clinical Facilitator Nurses on Medical Wards**

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Abstract

This thesis investigates the effects of clinical facilitator nurses on medical wards in hospitals. These staff are the current culmination of recent attempts to situate nurse education in the field of clinical practice rather than merely the lecture room. Therefore, the work sets out to gain an understanding of the clinical and educational needs perceived by policy makers; the methods chosen by local managers to fulfil these needs; and the practical manifestation of these initiatives at the bedside.

The thesis commences with a literature review consisting of historical context studies and a focused analysis of recent research literature. The context studies are of adult and nurse education. The review of clinical facilitator literature uses search criteria to identify and critically analyse previous research related to similar roles in the United Kingdom.

The researcher uses a modified grounded theory approach as a methodological framework for collection and use of data. The data is obtained primarily by field observations; semi-structured interviews with practising clinical facilitators; and from questionnaires completed by nursing students. In addition to this generated data, information harvested from official and academic sources is used to produce theory.

The discussion chapter explores the contestation that the themes generated indicate that the introduction of educationally focussed staff, into the area dominated by clinical need, is both problematic and essential. Problematic, as conflicts of role and leadership create misunderstanding and hardship for educators and clinicians. Essential, because in acute wards, where nursing skill is literally a matter of life or death for patients, a large proportion of nursing staff are in need of focussed educational support. The study proposes a model of managerial support for the introduction of educationally focused nurses in the clinical area which enables these clinical facilitators to operate in a valued and protected position.

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Introduction to Thesis

Introductory Chapter

“Clinical facilitator nurses [CFs¹] are an expensive luxury; the only workers that cash strapped NHS [National Health Service] trusts should be employing are front line patient care staff.”² These words were spoken by one ward sister at a meeting recorded as part of the field observations at the beginning of this research process. Nevertheless, they are typical of comments made by both front line staff and the general population when discussing support roles in public services. CFs are not there to provide patient care but they do inhabit the same environment as direct care staff and work alongside them. Why are they there? What are they doing? Are they a waste of money or a valuable asset? These questions put them into an interesting position worthy of study. It is this group of staff who will be investigated in this thesis. However, this exploration of the role and the effects of the CF on the wards began with no pre-formulated hypotheses. It commenced with a desire to observe and understand a newly existing phenomenon. The questions and answers would be generated not by the metaphysical musings of the researcher but by the data observed and recorded by him.

CFs are a new type of nurse educator, or more accurately facilitator, practising in the clinical area. They were introduced in the late 1990s and early 2000s. The reasons for their introduction and their specific activities will be investigated in this thesis. However, at this stage it is important to know that their existence is not universally accepted in health services and their job descriptions are diverse.

This chapter will briefly introduce the reader to the three case studies to be investigated. It will then describe the structure of the thesis. The main body of work is constructed in the following way: the first two chapters begin with historical context studies of adult education and nurse education; the third chapter is a focused literature review examining the recent studies of CFs; the fourth examines the research

¹ Initials and acronyms are listed in Appendix 11.

² These comments were recorded in a memo (this memo is identified by the code FO20050111C1. The method of codification will be identified in the pilot study outlined in the results chapter.

methodology which underpins the case study inquiry; chapters five to nine describe the stages of the research; the final chapter of the main body of work discusses these stages. The main body thus described will include the usual formal academic citation and referencing throughout using the Harvard referencing system. However, the text of this introduction and that of the final conclusion will not be interrupted by citations. This is because these sections will refer only to concepts which are either supported in the main body by citation or demonstrated there by research. It is now possible to outline the case studies to be investigated.

The Three Case Studies

The roles of the CF and similar supportive clinical educational posts were generated at local sites in response to changing national educational and clinical conditions. There were common changes, such as the increase in student numbers and the increasing proportion of critically ill patients on general wards, which instigated the deployment of these new positions. However, in the United Kingdom (UK), there was no national plan to provide the supportive structure that staff would require as a result of these changes. Each trust made its own decisions and this thesis will attempt to illuminate the results of those choices made at three NHS trusts.

The research is centred upon the activities of CFs in these three NHS trusts. These trusts are all situated within a single English county. The geographical location, names of the trusts and participants will not be specified within the text. This is in line with NHS research ethics standards as explained in the methodology chapter. They are a new group of staff who have not been investigated by researchers before. Similar roles and teams have also been instigated elsewhere and some of these have been subject to research. However, these three cases are all separately managed and financed. They were influenced by existing examples but not carbon copies of them. Each case was a response to local circumstances as well as to national processes. The national position will be discussed at length in the context studies and local events will be examined in the results chapters.

The three cases are as follows. Case 1 is the largest and central case to the research. It is a district general acute hospital trust at an English city. The trust was based on two hospital sites across the city. The case study specifically concentrates on the team of CFs and clinical facilitator staff nurses (CFSNs) working on the medical wards within that trust. This role began in 2001 with one CF and grew to a team consisting of two lead CFs and more than a dozen CFSNs by the time of the research study. The CFSNs mainly worked alongside learner nurses on wards within the hospitals while the lead CFs managed them and assisted with learner needs where required.

Case 2 consists of the community hospitals within a county wide primary care trust (PCT). The CF role there commenced in 2005 with one CF based on a single ward at one of the community hospitals. This grew into a team of CFs which covered approximately half of the community hospitals within the trust. This team did not have a central management structure but each CF was managed by the matron or clinical managers within their area.

Case 3 was another district general hospital trust. This one was at the second largest town in the same county. There were no staff entitled CF at this trust but there was a hospital wide network of staff with part of their role set aside to support learners and to manage the learning environment within their ward area. These were called learning environment managers (LEMs). These posts were conceived to provide a similar service and to solve the same problems as the CF/CFSNs at the previously described trusts. However, they are sufficiently different to provide a contrasting case study.

The cases will be described in more detail in the results section, with Cases 1 and 2 in the interview analysis chapter and Case 3 in the questionnaire chapter. It is now possible to further outline the structure of the thesis which will follow.

Historical Context Studies and Literature Review

The first three chapters of the thesis set the historical and contemporary scene. This is required in order to obtain a depth of understanding in which to place the case study research. The role under investigation was generated for a purpose, that being to provide support for front-line nurses attempting to teach students and newly qualified nurses (NQNs) in the workplace, how to care for patients at the bedside. This is a longstanding issue and has precedent in both adult education in general and specifically in the historical accounts of nursing. As workplace facilitators CFs had roots in the field of adult education and as registered nurses (RN). Consequently, the professional background of their trade needed to be examined. Contested historical accounts are prolific in the fields of education and nursing. Therefore, a critical historiographical approach was required to make sense of the time-lines which led to the creation of these positions. A 'long view' approach is taken, with events from the early nineteenth century being recounted. This is not just for completeness. It is required in order to find the origins of some of the debates which have been most important to the deployment and maintenance of these roles in the present day. These include disputes such as the teaching of theory and practice; skills versus knowledge; liberal against vocational education; emancipatory and conservative education; higher education (HE), or apprenticeship; what nursing is for; and the political and social positions of nurses and skills teachers.

The third chapter of the context study section consists of a literature search and review. This takes account of the research undertaken since the roles similar to the CF came into being in the late 1990s. The literature review chapter is also used in the research as source data for the third results chapter. The justification for this and the other elements of the research section are explored in the methodology chapter.

Research Methodology

The methodology chapter outlines the philosophical underpinnings and arguments for using the adapted grounded theory (GT) multi-method approach applied

in the forthcoming results section. This is necessary because the methods used are mildly controversial in scientific terms. Ethical, legal and bureaucratic considerations are also outlined. Once the base of the scientific approach is identified a superstructure of explanation of the research methods used is provided. This allows for the presentation of a flow diagram which outlines the overall research approach. This diagram could not be produced until after the research was completed as the adapted GT method generated new research questions which in turn required new methods to produce answers. This five stage process is outlined below.

Results

In the five chapters which make up the results section of the thesis, the stages of the flow diagram are described and analysed. This was an ongoing process which was generated from the data as part of the inductive research process. The stages will be briefly outlined below.

Stage one was a pilot study which took the form of a series of field observations over a few months at the beginning of the research period. This entailed taking notes of field observations using a standardised memo system.

Stage two was the central plank of the research. An initial hypothesis and an accompanying series of questions were generated by the initial pilot study. These were used to devise a set of semi-structured interviews and the questions which they were structured around. The interviewees were chosen as a result of the pilot study. It was decided that these would be the CFs themselves as the closest participants to the source material.

Stage three required a return to the literature reviewed in the context study. This was an anticipated source of data from the outset. The hypotheses generated from the interview stage were tested against the findings from the earlier literature.

Stage four was an attempt to widen the participant pool and to triangulate the data. The number of CFs interviewed was inevitably low. The percentage of CFs

questioned as a proportion of the total number of CFs was high. However, the total number of CFs in Cases 1 and 2 was less than twenty. This is not necessarily a problem as the kind of rich data collected from the semi-structured interview technique used does not require the use of large numbers of interviewees. Nevertheless, it was decided to use a questionnaire to collect data from a reliable proportion of the learners who had access to CFs. This amounted to over 300 participants including junior and senior students as well as NQNs.

Stage five resulted from the findings of the questionnaire analysis. From the theory generated in stage four it was necessary to return to the field observations commenced at the beginning of the study. This final stage permitted the use of over a hundred memos collected over four years at the three case study sites and at other meetings.

The use of this multi-method approach and access to the full range of participants allowed cross referencing and triangulation. This produced as broad an illumination of the case studies as possible and permitted the researcher to obtain a reliable generation of theory.

The final chapter is the discussion. As can be seen above a great deal of analysis and discussion was generated by the data as it emerged. This is to be expected in this form of inductive research and was included in the results section. Nevertheless, a separate discussion chapter was deemed necessary in order to gain an overview and to attempt synthesis.

Discussion

The discussion chapter attempts to assimilate and synthesise the arguments generated from the data in the results chapters. In this section, the theory generated during the research is critically reviewed and supported. The consequent model to identify CFs is supported and a tool for facilitating their deployment and maintenance is produced.

Chapter Conclusion

The overview of the forthcoming thesis is laid out in this introduction. It is now possible to commence the first stage of the context study. This will consist of a brief historical account of appropriate aspects of adult education over the last two centuries.

Review of Literature: The Clinical Facilitator Nurse in Context

Chapter 1: Adult Education in Context

Introduction

Figure 1: Bad News



(NHSU 2003)

Lifelong learning has a long history. As can be seen in the NHS University³ (NHSU) cartoon above, it is something that does not have appeal to all. Unlike the childhood education that these unfortunate schoolboys are experiencing, adult education remains a voluntary activity. Nursing relies on students being prepared to undergo as adults a pre-registration course of study in order to gain proficiency. This has been the case for almost 150 years. In recent years the regulatory body has insisted that nurses continue to learn after registration. Thus adult education and nursing are intrinsically linked. However, this thesis is primarily concerned with the activities and effects of CFs. Why is it necessary to examine the history of wider adult education? CFs and the educational support provided for the practical and theoretical teaching and support of nurse learners do not exist in a vacuum. On the contrary, they are at the centre of the highly politicised and contested arenas of education and health. Consequently, in order to gain an understanding of the environment within which they can be studied, it is necessary to engage with the historical and contemporary context of

³ The NHSU itself did not survive long after this cartoon appeared. It was dissolved in 2005 following an adverse report commissioned as part of the Department of Health's reconfiguration of 'Arm's Length Bodies' (DH 2004, Snook 2005, Wells 2004).

education and health. As commented upon above, this section will deal with the contextual historical framework of adult education. In a work of this nature the coverage will be, of necessity, quite brief and limited to areas related to the central subject matter. For fuller treatments of the context hinted at here, there is a large body of existing literature (Centre for Contemporary Cultural Studies 1981; Johnson 1988; and Kelly 1950).

Contested Definitions

The terms used to describe education for those older than the age required by legislation to be in schooling are contested. In this paper the terms ‘adult education’; ‘continuing education’; ‘lifelong education’; and other similar terms will be used interchangeably. That is not to deny the deep ideological differences often indicated by their uses. These arguments have been discussed in detail elsewhere (Fieldhouse 1996, Jarvis 2004) and some of the contestation is referred to in the text below. In this paper where such consideration is important it will be made clear. Therefore, on the whole no particular meaning should be assumed by the use of one term or another in this account.

Liberal Education and Vocational Training in Nursing

The context of nursing education particularly within the health sector is most pertinent. Therefore, the particulars of education specifically within the nursing profession will be examined in the next chapter. In a similar way to wider adult education, nurse education will be shown to have preoccupations and agendas outside the purely vocational. One of these preoccupations is the desire to raise the social status of nursing. Many nurse educators throughout the history of nursing have had the goal of professionalisation in order to raise the status of nursing (Dock and Stewart 1938). This led to moves, firstly in the United States of America (USA) in the early twentieth century, to university-based nurse education. These efforts promoted the idea that nurses should have a liberal as well as vocational education. Many nurses,

especially in the UK, opposed this, arguing for work-based apprenticeship training. Similar arguments were going on elsewhere and affected the discussion in nursing. In the late twentieth century this dialectic came to dominate discussions about nurse education and the teachers employed to deliver it. Therefore, the adult educational background within which the national and local decisions were made to employ CFs will be examined in this chapter.

Liberal and Vocational Adult Education

The dichotomy between the merits of liberal and vocational education has been an area of long standing dispute. In this debate liberal education is usually seen as being education for the sake of education, as a pursuit both enjoyable and worthwhile in itself. Vocational education is seen as the antithesis of this. This is ‘useful knowledge’ as it was described in the nineteenth century (Rauch 2001). Learning is seen in this narrative as entirely a way to improve the student’s ability to work. Any enjoyment or civilising effect it may have is seen as beneficial but a by-product not an end in itself. It can be convincingly argued, as Hart does, that this is a false separation and that all adult education is essentially in preparation for work (1992). Nevertheless, the concepts have become ingrained into the way that educators and policy makers think and judge. Consequently, whether they stand up to empirical and philosophical critique or not is less important than that they are believed to exist as concepts by the central actors in the field (Samuel and Thompson 1990). Judging by the statement below there can be little doubt where the then Secretary of State for Education stood.

We stand on the brink of a new age. Familiar certainties and old ways of doing things are disappearing. Jobs are changing and with them the skills needed for this new age, in which the key to success will be the education, knowledge and skills of our people (Blunkett 1998:1).

David Blunkett’s forward to the Green Paper on adult education reflects the concerns expressed by both James Callaghan (1976) and Tony Blair (1996) at their respective Ruskin College speeches. All of these leading Labour Party politicians are careful to stress that “we value learning for its own sake” (Blunkett 1998:1) and that the

social justice, which the Labour movement holds dear, depends on access to quality education for all. Nevertheless, it is clearly stated in these important testimonies that “[t]he goals of our education, from nursery school through to adult education ... are to equip [everyone] to the best of their ability for a lively, constructive, place in society, and also to fit them to do a job of work” (Callaghan 1976:2). As Blair puts it, “education will be a priority for me in government ... because of the fact that our economic success and cohesion depend upon it” (Blair 1996:1). Clearly, all of these politicians see education as a tool for social control, by acquainting the undereducated with the interests and values of the middle class, and to increase the labour value of British subjects (Chriss 2007). It is often argued, as Fieldhouse does, that in the intervening years of Conservative rule the concern for social justice and social control through education was dropped for ideological reasons (1996). The desired consequences of this were, that this led to a market driven education system and an increased emphasis on the needs of industry and vocationalism. The Conservative Party Campaign Guide made this clear in its criticism of “socialist ... egalitarianism in education” and their pride that their “training schemes” were equipping the unemployed with the skills to work in the jobs created by their growing economy (1989). However, as can be seen in the quotations from Callaghan and Blair above, the Labour politicians are similarly concerned with the economic imperative and the needs of industry for suitably educated workers. Therefore, in outcome terms at least, there would appear to be consensus, between the two major British political parties, in the practical goals of education to produce a skilled and productive workforce. Importantly this represents a position diametrically opposed to the dominance of liberal adult education in the earlier parts of the twentieth century (Field, 2000, Fieldhouse 1996, Steele and Taylor 2004, Taylor 2005). This chapter will attempt to go beyond the utterances of our political elite to examine the key events in British adult vocational education for the period from the Ruskin speech in 1976 to the events which led to the employment of CFs in the late twentieth century. As made clear in the introduction, it

is important to understand this context. This is because the decisions made to create and retain the CF role under scrutiny were made by people influenced by the thinking and practice about education and its uses engendered during this time.

Nineteenth Century Adult Education

In a historical account it is often difficult to decide where events become so remote that they have insignificant effect on the present. This subject has proven to be no easier than any other. Therefore, it will be necessary to comment on events in the two centuries preceding Callaghan's Great Debate in order to understand why this event has been chosen as a crucial point in this examination of current vocational education. Firstly an examination of the main strands of adult education in the nineteenth century will be undertaken. These were vocational; really useful knowledge; university extension; and professional education.

Vocational Education

Adult vocational education in Britain prior to the nineteenth century was catered for through seven-year apprenticeships. Until the repeal of the 1562 *Artificers and Apprentices Act* in 1814 (Fieldhouse 1996 and Thompson 1980) "an obligation was cast upon all suitable persons to take parish apprentices" (Batt and Webber 1967:12). This legal prescription was overturned as part of the general move from a paternalist legal structure towards the liberal-capitalist hegemony of the Victorian era. Other examples of this trend are the earlier Enclosure Acts (Hammond and Hammond 1987) and the later Poor Law Amendment Act 1834 (Thompson 1980). In the case of apprenticeships the state abandoned the provision to market forces. Although the relationship between master and apprentice continued to be governed by law (Batt and Webber 1967) there was no obligation for artificers or factory owners to take on apprentices if they chose not to. Similarly, this left the protection of craft status to power relations in the new economy. Factory based production and the ideas of Adam Smith (1979) removed the privileged position of large numbers of former trades

considered to be in the labour aristocracy. The resulting lack of recognition of skilled labour led to two oppositional conclusions in the bourgeois governing class. The first position was the conservative one that the working class was best left without any formal education as this led to them gaining an understanding of their oppressed economic position. This group also saw little profit in educating a class which needed none in order to toil in the fields, factories, and workshops of the period (Kropotkin 1974). The second position was the liberal one that the right sort of education would provide a sense of understanding and common purpose with the more privileged members of society. Despite being described as liberal, this can be seen as a straightforward attempt at social control. If the working class have common purpose with their masters then they are less likely to develop a sense of themselves as a separate united class. This led to both utilitarian vocational education and liberal non-technical education provision (Steele and Taylor 2005). As stated above, most of this was aimed at the working class. The liberal educational strand was either paternalistic provision from middle class benefactors or in the form of self help “mutual improvement societies” (Fieldhouse 1996:14). The formal education included Mechanics Institutes, Adult Schools (Rowtree and Binns 1993) and working men’s and women’s colleges. Fieldhouse argues that although these educational strategies were aimed at the working class, mainly lower middle class men and women took them up. The greater part of the education of adults continued to be through apprenticeships with “a third of a million apprenticeships in any one year” in the early twentieth century (1996:22). Vocational education along with the rest of social provision became of interest to legislators again towards the end of the nineteenth century. The Technical Instruction Act 1889 (Roach 1991) allowed local authorities to fund technical education. Again this coincided with macro-economic, political and social changes including the technical and administrative needs of a growing imperial government; increased competition from abroad; alongside a growing socialist and broadening trade union movement at home (Hobsbawm 1987). Nurse education, then as now, stood

outside and alongside these events. The growing movement to professionalise nursing and the educational institutions and methods which grew up alongside these events, will be brought into this wider context with reference to them in the next chapter. The social class position of nurses has always been contested. However, for the purposes of this chapter it will be assumed that Bradshaw's (2001a) contention, that nursing was an apprenticeship at least until the changes brought about by the Briggs Report, is correct (1972). This places nursing into the middle of the general field of 'adult' rather than established 'professional' or 'higher' education up until at least the 1980s.

Really Useful Knowledge

The point has been made above that adult education did not consist entirely of vocational education for the working class. Several other important ideologies of adult education existed both separately and overlapping which continue to inform present day conditions. Firstly, along with this vocational 'useful knowledge', nineteenth century radicals espoused 'really useful knowledge' (Johnson 1988), which was designed to provide the oppressed with insight into their exploited condition (Aronowitz and Giroux 1987 and Marks 1999). This knowledge would then arm them to overthrow the existing order. The origins of this thread trail back to the beginnings of recorded history. This strand runs through early unionism, Owenism, Chartism, the co-operative movement and later socialist and labour movement (Steele and Taylor 2005). It is arguable whether or not it maintains importance in the thinking of the early twenty-first century policy makers of the Labour Party (Peele 2004). Nevertheless, there can be no doubt that this is a strand of thought which has maintained importance to educators. Some evidence of this is that Gramsci's (2000⁴) and Freire's (1972) work, is continuously cited by present day academics (Coben 1998).

University Extension

A further division was that which gloried in its lack of usefulness. That is liberal

⁴ Originally written and published between 1916 and 1935

non-vocational education of the type championed by the old universities. Oxford and Cambridge were founded in the twelfth and thirteenth centuries (University of Oxford 2008, University of Cambridge 2008). Their position was not challenged until the nineteenth century with the foundation of universities in several English cities. This form of education was expanded beyond the walls of Oxford and Cambridge as part of the university extension movement in the mid-nineteenth century (Kelly 1950). The intention of this movement was to provide some access to bourgeois education for the working class. This was designed to engender a culture of inclusion within the establishment rather than the dangerous ideas of class antagonism and alienation suggested by Marx (1976). One of the legacies from these strands is the dichotomy between vocational and liberal adult education which continues today.

Professional Education

The final approach to education which has had consequences stretching into the present is professional education. Similarly to the apprenticeship this is designed to limit the numbers of those permitted to practise and to provide a body of knowledge to enable the individual to perform their duties competently. The three professions of clergy, law and medicine were university based and established within the ruling class. The macro-structural changes resulting from the move to a capitalist political economic system created a number of new occupations. Some of the practitioners within these groups looked to the established professions as models for them to emulate. Thus occupations such as teaching and nursing began to describe their trade and the education required for it as professional. Commentators outside of these new professions often dubbed them semi-professions (Etzioni 1969). This was, Etzioni argued, because they were predominantly made up of women and therefore could not achieve the status of the existing male-dominated professions. This is highlighted by many nurses and feminists as an example of the patriarchal oppression which has affected nurses throughout their history (Witz 1992). Nurse education will be described and discussed at length in the next chapter. For now it is sufficient to say

that professional education outside of the three established professions commenced during this period and again the legacy of the tensions of this time can be felt today. For example the use of ‘apprenticeship education’ as a pejorative way of describing a course of study continues (Bradshaw 2001a and Lane 1996).

Twentieth Century Adult Education

The outset of the twentieth century saw Britain as head of the largest empire ever known. At the same time this dominant world power suffered humiliating defeats at the hand of South African farmers. This shock led to social introspection and investigation into how this could have happened. Official research illuminated the reality of class division in which a majority of the population were in a worse state of health and opportunity than many of the subject people of the Empire (Fee and Porter 1992). Alongside other social and economic change this led to a period of social reform, commencing with the election of the Liberal Government in 1905. It should also be noted that events such as the formation of the Labour Party, suffragist militancy, syndicalist and Irish nationalist unrest were an indication to government that change would come with or without official assent. Therefore, the seeds of a welfare state, such as the provision of state pension and national insurance, were set in the pre-war period. Events during World War One such as state co-ordination of industry; massive death toll; the eventual introduction of conscription; and the consequent recruitment of women to previously male-only employment, encouraged the movement towards the acceptance of, and demands for, more state involvement in everyday life including adult education (De Groot 1996).

Liberal Adult Education

For adult education, this state involvement was reflected in the Ministry of Reconstruction Final Report of the Adult Education Committee (1919). This important document summarised the achievements of the preceding century and laid down the committee’s vision for post-war education for all. It emphasised the importance of

adult education as a tool to create active responsible citizens with the newly enfranchised population. As a result, the report encouraged liberal rather than vocational education (McNicol 2004). Since then the pendulum of governmental support has swung towards vocational education. This thesis is focused on an aspect of vocational education and therefore it is the vocational strand of adult education which will be discussed here except where non-vocational education is relevant to the subject.

Vocational Adult Education

At the same time, industry and healthcare were becoming more complex. The war had taken skilled men to the front at the same time as mechanised warfare created a demand for the products of engineering. The engineers replacing them required vocational training in order to continue to produce the munitions of war. War and its aftermath also created a demand for many more nurses with higher skills than had previously existed. Thus within adult education the historical epoch of 'The Age of Extremes' (Hobsbawm 1994) was to be riven by similar divisions to the previous one.

Apprenticeship Education

The pattern over the early to middle twentieth century was that government tended to act assertively to meet urgent training needs during times of crisis, such as the world wars, and withdraw afterwards. This lack of policy direction encouraged a return to the informal vocational adult learning which had been the norm in the previous century. In industry, as in nursing, this led to a form of learning on the job described as 'sitting with Nellie'. This describes the process of picking up things as the worker goes along (Stones and Morris 1972). There is merit in this as it flexibly allows new skills to be learned as the need arises. However, the downside is that the only check of quality is the product emerging at the other end of the production line. In engineering this may be cars and aeroplanes. In nursing it is patient care. Clearly, there was some advantage to having solid government training policy linked to producing competent workers. However, the period from 1945 to 1964 was mainly one of a return to

employer-led training. This was tempered by an increasing desire from both workers and employers for qualifications. The two world wars and international capitalist competition led to a perceived increased need for product-based vocational education rather than the time served, process-centred approaches often described as the apprenticeship model. Most apprenticeships were set at five years and were limited to the number entering the trade. The advantage of the product-focused approach was that more people could be trained using modern educational methods and the learner could be assessed to have reached an approved standard for a trade. It has been argued that this was opposed by the trade union movement in general (Aldcroft 1992) but Field convincingly contends that trade union conservatism was at most a marginal element in this (1996). Nevertheless, it was not until the mid 1960s that Government policy changed substantially to legislative intervention in the field of training.

The White Heat of Technology

In early 1964 the Conservative Government, in its last gasps of office, brought in the Industrial Training Act (1964). This was, in part, a response to concerns that the country was lagging behind in the level of worker skills compared to industrialised competitor nations. As the minister of labour said at the time “[t]he object of the Bill is greatly to improve training in industry and commerce through the establishment of industrial training boards” (Godber 1963). One of the clauses of the Act was to force employers to pay a training levy and establish the ‘Central Training Council’. It did not apply to local government or Crown organisations such as the NHS but did apply to all industries including the nationalised industries.

The Wilson Government of 1964-1970 made much of its approval of “the white heat of technology” (Wilson 1996) as a method of social improvement. The central idea of this was that Britain would thrive through the introduction and acceptance into industry and society in general of the latest scientific and technical innovations. This would require changes in the thinking and praxis of both sides of industry, capital and labour. Wilson had committed the forthcoming Labour Government to this strategy at

the 1963 Labour Conference (Wilson 1996). It is debatable how much of this was achieved in practice. One of the objectives of this time was a widening of participation in HE. Consequently, a new form of HE provision in the shape of polytechnics was launched. The focus of these institutions was on education rather than research and they tended towards the provision of vocationally-related courses. This period saw the introduction of perhaps the greatest innovation in the field of HE, in this case, a new form of university. What was first called a ‘university of the air’ when it was introduced in a white paper in 1966 later became the Open University (OU) (Sargent 1996). This was intended to open up HE to those previously unable to access it. The idea was to use technology such as television and radio to provide part-time study for anyone who wished to access it. The OU in its early stages specifically avoided vocational courses. It would not be until changes in government policy in the 1990s that vocational courses became the majority of its output. Consequently, the OU had little direct impact on the type of vocational training examined here. Nevertheless, it did signify a move to use new technology in adult education. This was also taken up by the new profession of industrial trainers who were being encouraged by government policy direction and the market pressures to increase industrial skills in the workplace. Innovations such as programmed instruction (PI) which were based on psychological research findings gained acceptance and by the 1970s many training officers claimed to use audio visual aids on a regular basis. These included the use of audio tape and video tape by the mid 1970s (Field 1996).

The Russell Report

The long awaited Russell Report into Adult Education was published in the early 1970s. This had been commissioned in 1969 “[t]o assess the need for and to review the provision of non-vocational adult education” (Department of Education and Science (DES) 1973:iv). The report outlined advice for an extensive programme for the future development of adult non-vocational education. As they said “[the] demands for adult education , which have risen steadily since the last war, cannot but continue to grow ...

These purposes demand a comprehensive and flexible system of adult education” (DES 2003:142). Unfortunately, during the four years since its inception, the educational and economic climate had changed for the worse. Consequently, little of these ambitious and worthy plans were undertaken. The main exception to this was the acknowledgement of issues relating to adult literacy and basic skills (Clyne 2006).

The Skills Gap

The 1970s saw an increase in unemployment partially blamed upon the ‘skills gap’. The economic changes were part of a world recession caused by the oil price shock of 1973 (Dinan 1994). Nevertheless many felt that Britain’s position remained worse than that of its competitors. This again led the Government and industry to look to training as a method of skills improvement. More cynical observers would see this period as the beginning of Government use of training as a tool to reduce unemployment by creating training schemes so that the unemployed did not show as such on statistics. In addition to the Middle East crisis, in 1973 the UK entered the European Economic Community (EEC). There were arguments about restrictions on sovereignty mainly pursued by politicians on the left of the debate, which led to a Labour manifesto commitment to hold a referendum on membership. However, amongst other benefits, membership of the EEC brought access to the European Social Fund to spend on training for the unemployed. This increased the amount and professionalism of training. However, it is also contended that the link to unemployment led to a reduction in the social position of those associated with vocational training (Martin 1983). Concerns for other reasons about social position would also have an effect on teachers of clinical nursing skills in the 1980s. More of this will be explored in the next chapter. The use of increased funding for training related to the up-skilling of unemployed people encouraged the view that the unemployed themselves were to blame for unemployment by their inadequacy to fulfil the requirements of employers. This focus on the supply side to alleviate unemployment rates has been continued by successive Governments since (Beardshaw

et al 2001).

The Great Debate

In 1976 the newly instated Prime Minister James Callaghan chose the bastion of adult residential education, with its historical links to the labour movement (Ruskin College 2007), to announce the commencement of a great educational debate. This debate was to discuss the merits, in both child and adult education, of the focus on liberal non-vocational education and democratic student centred approaches. The consequences of this debate are still being played out. However, due to the timing of the general election, the immediate results did not begin until the election of the Conservative Government in 1979.

The New Training Initiative

The Conservatives brought with them a market driven neo-liberal ideology. This prioritised the needs of business and deified the unrestrained market. It favoured a reduction in the size of government to reduce taxation; lessening of Governmental interference in the private sector to stimulate business enterprise; an increase in anti-trade union legislation to reduce the power of the trade union movement; and it considered unemployment as an inevitable and not unwelcome side effect of a free market (Beardshaw et al 2001). As the archetypal neo-liberal Hayek had said “[e]ven re-training, which certainly ought to be provided on a liberal scale, cannot entirely overcome [unemployment] ... those who can no longer be employed at the relatively high wages they have earned ... must be allowed to remain unemployed till they are willing to accept work at a relatively lower wage” (1986:153-154). However, in order to make this Hobbesian ‘dog eat dog’ world view (Hobbes 1985) in any way palatable they tagged onto it the meritocratic paraphernalia that each individual could make their own destiny despite the prevailing economic and social conditions. This meant that adult as well as child education were important to their social policy. The inevitable consequence of this was that vocational education now became the favoured strand of

adult education. This was especially the case for unemployed workers. The new training initiative introduced in 1981 was designed to reform skills training; equip young people with the ability to find work and to enable adults to re-train for different work throughout their lives (Fieldhouse 1996). This was a completely different emphasis to the kind of future envisaged by Russell (DES 1973).

Perhaps surprisingly, considering the ideological alignment with low taxation and small government, this emphasis on vocational education as a tool for increasing labour value and flexibility, led to the tripling of Government spending on training during the 1980s. One major outcome of this stage of development was the creation of National Vocational Qualifications (NVQ). These were intended to create a framework for making vocational qualifications both measurable and transferable. Hence they concentrated on the outcome of the education rather than on the educational journey. This intentionally stood the concept of 'time served' apprenticeship on its head. It could be seen as part of the Thatcherite war with trade unions. However, confrontation directly related to traditional apprenticeships was only really an issue in confrontations such as those with the print unions (Laybourn 1992). The trade union movement's involvement in education had progressed at a similar rate to that of industry. This was especially the case in relation to the training of representatives (Holford 1994). Consequently, rather than being a reactionary movement fighting a rear guard action to defend old privileges the trade unions were often part of the call for improvements in the standard and access for workers and the unemployed to education. The battles which took place over training were similar to those over other aspects of industry in that they related to a Government ideologically committed to removing trade union involvement in decision making at all levels.

Transferable Education

The effects of this attempt to make educational qualifications comparable to each other spread beyond the confines of the National Council for Vocational Qualifications (NCVQ) to encompass all forms of education. This movement to have comparable

outcomes-based measurement, resulted in all forms of education seeking comparability. Prior to this there had been no attempt to measure vocational courses against each other. A police training course, for example, was designed to license police officers and if that officer decided to change careers, then the course would have no academic credit outside of policing. However, from the mid-eighties onwards all vocational training began to be measured against external academic criteria and became theoretically transferable (Hodgson and Spours 2003). Included in this group seeking educational equivalence was nursing.

Higher Education

The 1991 White Paper – Higher Education: A New Framework and Training for the Twenty-First Century was one of a raft of papers in that year designed to reorganise the post-compulsory educational landscape (Bryman and Cantor 1992). One of the main outcomes of this was that the polytechnics, which had been founded in the 1960s, were given university status. The market ethos continued with successive Conservative Governments. Consequently, adult education within the further education sector joined many other public services, by being split into self-governed bodies based on individual colleges in the early 1990s. This was achieved as an aspect of the Further and Higher Education Act in 1992. This deliberately set college against college in financial competition for funding mainly obtained from the newly established Further Education Funding Councils. The Act clearly stated the limits of activities to be funded and these were strictly functional or vocational (Fieldhouse 1996). This favoured vocational education in general but nursing was in the process of moving from an NHS apprenticeship to HE. This led to an overall lowering of numbers being trained in the early 1990s compared to the late 1980s.

The Learning Age

Following their election in 1997 the New Labour Party had declared that education was to be the most important tool in the creating of the New Britain it wanted

to bring about. Again this would concentrate on vocational subject matter, but the plan was for this to be on a much larger scale than before. Nursing and teaching, which were both now offered as areas of study in higher education establishments, were particularly targeted as needing greater numbers of trainees and consequently more courses were laid on to provide this. However, the market ethos of the previous administration was deliberately continued. Therefore, the fragmented competitive structures inherited from eighteen years of Conservative rule were modified only slightly to provide this increased provision.

The Dearing Report

The Dearing Report outlined the proposals for the future of HE. This would influence nurse education as the paper saw technical and vocational HE courses as leading to future higher graduate salaries and better employment opportunities. Nursing was a vocational speciality named as an example several times in the report, alongside such subjects as engineering. These were seen as rational choices for students, rather than liberal arts courses, which were less likely to lead to employment. Consequently, they should be encouraged by government policy to expand (National Committee of Inquiry into Higher Education 1997). With reports of reductions in the quality of patient care partially due to a lack of nurses this led to a commitment to increase student numbers over the coming decade (Department of Health (DH) 2000).

Leitch Review of Skills

The purpose of this historical context study has been to provide a backdrop to the events leading up to the introduction of CF type roles in the early Noughties. Nevertheless, it would be neglectful to leave out the policy framework in the following years leading to the writing of this thesis. Government policy has moved further towards the vocational utility of adult education. This can be illustrated by the influential Leitch Review of Skills (2006).

Leitch was tasked with reviewing what the “UK’s long-term ambition should be

for developing skills in order to maximise economic prosperity, productivity and to improve social justice” (2006:2). These terms of reference were specifically aimed at producing Government policy in adult education along the lines of the Victorian idea of ‘useful knowledge’. As Leitch said in his introduction “[e]conomically valuable skills’ is our mantra” (2006:2). In a similar vein to Wilson in the 1960s the concern here is to ensure that the UK skills base does not lag behind that of other developed economic nations. Leitch’s reasoning leads to a recommendation for emphasis on adult rather than childhood skills education. This is because of the aging profile of the UK’s workforce which means that seventy percent of the 2020 workforce had already left school in 2006. Consequently, adult vocational education is a crucial policy instrument to achieve the dominant global skills position that Leitch envisaged.

Chapter Conclusion

The history of adult education has been one of continuous change in direction and emphasis. The current emphasis on vocational, or useful, education is part of a utilitarian paradigm, which is usually seen as starting with the 1976 Great Debate speech. Despite the ambitions of the Russell Report, it can be argued that there was a movement in government from the mid 1960s along this path. However, notwithstanding this short term view related to governmental involvement, the history of vocationalism goes back beyond the 200 years examined in this chapter.

Suffice it to say that government intervention in adult education can be justified on utilitarian and deontological grounds. That is, from a consequentialist viewpoint, it is a useful investment for the nation, as it provides the skills and knowledge required to engender a prosperous society for its entire people. From a duty based perspective, it is the right thing to do because it enables disadvantaged individuals in their adult lives to access the education denied to them as children or young adults. It must be remembered that in order to provide skills education of any kind it is not possible to entirely rely on classroom or lecture theatre teaching. ‘Sitting with Nellie’ is used as a

pejorative description of learning on the job. However, most would agree that, it is much easier to learn a new skill by being shown, supervised, observed and assessed while practising the task. This requires skilled teachers in the workplace or in a simulated workplace. In manufacturing industries these are the industrial trainers. In nursing this job has been done by a variety of people. These include doctors, ward sisters, staff nurses and other health professionals as well as dedicated clinical educators. It is the history of the education of nurses which will be investigated next in order to provide a specific context for the research study that follows.

Chapter 2: Nurse Education in Context

Introduction

It is necessary for any understanding of the place of CFs within the education, profession and organisation of nursing, to gain some insight into their historical position. The previous chapter examined a historical overview of post-compulsory education in general. Consequently, this chapter will examine some of the political, social, economic and theoretical themes emerging from nursing history.

Unsurprisingly, for one of the numerically largest trades in existence (NMC 2007b) there are many accounts of histories of nursing in the literature. Whether nursing is a trade; a vocation; a job; or a profession is disputed and has been since Nightingale's time (Messer 1914). The arguments on all sides are interesting and important as the term used for description informs the social, economic and political position ascribed to the collective body. However, important as they are, these concerns are not the central issue within this thesis. Consequently, on the whole, the terms shall be used interchangeably and the reader should not assume any meaning is intended by their use beyond that of describing a group of workers. It will be necessary to discuss the differences of opinion when this is pertinent to the historical narrative. Where this is required it will be made clear. Nevertheless, it should be noted that taking a pragmatic position on this terminology, nursing has all of the modern paraphernalia of a profession. There is a recognised body of knowledge (Schön 1991 and Health Professions Council 2008b); minimum requirements for registration are set to be at degree level nationwide in the near future (Tweddell 2008); the title 'registered nurse' is legally recognised; all of those calling themselves such must be registered with, and can be disciplined by, the professional body, which is currently the Nursing and Midwifery Council (NMC), as described in subsequent Health Acts and Nursing Orders (Dimond 2005). As a consequence, the grouping can, in addition to the other descriptions, safely be referred to as a profession. Descriptions of nursing as a semi-

profession or neo-profession are interesting as they ascribe a lower social status. These terms are generally justified by the large proportion of women in the trade and/or because nursing has become active in a state controlled sector. As commented upon in the previous chapter, these descriptions define the oppressed position of the profession within the existing capitalist/patriarchal hegemony (Zmroczek and Mahony 1999). This will be returned to later.

Historiography

Historians and nurses have accumulated and interpreted accounts since nursing began to be described as a profession in the late nineteenth century. For this chapter various strands of these histories as well as original research and primary materials will be used. The historiographical strategy used will be that suggested by Rowbotham (1977). This approach is that the past informs the present and that the radical or repressed voice has as much historical legitimacy as the official text (Rowbotham 1999, Kean et al 2000). This is deliberately antithetical to the approach of historians in general because the repressed voice is often prevented from creating official verifiable accounts. The historian is typically represented as interpreting solid and verifiable facts found in official archives (Plekanov 1940). However, it is argued convincingly by increasing numbers of historians that the approach of those attempting to find the hidden histories of the oppressed does not imply an anti-scientific approach or any reduction in academic rigor (Samuel and Thompson 1990). This is especially the case when checked against other sources, either official or otherwise (Jenkins 1991).

Why does this matter in connection to a context study of a discipline such as nursing education and those who pursue the particular part of it found in the clinical area? The answer to this is that, as stated earlier, nurses are an oppressed group on at least two fronts, sex and class, and have belonged to these groups from their inception as a professional or vocational group. This is important because it highlights one of the central social dialectics within nursing. That is, on the one hand nurses are a powerful, numerically impressive grouping, with the trappings of a legislatively accepted position

in the social order. On the other hand they are seen as, and often behave collectively as, victims of circumstances rather than proactive agents of policy making. As stated above, the source of this situation it can be argued is gender and social class relationships. Sexual discrimination will be discussed first, followed by class.

Sexual Discrimination

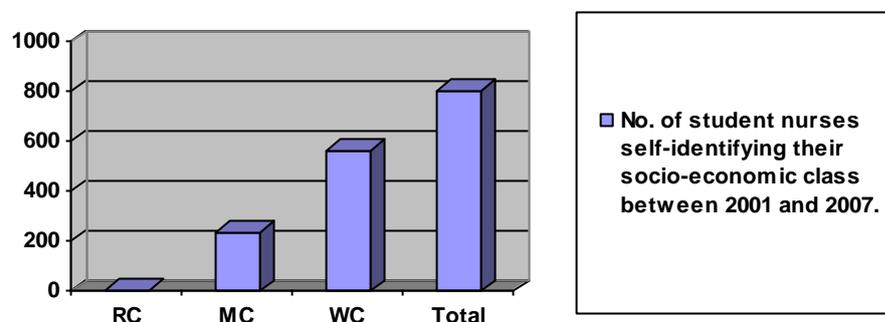
Nurses are and always have been mainly women. The general public see nurses as female and nurses themselves often describe an unnamed individual nurse as 'she' (Bradshaw 2001a and Watson 1999). It goes without saying that this homogeneous description is not entirely true. From the beginning there have been men in nursing. However, it is factual to say that nurses have always been overwhelmingly female and there has been little percentage increase in the number of men taking up the profession in recent years. According to the NMC, currently the UK nursing workforce is 10.73% male (NMC 2007b). This is an increase of 2.36% of the total since 1990 (NMC 2000). If the trend continues to climb at the current rate then it will take a further 300 years to achieve numerical gender equality in the profession. Any extrapolation of this length is likely to be of little value in real terms but it does show that there is almost stasis in the percentage of nurses of either gender at the present time. It also shows that there is little sign of change in this likely in the near future. To compound the real world numerical minority of men further, there are statistics within the detail which make it sensible to claim that the profession, especially the profession involved in direct, hospital ward based physical care that is the main focus of this thesis, can sensibly be described as overwhelmingly female. These details include that the men who are in the profession are over represented in particular parts of the job. Similarly, to elsewhere, due to the well documented patriarchal nature of society, men feature disproportionately in management and other senior positions (Lane 1998). In British nursing there are four branches to the register. These are adult, child, learning disabilities and mental health. Men make up 50% or more of the proportions of mental health and learning disabilities nurses. Consequently the number of women in adult

branch, which are the nurses involved in the majority of physically orientated general hospital care, are made even more overwhelmingly the majority than would appear to be the case from the headline figures. Therefore, nurses are demonstrably perceived as a female profession and empirically the majority of individuals working as clinical general nurses are women. From this analysis it can be claimed solidly that nurses and nurse educators and other sub-specialities with the profession are likely to face a similar set of prejudices and injustices that women in general face within society.

Socio-economic Class

When asked to identify their own class background, most nurses identify themselves as working class. As part of the background research to the case studies investigated in this thesis nurses were asked whether they identified their class background as working class; middle class; or ruling class. The results below show that a significant majority identify with the most oppressed class.

Figure 2: Class Backgrounds Results



RC= ruling class (n4); MC= middle class (n235); WC= working class (n562).

(Whitehead 2007)

This self-identification is not sufficient and requires examination from a variety of view points. Looking at social position and class from the perspective of oppression requires consideration of the Marxist argument because this remains the pivotal critical theory in relation to economic repression (Prasad 2005). From a Marxian perspective, as employed paid workers nurses are working class. However, using this classical defining methodology includes all other members of health professions operating in

NHS hospitals today including medical staff such as consultant surgeons and senior managers. This creates an analytical problem when proposing subjection of one part of the same group by the other. Nevertheless, Marx himself made differentiations between waged workers on the grounds of “badly paid” and “best paid” (1976:822-828). Despite this accepted division, Marx concentrated his politico-economic analysis on the conflict between bourgeois and proletarian. The oppression he described was famously that of capital over labour through commodification of everything in existence in capitalist society. This theory engenders a specific view of the oppressor class as the owner of capital and the oppressed as those whose worth is valued by their labour. In a state healthcare system such as the NHS this sounds like a distant and unconnected battle. However, again in Marx’s *Capital*, he makes it clear that the relationship of the waged worker to the product, or more correctly commodity, need not be direct and that any worker whose labour directly or indirectly assists with the production of surplus value is engaged in productive labour, intrinsically creating surplus value for the increase of capital. This concept can be as easily transferred to the repairers of workers, as it can to the teachers working in learning factories who Marx described. However, the conflict, referred to above, which Marx saw as the engine of his theory of “the materialist conception of history” was chiefly to be fought between the direct combatants (Lenin 1935). Therefore, conflicts and oppressive behaviour within the hierarchies of the health service would be seen as “peripheral phenomena [which] can be ignored when considering capitalist production as a whole” (Marx 1976:1048). Later Marxian theorists, such as Marcuse, expanded politico-economic oppression to the bureaucratic military/industrial complex (1964). In this case it is more useful to consider social class as one of multiple oppressions affecting suppressed groups. This theory of general oppression initially proposed by feminists such as Plumwood (1994) allows for unjust inequalities of any kind such as race, age, gender and social class to be taken into account rather than assuming, as Marx did, that all such injustice results from economic inequality created by the accumulation of capital.

Usefully it does of course also allow for this form of oppression within the canon of unfairness. Nevertheless, it does not require that one power relation have ascendancy. As Phillips says “[t]his broader conception of power has been cited as one of feminism’s major innovations” (1991:102). This is not to claim that it is a view followed by all feminists. This would be far too simplistic a vision of the multi-layered analyses of feminisms. Nevertheless, it has become a common thread to the arguments about power relationships postulated by many feminists in the past few decades (Kemp and Squires 1998). Using this ‘multiple sources of oppression’ model to assess the social class of nurses as a group requires the examination of a variety of indication factors. The Marxian formulation cited above remains valid, but under this form of analysis is just one argument for socio-economic position. Liberal statisticians have attempted social classification for many years using a variety of indicators to create hierarchies designed to assist policy makers and researchers. The current version used by the Office for National Statistics (ONS) is the Standard Occupational Classification 2000 (2008). This method of classification was adopted in order to match the International Standard Classification of Occupations as closely as possible. This standard consists of a nine point scale and all UK occupations are mapped to positions within it. The nine points are each given titles descriptive of the occupations listed within them. These are as follows:

- 1 Managers and Senior Officials
 - 2 Professional Occupations
 - 3 Associate Professional and Technical Occupations
 - 4 Administrative and Secretarial Occupations
 - 5 Skilled Trades Occupations
 - 6 Personal Service Occupations
 - 7 Sales and Customer Service Occupations
 - 8 Process, Plant and Machine Operatives
 - 9 Elementary Occupations
- (ONS 2000:1)

The positions within this are arrived at by empirical observation of the power relationship between occupations and the level of autonomy of occupational groups. Within the main nine points are subgroups (ONS 2008). This method of classification places nurses in group 3 “Associate Professional and Technical Occupations” (ONS

2000:6). The final sub-group which encapsulates nurses within this tier is “Health Associate Professionals”. Therefore, within this officially sanctioned hierarchy, nurses are classified at the level below medical practitioners and pharmacists. This indicates that, although nurses have been successful in raising the socio-economic status of the profession from that of carers who do not have the paraphernalia of registration and a professional body, they have not obtained a social position of equivalence with the recognised fully professional groups. This clearly indicates that they are in the semi-professional class discussed by Stronach et al (2002). As noted earlier this is a group of professions which are identified by their majority female membership and lower social position (Etzioni 1969 and Witz 1992). In the current climate of the rise of managerialism (Shain and Gleeson 1999) it can be argued that the main area of conflict and oppression for associate professionals is with management.

An Oppressed Profession?

If the nursing profession was in the kind of position of power which law and medicine hold, then they would be able to protect their privileges, in a contemporary liberal capitalist democracy at least. On the other hand, that they are considered professional at all indicates that the processes of proletarianisation (Stronach et al 2002) and deprofessionalisation (Hyland 1998 and Shain and Gleeson 1999) are not yet complete.

In many ways the interests of the profession and employers do converge. Both wish to provide excellence in their service to the client group. Both wish to provide an environment where patients feel safe and valued. Of course, in some arenas, the aims of management and professionals will be divergent. For example, NHS trusts are forced to meet year on year cost improvement programmes (Stronach et al 2002). Consequently, it is hardly surprising that professionals end up in conflict with management (Hartley 2003). When these disputes arise there is a straightforward industrial confrontation of the type involving any group of organised workers and management (BBC 2007). This power relationship difference of interests is enshrined

in law (Employment Relations Act 1999). The undisputable empirical reality of this state of potential and actual confrontation dates back to the early industrial period and arguably back to the beginnings of civilisation (Webb and Webb 1920, Linebaugh and Redicker 2000 and Whitehead 2001). A manifestation of this conflict is the long history of nurse trade unionism (Confederation of Health Service Employees (COHSE) 1993).

The position of nursing within the socio-economic framework, is one of a relatively oppressed group. Not as low in the social scale as some, but certainly not in the upper professional tier. Considered in line with Marxist theory, liberal empirical sociological practice or the position of professions within the social milieu, it can fairly be concluded that nursing is below a number of important other occupational class groups. All of this means that the multi-disciplinary group which makes up the team caring for patients is not a democratic socially equal team. A consequence of this is that the official line which nurses and nurse educators have been taking for decades (Corrigan 2002) can demonstrably be shown to be a fiction. Nurses are a part of an oppressed class and additionally as semi-professionals are a subordinate profession.

Hidden from History?

From a historical perspective these twin oppressions of sex and class potentially place nurses into Rowbotham's 'hidden from history' category (1977). From this perspective she argues that the history of women, and particularly working class women, has been deliberately repressed by patriarchal society. However, as stated above there have been numerous histories written about nurses and nursing. These vary in tone and purpose depending on the author's position either as professional historian or nurse historian and various other perspectives. History and other academic disciplines have often been used to support their author's argument, ideology or campaign. As Rafferty et al say

[m]any of the early nursing histories were written by nurse leaders and their sympathizers operating as extensions of their campaigns for nurses' registration or suffrage. Accounts of nursing history are revealing of how nursing work is

perceived and defined at any given point in time. Take the early nurse historians, Lavinia Dock and Adelaide Nutting, for example. Their association of nursing with the instinctual basis of caring celebrated in Peter Kropotkin's *Mutual Aid* drew an analogy between the biological and social worlds. Nutting and Dock were keen to associate nursing with the evolutionary characteristics of altruism and co-operation, attributed by Kropotkin to the survival of superior species (Rafferty, Robinson and Elkan 1997:3) [original US spellings retained].

Dock and Nutting were both women's suffrage activists. They deliberately used the medium of the historical account to both promote nursing as a socially respectable profession and to radicalise those associating with it. They convincingly associated nursing with part of the classical anarchist Kropotkin's ideology of anarchist communism (Nutting and Dock 1912). In a later, single volume, version of this tome Dock presented copies of a number of "nursing oaths", which she described as having a similar purpose to the medical profession's Hippocratic Oath. One of these is as follows:

I solemnly pledge myself before God, and in the presence of this assembly to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care (Dock and Stewart 1938) [original US spellings retained].

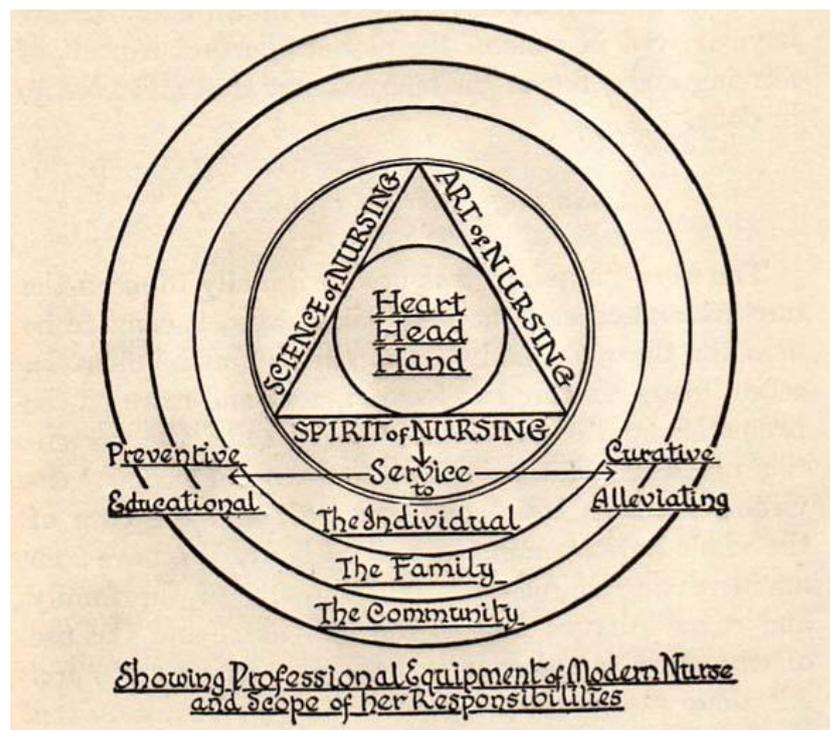
As she makes clear these are presented to show that in times past female nurses saw male doctors as all powerful and by implication that this was not now the case. Similarly to the political motivation of Dock and Nutting, in more recent years Bradshaw has used her histories of nurse education to support her thesis that nurse education should primarily produce practical, skilled, caring nurses (2001a and 2001b). Neither of these examples are mere propagandist historical manipulation. They are both academically rigorous and well executed. Nevertheless, they would not have been written unless their authors had a contemporary issue to support. The work of professional historians such as Abel-Smith (1960) is not immune from contemporary agendas. Bullough (2002) argues that the eminent historian was foremost in moves to modernise the education of nurses in Great Britain, culminating in the appointment of a fellow historian as chair of the influential Briggs Report (Department of Health and

Social Security (DHSS) 1972). The purpose of this account is similar. That is, rather than being a pure historical presentation, the chapter will examine the historical evidence through the lens of the present to gain some insight into the circumstances which led to the instigation of the CF and the issues faced by them.

Professionalism and Clinical Skills

One of the crucial dialectics in contemporary nursing is between the desire of this ‘emerging’ (Freidson 1994) or ‘semi’ profession (Etzioni 1969) to gain raised status through cognitive educational ‘award’; and to maintain clinical effectiveness while maintaining the confidence of the public through “fitness for practice and purpose” (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1999 and 2001). Roles such as the CF can be seen as standing at the interface of these arguments. Much of the literature describes clinical education roles as being essential for linking theory with practice. This is not a new desire as can be seen from the diagram and quotations below published in 1938.

Figure 3: Professional Equipment of a Modern Nurse and Scope of her Responsibilities



All vocations, even in their early stages, show three main phases of development. These three phases are represented in the diagram as the art, science and the spirit of nursing. (...)

It was Florence Nightingale who first insisted that nursing was an art, "the finest of the fine arts." Up till her day it had been looked upon generally as a form of manual labor, regardless of how low or lofty the motive might be that promoted the service. Many people still think of nursing as a handicraft rather than an art, and probably this is a correct term for much that goes by the name nursing even today. (Dock and Stewart 1938:356-357) [original US spellings retained]

The general opinion of those who have studied the question [is nursing a profession?] seems to be that nursing belongs in the group of professional occupations but that it is not yet as well developed, especially on the educational side, as some of the older professions. Because of its educational lag it has been called an "emerging" profession rather than one that has actually "arrived." A better educational foundation for those who enter nursing schools, and better standards of preparation in the rank and file of these schools would help greatly in giving nursing the full standing that is implied by the term "nursing profession." (Dock and Stewart 1938:365)

As can be seen above the debate over the status of nursing as a profession and the linkage of this debate to the status of physical work and education have a long history. There is no doubt that this is important as it affects the economic, academic and social status of those involved in carrying out direct patient care. This is especially true in those nursing specialities, such as medical and elderly care wards, known for their high levels of physical care. In educational institutions the status of those involved in teaching skills rather than more academically respected subjects is similarly affected (Martin 1989). This can be seen in the historical narrative of the emergence in the 1950s of a specific clinical teacher (CT) role. The emergence of the CT will be discussed in more detail later in the chapter but a brief account is required at this stage to make this point. The practitioners were paid on a lower grade than other nurse tutors and were required to do a six month teaching course rather than the full tutor twelve month programme. This led those questioned in a survey by the Royal College of Nursing (RCN) in the 1970s to describe the way their role was perceived by colleagues as that of "failed tutors" (Hinchliff 1986:37). Martin describes nurse tutors and CTs as identifying themselves as teachers rather than nurses when questioned about their professional affiliations (1989). This debate about the status of clinical practice led to the removal of the specific CT role during the changes in nurse professional registration and education which took place in the late 1980s (Mjojo 2002). This remodelling

followed the Briggs Report on Nursing (DHSS1972) which began implementation with the Nursing, Midwifery and Health Visiting Act (1979). This was at a similar time to the removal of the enrolled nurse (EN) and the switch from apprenticeship to HE (UKCC 1986). This concept of making a single status for nurses and nurse educators was designed in part to improve the low status given to those nurses and educators involved primarily in the giving or teaching of direct care. However, the consequence was widely perceived, by the general public and health professionals, including many nurses, as being that RNs and nurse educators withdrew from direct patient care such as washing, feeding and toileting (DH 1997, Olese 2004). This became an issue to the extent that questions were raised in the House of Lords (Bradshaw 2001b). The profession and the Department of Health announced measures to raise the amount of clinical skills taught to students in pre-registration education (DH 1999, UKCC 1999) and finally to re-introduce a specific practice teacher qualification to the register (NMC 2006a). Lately, the NMC has taken the decision to insist on a list of skills to be taught by universities prior to a nurse being permitted to register (NMC 2007a). Is this the behaviour of a first level profession? It would appear more like that of a craft based occupation returning to its origins. If the theory is accepted that nurses are an oppressed group, then the action to reintroduce clinical skills as a central theme is simply another act of repression by the powerful political and managerial policy makers. As Tschudin says “[n]urses have, for very long, suffered from the fact that policies and rules were made for us rather than by us; made by men for women; by politicians for nurses” (1999). Along with other semi-professions at the beginning of the twenty-first century nursing has been increasingly regulated. Teachers for the first time in England have to belong to a professional body (General Teaching Council (GTC) 2000). Similarly nursing and other “associate health professions” such as occupational therapists had their professional regulatory bodies reconfigured at this time (NMC 2008a and Health Professions Council 2008a). For nurses this entailed the introduction of a replacement professional body, the NMC. This was not a simple

name change. The previous body the UKCC had a majority of its members democratically elected and separated the educational function into four separate national boards. The NMC would finally lose all democratic trappings to become an entirely appointed committee in 2008 (NMC 2008a, DH2007, and Privy Council 2007b). This is in contrast to the General Medical Council which, subject to the same legislation, retained its right to elect the medical membership of the council (Privy Council 2007a). Nevertheless, even this group of primary professionals succumbed to the direction of travel towards appointment of council members and external regulation by the following year (Privy Council 2008). There can be no doubt that the nursing profession as a whole is following the agenda of the more powerful members of society in pursuing a more skills-oriented approach. However, this cannot be simply looked at as the result of an oppressed group being forced back into a lower social position. Most of the profession's membership would agree that clinical skills are highly important for nurses and there can be no doubt that the majority of rank and file nurses support the move towards a skills-oriented education (Bradshaw 2001b). This will be returned to in the research findings section of this thesis. The introduction of CFs and similar roles can in part be ascribed to this. Nevertheless, there were other factors, such as recruitment and retention considerations, which also led hospital trusts to introduce the role. This will be discussed in the literature review section and will also be investigated in the findings chapter and the ensuing paragraphs of this section.

The social and professional considerations described above do not completely explain the historical condition leading to the prevailing conditions in which the current CF role is situated. Consequently a more detailed narrative and discussion will now be presented.

History

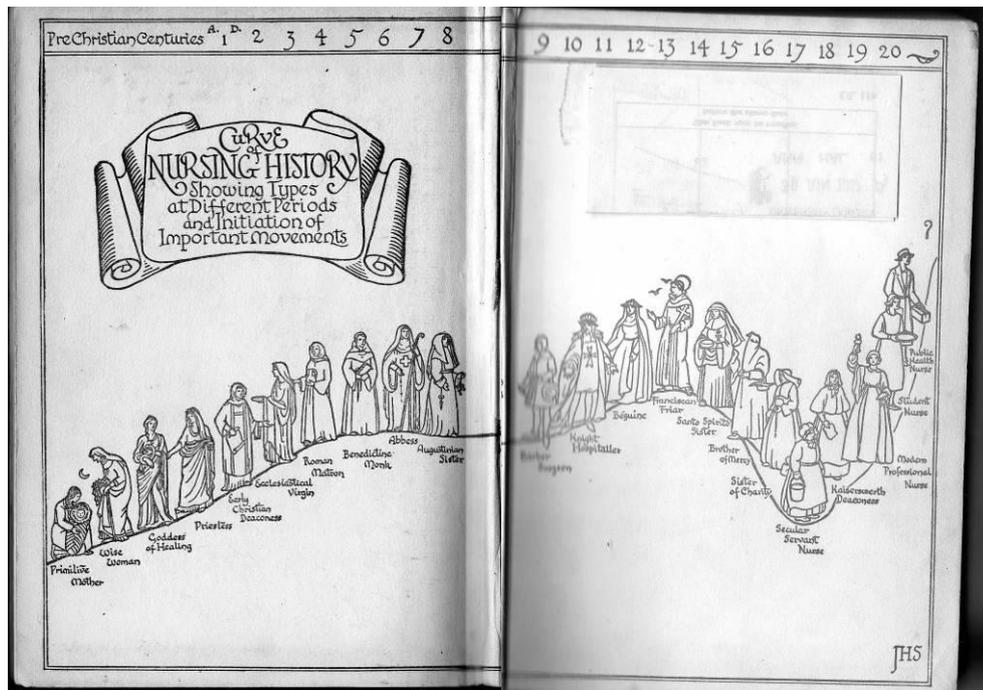
When writing any historical account it is both difficult and important to decide upon the starting point. As previously made clear, the purpose of this version of events is to set the scene and provide data for the case study research in the forthcoming

chapter. Bradshaw convincingly argues, through research based on the core textbooks spanning one hundred years of nurse education, that much of the ethos and content of training courses was based on the principles emanating from the late nineteenth century (2001a). Consequently, it is necessary to look back to the origins of the apprenticeship nurse training model, because this is a model to which many nurses educating and practising in the early twenty-first century refer (Rideout 2000). It is often seen as an ideal type for producing competent and caring nurses. It goes without saying that this is a debatable point. As an oppressed group, nurses struggle to see beyond the terms of reference of their bondage (Freire 1972, Marcuse 1964, and Marx and Engels 1996). Therefore, it is understandable that many nurses see apprenticeship training, with its accoutrements of servitude to the medical profession and self sacrifice to the hospital administration, as a historical golden age. However, even politically aware and critical academic nurses have begun to question whether the direction of travel for nursing away from the hands on, clinical, “knowledgeable doer”, described by the UKCC when they were setting out their plans for Project 2000 (1986), has gone too far in the direction of the ‘knowledgeable’ from the ‘doer’ (Drennan and Hyde 2008).

Origins of the Apprenticeship Model

The beginning of apprenticeship nurse education appears a good starting point, whichever explanation is selected for this phenomenon. From a secular British viewpoint this can be dated precisely to the time of the first Nightingale school at St. Thomas’ Hospital in June 1860 (Seymer 1957). That is not to suggest that nursing began in 1860. There were nurses or people who cared for the sick going back into pre-history. Nurse historians such as Dock have attempted to trace its origins back beyond recorded history as can be seen in her visual representation of a nursing timeline below.

Figure 4: Nursing History Timeline



(Dock and Stewart 1938: inside front cover)

In this account she provides a creation mythology which is important to the sense of imagined community she was attempting to foster amongst the profession (Anderson 1991 and Samuel and Thompson 1990). As can be seen in the illustration Dock commences her story in pre-history. It is not a Whig account of continuous progress as her timeline is in two dimensions and the section from the friar to the servant is all downhill. With the Kaiserwerth School for Protestant Deaconesses she charts a move in the direction of progress. This school was an attempt to create a Protestant version of the Catholic ‘Sisters of Charity’. The founders provided broad training for the deaconesses including pharmacy, ethics, anatomy as well as cooking, cleaning and other practical skills related to the care of the sick. Kaiserwerth was where Nightingale gained her inspiration for nurse training. Consequently, Dock puts the professional nurse ahead of the student nurse in her chronology (1938). Nevertheless, this chapter is a history of formal nurse education. Consequently, the formation of the first secular training school for nurses is a sensible point to commence. Nurses had been taught things prior to this and the hospitals which became the illness factories of the nineteenth century required skilled operatives to run them (Foucault 2003). In addition,

there were, of course, women who nursed the sick in the army prior to and contemporaneously to Nightingale's time in Scutari. Some of these were remembered either in their own words (Seacole 2005) or through local campaigns of charitable giving for their retirement (BBC 2008). However, the image of the nurse at the time was increasingly of the untrained nurse depicted in Dickens' 1844 novel *Martin Chuzzlewit* (Dickens 1994).

Figure 5: Sarah Gamp



(Kalisch and Kalisch 1987:14)

This concept of dangerously incompetent care in British hospitals was supported by Nightingale's experience in the Crimea. The Crimean War death rate, which Nightingale showed with an early use of pie charts, had been in main part caused by disease exacerbated by poor care, led to support for formal nurse training. Nightingale is seen as the historical character who founded the first school of nursing. It is a matter of historical record that she was the founder of this first real secular school of nursing at St. Thomas' Hospital in 1860. However, it must be considered that some such course of events would have taken place with or without her. The hospitals were becoming an area for treatment rather than a repository for the sick poor. In addition women were at this stage beginning to be accepted into HE and the professions. This was, in part, a response to the radical and liberal challenges to the old patriarchy by thinkers such as Wollstonecraft (1996) and Mill (1996). However, it was also an empirical phenomenon that was, arguably, happening independently of philosophical

theorising. For example, the first woman to join the medical register in the UK was registered in 1868. She had gained her medical degree in the USA in 1849 and she formed the women's medical college in England in 1869 (LeClair, White and Keeter 2007). Other professions also began to reluctantly be forced to accept women because of materialist processes such as the phenomenon of 'surplus women' during the period (Bolt 1995). This numerical superiority of women to men at the time was caused by a variety of factors and meant that there were not sufficient eligible bachelors to ensure the Victorian ideal of the family. Some of these capable women were encouraged to become student or probationer nurses.

Probationer Nurses

The probationers had a set period of one year at the outset. There were weekly lectures but the main form of education took place on the wards with the matron in charge of the day to day education and discipline. "A strict timetable of supervision and certification was imposed on the probationers" (Bradshaw 2001a:10). The range and content of the nurses' duties and skills is a matter of historical dispute. Most historians relying on official records point to the contents of documents such as the St. Thomas' School application form which listed the following duties:

Duties of probationer

You are required to be sober, honest, trustful, trustworthy, punctual, quiet and orderly, cleanly and neat.

You are expected to become skillful-

- 1 In the dressing of blisters, burns, sores, wounds and in applying fomentations, poultices, and minor dressings.
- 2 In the application of leeches, externally and internally.
- 3 In the administration of enemas for men and women.
- 4 In the management of trusses, and appliances in uterine complaints.
- 5 In the best method of friction to the body and extremities.
- 6 In the management of helpless patients, i.e. moving, changing, personal cleanliness of, feeding, keeping warm, (or cool), preventing and dressing bed-sores, managing position of, etc.
- 7 In bandaging, making bandages and rollers, lining of splints, etc.

- 8 In making the beds of patients, and removal of sheets whilst the patient is in bed.
- 9 You are required to attend at operations.
- 10 To be competent to make gruel, arrowroot, egg flip, puddings, drinks for the sick, etc.
- 11 To understand ventilation, or keeping the ward fresh by night as well as by day; you are to be careful that great cleanliness is observed in all the utensils, those used for the secretions as well as those required for cooking.
- 12 To make strict observation of the sick in the following particulars:–
The state of secretions, expectoration, pulse, skin, appetite; intelligence, as delirium or stupor; breathing, sleep, state of wounds, eruptions, formation of matter, effect of diet, or of stimulant, and of medicines, etc.
- 13 And to learn the management of convalescents.

(Dingwall et al 1988:54)

However, Baly (1986) and Dingwall et al (1988) convincingly cast doubt on this by citing evidence from probationers' contemporary diaries and reports. These indicate that tasks such as temperature, pulse, and respiration taking and recording were done by medical students; and the nurse's involvement in wound dressing was mainly in preparing the poultices. As indicated previously, this disconnection between theory and practice is something which would continue to be an issue in nurse education throughout the next century to the present day. The point that Baly (1986) and Dingwall et al (1988) were making was that this implied a lower status for the standard of education and actual work undertaken than for that laid out by the school authorities. It also meant that hospitals were using students as pairs of hands rather than teaching them valuable skills. The question that must be asked is: what makes the cleaning of patients and the provision of essential care less important than recording temperatures? This was precisely the point that Nightingale made over and over to her probationers and to the governing class at the time (1914 and 2005). It remains an issue for nurses in the twenty-first century. In recent years the RCN debated the motion 'are we too posh to wash' with regard to expanding nursing careers and the retreat from the bedside (O'Dowd 2004 and Bore 2004). This was not an isolated or ironic debate. Nevertheless, whether the probationer was learning how to record observations or how to make beds they were undergoing a certificated training course.

Certification or Registration?

At the end of the year the probationer became a hospital nurse and was entered on the hospital register as a certified nurse. This was prior to compulsory national registration and in later years when this was discussed, Nightingale was a staunch opponent of compulsory registration. “[S]he felt it would do great damage to the cause of nursing” (Abel-Smith 1960:65). “Seeking a nurse from a Register” she wrote “is very much like seeking a wife from a Register, as is done in some countries” (Nightingale cited in Abel-Smith 1960:65 [original capitals retained]). Other nurses, such as Bedford Fenwick, and doctors, such as Acland, argued that nurses, similarly to medical practitioners, should be registered to ensure quality and consistency of training (Dingwall et al 1988 and Bradshaw 2001a). However, Nightingale was influential and well connected and partially due to her interventions national registration for nurses, and the regulation of minimum educational standards which comes with it, would have to wait until well into the twentieth century.

Nurses Registration Act

In 1904 and 1905 parliamentary select committees were convened to discuss the issue of compulsory nurse registration. Despite strong argument from the anti-registrationists they found in favour of registration. Nevertheless, state registration and the professional standing which came with it were not to be enacted until the 1919 Registration Act (Abel-Smith 1960 and Hart 2004). Bradshaw sees the Act following directly from the intellectual arguments put forward at the committees (2001a). However, this delay of fourteen years cannot be dismissed easily. It would appear likely that the registration of nurses came when it did because of events in the wider political, social and economic context. This was immediately after the war and the extension of the electoral franchise to all working class men and to all women over 30. It was in a period of increased industrial militancy during a brief period of economic boom (Pribicevic 1959 and Rosenberg 1987). The factors influencing other workers were also affecting nurses. Nurses, especially asylum workers, were beginning to

unionise and take industrial action (COHSE 1993, Hart 2004). One of the issues at stake was that of the Voluntary Aid Detachment (VAD) nurses. These volunteer carers had little or no training and were recruited in large numbers during the war. Dingwall et al go so far as to say that “VADs gave the nurses a common enemy against whom they could unite” (1988:74). This was similar to the concerns of other trades during the war who had been required to accept unqualified workers into their fields of employment (Mann 1967). Also, the issue of women’s suffrage had an effect on the priorities of parliamentarians, as evidenced by the comments of an incumbent of the House of Lords in the year just prior to the Act. Earl Russell said ...

[t]he position is this, women now have the vote, they have to be considered more than they used to be. It is not so easy to say ‘I don’t like this registration of nurses’. Women are now likely to get what they insist on having ... (Earl Russell: House of Lords Debates 27 May 1919, col. 846 cited in Dingwall et al 1988:84)

These combined forces were compelling and led to a radical change in the composition of British social life. This was the beginning of the rise of labour in both a political and industrial sense (Hobsbawm 1978). The Government responded with initiatives in social reform such as the creation of a Department of Health and with attempts to de-radicalise potentially organised labour. This encouraged the setting up of regulations to control professions. Nursing as one of the largest was on the front line for regulation. This initiative would organise them under what government saw as appropriate senior members of the profession. The more positive aspect of this for the profession was that it would give them “what they insist on having” by regulating their training and restricting the membership to those licensed to practise. The General Nursing Council (GNC) was formed as a result of the legislation. From shortly after its inception to near its end it required a set syllabus and state final examinations for all training courses. These requirements for registration, in continually evolving form, continued as the basis of the profession until 1977. The registration of nurses was an important step for nursing to be recognised as a legally defined occupational group. However, it did not lead to a radical change in the methods or content of training. Bradshaw argues, with strong historical evidence, that this continued the ethos of the

Nightingale nurse education method. That is that nurses needed to be of high moral character and be practically skilled rather than theoretically knowledgeable (2001a).

Recruitment and Retention

Other issues faced by nurses and their employers such as, recruitment, retention and the attainment of appropriate skills also remained the same after registration and still concern these groups today. It would appear self evident that the two factors of the Nightingale ethos and falling recruitment were linked. The continued oppressed position in which this put the profession would be raised continually in the reports of numerous attempts at understanding the problems facing the profession.

In the following fifty years there were many reports and studies, and all indicated that apprenticeship training was inadequate but that it should continue in a modified form. It will be useful to illustrate the transition from early registration to the beginning of university based education by reference to these reports.

The Lancet Commission on Nursing

The first of these was the Lancet Commission on Nursing, set up in 1932 to “inquire into the reasons for the shortage of candidates for nursing” (Martin 1989:9). They concluded that part of the problem was poor working conditions, lack of trust, over-work and under-pay. This led to an attrition rate of approximately a third. A high drop-out rate on top of inadequate recruitment was creating acute shortages (Lancet Commission on Nursing 1932). The report recommended that preliminary classroom training become universal before students went out onto the wards. This was already the case in 60-70% of hospitals and subsequently became the norm. Thus they accepted the necessity of lectures by nurse teachers. The widely accepted practice in America by this stage was for learner nurses to be full-time students. Nevertheless, the Commission did not recommend that British trainee nurses become supernumerary students. This was because they felt that the practical skills were best maintained by hands-on direct nursing care (Martin 1989).

The Athlone Report

The Athlone Report was published in 1939. Its terms of reference were the same as the Lancet Commission: recruitment, retention and skills. The RCN put forward evidence for a register of trained tutors and for student status for trainees. These were rejected, as again the committee considered that nurses required primarily practical training. Its recommendations roundly supported the conclusions of the previous report and also recommended government regulation of maximum working hours of a 96 hour fortnight and minimum wages. However, these were rejected by the Government because they did not feel it was appropriate for them to become involved in setting salaries for a particular profession (Athlone Report 1939).

The Wood Report

During World War Two VADs were again deployed, and along with many other trades, nurses were temporarily forced to work alongside untrained volunteers and hastily educated workers. In 1947 a working party on the recruitment and training of nurses reported. This was known as the Wood Report and was widely critical of the London based GNC. It proposed giving the power to standardise and regulate training to regional committees appointed by the Ministry of Health (1947). The recommendations were partly brought into being by the Nurses Act of 1949. This also changed the composition of the GNC to include more nurse educators (Nursing Times 1950). A further recommendation of the report was that there appeared to be little sign of actual ward-based teaching other than the 'sitting with Nellie' type discussed in the previous chapter. The committee reported that there was a paucity of research evidence about the work of nurses, and partly as a consequence, research was commissioned which reported in 1953 (Goddard 1953). This reiterated the view that there was little or no ward teaching occurring. It stated that most learning was from more senior students and advised that selected ward sisters be provided with a course of teacher training to become teaching sisters. These should be set apart to undertake bedside teaching on behalf of the managing sister. The logical conclusion was for specially trained and

separately funded clinical tutors to be created. Clinical skills were theoretically prioritised throughout this period as shown by the outcomes of these reports. However, it was now becoming evident that the acquisition of these skills was haphazard and often left to the efforts of the student and chance.

A Case-Study in the Functioning of Social Systems as a Defence against Anxiety

It was hardly surprising that gaining the skills and knowledge required was haphazard under the existing circumstances. For example the administration of a London teaching hospital was so concerned that the status quo was not an option that it commissioned a study into developing new methods of nursing organisation. The statistics published with this research alone illustrate the problem. Student nurses numbered five-hundred and fifty out a nursing workforce of seven hundred at the hospital. This left only one-hundred and fifty matrons, sisters and staff nurses in total to train and supervise them. The students as a result were so pressured to provide the care for the seven hundred inpatients that between 30 and 50% left before they reached the end of their training (Menzies 1960). Menzies⁵ took a psycho-social methodological approach to this study and concluded that the organization was a pathological example of a social defence system against the otherwise unbearable anxiety in which the nurses and students were placed due to their workplace position as essential carers. She took the final position that unless the structural organisation systems such as task lists and decision avoidance were modified to less alienating and more empowering systems the nursing social structure was heading towards crisis (1960). Clearly, education would be an important component of any changes required considering the numerical importance of student nurses within this structure and the increasing level of patient morbidity evident due to the introduction of a comprehensive health service and ongoing medical advances. The CT would be a part of the

⁵ Later to be known as Menzies-Lyth

educational reform introduced.

The Origins of the Clinical Teacher

The GNC syllabus and final examination instructions were highly prescriptive to provide national conformity of education and achievement. This included the use of a nationally agreed 'nurse's chart' which was designed to record when the probationer had achieved proficiency in a list of procedures (Bradshaw 2000). Therefore, from the beginning of the GNC's reign there was supposed to be formal and regulated assessment of clinical skill by ward based staff. The appropriate person to do this was seen as the most senior and experienced nurse at ward level. However, there were no regulations governing the ability of these clinical experts to teach or assess. That is not to say that there was no training of ward based educators. "The first sister tutors had been appointed to St. Thomas' Hospital in 1914, and in 1918, under the auspices of the RCN, the first course for tutors was established at King's College of Household and Social Sciences" (Martin 1989). However, the main CT and assessor from the late nineteenth century on was the ward sister and the vast majority of these had no formal training in teaching or supporting students. This state of affairs continued through World War Two into the foundation of the National Health Service (NHS). At this time the hospital-based nurse training schools became part of the NHS. Nurse education remained the responsibility of the hospital. However, following the Wood Report (1947) and the Nurses Act (1949) the funding for some of the educational costs was removed from the hospital budget and the regional committees set up by the Act were given powers to instigate experimental training courses. As a result of one of these attempts in Scotland 1955, a by-product was the employment of the first CTs in the UK.

The CT can be seen as the first real fully committed role in the UK to teaching practical skills at the bedside. They were entirely employed by the school of nursing and directed towards teaching pre-registration students. Nevertheless, the correlation which nurses in the twenty-first century make between these roles and those of CFs is a

fair one in this primary purpose at least. These were similar in function to the already existing clinical instructors used in the USA. Their remit was to teach clinical skills at the bedside and in the clinical simulation room of the school of nursing. The first of these spent four months in Canada, where the role was already in existence. There she underwent preparation for the work and later wrote up her experiences for a Nursing Times article (McNaught 1957). The CTs were required for an experimental course at the Glasgow Royal Infirmary. The experimental course itself was not well reviewed, but the CT role was welcomed from the outset and came out of the formal evaluation well (Scottish Home and Health Department 1963). As a consequence of good initial feedback, new CT posts were created to assist with the teaching and assessment of students on traditional courses nationwide. The first in England were at Leicester Royal Infirmary but most hospitals' schools of nursing followed suit during the ensuing years. The RCN was the first to devise a course purely for the instruction of CTs. This began as a six month course in 1959 and several others were created in the years following. The main differences between these courses and the full nurse tutor courses were that the CT courses were shorter and were based on the teaching of practical clinical skills rather than on the student's professional development. As a consequence of this and of academic prejudice against skills rather than theory teaching, these roles would be described as transitional roles for those wishing to see if teaching suited them. This would continue to be the attitude of many nurse academics up to the present time, as will be seen in discussion of Rowan and Barber's article (2000) in the next chapter. Another consequence of the 1947 Nurses Act was the upgrading of what had been termed assistant nurses to state enrolled nurses (SEN) who had to meet a level of competence set by the GNC and were registered. Learners preparing for SEN status began to be called pupil nurses to differentiate them from the state registered nurse (SRN) students. Pupil nurses had to complete a two year instead of three year course to register. Pupils had less time in the school of nursing but similar amounts on the wards to students. They were prepared in the practical aspects of nursing but less so in the

theoretical (Iley 2004). A special six month training course was created for teachers of pupil nurses and this was eventually merged with the CT course in 1968. There was a long period of dispute over the status and requirements of CTs. They were often used as lecturers in the school to the detriment of their position in the clinical area. It would not be until 1970, long after their presence had become the norm across the country, that they were finally given the status of a registered clinical nurse teacher by the GNC. This ensured that they had a minimum level of teacher training which was the City and Guilds Further Education Teaching Certificate. In 1977 the required qualifications for CT registration were extended to include a diploma in nursing as well as their initial registration and teaching certificate. This state of affairs continued until the amalgamation of the registered nurse teacher (RNT) and CT roles in 1988 (Martin 1989). This is in contrast with the current position of CFs. The majority of their employers require little or no post registration educational attainment and at best minimal teaching qualifications as will be seen in the next chapter. However, the NMC has recently introduced new requirements for the registration of nurse educators which appear to reintroduce a skills teacher level in the guise of the practice teacher (PT). There is no requirement for roles such as CFs to be registered as PTs but this is clearly the direction of movement that is intended (NMC 2006a).

The Modernisation of Nursing

During this period of the rise of the CT there were very great changes going on in nurse education, nursing and British life in general. During the 1960s the same social forces which led to Wilson's "white heat of technology" speech (Wilson 1996) resulted in changes in the educational system at both school age and beyond. In nursing this allowed the GNC for the first time to stipulate minimum entry requirements of 2 'O' levels for entry to nurse training. Changes in the social status of women; the aspirations of the newly invented teenagers (Hamblett and Deverson 1964) and the expansion of HE of all kinds changed the possible life choices of applicants who previously had more restricted options and made nursing with its strict hierarchy and

long hours look less appealing. Consequently, continued poor recruitment and high attrition rates resulted in further investigations and reports on nursing and nurse education such as the Salmon Report (Ministry of Health, Scottish Home and Health Department 1966).

The Salmon Report

This report into senior nurses and nurse administration marked a clear change from the past. It created a new set of nurse administrators which signed the death knell to the old dominance of the matron. It was not a report on nurse education as such but it had a definite effect. In Martin's research into the period, one of the nurse lecturers interviewed in the late 1970s said "Salmon set all us tutors free" (Martin 1989:24). This was because one of the results of the report was that management of schools of nursing on a day to day basis was put into the hands of a nurse educator and recruitment of students was left entirely to the school. The major report which had the most influence on nurse education in the late twentieth century was about to be commissioned.

The Briggs Report

The move from hospital-based to university-based education in nursing is usually traced back to this report from the early 1970s. The Briggs Report (DHSS 1972) was set up as one of the final acts of the outgoing Labour administration in 1970. The report of the Committee on Nursing was finally published in 1972. The committee did wide ranging and in-depth research to examine its terms of reference. They presented their research findings as well as their interpretations and recommendations in the published report. In relation to the teaching of clinical skills on wards, which was supposed to be the centre of the curriculum, there were some worrying results as can be seen in the chart below.

Figure 6: Balance between Learning and Working

	<i>All trainees and recent trainees†</i>	<i>Registered nurses</i>	<i>Enrolled nurses</i>	<i>Student nurses</i>	<i>Pupil nurses</i>
(B) Balance between learning and working in wards Weighted base:	3,027	714	566	1,142	388
	%	%	%	%	%
Too much learning	—	—	—	1	—
Too much working	56	49	46	70	48
Balance right	42	51	47	28	52
Don't know	2	—	8	1	—

Source: Personal interview survey.

* Columns may not sum to 100 due to rounding.

† Includes student and pupil midwives. "Recent trainees" are staff who completed basic training less than five years ago.

(DHSS 1972:65)

This chart shows that a majority of nurses saw the balance of working and learning on ward placements as too much working and not enough learning. This was one of numerous pieces of evidence presented to show that the existing system of education was not sustainable. The committee presented carefully costed plans to radically overhaul nurse education. The costings had to take into account the removal of the student nursing workforce because Briggs intended that student nurses should cease to be workers and become full time students. This was initially shelved on publication as too costly but in the late 1970s was picked up again. Another aspect of the Committee's recommendations was that the GNC and the other nine "separate bodies across the United Kingdom" (NMC 2008e) should unite as the UKCC. Both the recommendations for nurse education and for the regulatory body were eventually adopted almost in full with the passing of the Nurses, Midwives and Health Visitors Act 1979.

End of the General Nursing Council National Syllabus

This was the beginning of the end for the apprenticeship system of nurse education. Bradshaw argues that the end came when the Briggs recommendations were accepted in 1977, which led to the final publication of the GNC national syllabus in

that year (2001a and 2001b). There can be no doubt, that with the benefit of hindsight, it is possible to trace back the eventual implementation of HE-based nurse education to this point. However, the form of nurse training which incorporated a majority of time working as a salaried employee of the hospital continued until the mid 1990s. The CTs and hospital-based schools of nursing continued with them. Therefore, the experience of the students undergoing this training remained the same, whatever government or professional body policy was. Essentially, the majority of student nurses remained apprentices until then. CTs were kept busy in both classroom teaching and assessing the four ward-based practical assessments which were introduced in 1969 by the GNC and were only rescinded with the advent of Project 2000 (Bradshaw 2000). These assessments required demonstration of an acceptable level of proficiency in four separate skills. These clinical skills were the drug assessment; aseptic technique; total patient care; and management of a ward (Elliott, Jones, and Spoor 1973). Along with the final examination, these formed the mainstay of the assessment of nurses until the implementation of Project 2000.

Continuous Assessment

With Project 2000 this series of four practical examinations was to be replaced by continuous assessment by ward-based mentors. These mentors would be existing ward nurses either staff nurses or sisters. They would observe the student throughout their placement and make a judgement as to whether they had achieved a list of competencies at every stage of their nurse education (UKCC 1986).

Project 2000 was the final materialisation of the recommendations which Briggs made in 1972. As stated earlier these were accepted in 1977. However, the process of implementation would take a further ten years to be accepted and it would not be until the mid-1990s that all student nurses were finally given full supernumerary student status. The next section will examine the road to supernumerary and bursary rather than salaried employee status, which radically changed the nature of nurse education. This would be especially the case for the practical skills aspect of the course.

Nurses, Midwives and Health Visitors Act

The 1979 Nurses, Midwives and Health Visitors Act went onto the statute books at the transition between the Labour and Conservative administrations of that year. In fact, the incoming Conservative Government attempted to stop its implementation, but backed down following an outcry from the profession (Martin 1989). The Act included many aspects of the Briggs recommendations. There would be one single UK body to regulate nurses, midwives and health visitors. This took the place of ten geographical and professional bodies (DHSS 1972). There would be a separation of responsibility for nurse education to four national boards. The Government for the first time devolved the responsibility for regulation and education to the profession. This was in sharp contrast to the previous regime of the GNC, which had been both interdependent with medical staff and constantly interfered with by the Department of Health. The new self-regulatory bodies were brought into being by this Act in 1983.

All of this was again happening during a period of great social, political and economic change. The decision to implement the move to HE for nurse education and the move to professional self-regulation took place in the years after Callaghan's Ruskin speech and the Great Debate about the purpose of education which followed⁶. Nursing would be as affected as other semi-professions by the forces which led to vocational courses being brought into line with transferable values. As a vocational training course it would be part of the new wave of educational programmes which, two decades later would dominate the HE landscape (see previous chapter). One of the biggest shocks of the age was that after decades of almost full employment, mass unemployment was reaching highs of over three million out of work. In nursing this led to less pressure on recruitment, as nurse education became comparatively a more attractive option and qualified nurses had fewer career options to move into. The women's movement had won several victories including the Equal Pay Act (1970) and the Sex Discrimination Act (1975). In addition to this legislative liberal feminist

⁶ See Chapter 1 for more detail about the Ruskin Speech and the Great Debate.

success, the profession had become more active in industrial relations. This was especially marked in the pay disputes of 1974 (Hart 2004). As a consequence the history of unquestioned subservience of nurses to doctors and management was being challenged. It is no coincidence that during this period the leaders of the profession felt confident enough to implement the 'nursing process' nationwide. This professionally empowering intervention was, however, done in a typically authoritarian manner by providing a nursing Kardex which ensured that the four stages of the process were completed by all hospital nurses. These stages were the steps developed in the mid 1970s of assessing, planning, implementing, and evaluating patient care (Walker Seaback 2000). This process marked nursing as a separate and autonomous profession because it implied that there were aspects of patient care to which the nurse was the primary assessor as well as deliverer of treatment (Habberman and Uys 2005). With this background the profession could feel confident enough to call for and implement the changes in education and status for students and qualified staff that had been suggested by those who had been in favour of raised professional status for some time.

Project 2000

The result of these calls for professional education to match professional status was what would come to be known as Project 2000. This was initially a paper produced by the UKCC in 1986. It called for many of the reforms outlined in the Briggs Report and in some ways went further. It saw the future of nursing as residing outside of hospitals and claimed that by the year 2000 there would be few nurses working in general hospitals. Those who would be left working in institutions would be in highly specialised and technological fields such as intensive care units (ICU) and coronary care units (CCU). This was extrapolated from the reduction in hospital beds which was taking place at the time and from moves that were taking place in mental health to reduce hospital admission to a minimum. They argued that, when asked, the majority of patients said that they would prefer to be cared for at home. Consequently, the health professions would have to provide care in the future which delivered this

aspiration and thus move away from the majority of nursing occurring in hospitals. This, they argued, required a very different type of nurse for the future. The training which had gone before, which relied on experience of a series of hospital wards, would not be appropriate for this new kind of nursing (UKCC 1986).

The single status nurse followed on from this. Briggs had suggested retaining the two status levels of nursing, but changing the second level nurse from SEN to certified nurse. These would have completed the same first eighteen months of their course with the RNs but then stepped off (DHSS 1972). The Project 2000 proposal was for one level of RN. In addition, for the first time there would be a requirement for achievement of an academic standard as well as a professional one for registration. The academic standard would be at diploma in HE level. Previously to this there had been no academic equivalence for the majority of nurses achieving registration. A minority of nursing students had been on degree programmes which usually achieved registration in four years rather than three. However, these were unusual. The requirement for diploma of HE level was in-line with other Government initiatives to give academic status to vocational courses. This was discussed in the previous chapter. In addition, the UKCC argued that academic education would provide the sort of inquiring, evidence-based nurses which would be required for the new world of nursing that they envisaged (Davies, Beach and Beech 2000).

A logical consequence of single status for initial registration was that nurse educators, who had for decades been divided into CTs and nurse tutors, should both be given the same status. The new nurse tutor would be a combination of both of the previous clinical and theoretical educators (Jolly 1997). Each tutor would be required to spend a proportion of their time in clinical practice as well as the classroom. The UKCC envisaged that this would help to close the theory to practice divide which at that time appeared to be widening.

The final proposal was that students and their teachers would be removed from the NHS and placed into a small number of HE institutions. This would ensure that

education staff and students could not be used as clinical staff by the hospitals. It also, as Briggs had anticipated, would remove a mainstay of the nursing workforce at a stroke. The proposal was to replace these with a new type of carer called support workers (UKCC 1988) and later re-branded by the Secretary of State as health care assistants (HCAs). These would be trained on the job with NVQs.

The End of the Nightingale Ethos?

The government of the day surprised most nurses and their representative bodies by accepting the proposals almost completely as they were requested. This was perhaps surprising at first as the proposals would be expensive and fall entirely onto the taxpayer. This was at the time of the ambulance dispute and the Poll Tax. Both of these disputes had involved nurses and other health workers in bitter confrontation with Government (Kerr and Sachdev 1992, Whitehead 1997). The case of the Poll Tax highlighted the oppressed position of nurses and their lack of student status at the time (Nursing Times 1990). Other students had an 80% reduction in the tax but student nurses were excluded from this as the majority of them at the time were still undertaking apprenticeship-style courses. As paid employees they were required to pay the tax in full, as Conservative Central Office made clear, in an explanatory leaflet, at the time.

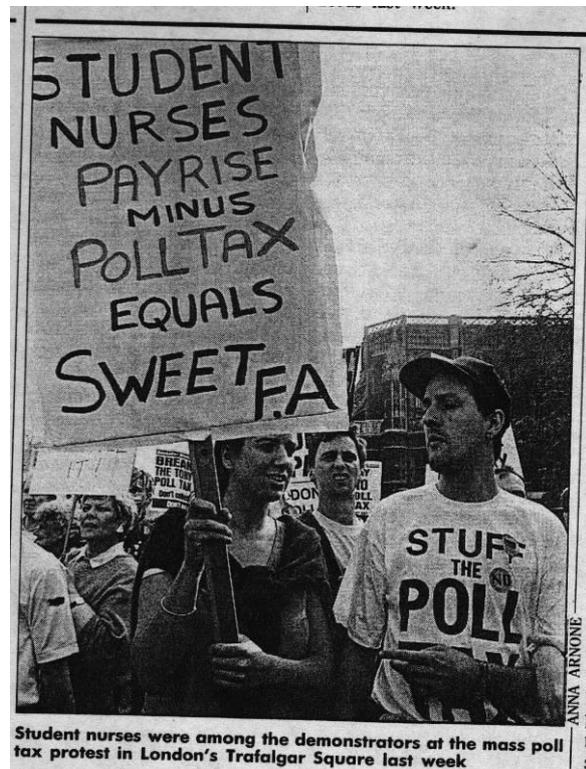
*Students will be liable to pay just 20 per cent of their Community Charge at their term-time address. They will not be liable for Community Charge at any other address, though they will have to pay for the full year where they study regardless of the amount of time they actually spend there.

*Student nurses training under the existing arrangements will be treated in line with other salaried trainees and will not be entitled to student relief. Nurses training in the future under the auspices of the Project 2000 scheme - where they receive a grant rather than a salary - will pay just 20 per cent of the charge. (Conservative Central Office 1989:18)

However, the Poll Tax and the campaign against it also showed that nurses could no longer be expected to behave in the submissive way that society expected. A case study completed at the time indicated that the majority of nurses at a general hospital nurses' home were members of a student nurses' anti-Poll Tax group (Whitehead 1997). The Nursing Times both chronicled and supported the student nurses' campaign

with articles and photographs in almost every issue during 1990. Student nurses were involved in the London demonstration, in the image below, which culminated in the Battle of Trafalgar Square.

Figure 7: Student Nurse Demonstrators



(Arnone 1990)

The eventual outcome was that student nurses of all kinds were specifically exempted from the Council Tax, which replaced the Poll Tax (Local Government Finance Act 1992). This continues to benefit student nurses, as a significant minority are seconded from health service posts and thus receive a salary rather than a bursary during training. This brave and principled political stance was not the only newsworthy event at the time which would change the governmental and social perception of nurses.

The year after the Poll Tax campaign serial murderer Beverly Allitt killed four children in her care. She had recently qualified as a SEN and her betrayal of trust would affect the way that all nurses were perceived by the general public (Batty 2007). The case of Harold Shipman, which came to light in the late 1990s, had the same effect for the medical profession (Guardian 2007). A result of these extreme serial murder

cases and of concerns about the general competence level of nurses led to action being taken to reintroduce governmental control of the nursing profession in the shape of the NMC. The NMC was an event for the future at this time but other changes were occurring.

A Return to Apprenticeship?

The first Project 2000 courses were commenced in September 1989 (Bradshaw 2001b). As previously asserted, these were, at that time, a minority of courses and the majority of nurses continued to be educated under the apprenticeship system until the mid 1990s. Nevertheless, the gradual introduction to all schools of nursing had been agreed and set on track. Therefore the reality of the new type of preparation for registration was now foremost in the minds of nurse regulators and managers. This would lead to concerns about the ability of the new regimen to produce competent skilled nurses. As Project 2000 and continuous assessment was being introduced, CTs were being removed from practice and the UKCC proposals for the content of future pre-registration education did not specify the skills which should be acquired by nursing students. It could be argued that Project 2000 removed clinical examinations and specified clinical educators and as a consequence was moving back to a previous definition of apprenticeship rather than forward into HE: the old kind of time-served apprenticeship discussed in the chapter on adult education. This was an expectation that by spending enough time in the company of experts doing the job, expertise would be acquired by the apprentice. In theory this was not the case, as each student had a mentor who was allocated to solely monitor his or her progress. However, this mentor was primarily a care provider and often a very busy one. Consequently, many students were left to pick up what clinical skills learning they could or not without any specific guidance (Cahill 1996).

Continuing Professional Development

The next stage to the implementation of the new order in nurse self-regulation

would be the concept of compulsory post-registration education and practice, which would be introduced as a UKCC project in 1990 (Post-Registration Education and Practice Project: PREPP) (O'Bryne 1990 and UKCC 1990). This was designed to ensure that once nurses qualified they would be expected and encouraged to continue studying to remain competent. In addition to maintaining educational proficiency they would also be monitored to ensure that they were working sufficient hours in an appropriate role to remain on the register. This twin system of assessing the continuing ability of RNs again emphasised the apprenticeship concept of 'time-served' as a measure of ability rather than regular examinations or some other objective method of academic assessment. However, this time it was during rather than prior to the RN's practice. The proposals were finalised in 1994 and became known as PREP as it was no longer a project (UKCC 1994 and 1995). The project had also introduced the idea of preceptorship for the first time. NQNs were perceived to be in need of a period when they could be supported by a more senior nurse for a period following registration. The space of time was not specified but a period of four to six months was suggested. This was recommended as good practice rather than made compulsory by the NMC. Part of the reason for the introduction of preceptorship was concern that nurses were not sufficiently competent in clinical skills following registration. The theory was that as they had previously been paid employees as students they would have learned the ropes. However, under Project 2000 this could not be guaranteed and therefore a period of adjustment after qualifying should be allowed for. This sounds like an admission that they were not entirely convinced that the move to continuous assessment would be effective in ensuring sufficient assessment. As such the move to provide a period of supervision after qualifying would appear to be a sensible insurance policy. However, the issue of staffing reduction following the withdrawal of cheap student labour had not gone away. There had never previously been a grade of staff required to support NQNs as they were expected to progress along a continuum seamlessly from being a senior student. Consequently, as no one else was available,

existing staff nurses and ward sisters were expected to take on the role of preceptor in addition to their primary caring role and new responsibilities as continuous assessment mentors. As a result, a period of real preceptorship was an expensive luxury that significant numbers of NQNs did not receive. This brought back the necessity of ensuring that when students qualified, they could 'hit the ground running' as fully formed and able, qualified nurses. The debate over whether nurses should be able to commence as entirely competent RNs as soon as they registered or whether there should be a post-registration period of consolidation continues to the present.

Nevertheless, the practical reality for most NQNs in the 1990s was that they were in a position of accountability from the start. This would usually include having complete responsibility for a group of acutely ill patients for a shift at a time.

Concerns about Competence

In the latter half of the 1990s Project 2000 had been fully implemented nationwide. All of the students qualifying had gained their qualification under this system and in some parts of the UK this had been the case for many years. Those nurses in positions of authority within the educational and regulatory establishment remained committed to the professionalisation agenda. All nurses now qualifying had diplomas in HE as a minimum requirement for registration and the logical next step was to convert nursing to a graduate profession. However, outside of these hallowed circles, the frontline carers, their managers and the patients in their trust were sceptical that this was the route of most benefit to them (Cowan et al 2007). This became highlighted in governmental circles most effectively when prominent politicians were able to observe, as hospital inpatients, at close quarters the nursing care delivered, both good and bad. One such was the former academic and active politician Lord Morris. As he said in the opening speech on a debate on nurses and the NHS,

[t]he facts are not in dispute. We are facing the worst nurse shortage crisis in 25 years: the first ever shortfall in applications for nurse education places in England. In 1993/4 there were 18,100 applications for 12,000 places. In 1996/7 there were 15,400 applications for 16,100 places. Turnover among registered nurses was 21 per cent. in 1997, up from 12 per cent in 1992. Vacancies remain unfilled. One report in 1997 suggested that there was a shortage of more than 8,000 full-time

posts across Britain. The Royal College of Nursing reports that the number of nurses aged over 55 will double over the next five years, with 25 per cent of registered nurses in the NHS eligible for retirement by the year 2000. (...)

One thing comes through again and again about pre-registration training: practical clinical skills are not sufficiently achieved by the student. The clinical teacher role has gone and quite senior clinicians have to waste their time teaching new nurses how to do things on the wards. Perhaps an internship for the diplomates at the end of their course is necessary. After all, new nurses are in law accountable for their practice from day one (Morris 1998: Column 1540).

This neatly sums up the issues as he and many others saw them. There were not enough nurses to provide quality care; the ones that were left were likely to leave soon; attempts to increase the number of those in training to remedy this had not been met with sufficient applicants; CTs were no longer available, which put the burden of teaching clinical skills onto 'clinicians'; and Project 2000 was not producing nurses with skills fit for purpose without a period of 'internship'. Clearly, something must be done, and simply expanding the number of places on Project 2000 courses would not be sufficient remedy. Further research and reports such as that presented by Aston et al (2000) for the English National Board (ENB) would highlight the need for nurse teachers to fulfil a practice education role.

Making a Difference and Fitness for Practice

Two policy documents would provide a blue print for the changes to nurse education. The first was the UKCC's 'Fitness for Practice' (1999). This endorsed the concerns that nurses were qualifying without sufficient skills and put forward recommendations including a competency based curriculum; the use of clinical skills laboratories; earlier exposure to clinical practice placements; a three month final placement and the implementation of proper preceptorship. 'Making a Difference' was the second influential document. Produced by the DH (1999), it took on board much of the recommendations made in the UKCC paper and gave them governmental impetus. The document laid out plans to commence pilot sites at 10 universities in September 2000 and added that practising clinical staff should be provided with teaching roles in conjunction with universities. This commitment to modern day CTs appeared to be based on the existing, very limited provision of lecturer practitioners (LP) (Leigh et al

2002). However, this was not specifically stated and thus allowed universities and hospital trusts to experiment with new practice education roles. Some of these will be explored in the next chapter and the role of the CF at the centre of this thesis is one of them.

Chapter Conclusion

Nurses from the mid-nineteenth century to the present have been required to obtain a sufficient level of skills to practise safely. Since the beginning nurses have attempted to ensure that their education and supervision would make this happen. For most of the history of nursing there have been problems recruiting and retaining sufficient nurses. Exacerbating and often defining these issues has been the socially oppressed position of the nursing profession. This has led to constant interference from the medical profession and politicians.

Across the country many novel attempts to meet a need for support of practical skills achievement and to provide preceptorship for NQNs have been made in recent years. These new roles were ripe for research and evaluation. Several of the resulting reports have been published in trade journals. In the next chapter these will be reviewed with a view for use in the analysis.

Chapter 3: Review of Clinical Facilitator-Related Literature

Introduction

This chapter will review previously published accounts relating to CFs in practice. The purpose of this is to complete the process of placing the findings of the research study into the context of the existing body of knowledge (Streubert and Carpenter 1999; Hart 1998). The previous two chapters have placed the subject matter into a wide historical context. Initially, the context within the field of adult education and then the historical context within nursing were explored. This chapter will consist of the following: a discussion of the approaches possible to take in a review of existing knowledge; the technical process of literature searching; and finally the specific articles selected by this process will be reviewed.

Approaches to the Review

The usual approach in a work of this sort is to base the literature review around the specific hypothesis. Following this the research leads to new knowledge or evidence which supports existing theory. However, using a modified GT approach, as described in the next chapter, this is not possible. This is because the process of data gathering enables the researcher to generate the theory as the research progresses (Glaser and Strauss 1967). Thus, the researcher needs to continually check the body of literature related to the emerging theory while conducting the research (Stern and Covan 2001). Glaser (1978) specifically advises against conducting a pre-study literature review as this may cause the researcher to have preconceived ideas about the research subject, which according to GT methodology should emerge from the data. He argues that this is the first and essential “step in gaining theoretical sensitivity” (Glaser 1978:2-3). However, both Glaser (1978) and Schreiber (2001) do advise reading related technical and popular literature around the general area of study. As Schreiber says “the researcher can subject [the literature review] to the challenge of ongoing comparison with data ... to better ensure the rigor of the findings” (Schreiber

2001: 58). Therefore, it was decided to conduct a formal literature search to create the criteria for seeking previous work in this area. This informed the initial pre-study literature review. The outcomes of this review were also used for ongoing comparison as described above.

The Origins of the Clinical Facilitator

The role of the CF is a relatively new one both locally and nationally. The term CF appears to have been coined by Beckett and Wall. Their brief speculative article (1985) described a possible role for all ward-based nurses to facilitate student learning using the approach described by Rogers (1983) and Heron (1977). This approach involves continuous enquiry by the learner and their facilitator. Thus their description was of a method of facilitating clinical learning rather than of a possible new post. As can be seen from the previous chapter, this attitude was in line with that of the UKCC. In the following year the regulatory body would produce the outline of the new form of student nurse education (UKCC 1986). This would rely on continuous assessment of learners by general nurses rather than by specified educational staff. It was not until changes in nursing policy relating to concerns about the mastery of clinical skills were highlighted that specific clinical education roles were again considered. The first instances of CF as a nursing job title appeared in the late 1990s following these concerns that student nurses were not gaining clinical competence (UKCC 1999, Bradshaw 2001b). In the geographical region investigated in this study it commenced in 2001. Consequently, it could be argued that there was no body of pre-existing knowledge on this specific subject prior to these dates. Nevertheless, to be thorough it was necessary to take a broader view of the potential areas for research to be generated.

The Clinical Facilitator in Context

The research undertaken was designed to illuminate the effects of CFs on the clinical area. This required prior insight into the history of nursing and education. These two professions were chosen because they both have influence on the decisions

made to devise the job descriptions and deploy people into these roles by the organisation under investigation. In addition to their importance for initial decision making, the histories also explain the prevailing cultural, economic, political and societal situation within which the actors under investigation exist (Tonkin 1990). This has influence on the ways in which the various actors perceive the roles of nurse and educator; the perception of clinical education and how it should be done; and consequently provides a context in which to set the interpretation of the data collected during the field studies. In addition to this general historical investigation the literature generated since the commencement of the specific CF role is presented. The existence of similar studies does not preclude this investigation, but their presence may provide further evidence of generalisability and their authors' ideas for further required study in the field provide this research with possible avenues of inquiry. It is important to know how data about the existing studies was generated as well as the 'why', which has just been described. Consequently, the technical process of the literature search will now be presented.

Literature Search

It could be assumed, as clinical education staff such as CFs had been around for decades that a large amount of examination of this group would have been done. This is certainly the case. A preliminary search using a meta-search engine, provided by the University of Nottingham, to search relevant clinical and educational databases was undertaken. The meta-search engine consists of software which interrogates up to ten academic and clinical databases using the same search terms (University of Nottingham 2007b). The ones chosen were those designed to search nursing and education related journals. This ensured that the majority of relevant double-blind peer-reviewed articles would be interrogated. It was decided only to search this level of academic source rather than include grey and popular literature because the purpose of this search was to find credible descriptive accounts and research articles rather than opinion pieces. In addition, the CF role, although of vital importance, is not one which has gained public

attention and is therefore more likely to appear in the academic and relevant trade (nursing and educational) journals. The initial search was designed to be as wide as possible within the bounds of these respectable academic sources and therefore the wildcard Boolean operator (*) was used to ensure that all words with their root meaning were detected. In addition, using the instruction ("") around the terms was necessary to ensure that only adjacent words were detected (Hart 2001). For example using the text "clinical facilit*" it is possible to find the phrases 'clinical facilitator'; 'clinical facilitators'; and 'clinical facilitation'. Search terms including popular role descriptions such as "lecturer practitioner*"; "practice educat*"; "practice teach*"; "clinical facilit*", "clinical education facilit*"; "clinical educat*"; "clinical instruct*" and "clinical teach*" were employed. These terms were used because of the variety of job titles used by staff involved in education of nurses in clinical areas. The search discovered over 1,000 articles. Unsurprisingly, using such a wide search ensured that the majority of these articles were false hits. Many referred to medical education or other health professional roles, which are outside of the remit of this project. Using narrower parameters to find more appropriate content, it is possible to reduce this to a more manageable number with relevance to the research. This was achieved by using terms such as "organisation", "nurs*" and "hospital". These terms focused the search engines onto articles referring to hospital attached nurse facilitators rather than those of other professions or those based mainly in community or university settings. In addition to this electronic search, library catalogues have been interrogated for books and promising references from bibliographies and footnotes investigated. A great deal of time was spent considering these writings and at the end of the process it became clear that those with what appeared to be similar clinical nurse education roles were in fact quite dissimilar to the CFs under investigation. This is because initially the researcher considered that all education roles situated within the clinical sector had a similar focus, purpose and effects on the clinical area. However, when investigating these cases it appears that many are so different from the CF that they do not bear

comparison. For example, the practice educator (PE) role is almost exclusively one where technical experts in areas such as ICUs teach specialised skills to new staff experienced in acute rather than critical care, who are unfamiliar with the environment or technology (Farnell and Dawson 2006); or the PE is used as a term to describe a form of mentor/assessor for student community practitioners such as nurses training to be health visitors (Byers 2002). Another of these job titles is LP these are usually employed jointly by university and practice employers. They are university teachers, delivering lectures in their speciality, who continue to work as practising nurses for part of the week (Elcock 1998, Leigh et al. 2002). These are very different from the role and purpose of the CF at the case study sites. According to their job description their main role is educational and professional support in the care providing workplace rather than as lecturers, assessors, or technical experts (Appendix 1). Consequently, a set of criteria were devised from field observations, and NHS website searches for job and role descriptions. The set of criteria generated is as follows:

Figure 8: Set of Criteria for Literature Search

• Educational role	A facilitator of learning rather than a teacher. Mainly working alongside the learner as a knowledgeable resource rather than providing instruction, teaching or demonstration.
• Practice based	Works mainly in the clinical area to support students and staff learning.
• Service employed	Employed by the NHS or other care provider rather than by a university or other education provider.
• Facilitates all learners	Supports students, NQNs, returning nurses, health care assistants, and any other worker within the geographically defined area of their ward or department.
• Additional to numbers or supernumerary	The CF works as part of the ward team but with a clearly defined responsibility for education and support of staff and students rather than with a responsibility to provide care to patients.

This set of criteria only appears to fit well with those positions described in the UK and Ireland as CFs. Even limiting the results to those posts named CF could not entirely generate the criteria described above.

Clinical Facilitator Literature

After much consideration it was decided to formally review only work completed

on roles which fitted these criteria to the closest extent. Various types of work were detected using these methods. These included, research articles, descriptions, journalistic pieces and existing scholarly published literature reviews. One of these reviews, Lambert and Glacken (2005), was particularly useful and has been used to compare with the search completed for this study; interrogate reference lists for further sources; and to gain insight into areas of potential research interest for this study.

Literature searching has detected several studies in nursing and educational journals but little appears to have been done in this area locally. The researcher detected six articles examining four case studies which had been completed in both hospitals and community settings during the period from 1999 to 2004 (Bick 1999, Clarke et al 2003; Ellis and Hogard 2003; Kelly et al 2002; Richardson et al 2001; and Rowan and Barber 2000). In addition the papers examining LP and other similar joint appointments were examined. These roles have both similarities and differences to the CF role, but importantly, they also attempt to bridge the perceived gap between theory and practice. Of those identified and considered for more detailed analysis Salvoni (2001) was the most comprehensive and recent. Therefore, this was also included in this literature review section. The research articles use mainly qualitative approaches to gauge the role function by examining the perceptions of various participants. The informants included CFs, staff nurses, sisters and student nurses.

There are studies done in the US and Australia mainly around similar educators entitled clinical instructors. The focus of the current study is on the effects of creating these roles upon the organisation, especially at the micro level. It is often assumed by researchers that these staff are solely involved in technical skills teaching and bridging the theory to practice divide. The foreign studies mentioned above focus mainly on these aspects (Dickson C. Walker J and Bourgeois S. 2006, and Hogard 2002). The researcher contends that there are other causes and effects related to these roles which have equivalence or even primacy over teaching technical skills alone. Therefore, the literature search has concentrated on finding studies which investigate the

organisational effects and supportive focus of these roles.

Using the set of criteria described above, the UK CF articles were critically analysed. These and other archive sources were mainly used as part of the primary data to inform the GT process. Therefore, the methodology of this process is presented as part of the research strategy and the meta-analysis is provided as a section within the research findings section of this thesis. However, it seems appropriate to present the commentary and review of these at this stage as it informed the initial data collection and research design of the study. Nevertheless, the primary use of the reviews of these papers is to provide data for the research process to be presented in the forthcoming chapter. Therefore, these will be presented in sequence as individual review pieces.

In the case studies under investigation within this thesis the organisation and implementation of a preceptorship programme for NQNs is a central element of the CF job. As has been seen in the previous chapter preceptorship is seen as an important element of ensuring clinical skills improvement and to assist recruitment and retention of nurses. In fact the initial post in the first case study was advertised in late 2000 as a twelve month fixed term secondment to implement a rotational, support and development programme for NQNs. Consequently, the first of these papers to be discussed will be Bick (1999) which describes a similar process. The other papers investigated will be Rowan and Barber 2000; Ellis and Hogard 2003; Richardson et al 2001; Kelly et al 2002; Salvoni 2001; and Clarke et al 2003. These reviews will make up the selected canon from which data will be presented and analysed in a later chapter of this thesis.

Commentary and Review of Papers

Please Help! I'm Newly Qualified (Bick 1999)

This descriptive article, interwoven with findings from a questionnaire survey, is written by a former hospital-based CF. The main focus of the report is on a support programme for NQNs, but she also describes the role of the CF at this hospital along with survey findings about the perception of the CF role. For reasons already outlined

these programmes became increasingly popular in the late 1990s and the early 2000s. They are pertinent to the CF role because as in Bick's study (1999), and the one described in this thesis, CFs often facilitate or organise the learning and support of NQNs. Bick (1999) describes three main issues which make the implementation of support for NQNs on hospital wards and a CF to facilitate this necessary.

Firstly, NQNs suffer 'reality shock' (Kramer 1981) for the first few months of their career. This is the identified phenomenon that a newly qualified practitioner, moving from the protected position of university-based supernumerary student, is placed into a position of responsibility as a registered and hospital-employed nurse. In this new role they are accountable for the lives of patients. Understandably they find this stressful. Secondly, the point is made here that it is not only deontologically ethically desirable for the organisation to protect the individual NQN from this stressful position, it is also in a time, when nurse numbers are increasing, a practical necessity to recruit and retain as many staff as possible. If those NQNs who make up the majority of new recruits are subjected to stressful situations they are likely to leave within a short period of time after qualifying, thus leaving another vacancy to be filled. As Bick (1999) argues, when looking for posts NQNs will sensibly select the hospitals with the most attractive recruitment package. This consideration will include the level of support they will receive as a NQN to both reduce the 'reality shock' and to provide them with the skills they need to operate as an effective and confident RN. The final issue relates to the perceived lack of nursing skill or 'fitness for practice' which was becoming a concern since the introduction of Project 2000, which replaced the nurse apprentice training that preceded it (UKCC 1999, Bradshaw 2001b). This related to the reduction of time spent in both simulated and real clinical practice during the pre-registration nurse's education since the move to HE had been completed. Consequently, NQNs considered themselves in need of learning essential skills after they had qualified. As has been related in the previous chapter, this opinion was shared by more experienced staff and managers, who had undertaken the previous

training regimen and were sceptical about the merits of Project 2000.

Bick (1999) goes on to describe the process of preceptorship which was implemented as a UKCC policy in 1990. Preceptorship was seen by the UKCC as a method of bridging the gap between student status and that of a fully fledged RN. It was envisaged that a similar role to that of the mentor for students would be undertaken by experienced nurses working with NQNs. The crucial difference was that the preceptor's main focus would be on the support of the NQN over this stressful period rather than on the continuous assessment of their ability to perform as a nurse which the nurse mentor must perform (UKCC 1999). However, as Bick describes, there are clear problems with the reliance purely on using staff nurses as preceptors. The main purpose of nursing roles such as staff nurse and sister must be to provide nursing care to the patients in their charge. Thus additional considerations such as supporting NQNs will take second place at best. If, as is often the case, their workload in this respect is high, then this support may not be undertaken in a meaningful way at all. Bick's initial survey of NQNs using the preceptorship system alone supported this hypothesis. As one of the NQNs in her survey said "I think [preceptorship is] a good idea, but I didn't really feel that well supported. I felt that my preceptor had her own job to do, and wasn't there for me all the time" (1999: 45). A possible solution to this is a dedicated member of staff to provide this support as their primary purpose.

In Bick's trust as in the ones under investigation in this thesis it had been decided to design and trial a specific role to do this. Bick (1999) describes the ways in which the CF attempts to fulfil this role. She describes it as additional support to the existing preceptor system rather than removing the preceptor and replacing them with a CF. This is explained as being done in a systematic way for each intake of NQNs. The CF provides information about what the NQN can expect from them; how the NQN can contact them; each NQN is allocated time to work alongside the CF; an individual assessment is made of each NQN's needs "for additional clinical support" (1999:45) and time is allocated according to need.

Bick outlines a further questionnaire survey of the first batch of NQNs to undergo preceptorship augmented by the CF and a series of study days in which the NQNs are taken out of the ward for classroom teaching (1999). She summarises the results of this survey as indicating a higher degree of satisfaction with their transition from student to RN. She had included specific questions about the CF role and NQNs uniformly supported this initiative. In addition to this survey Bick collected data on retention rates for the NQNs. In this she reports only one out of thirty-one NQNs leaving the hospital. Bick makes a good case for the satisfaction of the NQNs with the support received during preceptorship with the assistance of a CF. There is no attempt made to discern the effects on or feelings of other staff. Similarly the feelings of the CF themselves are not investigated. This is understandable as the focus of the article is upon the NQNs experience. However, for the purposes of this thesis it leaves the reader wanting to know more about this case. Of the initial three issues, the matter of stress and recruitment/retention are addressed in Bick's surveys. However, there is no mention of whether perceived ability to perform essential skills is improved. Overall this gives us a limited vision of a hospital which appears to have implemented a similar programme and role to address similar issues to the trusts investigated in this thesis' case studies. As such it provided both initial insights to assist the writer to design the case study and provides data for comparative analysis in the GT process (Glaser 1978).

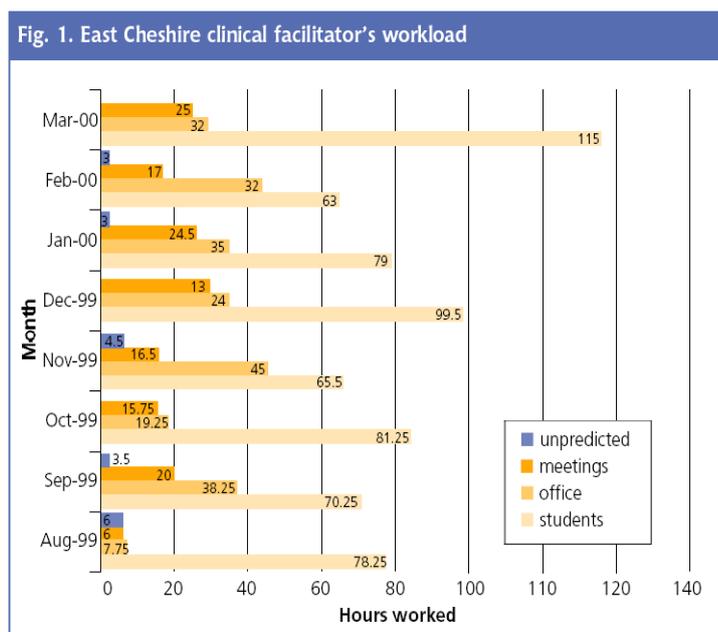
Clinical Facilitators: a new way of working (Rowan and Barber 2000),

This report of a twelve month pilot study was written by a participating CF working for one of the hospitals and a nurse lecturer employed by a local university. They present the results of an audit process overseen by the trust's audit department. Similarly to the Bick (1999) case above, the pilot study described was initiated because of the recommendations of two policy papers: Fitness for Practice (UKCC 1999) and Making a Difference (DH 1999). As outlined in the previous chapter, these papers were both reactions against the professional and public outcry following the reduction in time spent by student nurses on hospital wards following the introduction of Project

2000 (Morris 2001). The perceived consequence of this lack of time spent on the wards was that “key practical clinical skills” (Rowan and Barber 2000:35) were not being taught or mastered by students prior to qualifying. Both policy documents recommended measures to ensure that this happened in the future. The role of the CF in this instance was seen as being to facilitate the improvement of these skills during pre-registration learning. This is a different emphasis to that of the Bick (1999) study above. In Bick (1999) the role was focused on the support of NQNs. This illustrates one of the central arguments in the debate about ensuring effective nursing skills. As outlined in the chapter on nursing history, this argument is about whether nurses should be able to work immediately upon qualifying as autonomous professionals or whether they should require a period of supervised practice following qualification. The Rowan and Barber (2000) paper concentrates on the CFs supporting students to enable them to work as fully proficient RNs. In this study the CFs were employed in six hospital trusts within an NHS region. The selection criterion for their secondment was that they were “clinically competent practitioners” (Rowan and Barber 2000:35). Teaching qualifications and their ability to teach or facilitate are not mentioned in the article. Nevertheless, their remit was to be to work alongside student nurses to ensure “fitness for practice” (Rowan and Barber 2000:35), a role which would primarily involve the CF in facilitation of learning as the job title suggests. It would appear odd that teaching qualifications were not felt necessary when the primary function of the new role was to teach. However, Rowan and Barber explain this seeming incongruity by describing the purpose of on-ward experience as “learning by doing” (2000:36) and thus the CF merely needs to be able to create the space for the student to learn by example and practice. This is reminiscent of the process of learning by ‘sitting with Nellie’ described in the previous two chapters as at the centre of the apprenticeship model. The new role is supernumerary thus allowing the CF time to spend with the student rather than prioritising patient care. The CF is still involved in patient care but this is mainly to teach the student how to provide the best care. The role is explicitly the

opposite of that of the mentor or preceptor as these prioritise nursing care and support learning as a secondary aspect of their job description. The role is compared to similar roles from abroad. Significantly, they compare this with a Canadian study (Campbell et al 1994) which attested that one of the more important aspects of learning in the clinical area was learning from the example of clinical instructors. They also discuss the historical role of the CT, which became defunct in the late 1980s (see previous chapter for more detail). As Rowan and Barber say, part of the reason for the CT's demise was a perceived lack of clinical credibility which was to some extent due to the employment of these staff by the school of nursing rather than by the hospital (2000). This created conflict in the CT's role between ward-based working alongside students and classroom teaching (Forrest et al 1996, Martin 1989). Rowan and Barber compare this with CFs. They argue that because CFs are ward-based and have no university commitments to teach in the classroom they are able to maintain clinical credibility and prioritise working with students on the ward (2000). They use working hours collected during the audit to show that the majority of reported CF time is spent in the clinical area with students. This is illustrated in the chart below.

Figure 9: East Cheshire Clinical Facilitators' Workload



(Rowan and Barber 2000:35)

As can be seen the single largest reported number of hours spent is working with students. This would, of course, also be the case for the existing role of mentor. However, the important difference according to Rowan and Barber (2000) is that the CF is supernumerary and can thus truly focus on facilitating the student's learning.

Working alongside students to directly facilitate their learning is viewed in Rowan and Barber's paper as one of a series of important aspects of the CF role (2000). Another aspect is helping existing ward staff such as mentors to perform an educative function with students. It is argued that CFs are better placed to do this than other roles such as the university link teacher or the historic position of CTs because the CF is based at, and spends the majority of her/his time on the ward.

Both working directly with students "in a realistic setting, managing a caseload of patients under the direct supervision of the clinical facilitator" (Rowan and Barber 2000:36) and helping the ward staff to support student learning are seen as ways of narrowing the theory practice gap. How this follows is not so clear. The authors appear to be making the point that, even after the move to HE, the usual position of the student on a hospital ward placement is that of unofficial worker and that the presence of the CF ensures that education becomes a priority. They illustrate this by saying that a CF may for example create a situation where a more senior and junior student – perhaps a third year and first year – work together for a shift. They argue that this would not normally take place because if two students are working on the ward then they are likely to be put at opposite ends of that ward. The inference of this is that the students are being allocated a workload. This is rather than, as should be the case, the work they do being primarily for their educational need. If the CF is changing this practice then certainly they are creating the opportunity for more senior students to learn the teaching skills they will require as a mentor in the future and providing the opportunity for the junior student to learn from the senior. This is an improvement on the position of the student over that of unofficial worker. However, it is less clear that this reduces the theory/practice divide. In order to do this it would be more reliable to

introduce an evidence-based formal teaching plan into the practice environment. This would have to be cross-referenced with the university teaching on the subject to be covered and also referenced against the procedure guidance of the service provider overseeing the clinical practice placement.

A more convincing argument is put forward regarding the relationship between the placement and university staff. Aston et al. (2000: 178) showed conclusively in their extensive study that university lecturers were not best placed to support students in practice. This was because they were “unprepared, unsupported and unmonitored” (Aston et al. 2000) by their employers. Rowan and Barber (2000) argue that the position of the CF embedded within the placement area makes it easier for them to have ongoing relationships with the ward staff. Additionally, their education remit enables them to build relationships with the university link lecturers. Consequently, there is better liaison between the placement area and the university. The authors go further than this and suggest that the CF can ensure that the appropriate practice level assessments are put in place by the university in order to “reflect the practice environment” (Rowan and Barber 2000: 37). The assumption made is that the CF being closer to the current implementation of nursing practice has a superior understanding of the most appropriate things to be assessed and the methods of assessing them. Given the lack of requirement for the CF to have teaching or assessing qualifications mentioned above it is difficult to see how the CF could be fairly asked to make this decision. The authors make this point themselves in their findings section. The CF is described as grounding the link tutor in current clinical practice while in this symbiotic relationship the link tutor was “building up the clinical facilitator’s confidence in curricular issues and skills” (Rowan and Barber 2000: 37). This is put forward as a possible alternative model to that of employing LPs. This is an important point, as one of the central criticisms of the LP role has become that it is a near impossible task for one person to carry out the very different and often conflicting roles of the practising nurse and the teaching lecturer. This is often described, as Leigh et al

do as “doing two jobs and serving two masters” which leads to burn out and most LPs leaving the role after a short period (2002:212). However, the way Rowan and Barber describe this symbiotic model is clearly a very different proposition to that of the LP (2000). The LP is a practitioner qualified as both nurse and teacher, who works in both university and practice environment. The CF and tutor as described here have separate roles with the tutor appearing to be coaching the CF in the ‘advanced arts of university life’ and procedures while the CF merely provided the tutor with access to the ward. This is not necessarily a bad thing as it can be seen as potentially improving the CF’s abilities to fulfil the role or more likely to ‘progress’ to a higher status lecturer role in the higher education institution (HEI). Nevertheless, it is clear that the accepted relationship between theoretical university-based education and practical clinically-based teaching remains hierarchical with education in the superior position. This is just as Martin concluded twenty years previously (1989).

In an attempt to evaluate the impact of the role the authors claim that “[a]ll ward staff and managers have received [the CF role] positively” (Rowan and Barber 2000: 37). To back this up they describe an audit process which was used to “collate evidence in support of the perceived benefits of the role” (Rowan and Barber 2000: 37). This is not an ideal starting point for an evaluation as clearly the authors have decided that the role is of value and that they must collect evidence which supports this. In addition to this concern is that the audit department referred to is there to support clinical audit. In NHS jargon this refers to the process of evaluating systematically an existing practice (NICE 2002). To evaluate new practices such as the introduction of the CF role the appropriate NHS procedure would be to use the research department (DH 2008c). This may indicate that the authors were attempting to use the resources they had to evaluate the role or it could be that the level of effort required to undertake an NHS research project was too great for the scope of the evaluation. Whatever the reason, it appears unlikely that the audit department would have been the most appropriate resource in this case. The authors attempted to triangulate their sources of

data by sending questionnaires to all sites in the region and to various grades of staff such as students, ward staff and university teachers. Reflective diaries were also kept by the CFs themselves. The article does not go into detail about the number of returned questionnaires nor does it describe the content or quantity of diaries completed. The sole comment on this is that the “evidence suggests that the role benefits students and ward staff” (Rowan and Barber 2000: 37). There is no explanation of how this benefit is manifested. The authors are honest about their intentions for the gathering of data. As they say, the project has been extended and they will need to “strengthen the evidence to support this role so that permanent funding will be made available” (Rowan and Barber 2000: 37). Sensibly, they advise the collection of data regarding attrition rates. They also suggest that there are possible logical expansions of the role, such as the extension of the remit to cover NQNs during their preceptorship period. Again they suggest the use of recruitment and retention data to support claims of effectiveness of the role. As a final method of measuring signs of effectiveness it is suggested that students lack confidence in their abilities to complete nursing “task-oriented skills” (Rowan and Barber 2000: 37). However, their suggestion for measuring the success of the CF in this area is that the level of the NQNs’ confidence is increased rather than measuring whether they are able to complete a set of skills. This appears odd as this is a less direct method than is available and may be something to do with the authors being unwilling to criticise the university’s assessment of these nurses who have recently passed their course of study.

Rowan and Barber (2000) suggest research as a possible method of providing an evidence base. Ellis and Hogard (2003) went on to complete a research study in this area and they were aware of this initial article and the work done by Rowan and Barber. Ellis and Hogard’s work will now be examined.

Two Deficits and a Solution? (Ellis and Hogard 2003)

This article deals with the same case study area as the one above. The ‘two deficits’ in the title of this research article refer to NQNs having insufficient nursing

skills and a perceived lack of supervision for students on their placement wards. The potential solution to these deficits to be evaluated is the role of the CF. As mentioned earlier, this evaluation was conducted for the same group of CFs as that examined by Rowan and Barber (2000). However, this study is of the period immediately after that looked at by the previous study. It is also of the slightly longer period of eighteen months. The researchers have more substantial research credentials and are both university academics. They appear to be more remote from the project than the previous researchers. This could be seen as an advantage from the perspective of the traditional objective researcher or the “free-floating intellectual” described by Mannheim (1936). Nevertheless, it can also be a disadvantage if that distance means that nuances of the case study are missed or that an imbalance in the power relationship influences the perceptions of the researcher (Reason and Bradbury 2001).

Ellis and Hogard make it clear that they felt that the earlier attempt to evaluate the pilot scheme had been flawed. They attempt to rectify this by the use of a more robust research strategy. They describe this as “a novel multi-method approach” (2003:19) which incorporates three main components: outcomes measurements; process analysis; and multiple stakeholder perspectives. In addition to the issues raised as the two deficits, they isolate retention of students and NQNs as an additional problem which occurs as a consequence of increased busyness; consequent lack of skills teaching by clinically focused staff; and resultant inadequacy of skills learned in order to adequately perform the role for which they are qualified. They identify the causes of these problems resulting from the abolition of the CT role and the increasing workload of staff. While identifying that there is a long list of staff involved in the support of students on clinical placement, they put forward the notion that the use of a new title would encourage an innovative approach.

The paper describes the initial implementation of the Pilot CF Project. Part of this involved giving the CFs the task of setting objectives for the role. These were agreed and accepted by the education and training consortium which had commissioned

the project. They were as follows:

- to work alongside staff to enhance the pre-registration students' experience within the clinical settings of acute medicine and surgery, complementing the clinical setting by use of workshops and group settings;
- to improve the clinical competence of pre-registration student nurses within the clinical settings of acute medicine and surgery;
- to facilitate broader external /internal communication links;
- to maintain their own clinical professional credibility as a clinical practitioner; and
- to monitor the effectiveness of the role. (Ellis and Hogard 2003:19)

Consequently, part of the intention of the paper was to evaluate their progress towards these self identified objectives.

The paper provides a breakdown of the research subjects' composition. This included a breakdown of average age; total number; qualifications; and length of time since initial qualification. It is noted here that most had fairly basic teaching qualifications and a few had or were working towards degrees or higher teaching qualifications. This is not commented upon as an issue. Again it can be assumed that the authors consider the nature of practice education as requiring clinical experience rather than educational expertise.

The paper then goes on to describe the efforts made to enact their multi-method approach. Their attempts at outcomes measurement were inconclusive. However, it must be said that their approach to this was initially naïve and concluded with an ill-conceived attempt to resolve this. The authors say that “[i]t was anticipated that there would be university assessments of the students that could be compared for those that did and did not receive clinical facilitation” (Ellis and Hogard 2003:20). Given that one of the reasons for the project was that students were qualifying without the perceived level of skills required it should have been clear that this would not be the case. Otherwise only those students achieving adequate skills would qualify and if the training they received was inadequate to support them achieving the required standards then very few would make it. This is not the case, however, as they discover that the nurses reaching the final stage of their programme overwhelmingly (97% in the area evaluated) pass their final clinical placement. As the university uses a system of continuous assessment then this is the area where these skills are last evaluated by a

ward-based mentor. In an attempt to create some form of evaluation which would quantify the skills deficit, the researchers devised some objective structured clinical examinations (OSCEs). OSCEs are designed to test clinical skills in a simulated environment remote from the clinical area (Burton and Birdi 2006). Unfortunately, the level of skills they were designed to assess were way below the level required of a NQN. Hardly surprisingly the results of comparative testing of students on CF and non-CF wards were inconclusive (Ellis and Hogard 2003:21).

The process analysis section of the multi-method approach was much more appropriate. The objective of this was to discover what the CFs actually did in their role. Rowan and Barber had also attempted this as part of their questionnaire. This had been to straightforwardly quantify the number of hours working alongside students or in other tasks (2000). The methodology and results of the Ellis and Hogard (2003) study generated much thicker and richer data (Gilchrist and Williams 1999). They considered and quickly dismissed what they described as empirical (field observation) and analytical (determining practice from first principles) approaches to finding out what CFs actually do. The method selected was the third option of a consultative approach. This would involve in-depth interviews and focus groups with the CFs. This seems like a sensible approach and appears to have generated useful data. The interviews appear to have been structured around specific open questions designed to build a picture of the individual CF which could be compared and cross-referenced against the others.

The CFs were asked “what motivated you to become a CF?” The researchers obtained answers which were consolidated into four broad categories: commitment to nursing; their own competence for the post; potential to improve learning and the quality of nursing; and bridging the theory/practice gap. Interestingly these are all altruistic socially-centred rather than individual career-focused answers. However, this point is not followed up in the subsequent discussion. They were then asked “what skills should a CF have?” This unsurprisingly received the response that they needed

communication skills and expert nursing skills. However, they did not mention teaching skills which is remarkable for an education centred job. Again this is not followed up in the discussion section. The next part of the interview is reported as a description of a typical day. The outcome of this line of inquiry was that CFs described their own activities but found it difficult to relate these to a specific student learning outcome. This begs the question, why? Again, this is not followed up but there is likely to be a link between the low level of requirement for teaching qualifications and an inability to relate to learning outcomes (Darling-Hammond 1999). The researchers now go on to extrapolate the outcomes of these interviews into a model to describe the activity and role of the CF. They verify this model by discussion with the CFs.

This model is a useful extrapolation of the evidence and this can be tested against results from other studies, including the one central to this thesis. The model consists of four levels of work responsibility which could be taken on by CFs to improve the quality of the clinical learning environment. Interestingly the levels described were not all currently being undertaken by the CFs in this study but Ellis and Hogard felt that these roles would be beneficial (2003). The levels described were:

1. direct face to face supervision of students;
2. the management of student learning through arranging learning experiences and supervision/instruction of students by others;
3. maintaining an overview of student placement and learning at an organisational level, for example a group of wards in a hospital; and
4. undertaking a strategic planning role for a higher education institution in securing and quality assuring clinical placements. (Ellis and Hogard 2003:22)

They go on to say that the CFs in this study were mainly at the first two levels. The authors make no explicit value judgement about this but it is clearly the case that they have in mind role, and pay evaluation tools, such as Hay (Trade Union Research Unit 1984) and the NHS Agenda for Change system of evaluation which was just about to be implemented (Agenda for Change Project Team 2004). When this is considered it could fairly be argued that the authors are placing CFs at an entry level to the business of education. This is a similar assumption to that made by Rowan and Barber (2000) when they discuss the relationship between the university lecturer and the CF. That is

that the clinically-related post is of lower status.

A further tier of refinement of this model is made for the bottom rung in this hierarchy which is supervising learners face to face. This further level of analysis is justified by the authors because they say that the CFs concentrated on this in their evidence. The further refinement is a list of six categories of teaching activity:

1. demonstrating a skill to a student;
2. pointing out good practice to a student (denotation);
3. giving the student a chance to practise a skill;
4. discussing the student's work with them;
5. giving the student a chance to practise in a skills laboratory or workshop;
and
6. giving the student a lecture about a skill. (Ellis and Hogard 2003:22)

These activities are a list of teaching and learning methods for skills. It seems odd that the researchers are so specific about the subject of the teaching. Otherwise this is a list of teaching methods. Again it appears that the researchers are making the point that the CFs are subject specialists in the subject of clinical skills rather than theory. For example, it seems likely that anatomy and physiology in health and illness, related to the clinical speciality are taught by CFs. These are all experienced professionally qualified staff, it would be reasonable to assume that these subjects and others related to professional practice would arise during the discussions mentioned in the list. This splitting apart of the aspects of nursing practice, between cognitive theory and psycho-motor practical skills, is common. It may even be the solidly held belief of the CFs as well as the researchers. However, is it a true reflection of the actual practice of teaching? It would seem more likely that nurses teaching nursing, whether in the university or the hospital, would teach both aspects of nursing. The theory is taught in order to support aspects of practice. Practical skills require a theoretical base in order to be completed effectively. In nursing as in other professions the learning prescribed by any course of study is not for abstract philosophical advancement but for the utilitarian needs of the profession and the patients it serves (NMC 2004a). Consequently, it could be argued that practical skill should take precedence in professional education. However, the researchers in this article do not address this and

take the usual socially accepted hierarchy of theory over practice. The researchers continue on this theme in the next part of the research process.

The final ‘multiple stakeholder perspectives’ approach of the research method could have been used to provide triangulation to gain validity for the results solicited from the CFs in the previous section. To a certain extent it does fulfil this function. However, the researchers say that it is the final part of their three component multi-method approach and as such it has a different emphasis to the previous approach. In this they attempt to find out whether stakeholders, including students and CFs, as well as university staff and ward staff believed that students were better prepared by CFs than by others involved in teaching students on placement. The researchers used interviews, focus groups and a questionnaire to generate data. They had reasonably representative samples. All the stakeholder groups mentioned above were asked to complete similar questionnaires. In addition, some were interviewed and some participated in focus groups. All three methods of data collection were attempting to gain the same information. Therefore the answers can be placed into tables for comparative delineation. The first of these tables depicts the results of a set of questions where the participants were asked to put a list of roles into order of importance with respect to their “utility for student learning on placement” (Ellis and Hogard 2003:23). As can be seen in the table below there is a great deal of similarity between the answers given. Only the university staff vary to any significant degree in their answers.

Figure 10: Comparative Ranking of Roles: Table 1

Table 1 Comparative ranking of roles with respect to utility for student learning on placement

<i>Role</i>	<i>Clinical facilitator ranking</i>	<i>Students' ranking</i>	<i>Ward staff ranking</i>	<i>University staff ranking</i>
Assessor/mentor	1	1	1	1
Clinical facilitator	2	2	2	3
Link tutor	6	6	6	5
Ward sister	4	5	4	4
Staff nurse	3	3	3	2
Health care assistant	5	4	5	6

(Ellis and Hogard 2003:23)

The authors comment upon this as a sign of stakeholder agreement with the CFs view of themselves. However, they do not make the point that the role of assessor/mentor is a very different position to that of all the others in the list. This role is carried out as a part of one of the other roles and could be held by the staff nurse, sister or CF. More specifically, it is a role which on many placements is held by all of the RNs no matter what their title is because of the volume of students. Consequently, the respondents were effectively ranking themselves twice. With this in mind it would appear odd that the university staff would rank a CF who is the only member of staff with practice-based education at the centre of their job description behind a staff nurse who is not that specific student's mentor. Perhaps there is more to this than the mere conservatism of the university staff, which the researchers cite as their explanation. Is it possible that the CF is seen by the link tutor as an unwelcome rival?

The second question put to the participants used the CFs' list of six teaching methods from the previous section. The researchers make the point that, as can be seen below, there is complete agreement between the practice-based staff and students.

However, there is significant difference between these and the answers given by the university staff.

Figure 11: Comparative Ranking of Roles: Table 2

Table 2 Comparative ranking of clinical facilitator (CF) teaching methods with regard to utility for student learning on placement

<i>CF's teaching methods</i>	<i>CF ranking</i>	<i>Student ranking</i>	<i>Ward staff ranking</i>	<i>University staff ranking</i>
Demonstrating a skill	1	1	1	1
Pointing out good practice of a skill	3	3	3	3
Giving the chance to practise a skill	2	2	2	5
Giving a lecture about a skill	6	6	6	4
Discussing the student's work with them	5	5	5	2
Giving the chance to practise in a skills lab/workshop	4	4	4	6

(Ellis and Hogard 2003:23)

The researchers note this difference but do not suggest a possible explanation. Perhaps this is because it is fairly self-evident. As suggested previously, cognitive learning and the teaching methods traditionally associated, are prized more highly by professional teachers than psycho-motor learning and their associated teaching methods. This is particularly apparent from the ranking of the two, learning by doing activities as rank 5 and 6. This academic prejudice is well illustrated here and will be returned to in the case study and discussion sections of this thesis.

The final question of this section addressed a set of positive statements about CFs with regard to student achievement. Participants were asked to grade their agreement with the statements using a Likert scale (1932) from 5 'strongly agree' to 1 'strongly disagree'. As can be seen below, students and ward staff on the whole agreed or strongly agreed with the statements. The one exception was regarding communication links between placement and university. Again the university staff were more sceptical. All of their mean scores were in the undecided band.

Figure 12: Mean Agreement/Disagreement Scores: Table 3

Table 3 Mean agreement/disagreement scores of students, ward staff and university staff with statements regarding clinical facilitators (CFs). 5 = strongly agree; 4 = agree; 3 = undecided; 2 = disagree; 1 = strongly disagree

<i>Statement</i>	<i>Students</i>	<i>Ward staff</i>	<i>University staff</i>
The CF helps students to integrate theory with practice	4.4	4.5	3.5
The work of the CF has improved students' clinical skills and confidence	4.4	4.5	3.9
The CF worked well with ward staff to enhance students' experience in the clinical setting	4.3	4.5	3.9
The CF improved communication between the university, the student and the ward	3.3	4.0	3.4
The CF has high professional credibility as a clinical practitioner	4.5	4.4	3.6
The CF was keen to monitor the effectiveness of her/his role through taking feedback from me	4.3	4.0	3.1
The CF helped the student to meet the patients' needs	4.2	4.4	3.4
The work of the CF integrated well with the university course	4.1	4.1	3.2

(Ellis and Hogard 2003:23)

It is perhaps unsurprising that the communication with the university is seen as less positive due to the clear scepticism and perhaps even hostility of the university staff questioned evident in all their answers.

The researchers round off the article with a brief discussion. They remind the reader of the two deficits of their title. These were the shortage of placements and the perceived lack of skills of NQNs. They make the point that the most important distinctive feature of the CF role was that it focused, full-time, on education in the clinical area. Consequently, they claim that it goes without saying that they increase the quantity of supervision available to students. Their view is that the third part of the three-pronged method of data collection showed that ward staff and students agreed that CFs met their six goals. However, they make the point that the actual measurement of skills achievement had not been possible using the methods they had attempted. They go on to discuss the six teaching methods deployed by CFs and recommend that research be carried out into optimal methods to provide learning for skills. They do not discuss whether CFs are solely involved in skills teaching or whether this can be fairly split from theory teaching.

In the final evaluation they conclude that CFs are an expensive solution. They then reintroduce the possibility of the four level model to justify the cost by introducing higher level functionality to the posts. This is one possibility, the idea of restricting the

functions of the role to the bottom rungs of the model is not considered. If the form of job evaluation which this model is similar to were used then the post would be likely to attract a lower salary level and therefore be more affordable. This positioning of CFs in the pay and social hierarchy of health and education will be returned to in the case study part of this thesis.

The next article to be reviewed describes a CF project in a series of nursing homes. This means that it does not fit the 'criteria set' described in the introduction to this chapter but it is interesting because the CFs are given space to publish their own versions of the first few months of their new role.

Student Placements in the Nursing Home Setting (Richardson et al 2001)

This paper is a description of a case study where CFs were employed by a university to improve the clinical education experience of pre-registration student nurses in nursing home placements. The authors are all explicitly involved and their evidence is given with this clearly stated. The lead author is the placement co-ordinator and the others are the CF team. The report lists the familiar issues as lack of supported placements and increasing numbers of students requiring placements as the reason for introducing the new CF role. This paper is about a very different set of clinical placements to those in the previously reviewed papers. As can be seen from the job description, in the box below, the CFs are led by university priorities such as educational placement audits.

Figure 13: Clinical Facilitator Job Description

Box 1. Clinical facilitator job description

The key base of the appointee would be the locality group but accountability would be to the placement co-ordinator.

Job purpose
To develop the learning environment and in particular support the clinical assessors in the supervision and assessment of student nurses.

Main responsibilities

- Following up action plans set at initial audit
- Facilitating staff identified as assessors in accessing clinical assessor workshops
- Participating in the preparation and updating of clinical assessors
- Providing support to staff in using open learning materials in preparation for supervising and assessing students
- Facilitating the identification of learning opportunities
- Supporting clinical assessors, in particular, over the period of the first student visits and subsequently as necessary
- Negotiating with staff and students in any practical difficulties with the placement
- Agreeing with each placement the nature and level of continuing support
- Facilitating the development of learning resources
- Carrying out audits according to the agreed cycle
- Liaising with the locality co-ordinator and placement co-ordinator as necessary
- Enabling the clinical assessor and student to broaden the nature and scope of learning opportunities
- Facilitating the application of theory to practice and practice to theory through the Action Learning Group system

(Richardson et al 2001:40)

The nature of the job description is as would be expected of a university employed CF. That is, it is entirely centred on the student experience. However, as can be seen from the job purpose section the main focus is supporting the mentors to support the students rather than directly the students themselves. This seems entirely justified as the report makes it clear that each CF is employed only one day per week and has between seven and twenty-three homes to support.

Differing from the other case studies, the nursing homes in this paper were new to the concept of being a student placement. Therefore part of the CF role was to provide the additional support which existing university link staff could not because they were already supporting existing placements. The CFs at the outset envisaged that the nature of nursing home work would make both the mentors isolated in their individual home placements and the CFs isolated from each other. Therefore they set up regular meetings of the CF team and of the nursing home mentors. Additionally, in order to maintain a similar approach to the post they drew up a joint action plan as can be seen in the box below.

Figure 14: Clinical Facilitator Action Plan

Box 2. Clinical facilitators' action plan
<p>Clinical assessor support</p> <ul style="list-style-type: none">■ To improve library access by ensuring that all nursing homes have a library card and to discuss with the librarian the accessing of bibliographic databases■ To create a reading package for clinical assessors to meet preparation workshop criteria which are available in each home■ To implement a clinical assessors' support group for each locality■ To devise and distribute a list to each home of the names and addresses of all nursing homes that have students■ To provide all homes with a course prospectus and course handbook and ensure they are on the department mailing list■ To provide seminars on relevant and current research topics■ To provide information on theory content of first year pre-registration studies■ To provide feedback on student evaluations of their placement experience■ To provide dates of new clinical assessors' workshops■ To investigate conducting preparation workshops for clinical assessors in the nursing home setting
<p>Student support</p> <ul style="list-style-type: none">■ To provide names of students' personal tutors■ To discover whether longer placements are feasible in the revised pre-registration curriculum
<p>Learning environment</p> <ul style="list-style-type: none">■ To provide resource material for students' reference during their placement■ To provide guidance on the production of an orientation pack■ To explore the feasibility of providing training for nursing homes in manual handling, infection control, first aid and resuscitation■ To carry out the learning environment audits■ To follow up objectives set at audit
<p>Data collection</p> <ul style="list-style-type: none">■ To provide facilities for and complete records of attendance at follow-up workshops and annual updates for clinical assessors■ To identify potential new clinical assessors■ To keep records of placement numbers and profiles■ To explore potential new areas for placement within the private sector
<p>Personal development</p> <ul style="list-style-type: none">■ To complete attendance at the clinical assessors' preparation workshop■ To attend the practice teacher course■ To assist in running clinical assessor workshops■ To take responsibility for the development and implementation of clinical assessor workshops

(Richardson et al 2001:41)

It can be seen from their accounts that for each CF this joint action plan was more or less of a priority depending on their homes' circumstances. In addition to this joint action plan the university intended that the CFs base their efforts on completing the audit generated action plans for each home. Again this was a different approach to the previous studies where the CFs had been given a wider and less defined agenda for their work.

The report's authors took the approach of letting each CF tell her/his own story of the initial six months of their role. These accounts are printed verbatim. Each CF account describes this in individual fashion. These personal accounts are left to stand by the joint authors with only summing up comments at the end. Clearly this was

considered to be an initial exploratory article rather than the final word on the subject. Despite this it gives a valuable insight into the CFs' perception of their roles, difficulties and achievements in this case study. Indeed, the way in which each CF presents their evidence shows the different approaches, styles and issues faced by these individuals given the same job description and joint action plan. This is inevitable but often overlooked. It stands out here as each account is presented in series and is thus instantly comparable.

Issues which stand out from the set of stories are as follows. As the authors explain, each CF has a range of prior experience and attributes. Each CF's workload has its own advantages and challenges. The politics behind the decision to provide one CF with a casebook of three times as many nursing homes as one of the others is unstated. However, the areas covered have clearly been chosen with reference to the jobs the CFs do during the rest of their working week. The CF with only seven homes for example, works for the company which owns those homes as a training officer. This is an inequitable workload, considering that another CF has a list of twenty three homes. Nevertheless, it makes sense if the university is attempting diplomatically to integrate the service into existing structures within the nursing home sector.

All of the accounts place supporting mentors as their priority. Most of them list the isolation of the mentors from each other and the university as one of the key problems that they can help alleviate. These problems were anticipated by the group. However, lack of access to library facilities appears to have been an important factor in the additional problem of alienation from the university felt by mentors. This was not predicted but was quickly identified. Importantly the CFs managed through their university contacts to obtain library access for nursing home mentors. This early win surely helped to gain the confidence and appreciation of the mentors (Watkins 2003). One of the reasons that the mentors requested library access was a reported lack of confidence in their abilities to provide mentoring and teaching service to students. As stated earlier this led the CFs to concentrate on supporting the mentors in the first

instance rather than directly working with students. A by-product of this support and linkage to the university is the increased access and uptake to teaching courses for nursing home staff. As with the other cases presented in this section the funding for CFs is limited and provided by an external education body, the Wiltshire Education Consortium in this instance. The authors end the article with a plea to continue funding. They support this by claiming that the CF service or something similar is now a necessity rather than an expensive luxury. As they say “[t]he timing for the academic role in practice to be re-examined is critical. There are many alternatives that might be considered, but being a link lecturer might not be one of them” (Richardson et al 2001:44). Therefore as with the other cases, whether CFs are the solution to the issues of requiring suitable placements and increasing skills or not, simply carrying on with the status quo is not an acceptable answer, as the issues will merely continue.

An Action Research Project to Evaluate the Clinical Practice Facilitator Role for Junior Nurses in an Acute Hospital Setting (Kelly et al 2002)

As the title explains, this article uses action research methodology to present an evaluation of the clinical practice facilitator (CPF) role in one large inner city hospital. The pilot takes place on eighteen acute ward and departmental areas including medicine surgery and accident and emergency. The role of the CPF is another variant of the CF role investigated in this thesis. The title of facilitator is justified in this case using a definition from Burrows’ (1997) article on the subject. The authors quote the UKCC (1999), when describing the familiar theme of the perceived lack of skills of NQNs, to justify the employment of CPFs. In this case the post holders are directly employed by the trust rather than by a university. Consequently, again as made clear in the article title, the emphasis of the job description, is on the support of junior nurses rather than students. The argument that student nurses are not taught sufficient clinical skills can be dealt with in several ways. In this case the input is with NQNs to ensure skills quality at the start of their career rather than with students before they qualify. This approach fits trust employed educators well, because the reason why it is important that students learn clinical skills is that they are expected to have them when

they become qualified. Trusts do not know whether any particular student will take a job with them when they are qualified. Therefore, supporting NQNs makes good economic sense because the facilitators can concentrate on staff known to be existing employees rather than those who may or may not be.

Kelly et al (2002), describe the action research process used in the research project in some detail. It is appropriate to explain and justify the research method in a research article. However, in this case there is perhaps too much emphasis on this rather than the findings and discussion. This is especially the case as two of the authors have previously published an article concentrating on the research process for this particular project (Kelly and Simpson 2001).

During the process of explaining the research method the authors describe the objectives of the project. In line with action research methodology, as the authors are keen to profess, these objectives are aspirational as well as investigative. The objectives are, “to pilot and evaluate the CPF role; to determine key factors which contributed to the success of such posts; to develop a framework for CPF practice to support its function; to identify the future potential of the role for the trust” (Kelly et al 2002:91). The authors are so evangelical about this role that they make it clear at the outset that they used action research as a framework in order to allow them to “bring about change in human situations” (Kelly et al 2002:91) and that a certain amount of the pain which goes with organisational change (Clegg 1990) is to be expected and will be worth the sacrifice for the benefits that the CPF role will bring.

The researchers describe the first stage of their data collection as a combination of creating new data from questionnaires and the collection of existing data from recruitment data and educational audits. The questionnaires are designed to produce quantitative data. This is presented using bar charts. The main finding is that staff nurses have lower morale than either managers or HCAs. The authors relate this to other answers which indicate a perceived lack of support and positive feedback. Existing data was unsurprisingly more difficult to make generate meaningful

information related to the objectives. Recruitment and retention data collected by human resources does not differentiate between those staff leaving the clinical area and those being promoted within the clinical area. However, despite this, the authors felt confident that they could claim that junior nurses are a transient workforce with “only one clinical area retaining more than 50% of their D grade staff for more than 12 months” (Kelly et al 2002:93). ‘D grade’ was the entry level NHS staff nurse grade until Agenda for Change grading was introduced (Agenda for Change Project Team 2004). Thus this indicates that half of NQNs leave their initial post within a year. They present qualitative data collected at exit interviews alongside this to suggest that a main causative factor in the decision to leave is “dissatisfaction with the level of support” (Kelly et al 2002:94). The educational audits provided information about dissatisfaction with the link lecturer role as a method of providing linkage with and support from the university.

The authors sum up this stage of the research as indicating that staff and the organisation have a number of problems indicated above. These can all be alleviated by the introduction of the CPF role. The researchers elicited a list of expectations about the CPF role from nurse managers considering these findings. These were, “to help junior staff acquire and develop clinical skills; to provide regular teaching; [and] to facilitate individual support and supervision” (Kelly et al 2002:94).

Stage 2 of the process involved the process of action learning by the CPF team alongside the research process. This supportive procedure included monthly team meetings with specific organisational objectives. In addition they were used to generate data for the research alongside reflective diaries kept by the CPFs.

The final evaluative stage was reached eight months after the employment of the CPFs. The researchers see this as much earlier than would have ideally been the case. They justify it by the understandable reason of funding constraints. This final stage was conducted on a single agreed date. The researchers visited the ward to deliver and collect a questionnaire designed to elucidate the staff nurses' and HCAs' perceptions of

the service provided by the CPFs. One of the key questions related to the purpose of contact with the CPF. This data is relayed in the table below

Figure 15: Purpose of Contact

Table 3 Purpose of contact with CPF per grade

Purpose of contact	Grade			
	HCA	D	E	F & G*
Clinical skills development	64%	55%	20%	42%
Career advice	41%	33%	32%	15%
Ward teaching	64%	61%	36%	73%
NVQs	58%	0%	12%	36%
Advice & support (educational issues)	41%	67%	48%	68%
Advice & support (practice issues)	35%	67%	28%	57%
Providing cover on the ward/unit	5%	37%	24%	47%

*Most F and G grades accessed the CPF to plan input in their area. For other grades contact was more personally focused.

(Kelly et al 2002:97)

Perhaps unsurprisingly for a role designed to be for support, education and skills teaching these are the main reasons given for accessing the CPF. Despite this a reasonably large percentage of the reasons given for contacting the CPF are to provide cover for patient care rather than education, training and support of staff. Surprisingly, this is not mentioned by the researchers. If the nurses with responsibility for ensuring safe staffing levels (F&G grades), are contacting the CPF at the rate suggested, then there is clearly role conflict between providing an educational and direct patient care service. In the qualitative comments provided with the questionnaire almost all comments from staff are positive and supportive towards the role. The CPFs writings in their reflective diaries show similar rewards and challenges to those found in the other studies in this review. They mention the difficulty in moving from a member of a team designed to care directly for patients to the “relative isolation” of the role (Kelly et al 2002:96). Again similarly to other studies the CPFs identified the monthly meetings as essential in providing them with group support and role reinforcement. This study reinforces many of the findings from other research. The researchers also comment on the similarity between the role and the defunct role of CT. Nevertheless,

in this trust based form the principle difference is that the service workers have priority access to these staff who are embedded within and employed by the hospital, rather than by the university, for students.

Joint appointments: another dimension to building bridges Salvoni M (2001)

This is an explorative paper concerning joint appointments between the health service and HE providers of nurse education. It is a useful overview of the issues and problems linked to joint appointments. Salvoni writes from the perspective of a post-holder herself. The paper postulates that there are three appropriate models (Mason and Jinks 1994). In the case study she describes this as made up of LPs who have responsibilities for education in specialist fields of nursing; CFs who are generalists working in surgical or medical wards; and her own role of senior nurse/lecturer in practice development which is a strategic role promoting and planning the development of education, research and practice development across the trust and university. As, with most studies of roles designed to link theory to practice, or ‘build bridges between HE and the NHS, this paper traces the origins of these attempts to the CT.

Salvoni relates the literature on LP posts over the preceding two decades. The idea post Project 2000 was that all nurse lecturers would spend a percentage of their time in practice thus maintaining the theory/practice link and not recreating the two tier system of CT and RNT (ENB 1989). LP roles had been around, in very limited numbers, since the early 80s and were on the whole specialist nurses. These were never designed to replace the CT. However, they were always likely to be compared to the CT as both are roles with explicitly direct links to theory and practice. Consequently, in the mid 1990s, when doubts began to be raised at DH level about the ability of Project 2000 to produce nurses fit for practice, LPs were examined as a possible replacement for the CT. This led to a number of studies including an investigative report to the chief nursing officer. This report reaffirmed that these LP roles are specialist and limited in number with estimates of between 123 and 262 being employed at the time of writing (Hollingwoth 1997 cited in Salvoni 2001). When set

against more than 686,000 RNs in the UK (NMC 2007b) and 20,000 new recruits required each year to replace those leaving the NHS (The Information Centre for Health and Social Care 2008) it can be seen that the amount of LPs cannot be considered numerically significant enough to replace the CT role where there would need to be enough to provide one to one teaching for thousands of students. Additionally, it appears that they would not be well suited to doing this. The main findings of Salvoni's paper are that LP posts are specialist rather than generalist; that joint appointments are stressful with conflicting responsibilities and 'serving two masters'; but that they also bring the benefits of 'the best of both worlds' (Wright 1983). That is they provide links between the organisations and create LPs who have experience of both university and service. For Salvoni this means that an organisational structure is required which includes the three roles of LP, CF and practice development nurse (PDN). Each of these has a part to play in improving clinical skills and building bridges between university and hospital. In Salvoni's proposed model they respectively inhabit the separate spheres of specialist, generalist and structural overview of education and development. There is a lot to be said for this approach as the areas mentioned are very different and many of the other papers on the subject have argued that the CF role is too broad for one person to accomplish satisfactorily. However, the obvious weakness of the Salvoni proposal is that they are entirely separate and she does not mention any need for meetings, discussion, or organisational structure to provide a coherent and supportive approach such as joint line management.

In addition to her findings and proposals based on her reading Salvoni provides primary evidence of her own feelings and experiences as a PDN. She describes feelings of "guilt and inadequacy" due to having "a foot in two camps". She ascribes this to the issues of "[r]ole overload, dual accountability and authority" (Salvoni 2001:68). All of these are mentioned repeatedly in the LP literature.

Salvoni postulates a, sensible, multiple role model to address issues of skills

education and clinical practice development. She also indicated, confirmation first hand, of the experience of issues and challenges related to dual roles. These tie in strongly with those experiences described later in this thesis by CFs. These are all entirely employed by the trust rather than joint, HE/NHS appointments. Therefore, it may be the nature of clinical education in practice settings which creates these tensions rather than merely the joint accountability.

Clinical learning environments: an evaluation of an innovative role to support preregistration nursing placements (Clarke et al 2003)

This paper is an evaluation of a one year project, funded by an NHS education consortium using the research method. It was written by three university lecturers with a track record of publication in the field of educational research. The research subject is the role of the practice placement facilitator (PPF) in three NHS trusts used as placement areas for a university school of nursing. The role is similar to that outlined in Figure 8 (page 91), in that it attempts to link theory to practice. It differs in being placed firmly in the strategic level as each PPF has a whole trust with hundreds of students to cover. The article commences with a historical context study of nurse education in the clinical area. The researchers justify the contemporary move to employ educators in clinical practice as a current swing of the pendulum to this form of educational outcome. This is explained in the context of the usual policy documents from government and professional body such as Making a Difference (DH 1999); the NHS Plan (DH 2000) and Fitness for Practice (UKCC 1999). These are used to explain why more nurses with a requirement for better clinical skills education need to be supported in practice placements. They make the point that joint teacher appointments to sustain this are broadly supported by the DH (1999) and the RCN (Chaffer 1999 cited in Clarke et al 2003). Their final point of justification for trying out a role such as this is the increased patient throughput on acute wards. This makes the care responsibilities of ward-based nurses greater and consequently leaves less time and energy for supporting learners (Chaffer 1998 cited in Clarke et al 2003).

The publication date of the article means that a clearer picture of the context can

be gained than in earlier studies. This is an indication of the speed at which the support of learners in the clinical area was evolving at this time. The need for such roles can be contextualised as above by increasing workloads of the nurses who act as student mentors; increasing student numbers being commissioned; a perceived need for more effective skills teaching requiring more emphasis on the clinical placement and learning in the clinical environment in general. The authors clearly see these as the problems and that PPFs are part of a required solution. As with the other papers it can be clearly seen that the researchers align themselves with the PPFs. It would take a good deal of evidence against this group to produce a negative outcome in this paper.

The article illuminates the roles of three PPFs in three NHS trusts. One has 450 learners, and the other two have 150 and 110 respectively. Clearly, as previously stated it would be impracticable for the PPFs to offer each of these students direct educational support in practice. Therefore, the role is described as providing support to mentors; liaison between university and placements to optimise the numbers; and to find new places for students.

The structure of support for students in this case study is described as the university placement office covering all trusts; each trust having one PPF; every placement area having a Clinical Liaison Tutor (CLT), who also has responsibility for formally auditing placement quality; and individual students having mentors. The PPF role is described as a one year pilot but it is stated later that this became substantive. The role during the pilot period is a secondment from practice to a university managed and funded post. However, it is not stated whether this remained the case when the posts became substantive.

The method and data source section is split into three areas of interest: capacity to accommodate student numbers; quality of placements in relation to the PPF role; and the evolution of the PPF role. The capacity for student numbers was collated using existing data routinely collected by the university and by sample questionnaires of ward staff about the profile of learner in their area. Information about the quality of

placements was collected by sampling a selection of twelve wards and departments and asking questions of a range of participant staff. In this case these were mentors, ward managers, CLTs, PPFs and the university placement office. Students were not included in these questionnaire surveys as it was decided to include students by sampling a single cohort for a series of focus groups. The evolution of the role was measured by a series of ten focus groups spaced throughout the twelve month pilot. These consisted of the PPFs and were based on discussion of the role with reference to the initial job description. In addition the CLTs who covered the placements in the three trusts affected were invited to an additional focus group. Finally an individual interview was held with each PPF at the end of the pilot year. The focus groups and interviews were recorded on audio tape and transcribed verbatim. Questionnaire data was placed into a database. These sources were then coded and “topics and themes identified” (Clarke et al 2003:109). The findings were also split into these three areas. Surprisingly, it was found that the placements were working within their audited capacity levels. The maximum figure was 80% of their audited capacity level for student nurses. As previously stated it had been taken as a priori that placements were over capacity. Therefore either this meant that all the mentors and other staff were wrong to feel that mentors were overburdened with students or some other factor was hidden behind these statistics. The other data collected showed that the issue here was that there were many other learners in these clinical areas than student nurses. These include, as the article states: NVQ students, medical students and EN conversion students. The article does not include NQNs requiring preceptorship but these are often a large additional responsibility especially in acute care. According to Clarke et al these other learners make up on average 40% of the numbers of learners requiring support (see table below).

Figure 16: Learners in Clinical Areas

Table 2 Learners in clinical areas

	<i>Pre-registration nursing students from local university</i>		<i>Other learners</i>	
	<i>Number</i>	<i>Total learners (%)</i>	<i>Number</i>	<i>Total learners (%)</i>
Sample week 1 149 clinical areas (57% response rate)	174	59.4	119	40.6
Sample week 2 163 clinical areas (63% response rate)	368	62.0	226	38.0

(Clarke et al 2003:109)

When these are factored into the equation then clinical areas can be supporting as much as 120% of their audited capacity. This is a crucial point often overlooked by researchers focused on the university student rather than the clinical area. The PPFs in their focus groups state that it was initially difficult to get to the bottom of issues like this. The quality of placements as perceived by students in relation to the PPF role was unsurprisingly positive. However, much of their discussion in focus groups was about the quality of mentor rather than PPFs. This is to be expected as it is not part of the PPF role to work alongside students. Students felt that PPFs had enabled the placement to understand the student's needs and responsibilities.

Students appreciated having someone who made it their job to ensure that the learning environment was satisfactory, that staff were briefed about curricular issues, such as assessment documentation, who actively sought them out to ensure that their learning needs were being addressed and that was a familiar person who they felt they could approach with any problems (Clarke et al 2003:111).

However, they prioritised mentors and other clinical staff as enabling a good placement experience. The evolution of the post section dealt with the tensions between PPFs and CLTs. The article skirts around the issue of the CLTs but they were clearly antagonistic to the PPF role. Only 3 out of 15 invited attended their focus group; all of the quoted comments were negative or ambiguous about the value of the PPF role. For example, they complained that a PPF had given advice to a mentor about an academic matter which conflicted with advice they had given. The PPFs described

the familiar position of being positioned between two camps of the NHS and university. As usual this is seen as an uncomfortable position to be in. They especially felt vulnerable during the time when the posts were limited to one year's secondment. Once the posts became known to be substantive the PPFs described more optimistic and positive feelings. The final issue was one of lack of understanding or respect for university by service and visa versa. This led the PPFs to observe that practitioners undermined education and educationalists and that university staff undermined practice knowledge and practitioners.

In the discussion section the authors debate the issues found in the preceding section. This discussion is on the whole not relevant to the purpose of this literature review. One element of the final section is related to the subject matter of this thesis. That is, they make the case that the ENB felt in 1999 that LPs “had not achieved an integration of theory and practice” (Clarke et al 2003:114). On the other hand the authors did commend the CF role as described by Rowan and Barber (2000). This is in line with other findings that the CF role is more effective at this task than the LP.

Themes and Issues

This chapter is primarily designed to provide data for the research findings sections of this thesis. Consequently, the series of reviews have focused on description and interpretation of the individual cases. The data generated will then be processed using the method described in the next chapter to identify issues, create themes and generate theory. However, it would be remiss to leave this section without summing up the themes and issues which clearly link the cases discussed in the articles above. Therefore, these will now be described.

The issues linking many of the articles on CFs can be summed up as ‘who employs the CF’; and ‘short term or permanent funding’. Themes running through the narrative include ‘the CF is seen as a possible solution to problems’; ‘Researchers in this field are not objective but are usually explicit about their motivations’; and ‘the role is seen as transitional to another rather than an employment destination in itself’.

These issues and themes will now be briefly introduced. They will be expanded upon in the chapters which follow with reference to the case studies under examination.

Employers Matter

It makes a difference which agency employs the CF. This is because the employer drives priorities in the direction of their responsibilities. In the nursing homes' case (Richardson et al 2001) the university employs the CFs and thus directs priorities such as educational audits. This case is the only one where the CFs are limited to one day per week. Historically, the CTs were pulled into classroom lecturing by the school of nursing. In the contemporary situation this would logically fit with the university's interests. In the other cases it is either a joint appointment or the NHS trust which employs the CF. For joint appointments the emphasis remains on university students and such areas as ensuring mentors are supported and placements protected. The main advantage of the joint appointment is that in theory it ensures that the individual is not co-opted into inappropriate duties by either employer. The main disadvantage is that in practice the practitioner feels pulled in opposite directions by two masters. These posts tend to be time limited as part of a project. This makes the CF feel understandably unsettled and often undervalued. Where the NHS employs them the priority is likely to be with trust staff. That is, the official emphasis of the role is on the support of the trust employed staff rather than students. Consequently, the CF is often given the responsibility of ensuring that a meaningful preceptorship takes place after qualifying. This group of staff have problems with role definition. They are usually based on a ward and as such are very close to any staffing problems which arise in the primary business of the employer which is patient care. This can lead to them being called into clinical work rather than education.

Short Term Funding

As mentioned above the posts in the case studies reviewed are often temporary appointments. CFs are often seen as an expensive luxury which can only be afforded by short term funding by an outside body such as a workforce development consortium. However, the reports make the point that this is a long term issue and if CFs cannot be

afforded then other solutions need to be found as the problems remain. For the trust based CFs whose main priority is preceptorship there are recent signs of long term commitment to ongoing increasing funding by central government in the Darzi Report. This commits to a three fold increase in spending on nurse preceptorships over the next three years and this has been clarified as £10 million in the first year by a parliamentary question (DH 2008a; Bradshaw 2008).

The CF as a Solution to Problems

The CF is often seen as being introduced to solve the problems of recruitment, retention and skills deficit. One of the articles makes this explicit in the title which is 'Two Deficits and a Solution' (Ellis & Hogard 2003). The main issue does not appear to be whether they work as a solution, most of the contributors appear to conclude that they do improve education and support existing educators. The problem is whether they are an affordable solution. Again this comes down to prioritisation and funding.

Researchers in this Field are not Objective

There is considerable evidence that researchers in this field are not objective. This sounds like a severe criticism. However, in most cases the authors make explicit reference to their involvement in other aspects of the introduction of the role as well as research and evaluation. It is commendable that the source of the evidence is the direct and clear statements of the researchers themselves that they have an agenda. This makes it easier for the reader to make judgements about their findings as they do not have to guess at the position the writer is coming from. It can be argued, and often is, that the objective position adopted by academics is artificial (Reason & Bradbury 2001; Mannheim 1936), disingenuous (Lorde 1994) and unnecessary for meaningful research (Chapman 1995). It can be argued that this is the case in all forms of research but tends to be more honestly dealt with by qualitative researchers. These reports leave the reader in no doubt of their subject position as supporters of the role. However, the evidence presented is as strong as the quality of collection and presentation rather than whether the researcher takes a Mannheimian position of the free floating intellectual or the feminist position of participant.

The Role is seen as Transitional

It has been stated above that many of the cases describe short term contracts and project based roles limited by time or funding. However, even where this is not the case, there appears to be the assumption that the role is a stepping stone to higher positions rather than a final destination. This seems to be because CFs are seen by university staff as inferior to lecturers and that it is just a potential career development role. This fits with the opinions represented by the correspondent CTs and tutors in Martin's research in the 1970s and 1980s (1989). Considering the importance of the effective work of nurses working directly with patients this is surprising. Using a utilitarian measure of the purpose of education this could be seen as the highest and most important aspect of nurse education rather than the geographically displaced practice of theoretical teaching in lecture theatres. Salvoni (2000) makes a similar point when she argues that LPs should be "a senior nurse with mastery of practice, education, management and research". The person fulfilling this could hardly be described as requiring a development role. In addition there are few nurses who could be described as meeting all of these criteria. This creates a quandary, as in order to provide the sort of educational experience required, which includes working one to one with learners, there needs to be several CFs in each hospital. Consequently, in order to maintain a quality service there needs to be a well designed and maintained management structure to the CF team. This is something which is only touched upon by the researchers above. However, the issues generated all indicate that the CF is in a vulnerable position. One potential solution to this is to embed the CF team into the existing structures of the hospital or university. For this they require a management and organisational structure in their own right. This is an area which comes through as important in the case studies to be related in the research findings section of this thesis and as such will be returned to then.

Chapter Conclusion

The cases presented here will be used to provide data for the research process to

come in later chapters. There is a solid base of existing knowledge to found the research upon. However, there are more issues and themes generated by the papers than are evident from each report alone. Many of these will relate to themes and issues from the case study to come. This will provide trigger data as well as triangulation. In the next chapter the justification and identification of the method used will be outlined. As previously stated the basis of the method will be a modified version of Glaser's strand of GT (1978). However, this research will not be restricted to any single grand theory but will pragmatically use sound research techniques of whatever kind are necessary to illuminate the subject matter. Therefore it is to an explanation and justification of this method that the paper will now turn.

Research Strategy and Methodology

Chapter 4: Research Strategy and Methodology

Introduction and Outline

In the first two chapters of this thesis the historical context within which the decision was taken to create this new CF position was elucidated. The chapter immediately prior to this one explored a canon of literature related to comparable case studies to the ones focused on in this research project. The current chapter's function is to examine some relevant underlying research philosophy; discuss ethical and procedural considerations and outline the structure of the fieldwork required to generate the data needed.

This is primarily a qualitative study. As Denzin and Lincoln say in their comprehensive handbook

[q]ualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible (2000:3).

The purpose of the research in this thesis is to illuminate the practice and effects of a new nursing and education role (the CF). This is a social activity within which the researcher has been located throughout the research process. Both sociological research and the subjective position of the researcher make this a contestable scientific process. The CF role remains in its infancy. The study of roles in an organisation, despite much being written on the subject, is a far from established science. However, the reason for arguing that there is no agreed paradigm within which to study the phenomenon is that it is a new post without an agreed theoretical framework (Kuhn 1996 and Winch 2007). Thus it is possible to assert that Kuhn's formula, which defines the majority of scientific progression as "normal science" and "puzzle solving" which takes place within an agreed theoretical framework, does not apply in the case of an investigation of this new role. The position of anomalous issues, such as that of the CF, within his thesis of progressive scientific revolutions, is the stage where one paradigm is becoming unreliable and another is required. This leads to the less well defined and in his view less productive but necessary stage of "extraordinary research" (1996).

Glaser and Strauss in their much used discovery of GT developed an inductive framework for generating new theory of social situations and their ideas will be drawn upon in creating a method to engender theory for this subject (1967). Consequently, as can be seen in the quotation above, the intention to observe, report and interpret this social situation makes the use of inductive qualitative research methodology attractive. Nevertheless, despite decades of use and discussion (Hall and May 2001) the whole field of qualitative study, as a legitimate source of scientific data, remains contested (Denzin and Lincoln 2000). As a result, in addition to the usual paraphernalia of a methodology section, there will be a brief attempt to legitimise the use of the discourse of inductive qualitative analysis through examination of the central philosophical texts.

As indicated above, despite some contestation, the use of qualitative methodologies in science has largely become accepted practice in recent years. The study design has been based on current techniques and methodologies used in social scientific research in order to uncover qualitative data. This can then be interpreted with the intention of generating theory and understanding from triangulated evidence. In this instance, the intention is to use the evidence produced from illuminating the particular case studies to infer general theory in a process of induction (Glaser and Strauss 1967). This form of evidence gathering and analysis is a common form of increasing human knowledge and has a long history (Hume 1988⁷ and Silverman 2000). However, in a study of this depth it is not sufficient to simply report that the method used and methodological justification is accepted practice. For a thorough epistemological grounding it will now be necessary to examine research philosophy to discuss some current dominant thinking on scientific method. This will make clear the author's position on this and enable a proper understanding of the data generated and inferences made from that source material.

⁷ Original date of publication 1748

Research Philosophy

Popper and Kuhn

When discussing research philosophy it is impossible and undesirable to ignore the work of Popper (1959) and Kuhn (1996). These two books use logic and historical analysis to outline theories of scientific discovery. In doing so they set the scene for two different and competing models for scientific endeavour (Lakatos and Musgrave 1970). Both of these ways of understanding and explaining science loom large in the early twenty-first century research community (Uchii 2002). Thus, in providing a platform for this thesis, it is necessary to debate their merits and to decide on a justifiable position from which to conduct the forthcoming inquiry.

The philosophical underpinning of science is particularly important to this study because it uses induction as its primary methodology (Glaser and Strauss 1967). As stated above, a return to basic philosophical principle is necessary because this form of inductive research extrapolating generalisable theory from data is contested (Popper 1959 and Lakatos 1970). Logicians use both inductive and deductive logic but argue that deductive logic provides much more powerful inference (Priest 2000). That is not to say that induction has no supporters. The inductive model of scientific endeavour has a long history and positivist thinkers such as Hume, writing in the eighteenth century, go so far as to present inductive generation of theory as a definition of science (Hume 1988). Nevertheless, in more recent years the concept of science as a methodology producing theory from empirical reality has been argued against to such an extent that standard textbook guidance for many research projects specifically excludes it (Davies 2007). Consequently, it is now appropriate to review a brief account in historical sequence of the debates around the justifications of science as a reliable means of describing, explaining and changing the natural and cultural world.⁸

Logic

It had been generally agreed that the basis of the scientific method was the logical

⁸ This historical account is in itself contestable and extremely simplified. See for example Lakatos (1970). However, the purpose is to illustrate the philosophical debate rather than to present a historiographical discussion.

process. In the pursuit of scientific knowledge since the ancients it had been accepted that human understanding of the universe consisted of a priori or self evident propositions and conclusions or arguments deduced from them. Aristotle formalised this system of logical deduction as syllogisms in his *Organon* (Collinson 1988). It was not until Bacon produced his “doctrine of forms” in the *Novum Organum* that this was challenged (Rawley 1857). As he said the “[f]ormation of notions and axioms by means of true induction is certainly an appropriate way to banish [false ideas]⁹ and get rid of them” (Bacon 1620:41). Bacon, and later Hume (1988), contended that the process of induction from empirical observable phenomena was the only way to logically interpret the world. Clearly, the latter definition best fits with GT, which is the primary method to be used in this thesis. However, both concepts of logic have inherent problems. Nevertheless, practically speaking, they have both been successfully used by scientists to increase understanding of the natural and cultural world. Consequently, it would appear pragmatic good sense to employ either and both as the circumstances suggest. Therefore, for the purpose of this thesis a fairly broad definition of logic will be used. As Mill argued this is “the science which treats of the operations of the human understanding in the pursuit of truth¹⁰” (Mill 1865:4). Mill makes the case that all logic, including Aristotelian syllogism, is inductive (Collinson 1988). However, it is not necessary to make this leap in order to accept that both deductive and inductive systems of logic can and do work effectively.

Probability and Falsifiability

The central positivist argument of the pre-Popperian period was that of probability (Popper 1959). This is exemplified by Mill’s statement that “the conclusion does amount to a practical certainty after a sufficient number of instances” (1865:487). Popper’s response to this was that no matter how many times a theory was validated it could never be said to be “true or even as merely probable” (1959:10). The basis of his

⁹ In the original text “idols” is the translation but when taken in the original context “false ideas” better represents the meaning.

¹⁰ “Truth” as a realisable goal of science is disputed by both Popper and Kuhn.

thesis on scientific discovery was that refutability was the main engine of scientific advance. This has become an important feature of scientific orthodoxy in the late twentieth and early twenty-first centuries. His argument was that no theory can ever be completely validated. However, scientists would and should abandon any theory which was falsified even in a single event. Upon this base is constructed his superstructure as follows.

Demarcation

One of Popper's main problems with the empiricist proposal was one that the proponents of positivism shared. This is the question, "where does the demarcation line between metaphysics and science lie?" The empiricists' answer was that science consists of those things which are observable reality. Popper, however, contended as can be seen above that nothing could be said to even probably exist but it could be shown to be false (1959). This leads us to a central problem in his view with the concept of induction.

Hypothesisation

Empiricists had contested that science was a process of induction from observable phenomena. As Wittgenstein said "the procedure of induction consists in accepting as true the simplest law that can be reconciled with our experiences" (2004:59). However, if Popper's ideas are taken seriously then it is not possible to identify a solid dividing line between the real and the imagined. Consequently, the empirical basis upon which we build this inductive procedure becomes shifting sand. Popper's answer to this is to put hypothesisation at the forefront of scientific procedure (Popper 1970:52). In this way he sidesteps this empiricist conundrum and embraces the concept that theory can be conceptualised separately from practice. The scientific process for Popper is to test the hypothesis against empirical concepts using his process of falsifiability. This results in the contemporary orthodoxy of deductive science.

The Structural Challenge

Kuhn argues that it is the sociological/historical process of paradigm and revolution which drives scientific advance rather than logic or falsification (1996). In

this explanation of science as a distinct arena of knowledge acquisition he avoids questions of inductive, deductive, empirical or logical consistency.

Paradigms

The central requirements are scientific paradigms which he defines as having two characteristics. Firstly, it must be “sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity. [Secondly,] simultaneously, it [is] sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve” (Kuhn 1996:10).

He argues that the most productive science takes place within a paradigm. This is a method of solving the puzzles or problems referred to in the second characteristic noted above. It is only when the community of scientists who are working within a particular paradigm agree that the new paradigm fits their observations better than the previous one that a “paradigm shift” (Kuhn 1996:85) takes place. He likens this to a Gestalt switch as the change must take place almost at once within the whole community of specialists. Whether this better fit is observable by a lack of anomalies or by positive correlation is not important to this definition. It is the acceptance of the paradigm by the community which is paramount.

Popper versus Kuhn

His argument in favour of this as a better explanation than Popper’s is an empirical one. He observes that the historical record is littered with theories which have continued to be accepted for long periods of time despite anomalous observations. No matter how many anomalies are observed it is only when a competing paradigm is tested by and accepted as a better explanation that the previous one is abandoned (Kuhn 1970 and 1996).

As he points out this is not a surprising result as historians have long measured other forms of human social interaction in epochs of this kind. Whether they are recounting economic, social, art, technological or political events they are measured in normal and revolutionary phases. Kuhn convincingly argues that the way in which scientific historical progress has been measured was an exception to this. Science had

been seen as a series of progressive steps. Kuhn shows through historical evidence that the social behaviour of scientific change fits with the measurements of the other historical epochs listed above. Consequently, he postulates that scientists work most comfortably within an agreed paradigm. Their main work is attempting to solve the puzzles within the agreed theoretical structure. This is what Kuhn described as “normal science” and he made it clear that this was not a disparaging term but a term to describe the often most productive phase of science where scientists could advance knowledge within agreed rules. Popper’s response to this was that he disapproved of the normal science described by Kuhn. He rails against the “normal scientist [who has in his] view been taught badly” (1970:52). In his treatise against Kuhn he goes on to describe the historical, sociological and psychological methods, employed in Kuhn’s thesis, as “spurious sciences” (1970:58). His main point seems to be that the more developed sciences such as physics and chemistry are entirely different from the emerging sciences he disparages. Kuhn deals with these issues robustly and convincingly. He declares his methods to be ‘sociological’ and that this is a strength, as how else could a group decision to progress science be understood than by the science of social interaction (Kuhn 1970)?

It is unsurprising that scientists need a paradigm in which to work and that they are reluctant to abandon it unless they are offered a better one. Given a basis of theory upon which the whole specialism can agree it is much easier to devise acceptable research programmes and discuss the puzzles generated. These traditions of research enable easier and faster progress within the paradigm and allow for appropriate change when a theory reaches a crisis point. This then enables extra-ordinary science to take place outside of the existing paradigm. This is not to say that Popper’s ideas are redundant. The regime of hypothesis testing and especially null hypothesis as method of anti-verification has become an embedded tool within scientific processes.

However, Kuhn’s theory of paradigm progression as an explanation of the central solidity of scientific advance has opened up the inclusion of a wide range of scientific

method and methodology for inclusion within the umbrella of scientific process.

It is now possible to turn to an explanation of the main guiding method employed in this thesis. The ideas of Kuhn were noted and used by Glaser and Strauss in their 'Discovery of Grounded Theory'. As they said "evidence and testing never destroy a theory (or any generality), they only modify it. A theory's only replacement is a better theory" (Glaser and Strauss 1967:28).

Grounded Theory

The design of the research has been constructed with GT as a guide. This is because the research is inductive in nature in that it starts with data gathered from case studies and derives theory from this through a process of analysis and triangulation. Inductive research has a history of usage in hard sciences such as cosmology as well as social science (Eastman 2005). However, it is currently most often associated with social science subjects because of the high level of complexity encountered in human social interaction. The ever changing and self generating nature of culture creates wide varieties of possible situations and therefore any preconceived position is difficult to justify. This leads the researcher to attempt to examine the actually existing intricacies of the social situation prior to hypothesising any theory. In the field of cosmology mentioned above this could be argued to equate to measuring radiation and astral observation. To a certain extent, whether the observations are recorded in numerical terms or by literary description, is less relevant than that it is observable data being described by the researcher. In some cases the observer is looking for a specific phenomenon. In others she or he is observing with a view to generate theory from empirical data.

Glaser argues that when attempting to illuminate the processes taking place in a new role through case study examination it is most useful to set out with as little preconceptions of what the issues may be as possible (1978). From this data and its analysis flows the theory generated. The reliability of this data can be ensured by triangulation from other sources. As discussed these other sources can include data

generated by archive study, by observation and interview analysis. Importantly, this is not just a process of scientific, sociological description it is to produce sociological theory or theories. This theory can then be tested back against the data. It is the theory of what is happening and what should happen which is most interesting and useful in a project of this kind (Glaser and Strauss 1967).

Case Study Methodology

A set of case studies make up the central aspect and foundation of the research elucidated in the thesis. Therefore, it is necessary to discuss the definition and concept of case study research as it remains a mildly contentious methodology. The ideas and principles described by authorities in the field such as Simons (2009), Stake (1995) and Yin (2003) have been used as guidance. The practical implications of the case study design are discussed further in the ‘Procedural Aspects of the Study’ section later in this chapter. Defining case study research, Yin states that “[t]he case study is the method of choice when the phenomenon under study is not readily distinguishable from its context” (2003). This makes the subject of this thesis an ideal candidate for case study research. It also indicates why this form of study is problematic. Geographical and temporal context are so interlaced with the phenomenon under discussion that the resulting data is more variable and potentially less reliable than in a more general method of subject selection such as representative survey. A strength of case study research is the richness and depth of illumination which can be achieved. For both of the reasons above multi-method data collection in case studies tends to be used. This allows triangulation for reliability and multiple perspectives for increased richness and depth. Of the six types of case study described by Yin the exploratory multiple-case study fits best with this design. This is a case study type which has become closely linked to grounded theory methodology as used in this research study (Glaser and Strauss 1967, Yin 2003). The case will be made in the later part of this thesis for generating theory from the particular instances of the case studies central to this research. This will be done by constant comparison and triangulation within and

external to the case studies represented.

Having described the philosophical and methodological justification of the research methods to be used it is now necessary to turn to moral concerns.

Ethical Considerations

Before the research could commence it was first necessary to consider the ethical implications of the project. In a research study of this type it is necessary to ask the following questions. “Will it do less harm than good to investigate and illuminate the issues to be considered? Are the rights of the individuals and groups involved in the study sufficiently protected? Will confidentiality and consent be respected?” These questions are framed within deontological and utilitarian constructs. Thus, the rights of the individuals involved are taken into consideration (Kant 2003 and Rawls 1972). Alongside these deontological concerns there are the consequentialist consideration that there may be greater good done than any potential harm committed (Mill 1993). These two ethical approaches are often seen as antagonistic. Despite this, they are both frequently used as the basis of ethical decision making. Within this thesis both approaches will be used and tested against each other. This is the approach adopted by the developers of the widely recognised four principles of medical ethics approach. It is well tested and generally approved. Therefore, this structure identified by Beauchamp and Childress (2001) will be used as a framework to justify or preclude methods, issues and cases. These principles are “autonomy, beneficence, non-maleficence and justice” and although usually employed to make difficult decisions with regard to the treatment of patients they can be used with reference to any subject. In this case the principles were used with reference to the research subjects who were hospital staff and student nurses. The four principles approach was chosen as a framework for ethical decision making in this research project because of its good fit with a subject group so closely working with vulnerable adult patients. The researcher felt that a robust and demanding set of well used criteria would be a good place to start in order to provide a solid ethical foundation for the study. Any research activity

within this project only took place if the principles could be met to the satisfaction of the researcher and overseeing ethics committees. These principles were considered for each step of the research process and when the three initial questions from this paragraph were tested against them a positive outcome was predicted (Appendix 5). The rights of the individuals were protected and the balance of detriment was considered to be favourable.

Legal Considerations

In addition to ethical considerations legal considerations must also be taken into account. The research must take place within the national legislative framework. For a RN this requires consideration of four arenas of accountability (Dimond 2005). These are criminal, civil, professional and employment law. In this case the most applicable of these are professional and employment law. Therefore, professional codes of conduct must be consulted. The author and all of the research participants were RNs and as such were bound by the NMC Code of Conduct (NMC 2004b and 2008d). The researcher and participants were also employees. For the researcher, the status of employee was complicated by at the beginning of the study firstly working for the hospital and then two years into the research changing employer to a university. The implications of both of these positions were discussed with the hospital and university research management authorities. Actions required to comply with employment procedures, such as acquiring an honorary contract were completed. With regard to this management permission and recognition needed to be sought from managers as appropriate. Also the embedded position of the researcher within the organisations needed to be considered. In some instances this meant there was managerial or tutorial responsibility either upwards or downwards to the actors. Where this occurred, advice was sought from the hospital research and development department. There were no instances in which the embedded position of the researcher caused known legal or ethical concerns.

Ethics Committees

The organisations to be studied all had ethics committees which had to be

approached for approval prior to any research being undertaken. This was a lengthy and arduous process. The mechanisms and protocols required for research governance and ethics within the NHS are constructed with medical research of an invasive kind in mind (NHS National Patient Safety Agency 2009). Examples of these include surgical and drug trials on ill and vulnerable patients. The disastrous outcome of the Manchester Parexel drug trial¹¹ illustrates the potential dangers of medical research to the participants (New Scientist 2006). Therefore, despite the fact that they did not prevent this worrying incident it is welcome and not surprising that the procedures are rigorous. However, for more benign and less well funded research strategies the process is bewilderingly complex and of arguable benefit to the public. In this case the process took twelve months from the start to the finish. This research project consisted of observation and interview of non-vulnerable adult staff and student actors. It is left for the reader to decide the level of potential harm which could ensue but it is hard to imagine a scenario in which serious danger outweighing the benefits of the research would follow from such a study. It has been noted by nurse researchers that this process, designed for and by medical researchers, reduces the quantity and quality of nurse research. This is because it is a process required to regulate medical experimentation rather than nursing's less hazardous, sociological studies (Mitchell and Fletcher 1998).

The arguments that this is a verifiable, ethical and legitimate endeavour have been made. It is now appropriate to move onto the practicalities of the conduction of the research.

Procedural Aspects of the Study

Scope of the Study

It is necessary to set parameters to the scope of the case studies in order to limit the quantity of data eligible for study. These were set within geographical and

¹¹ The drug trial caused multiple organ failure in six healthy volunteers.

chronological constraints (Stocking 1985). Using a modified GT approach it was possible to use data from outside of the particular cases to generate theory (Glaser 1978). As has previously been stated this can include anything relevant and will include the studies described in the previous chapter as resources. Nevertheless, the specific cases require boundaries to be set for the primary fieldwork aspect of the research.

Historical Constraints

The timescale of the study encompasses adult education and nursing history stretching back into the nineteenth century. However, much of this is used to provide context. Consequently, the main body of research has been limited to events emanating from educational changes and developments since the Callaghan Speech (1976); the professional changes brought onto track by the Briggs Report (DHSS 1972) and the consequent Nurses, Midwives and Health Visitors Act (1979). This is because these events made profound changes to the educational and professional landscape. The majority of the fieldwork itself was conducted between 2003 and 2007. However, as noted above, all data available will be used for analysis. This will include existing records and published papers from the previous three decades.

Geographical Constraints

Geographically the legal entity of England will be the ultimate boundary of the research. However, the majority of the data will be collected from a small sample of hospital trusts as case studies. These were chosen due to their accessibility and familiarity to the author. This was a pragmatic decision which is in line with a GT approach (Glaser and Strauss 1967) and it is hoped to obtain detailed qualitative information within known and transparent limitations, rather than representative samples. Three sites were examined. Due to limitations set by the NHS research ethics committee the locations and names of the sites cannot be identified. The first of these was scrutinized as a case study while the others were examined in order to provide comparative data to the first. Site 1 was part of an acute general hospital. This trust along with many others is organised into a set of directorates. Each directorate is based

around a medical or service orientated subject. Each has its own management structure. Specifically the medical directorate of that trust was chosen as the arena of interest. It should be recognised that the author was initially an employee of this trust in the position of CF leader for the medical directorate. This was his position during the pilot stage of the process described below. However, by the time of the central interview stage he had moved to a post in a local university. Site 2 was a large community hospital. The wards of this site are described as rehabilitation and as such take a large proportion of recovering medical patients. Site 3 was another acute hospital in the same region as site one and two. Again the medical wards were the main study area.

Method

The case studies were investigated using a variety of qualitative approaches. These consisted of semi-structured interviews of key actors; questionnaires; ongoing literature review; and field observations. In addition data collected from pre-existing sources such as published research studies and data obtained by the researcher which was initially generated for other purposes is used (Appendix 6). A narrative of the specific design of this study follows below.

Case Studies Chosen

Initially Case 1 was chosen. This was done by selecting a case known by the researcher to have a well developed organisational structure supporting the role to be investigated. Two comparable minor case studies were also selected in geographically close but organisationally separate hospital trusts. These were also known to the researcher as areas with either existing or emerging CF teams. The primary case was an area in which the researcher was initially embedded as an employee. This creates both advantages and problems. The advantages include trust, access and depth of understanding (Samuel and Thompson 1990). The disadvantages include problems of maintaining academic objectivity (Mannheim 1936). However, this can be overcome by taking an analytical approach to the data while being aware of the risk of bias. On the whole, this appears to be a more honest and justifiable approach than that of

Mannheim's "free-floating intellectual" (Mendel 2006).

Pilot Study

The first stage of the research project was to be a pilot study. The purpose of this was to generate the first issues and themes (Stake 1995) upon which to design the next part of the study. In this first period the researcher conducted observational research during his usual employment as a lead CF embedded at that time within Case 1. This was done by observing during meetings, general conversation and in clinical workplaces. The observations were recorded in a series of memos using a framework as advocated by Bogdewic (1999) (Appendix 2). This framework was designed to generate thick description and reflection on the content. These were written from memory shortly after the events. These observations were of the general running of events rather than of specifically designed interviews or other data gathering apparatus. This stage led to the discovery of themes and these themes provided the information required to create a selection of semi-structured interview questions.

Interview Stage

The next phase was the interview stage using this selection of semi-structured interviews on a sample of key actors was to be the centre piece of the research project. It was conducted during the actors' work time at their workplace with the specific encouragement and permission of their employers. The interviews were arranged several weeks before they took place. The format consisted of the researcher asking a series of questions in a pre-organised place where interruption was unlikely. They were designed to take approximately 45 minutes and in no instance did they last more than one hour. They were recorded using an electronic audio recording device and later typed up into transcript form by the researcher. The actors were chosen due to their positions within the organisation and consisted of a selection of CF managers, practising CFSNs and CFSNs who had recently moved to secondments in local universities. The data collected was stored using NVivo[®] software¹² and the coded

¹² Further discussion of this software will take place later in the chapter

word usage sorted using this powerful software application. From this the themes which emerged from the pilot study were verified and further themes induced.

Collection of data from existing sources

This stage in the flow diagram occurred during and after the initial two stages. During this process collection of data from existing sources such as journals and data collected for other purposes was ongoing. This is sometimes described as a constant comparative process (Schreiber 2001). This both allowed triangulation with other sources and produced further themes which could be included in the interview based research. This is an acceptable and essential part of inductive research as no new theory can be generated unless the research process can include new findings as the researcher moves through the process of understanding the subject.

Questionnaires

The final stage was designed to check and verify the information gathered mainly through interview with the CFs. This stage involved questioning samples of student nurses who were a part of the learner population during the time in which the project was taking place. This process was conducted by selecting two cohorts of first year student nurses and two cohorts of third years and issuing them with a questionnaire. This was followed up by issuing a similar questionnaire to a cohort of NQNs (Appendix 4). The students had recently been on practice placements as part of their course. Some of these had CFs attached to them. The universities collect data from students routinely in the form of placement evaluations. These were also obtained and searched for references to CFs. The students' comments collected in both of these data collection methods were from medical ward related areas. Not all of these areas were facilitated by CFs. This data was then analysed and compared to the data produced from the initial study of staff reactions, CF interviews and other data collected.

Overall analysis of the project

The data collected was organised using Nvivo[®] software which is designed to help the researcher to find themes and triangulations of data. The organised data was then analysed and interpreted by the author with the intention of extrapolating theory to

an appropriate level or generalisation to the evidence. The ultimate product will be a theory or theories derived from an inductive analysis of the data.

As stated earlier, this is an inductive research project. However, for the research to be meaningful the collection of data needs to be organised around theory at some stage. In this study themes began to emerge as putative theory during stage one. They would continue to be refined throughout the process.

Throughout the course of the research project the researcher continued to be involved in day to day activities from his position embedded within the case study areas. Thus he continued to collect data using the memo method described in the pilot section above. The data generated would be used as further triangulation to support the final analysis.

Research Objectives

To recap, the overall aim of the research project was to investigate the impact of the introduction of the CF post and similar clinical education and support roles onto hospital medical wards. As stated above and in line with the GT approach the researcher initially spent a period of time undertaking unstructured observation as a pilot study to generate some initial hypotheses (Schreiber 2001). This was conducted during routine staff meetings involving CFs, ward sisters, student nurses and NQNs. The observations were recorded as memos after the event from memory using a standardised form (Appendix 2). As made clear in the narrative above, these notes of particular phenomena generated thematic generalisations. From these themes a series of questions were formulated in order to illuminate them further in the interview phase.

Questions Generated from the pilot stage of research

The initial questions generated from these observations were as follows.

- Has the introduction of roles such as CF improved patient care?
- Has the introduction of roles such as CF improved recruitment of NQNs?
- Does the introduction of roles such as CF affect retention of experienced nurses?
- Does the introduction of roles such as CF impact on the authority of the ward sister?

These helped the researcher to construct some questions around which to build a series of semi-structured interviews (Appendix 3).

Following the collection of interview data a period of analysis generated further hypotheses. A key issue from this phase was that CFs felt that learners were both supported and facilitated by CFs better than by ward sisters and mentors alone. This is supported by other studies (Aston et al 2000, Pollard et al 2007). Consequently, data was collected from groups of students shortly after practice placements asking for their feelings regarding CFs. Information was gathered from student nurses who had, and had not, been placed in areas covered by CFs (Appendix 4).

Other themes were also generated which did not feed directly into the design of the research infrastructure. All of these themes will be presented and discussed in the research findings section of this thesis.

Interview Procedure

The main stage of the project was interviewing key actors in the three centres identified. As stated earlier, these centres are required by the NHS Ethics requirements to be anonymised for the purposes of this study. The actors were formally approached in order to gain informed consent to the interview process and the use of the data produced. A standard letter was written providing the informant with the project's aims and information about the interview practicalities (Appendix 5). The interviews only took place if sanctioned by the relevant NHS and trust procedures as advised by the trust research and development department. All interviews requested by the researcher were sanctioned by these departments. The data thus gathered was then analysed for the purpose of inductive research. This analysis is presented in the next chapter.

The research was case study based in an attempt to illuminate "individual cases and contexts" (Stake 1995:39). As described earlier, this involved the interpretation of thick descriptive data provided through interview and other collection methods. Consequently, the emerging cultural reality of the CF as well as social themes could be identified (Miller and Crabtree 1999). Triangulation of themes from a variety of data sources was used to validate the information collected (Gibbs 2007). Therefore,

although a minor aspect of the evidence presented for triangulation is quantitative in nature a statistical analysis was not conducted. This is because the interpretation relies on analysis of the narrative and the numerical data presented merely supports the narrative rather than being the central element of the arguments presented.

Now that the theoretical and practical aspects of the methodology and method of data collection and theory generation have been demonstrated it is necessary to explain some technical aspects of the procedure.

Safety Assessment

A formal risk assessment was conducted at the outset of the project and whenever appropriate during the study. As discussed above, this research process may not appear particularly risky but a safety assessment was a requirement of the NHS research management procedures (NHS National Institute for Health Research 2009). This was completed in line with health and safety law. Locally the trust risk assessment tool was employed. As the research involved note taking and audio recording at the participants' workplaces there were no major safety concerns. The author made arrangements to call upon the advice and guidance of the directorate clinical governance facilitator in all health and safety matters. There were no causes for concern raised regarding any of the procedures the researcher requested.

Data Handling and Record Keeping

Interview transcripts were the main form of data recorded. A database of electronic records within the NVivo[®] software environment was created and maintained. This facilitated the development of themes and the triangulation of data sources for analysis. It also fitted well with the bias of the author for electronic rather than paper storage and organisation. Nevertheless, it was necessary to store some paper records and documents. This was especially true of archive material and the initial phase of handwritten memos. Where possible this was scanned and entered into the database. Nevertheless, a paper filing system was also required for items not committed to electronic media. This paper system was in the form of an alphabetical filing cabinet. The filing cabinet was key locked and accessible only by the researcher.

Electronic data was password protected to ensure that only the author could access the file. The data when presented in the final thesis has been anonymised in line with the requirements of the NHS trust research and development department.

Rationale for interview of key actors

The participants selected were all important actors in the field. There are relatively small numbers of CFs in post because only one is usually required per ward and in some areas one CF of CFSN covers more than one ward. Consequently despite there being only seven formal interviews in phase 2 of the process this accounted for the majority of CFs working in case study areas 1 and 2. As the study focuses on illuminating the role and effects of the role of the CFs it would appear good sense in a study of this sort to select them for the richest source of data. A fuller explanation of the detailed reasons for individual selections will follow in the findings chapter.

NVivo usage

As mentioned above, the NVivo[®] software package was used extensively in this research. This is a powerful and purpose designed package to aid the storage, retrieval and coding of data in qualitative studies. It has been extensively used in qualitative research and is recommended and discussed in numerous research texts (Weitzman 2000, Meadows and Dodendorf 1999 and Gibbs 2007). This well designed package assisted fast and frequent cross checking across the transcripts for repeated phraseology of multiple kinds. This cannot replace visual check altogether as minor typographical errors and slight variations in terminology used by the actors can prevent the software from identification of all instances of near repetition. These similarities of phraseology or meaning are often obvious to the human observer but invisible to the computer. Nevertheless, the combination of the ability to do multiple searches and to store these quickly and reliably made this software a useful addition.

Conclusion

This chapter has discussed the methodology and method employed in the project. It has taken a comprehensive approach to the subject. This has encompassed philosophical discussion of science and of the ethical considerations related to research.

Legal and safety implications have been discussed. Justifications of the approach taken to this research have been put forward and the practicalities of conducting it have been explained. This has justified the general and specific approach taken. Finally, a description of the method to be employed in the next section has been laid out.

This framework will now be implemented in the following findings chapter. It is now appropriate to turn to the findings and discussion section of the research undertaken.

Research Findings

Introduction to Research Findings Chapters

In this section the results of the research undertaken will be described and discussed in line with the research philosophy explored in the previous chapter. This research findings section will be structured in line with the Study Design Flow Chart (Appendix 6). This will allow the reader to follow the journey taken by the researcher which led to reaching the conclusions portrayed in the final section. The events explained span several years from start to finish and several theories were generated (Glaser and Strauss 1967). Some of these were supported and some nullified by the evidence illuminated (Popper 1959).

As explained in the previous chapter, the initial pilot study and issue for investigation was chosen partly because the researcher was initially embedded within the organisation to be investigated. As discussed in the previous chapter, this is a contentious position to be in for a researcher. Consequently, it is important to explain the personal context within which this decision was taken (Chapman 1995). The author had been the first CF employed by the trust in 2001. In the intervening years the service provided by him had grown so much that approximately thirty CFs and CFSNs were now providing education and support both within the directorate and across the trust. Part of this grouping was a team employed by and within the Medical Directorate. This team was led by the researcher from the commencement of the PhD in 2003 until he left the trust in July 2005. During this period of the project the overall research strategy was designed; the historical context researched; the complex process of gaining NHS research ethics approval was gained; and the pilot study completed. The remaining stages were conducted during the following period when he was employed by the local university. These final stages included conducting the key actor interviews and obtaining questionnaire evidence. Therefore, the interviews of the CFs and CFSNs were undertaken by the researcher as an external actor rather than as an embedded participant. That is not to say that such interviews could not have justifiably

taken place if the researcher had continued to be a participant. The NHS research management and ethics committee had accepted the research process with the researcher as either an external or internal operator. However, it is important to know this, especially when interpreting the data collected from those within his former team in Case 1. Of the remaining sources of information the only directly obtained evidence was in the form of questionnaires to student nurses and NQNs (Appendix 4). The questionnaires were distributed and collected anonymously from students within the researcher's university. At the point of interpretation, the stage of education and practice placement undertaken was known but the students' names were not. The identities of participants were collected but these were separated from the data prior to interpretation.

The first part of the research findings to be presented was undertaken in early 2005. This was the pilot study which consisted of consensual overt observations. These were undertaken during the usual management meetings which the author was required to attend as part of his role within the hospital trust at that time. These findings will now be presented.

Chapter 5: Pilot Study

As stated in the introduction, the pilot study consisted of consensual overt observations. This entailed observing proceedings during the usual run of meetings and interactions undertaken by the researcher as part of his role. This job was one which he had negotiated with his manager from an initial twelve month trial in 2001. It had become a leadership role with managerial responsibility for a team of sixteen CFSNs¹³ and eight to sixteen rotation nurses. It involved a structure spanning two hospitals and the support and education of nurses on seventeen wards. This role was deeply embedded within the organisation.

Observation Procedure

The observations took place over several months at the beginning of 2005. Consent was gained from participants at the outset of the observed periods. Therefore the participants were aware that they were being observed for this research project throughout. Nevertheless, the researcher did not take notes during the observations and participated in events in a similar way to that in which he had done for the previous four years. The researcher did not detect any change in behaviour as a consequence of the change in his status from participant to that of participant observer. The nature of these observations was unstructured to the extent that the researcher recorded events relating to the broad subject of CFs as they happened. As stated previously this was done from memory shortly after the event using a standardised memo pad (Appendix 2). At times the events to be observed were predictable. For example, if the subject matter was listed on the minutes or if the meeting was specifically to discuss an issue related to CFs. At other times it was spontaneous. For example, if the issue of supporting newly qualified or student nurses was raised as a side issue to another subject under discussion such as ward skill mix. In either event the memo pad was completed to record significant observed events. Each observation was recorded on a

¹³ This reduced to 12 by the time of the interviews and has since returned back to 16.

separate form. Each form was given a date, time and number. The date was written in the format of “year; month; day” in order to facilitate easier electronic filing. The time was written using the 24 hour clock for the same reason. The number was a simple linear indicator starting at the first observation with 1 and ending with the last recorded observation of 12. The left-hand column consisted of the data identifying the context of the observation, for example “Monthly Sisters’ Meeting Medical Directorate” or “Bi-annual Trust CF Meeting”. In addition to the general context in this column a note was made of the specific context within the meeting. For example, “a sister undertaking a presentation to the meeting” or “the directorate manager answering a question”. In the right-hand column the specifics of the observation were described. At times this was a brief note at others a more lengthy explanation. Where it was necessary to name a participant a code was created to maintain anonymity. This was linked to the identity of that person but the data separated prior to interpretation. In the table below is an example of one of these memos.

Figure 17: Field Observation Form No. 3

CF Study Field Observation Memo Form	
Date 20050111	Time 1400
	No. 3
Bi-annual Medical Directorate CFSN meeting Agenda item CFSNs talk about their ability to recruit staff	CF 2 – talks to agenda item about how she plans to use CFSN team as a positive message to NQNs for recruitment purposes CFSN 6 – agrees with her that this is one of the most important reasons for having CFSNs on every ward. She feels that RN numbers are crucial to good patient care and that in a time of shortage having a CFSN to support them is a good recruitment tactic. To back this up she says that since her appointment a year ago the numbers of new nurses have increased and less nurses have left which has led to an increase from 10 Full Time Equivalent (FTE) RNs to 15.

As can be seen above the CFSN was proud of her involvement in a team which she asserted had increased RN numbers on her ward by 50%. From these brief field observations a set of themes were generated. These would later be used to create a set of questions for the semi-structured interviews which followed.

Results of the Pilot Study Observations

The observation described above was to be repeated several times in different

forms throughout the initial observation phase. The instance above was at a CFSN meeting but others included sisters' meetings and trust recruitment group meetings. Various staff, at many of these meetings, made similar points to this about the linkage between recruitment, retention and the employment of CFs and CFSNs. The linkage between recruitment and retention was not only considered to be about the CF supporting NQNs. It was also about showing students on placement that there was someone there waiting to support them when they qualified on that particular ward. In addition to this the CFSNs themselves were experienced nurses who would have been likely to seek a position as a sister or specialist nurse on another ward or department. Thus, the CF role retained them as well. As can be seen in the table below, the role of CFSN was considered to be a way to progress while remaining on the frontline of patient care.

Figure 18: Field Observation Form No. 9

CF Study Field Observation Memo Form	
Date 20050203	Time 1300
No. 9	
Trust Recruitment Group Meeting Discussion about CF and CFSN value for money	<p>Manager 3 – puts forward the idea that CFSNs are a nice thing to have but could be seen as an expensive luxury</p> <p>Recruitment nurse 2 – defends the posts on a value for money basis. She explains that the role has helped them to not only recruit and keep NQNs but has also increased retention on the wards of more senior staff. This is for two reasons 1. the CFSN stays on the ward rather than obtaining a more senior job elsewhere. 2. other more senior staff stay because they have reduced pressure from supporting NQNs and students.</p>

In addition to this the researcher was compiling recruitment and retention data for the directorate as part of his job. This data backed up the correlation of increased RN numbers to the medical directorate where CFSNs were deployed (Appendix 7). Consequently, this was considered a theme worth investigating further.

The second theme generated from these observations was the potential link between the introduction of CFSNs and an improvement in patient care. Several indicators of improved patient outcomes did advance during the period under discussion for the areas covered by the CFs and CFSNs (Derby Hospitals NHS

Foundation Trust 2009). However, finding empirical linkage between nurse education and improved patient care is notoriously difficult to obtain (Ellis and Hogard 2003). Nevertheless, this was an issue which was raised on several occasions by CSFNs in their meetings. One example of this is in the memo below.

Figure 19: Field Observation Form No. 5

CF Study Field Observation Memo Form	
Date 20050111	Time 1450
	No. 5
Bi-annual Medical Directorate CFSN meeting	CFSN 4 – describes the CFSN role as supporting staff directly
Conversation between two CFSNs at the meeting	CFSN 2 – agrees but says that they should make sure that they do not forget that the reason for staff being there is to care for patients. She believes that patient care is much better since they had the time to support new starting staff. This is because they can be better trained in the necessary skills for that ward.

As this CFSN points out, patient care is the central purpose of nursing and is, therefore, worthy of pursuing. However, the difficulty with making the link is that the CF and CFSN posts are deliberately set as roles to support and educate staff rather than patients. Creating a linkage from that support of staff to their care of patients is problematic because of other attributable factors. For example there is increasing evidence that patient morbidity and mortality decreases with increased ratios of RNs to patients (Ford 2009a). As we have already seen staff numbers were increasing at this time. If it were the case that a specific aspect of training was being delivered by all CFSNs then it would be easier to link cause and effect. However, the ethos of the particular team was that each area had its own needs and the CFSN delivered the support required for that area. This meant that there was a wide variety of approaches and interventions taking place. This was considered an important theme. Therefore, despite the previously explained difficulties this would be a question put to the actors at the next stage of the research. However, it would not be possible to claim a definitive link between CFSN input and patient outcome.

The final theme generated from this pilot exercise was a potential for role conflict between the ward sister and the CF or CFSN. This was never overtly verbalised by

sisters but, during the observation period, it was noted that a small minority would resist attempts to introduce such roles into their wards. In addition to this some CFSNs discussed these issues at their meetings and occasionally brought individual problems to their CF line managers. An example of a memo relating this is in the table below.

Figure 20: Field Observation Form No. 12

CF Study Field Observation Memo Form	
Date 20050314	Time 0930
	No. 12
Ad hoc meeting with a CFSN	CFSN 10 – explains that their ward sister is reluctant to allow her to support staff sufficiently and continually asks her to provide patient care rather than support NQNs and students.
Conversation between CFSN and the researcher	CF 1 – advises CFSN to work alongside the NQNs wherever possible in order to teach by doing. Reminds CFSN that he is her line manager and that if the ward sister does not permit her to do this he will be happy to intervene on her behalf.

This was also considered an issue by other researchers (Kelly et al 2002, Martin 1989) and from discussions with CFs in other trusts. Therefore this was identified as the final theme from this initial pilot study.

It would be grandiose to identify the themes identified in this pilot study as generating theory. However, they certainly raise several justifiable questions. This was the main purpose of conducting this study. Consequently, it was then possible to move onto the interview stage of the research with some hypotheses generated from the initial inductive inquiry. The pilot stage was an interesting and illuminating process in itself. Unlike the more formally constructed interview stage this allowed the researcher to observe the overall behaviour of a large number of staff. They were going about their everyday business rather than being specifically questioned on the subject of CFs. Consequently, it was possible during this stage to gain a less self-conscious perspective of the subject matter from a wider group of diverse participants.

Chapter Conclusion

To sum up, as noted in the previous chapter, the initial questions generated from these observations were as follows.

- Has the introduction of roles such as CF improved patient care?
- Has the introduction of roles such as CF improved recruitment of newly qualified

nurses?

Does the introduction of roles such as CF affect retention of experienced nurses?

Does the introduction of roles such as CF impact on the authority of the ward sister?

Framed as a combined hypothesis these equated to 'CFs improve patient care; improve recruitment; improve retention; and challenge existing authority'. These questions helped the researcher to construct some further questions to test these hypotheses and to attempt the generation of theory. These would be the basis around which to build a series of semi-structured interviews (Appendix 3). These interviews will be critically analysed in the next chapter.

Chapter 6: Interview Analyses

The hypothesis generated by the inductive pilot study was as explained in the previous chapter ‘CFs improve patient care; improve recruitment; improve retention; and challenge existing authority’. The purpose of this next stage of the research was twofold. Firstly, to examine empirical information with a view to testing this combined hypothesis and secondly, to induct further data with a view to engendering further themes. From these it was hoped that further questions and potential explanatory theory could be discovered.

The interviews analysed in this section were structured with reference to the interview procedure section of the methodology chapter. A total of seven interviews took place at two NHS trusts. These made up about half of the staff involved in the role of CF in the medically oriented sections of these two organisations at the time of these interviews¹⁴. The questions asked are listed and justified in Appendix 3.

To recap further, the purpose of the study is to illuminate the effects of the changes brought about by the introduction of practice based teachers such as CFs into acute care settings. This is set within a background of growing numbers of inexperienced and student nurses. More recently funding cuts in the NHS have led to reductions in the recruitment of NQNs and the failure to replace experienced nurses when they leave.

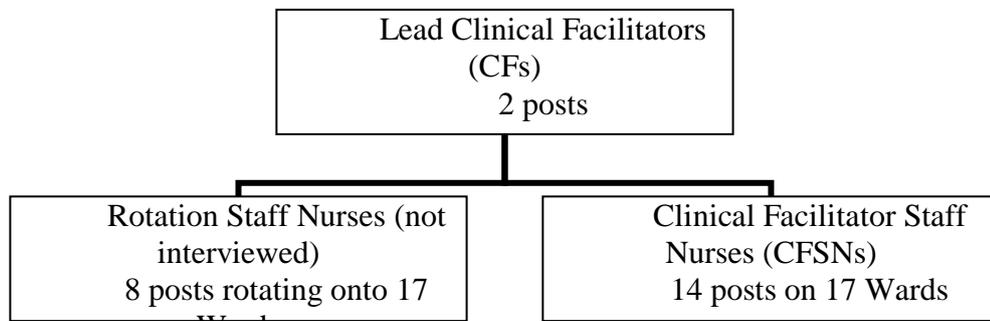
Case Study 1 Acute Medical Wards

Initial Analysis of Interviews conducted from 26 01 2006 to 26 07 2006

The research methodology chapter has outlined the approach. That is to interview key actors in case studies about the changes. In Case 1 the participants were chosen by positive selection of representative positions. These positions were chosen with reference to the management hierarchy within the Medical Directorate CF Team. This is represented in diagram form below.

¹⁴ There were 2 CFs and 12 CFSNs at case 1 and 3 CFs at case 2.

Figure 21: Medical Directorate CF Team Management Diagram



(Appendix 8)

The participants have been represented by code numbers. Codes rather than names are used in order to retain the anonymity required by the NHS ethics and research management protocols. These codes represent the date of the interview written with year first, then month and finally date. Hence, the 8th of October 2006 would be 20061008. In addition to providing anonymity for participants this also enabled efficient storage and retrieval on the computer system because this sequence of numbering is automatically listed chronologically by the machine. This is a similar system for the identification of dates to that advocated by the International Organization for Standardization (ISO 2004). The only difference between this method and that of the ISO is that in the ISO model there are hyphens between the year, month and day. Hence in their system 20061008 would be 2006-10-08. The ISO's recommended hyphens are not used here because the primary purpose is to have an identifying number rather than a date.

Interviewees 20060126 and 20060509 were chosen from the lead CF box of the diagram to gain an understanding of the views of the leaders and managers of the team. At the time of the interviews these were the only two managers of the team. 20060126 was a nurse with over ten years varied experience. She was a former CFSN who had recently been promoted to a lead CF following the previous post holder moving to a position in a HEI. Therefore, she had been a member of the team for over a year but only in a management position for six months. Unusually, previously to becoming a CFSN she was living in another city, had not been working as a nurse for several

months and her previous nursing position had been in another country. 20060509 was a nurse with fifteen years experience in medical and chemotherapy nursing. She had been in her post as a CF for four years and had been involved in the process of developing the team from scratch. She was co-author of the structure of CFs in the medical directorate. Consequently although they were at the same level and in similar positions they were likely to have different views and insights into the role, vision and purpose of the team.

Interviewees 20060607 and 20060622 were the first two ward based CFSNs to be recruited. Their recruitment was the result of a proposal for a pilot study put forward by the lead CFs. The pilot was deemed a success by the directorate nurse manager and therefore a year later all wards in the directorate were allocated a CFSN. As such they represented the most senior members of the CFSN team apart from their manager 20060509. They had both been recruited from staff nurse posts on their own wards. 20060607 was currently, the only male member of the team. He had been a practising nurse in cardiology for the previous six years and prior to that had worked on an acute medical ward for two years. 20060622 had over twenty years experience in several specialities, she had been a ward sister and had made a positive decision to return to a staff nurse role in order to have more direct patient contact several years ago. She had worked in another country for a short period but had returned to the UK ten years ago. Since becoming CFSNs both of these educators had been successful in their positions. This was to the extent that they had independently expanded their roles from part time to full time in order to fulfil the needs of their clinical area. One of these areas was a general medical ward. The other was an area divided between a technically oriented CCU and a cardiac ward with some cardiac monitor beds added recently.

Interviewees 20060719 and 20060726 had become CFSNs in a second wave of recruitment to the role. 20060719 had qualified five years previously and had worked continuously on the general medical ward she was recruited from. As such she was the

most junior member of the CFSN team. 20060726 had mainly gained experience as a staff nurse on a surgical ward at another city. She was the only CFSN who had been working in another practice teaching role prior to starting her CFSN post. She was also the only member of the team who had no medical experience. They were selected because the actors had both recently moved on to educational roles in local universities at the time of the interviews. They had used the experience gained in their CFSN roles to advance their careers and also had the distance to reflect on their previous roles.

The data gathering at this stage takes the form of semi-structured interviews using an audio digital recorder to capture the interview prior to transcription. The interview questions were designed to allow the participants space to offer their own interpretations while guiding them to the issues identified by the researcher (Stake 1995). The researcher anticipated that unexpected views and opinions would emerge from this space left to the interviewees. The intention of the researcher in granting this licence is to allow the “emergence of categories” and theoretical perspective (Glaser and Strauss 1967:40). In line with the GT approach, theory is generated by examining these emerging themes.

The researcher initially interpreted the answers given in the first interview in order to organise a structure for thematic comparison with further interviewees’ answers. The text was deconstructed and labelled in Roman numerals. This was designed to facilitate later grouping of emergent categories. The approach in the later interviews has been to examine the text with some reference to this initial interpretation but also with a wider view to allow the emergence of further categories.

As explained in the method chapter, NViVO[®] software has been used to analyse the interview transcripts. This has taken the form of word and text string searches. These searches have been chosen to reflect the themes and issues emerging from listening to the interviews and rereading the transcripts. The numerical results of these searches are listed in Appendix 9. More usefully in this form of analysis the software allows the researcher to view each transcript following these searches with the position

and incidence of occurrence clearly indicated. Now that the process of participant selection, data collection and method of analysis has been described it is possible to present the analysis of the transcripts generated. This will be done using the themes identified as subject headings for discussion. All of the transcripts are interpreted and compared simultaneously within this thematic format.

Transcript analysis Case Study 1

The issues identified by reading through the transcripts using the NVivo® enhanced scripts are partly led by the questions and partly by the preoccupations of the actors. These preoccupations became evident when leaving the actors to answer open questions freely. The themes indicated are discussed to some extent by all of the actors except where exceptions are specifically stated. These issues were as follows ‘recruitment and retention’; ‘role definition’; ‘organisational change’; ‘clinical skills improvement’; ‘practice/theory divide’; and ‘power and leadership’. Each of these will now be analysed below in turn.

Recruitment and Retention

The most popular label used by the actors to describe themselves was ‘supporter’. This term was used liberally by all of the participants. Lead CF 20060509 used the term by far the most and she summed this up by saying that “It is really difficult to choose one particular thing [to identify the primary purpose of the role]. However, I would say its core is to facilitate and support people in clinical practice.” Interestingly, for nurses in practice education posts, this was far more likely to be used in the interviews than ‘facilitator’ or ‘teacher’. This idea that the main job of the CF and CFSN was supporting front line care givers rather than a teaching position supports the hypothesis that the purpose of this role is to improve recruitment and retention of nurses. As lead CF 20060509 says “You support people in practice because there is empirical evidence to suggest that it motivates people. People who feel supported are more likely to be retained.” Only the two more experienced CFSNs 20060607 and 20060622 used the term teacher extensively. This may be because they have moulded

their local position into their desired model of teaching students and staff clinical skills. Nevertheless, they both clearly understood the origins of the role to be in supporting front line nurses in order to improved morale. When senior CFSN 20060622 was asked why she thought the role had been created she answered “I think from a financial perspective it was evolved to sort out recruitment and retention amongst trained staff. There was a period when everyone was demoralised. There wasn’t support for training of staff.” In describing her subjects and methods of teaching she said that “The subject of the teaching is not as important as the student knowing that someone is paying them attention and trying to meet their needs.” Again clearly identifying that the teaching was more of a device to show that the nurse was being supported rather than primarily to improve the learner’s knowledge and skills. CFSN 20060607’s strong identification as a teacher who planned a formal scheme of work of teaching sessions did not remove his understanding that this was a role about recruitment and retention. He makes this clear in the following passage.

We had to recruit more nurses and we had to retain the nurses we were training. So we had to make the job they were being asked to do more attractive. This was one of the things that made it more attractive. You could say to nurses that were coming into the job “you will get a series of study days throughout the year to prepare you for your job as a staff nurse, you will have a CF to support you in your new job”. You could attract student nurses in the same way. If you come and train at our hospital then not only will you have teaching support from the school of nursing, mentor, associate mentor but you’ll also have a supernumerary teacher on your ward wherever you are in medicine who will take you through and teach you things that otherwise you’ll not get to know (20060607).

20060726 who had recently moved to a HE role felt similarly. She was keen to make it clear that combining teaching with direct patient contact was what made her want to do it. As she said “[i]t was my dream job really being able to work as a nurse, teach students and use my knowledge to guide them.” However, she was also certain of the priority of support over education. “For me my main purpose on that ward was supporting the staff, all staff on that ward. Certainly... even from the sisters downwards.” Her current job, with a university, is even more explicitly designed to assist nurses to remain in frontline position as is clear from its title ‘mentor support practitioner’.

Clearly, there has been identified a problem amongst frontline practitioners which is that their primary role is caring for patients and this is a demanding task in itself. Nevertheless, there is an overwhelming case for these same people to be preparing and assessing student nurses to ensure they are fit for purpose. CFs are one of the solutions identified. They are not intended to take the place of practising nurses as mentors/teachers/assessors of students and as preceptors for NQNs. Their self identified role is to support these nurses in the task of doing this in such a way as to lighten their 'burden' as 20060126 put it. This puts the CF team into the uncomfortable position of being on the whole more experienced than the people they are supporting but at the same time genuinely believing that this is the correct way to do it. They value their role highly and clearly enjoy it as is evident from their descriptions of the role as "a joy", "a dream job" "the chance to get paid for doing something I really enjoyed as opposed to doing it in my busy schedule as a nurse". Nevertheless, that value is subordinate to their understanding of what it is to be a nurse. It is only useful in as much as it supports what frontline nurses do and thus benefits patient care. Despite their contractually clearly defined role as a facilitator many of them described instances where they were expected to "muck in" when colleagues were off sick and thus having to abandon plans made to teach. This leads to the next issue of role definition.

Role Definition: What it is to be a nurse? What it is to be a CF or CFSN? and Organisational Change

All of the interviewees described themselves as 'supporters' and 'facilitators'. Perhaps unsurprisingly the two lead CFs were the only interviewees to mention leadership or management in reference to their own role. 20060126 immediately volunteered this in answer to the question about role when she said "[w]e lead a team of twelve CFSNs who are based around the medical directorate." It would have been surprising if she had not done this as she had only recently been selected by competitive interview for a position advertised as a management and teaching post.

The more senior of the two CFs 20060509 described her role as a facilitator and supporter. It was only when the researcher asked a supplementary question about the CFs relationship to the CFSN team that she volunteered “[w]e line manage them but we don’t have budgetary control.” She then went on to describe detailed technical management information of the nuts and bolts of managing a team spread across seventeen wards on two sites. At the end of this description she realised her earlier omission. “When you asked me about my role I missed out the bit about line management.” This is unsurprising in that later in the interview she described her reasons for taking the role as to do with teaching practical skills. The growth of the role into management took place during her time in the post. By the time of the interview it had become leadership of a medium sized team across a large geographical and complex clinical area. Despite this demanding job, at the time of interview her line manager was about to ask the two lead CFs to work as staff nurses for three days out of the week for a period of three months on two wards due to expenditure cuts which were affecting the whole NHS. She did not know this at the time of the interview of course. However, she did believe that her post was vulnerable. In answer to a question about the possibility of cutbacks and redundancies she replied that,

[i]t shouldn’t affect it. What it should do is say “are we valued enough to keep it in place even if it means cutting it down”? Otherwise the wrong message will be given out to staff that they aren’t supported. Recruitment isn’t seen as important but retention is. But that sort of gets lost in the ether. It certainly is one of the first sort of jobs to go. Looking at other trusts they have gotten rid of their educators, they’ve gone. Looking within this trust in other directorates the CFSNs have gone. Not the CFs but the CFSNs. In one other directorate the CF time has been cut back. This is the only directorate left with CFSNs. However, there is a solid structure with sisters and matrons but those people only have power when the organisation gives them permission to use it. That’s how I see it. The NHS is a hierarchical organisation so it’s not really their decision. If it comes down from on top that redundancies are necessary then nurse specialist posts are the first ones to go. If you’re given the choice do you want a worker who delivers a frontline service to patients to go or do you want someone in an office who delivers support to staff If I was in their position it would probably be me. At the present moment I just think it is a matter of time. I think the CFSNs will be absorbed back into the numbers as a staff nurse without losing their job. That would mean going back to how it was before the CFSNs were in post. That is two CFs for medicine. In other directorates they have seen the value of CF posts and have decided not to recruit a matron in order to keep their CF and PDN. Our Directorate nurse manager and the director of nursing are both practice development background so they do think those things and hopefully CFs are important (20060509).

These nurses do not see themselves as purely managers despite their management

commitments. This indicates that they see their role as supportive to the front line and although they value their contribution they feel that a frontline nurse is more valuable than “someone in an office who delivers support to staff”. This concern was reflected by all of the actors. 20060719 who by the time of interview was working as a clinical practice educator (CPE) for a local university said in answer to the same question,

I thought that the educators would be seen as less productive and valuable than other members of staff and that they'd be pulled into staff nurse work, which has happened. It's not a great surprise but it is a great shame because there isn't the development there for future generations of nurses. They'll go back to each ward doing their own thing without any form of consistency. My old post has not been replaced since I moved here (20060719).

This appears to be more than just a natural fear of losing their job in a time of redundancy. It is a deep rooted belief that although their post is important it will be difficult to persuade other nurses of this and they also appear to be uncomfortable with their position when compared to more ‘productive’ staff. 20060719 discussed this issue of not producing anything concrete in nursing terms earlier in the interview. Her argument was that the produce of an educator is the learning and feeling of support in other members of staff. This she felt is difficult to measure compared to, for example, counting how many drugs had been administered or how many patients admitted or discharged by the nurse. This was even the case when she was visibly doing her job on the ward all the time and completing the records required by her line manager the lead CF. This was the case even though these records were specifically designed to provide evidence of the work that the CFSN was undertaking.

Senior CFSN 20060607 felt that some of his colleagues “even before this semi-crisis developed” had been expected to, and had allowed themselves to, be “drawn into doing the job. Or even if they had the CF[SN] uniform on they were still expected to do the drug round and basically work on the ward.” He felt that he was lucky in his time in the role to have escaped this. This is all despite the CFSN contract specifically stating that CFSNs are additional to the ward team and that their purpose in being on the ward is to facilitate staff not to care for patients. The comment that they were “drawn back into doing the job” is telling. It is almost as though CFs and CFSNs see

the role they are undertaking as almost too good to be true. Their view can be summed up as follows. Despite the evidence of benefit to staff and patients from it, that it is not a proper job at all. Real jobs have a concrete product and the CF role produces nothing but good morale and improved nursing care. Consequently, in times of scarcity those in positions of power will spot this straight away and move these staff into productive positions without delay.

It is arguable, even if it is the case that the role produces ephemeral results, that these posts are even more valuable at times of crisis. As 20060509 says, it “sends out the wrong message” to be culling these staff when these are roles junior nurses aspire to achieve in the future. It is wrong to say that the work that these staff do is not measurable. The lead CFs designed electronic record keeping procedures at the outset of the CFSN role. These ensure that each intervention which the CFSN makes is logged and recorded centrally. These recorded interventions include formal teaching; practice teaching; professional support; pastoral support and a list of other duties. The worry that the CFs and CFSNs have is not that they cannot be seen to be working but that this is evidence of process rather than product. For this reason the CFs monitor levels of recruitment and retention in order to show a link between the provision of CFSN services as recorded and the numbers of nurses joining or leaving the directorate (Appendix 7). Nevertheless, the purpose which appears the clearest reason for having educators in a ward environment is the improvement of the frontline staff’s clinical skills. Similarly to the number of nurses deployed, clinical skill has a direct bearing on the quality of patient care and is therefore important in the healthcare setting. The level of clinical skill achieved by staff is potentially measurable and in a time of rapidly increasing technological intervention in the patient care it would appear invaluable to have identified teachers to update existing staff and to induct new nurses.

Clinical Skills Improvement

The majority of the interviewees indicated that they applied for the job because they wanted to teach their colleagues clinical skills. Lead CF 20060126 had experience

of working as a nurse in other countries. She said that she applied for her previous position of CFSN because “I had worked in hospitals where they had roles like this and I had seen how it could enhance the learning and clinical skill development on the ward”. However, she had come to realise that it was more important to support mentors with the number of students they were being expected to assess and educate as they saw this as a ‘burden’ to be endured. When pressed on whether she believed that the role improved clinical skills she identified clinical skills as “everything which a nurse does as part of their job. From communication to more practical skills like, taking blood pressure or identifying when someone is really sick and needs some intervention.” This broad definition of what clinical skills are was shared by the other members of the CF team. This may appear surprising to the lay reader as skills are often associated with manual expertise such as those learned by a craftsperson such as a carpenter. These types of skill certainly play a part in the area defined by the CFs as clinical skills. However, they are also careful to include communication, management, empathy, reflection and other similar less manual topics within the definition.

Influential text books on clinical skills such as the ‘Oxford Handbook of Clinical skills in Adult Nursing’ (Randle, Coffey and Bradbury 2009) also use a wide definition and include a similar set of skills to the ones listed by the CFs. As lead CF 20060126 says it includes “everything which a nurse does as part of their job”. It is the use of the learning for practical production of care outcomes which is important to the definition of clinical skill rather than whether it is a physical or a cognitive function. This is almost the definition of the useful knowledge described in the first chapter. However, it is worth emphasising that the definition is not merely about the craft type skills. These are seen as important by the CFSN team and they describe teaching a range of these activities. These include wound care, feeding patients, bed making, manual handling and drug administration amongst others. However, it is clear from this incomplete list that these are not simply psycho-motor skills. Communication for example runs through each one of these as there is a human patient on the receiving end

of these tasks. In addition all of the participants identified the need to relate these skills to the evidence base to ensure that the best patient care was being provided. Therefore, the traditional divide between theory and practice is as blurred in their view of their teaching role as is that between practical skills and scholastic education.

Lead CF 20060126 went on to explain the student centred nature of the teaching methods used.

Part of the CF and CFSN role is to identify what people need on an individual level. Some people have different needs to others. If you can identify that then you can work on that with them. I think it depends very much on the individual's needs on an individual basis. Clearly some things come from above, from the trust, but from the CFSN point of view it is very much on an individual level (20060126).

The other CFs and CFSNs also felt that clinical skills learning needs were best dealt with when individually identified and that their range was vast. Senior CFSN 20060607 felt that the value of the CFSN, to the organisation and the individual learner, in increasing clinical skills and knowledge was a combination of their practical experience which should be of many years depth; their ability to spend time with the student due to being relieved of the usual nursing duties of a senior member of the nursing team; and the one to one or very small group teaching which could be done due to the structure of the role. As he said,

[i]f you are a student nurse and your education is bound by how busy your mentors are and how well staffed the ward is then you cannot guarantee that people will learn the clinical skills with the level of confidence they need on any particular ward. So by having a supernumerary experienced nurse who can work for long periods of time with an individual nurse then if they address the job in the right way then clinical skills will definitely improve as a result of this job. (20060607)

He was not the only one to express these feelings. In fact most of the CFs and CFSNs interviews made this point in one way or another. Lead CF 20060126 expressed similar views from the angle of the staff nurse who was also required to be a mentor. She said repeatedly that these nurses who were primarily care providers saw the role of teaching students clinical skills as a burden rather than as an acceptable and useful part of their job. If the nurse sees the role of teaching as a burden then s/he is likely to begrudge this and it would be logical for her/him to attempt to avoid the burdensome

tasks associated with this whenever possible. This makes Senior CFSN 20060607's observation that the clinical skills education of student nurses is likely to be hit and miss an even more worrying outcome. If this is a burden which nurses will attempt to avoid then the student is more likely to not be provided with quality skills teaching than be provided with it. If clinical skills are not guaranteed to be taught in a system without specified clinical teaching staff then the student nurse being produced by this system cannot be guaranteed to be fit for purpose (UKCC 2001).

Senior CFSN 20060607 particularly championed teaching methods which were in or near the clinical area, done by experienced practice based nurses with one to one or small group teaching. He goes further in expressing his opinion that university based teachers who do not also work in clinical practice cannot provide teaching which is relevant to students.

Practice/Theory Divide

These comments link clearly to the issue of the idea of a "theory/practice divide". This has been a contentious issue for many years, as noted in the historical context chapter. Especially since the introduction of HE based courses which resulted from Project 2000 in the mid 1980s (UKCC 1986). This led to the RN qualification being linked to academic achievement of a diploma in HE. By the mid-1990s all nurses qualified in the UK had to achieve this academic level in order to qualify as well as achieving clinical outcomes set by the UKCC and national boards. The programme was widely criticised by practising nurses, patients' representatives and other healthcare professionals for failing to prepare nurses adequately for the clinical role they would have to undertake (Bradshaw 2001b). In the late 1990s both the DH (2001) and the UKCC (2001) had been convinced that changes needed to be made and consequently courses of HE leading to registration were amended nationwide to ensure a more practice based curriculum. Also placement providers such as NHS trusts were to have involvement in the design and implementation of these redesigned courses. Their main concern was to be to ensure that future practitioners were fit for practice

and purpose as well as award (UKCC 2001). CFs and similar roles were in part re-created in response to this paradigm shift. Perhaps unsurprisingly for staff who mainly were convinced to move from practice to these posts in order to teach practical skills they felt that nurses learn most of value about the job from the clinical area and that all of their teaching should be to prepare them for their future role.

It's about practical knowledge from someone who has read the books, put the stuff into practice and knows what it's like to practise as a nurse. It's about being able to pass on that information in a way that students and newly qualified nurses can embrace (20060607).

Lead CF 20060126 was keen to share her belief that most nurses were opposed to university education of nurses. A popular belief amongst nurses she felt was that “they’ve got a degree but they cannot even take a blood pressure”. Later she made it clear that this was a belief she shared and that in fact she believed that

[t]he underpinning theoretical knowledge doesn't help you to do the job. It's only by learning in the clinical area that you pick up the skills you really need. To an extent the underpinning knowledge is like the icing on the cake. You don't need to have that to be a good nurse I don't think. I think a lot of people think the same. (20060126)

It is important to see this in the context that lead CF 20060126 was at this time undertaking a part-time degree in nursing. Consequently, this cannot be seen as a rejection of the value of HE or of an anti-educational bias. It is a view shared in various levels of enthusiasm by most of the rest of the team. Again the others have a range of personal educational levels of achievement. Some of the participants who qualified prior to the mid-1990s had professional qualifications which had no attached academic value. Conversely, those qualifying after this had all done HE based pre-registration courses with a minimum of diploma in HE level achievement. Several were working towards degrees or had already achieved them.

20060719, who had recently transferred to a HE employed position, was the exception in this. She felt that if anything the relationship between theory and practice should swing back towards theory as can be seen in the extract below.

I think that the split between theory and practice is about right at 50/50. You need to know the theory behind the practice. You need to have a certain level of knowledge before you even enter an area where you could cause harm. Preparation should include theoretical things as well as practical based things. Practical care is the main job of nurses but they do other things too. Such as

psychological care, emotional care, numeracy and lots of other things. I would not swing the mix any more practically based than it is now. If anything I'd swing it more towards theory (20060719).

Her role in the university was as a CPE, rather than as a theory classroom based academic and therefore it is unlikely that the move of employer has caused her to value theoretical education more highly. It is more probable that this is a long held belief as she was one of the last nurses to be educated under the Project 2000 regimen. Another possible influence could be her involvement with conducting the assistant practitioner training in the hospital trust immediately prior to her current role. In this she would have been facilitating theoretical as well as practical teaching to a group of HCAs using OU resources.

Wherever the individual places themselves on the continuum between rejection and praise for academic learning they all subscribe to the belief that one of the CF team's main functions is to bridge the theory/practice divide.

Power and Leadership

Are they in a position within the organisation to enact this link? Between the 1950s and 1980s under the 'apprenticeship' model of nurse education which had preceded Project 2000 the role of CT had been created to fulfil this purpose. Their purpose was to provide the type of clinical skills teaching at the bedside which the CF/CFSNs describe and champion above. Nevertheless, after 30 years of national provision the CT role was withdrawn in the late 1980s. One of the concerns which led to the removal of this role under Project 2000 was the relative powerlessness and low status of the nurses expected to undertake these positions (Martin 1989). The intention of the management structure identified in the diagram at the top of this section was to create a team of facilitators protected from local managers such as ward sisters. In the late 1980s, as now, the sister's main priority was providing direct nursing care to patients on their ward. This is what led to the role conflict between the staff education focused CT and the sister and potentially could lead to disputes between CF/CFSNs and sisters now. The CFSN team management structure was designed to reduce this by

taking the CFSN out of the direct line management of a sister with responsibility for patient care and into the line management of a lead CF with responsibility for ensuring staff support in education. Some of the CFSNs had conflicts with the ward sister for their area. 20060719 described an ongoing dispute between herself and the sister about her role.

In the beginning she was very supportive of the role but as it developed and evolved she became less supportive and more protective of her own interests. She in fact rang me at home to ask me to become a full time CFSN which I did. After that it went completely mental because she couldn't cope with me being a full time CFSN. The fact that the whole time I was on the ward I didn't produce anything tangible. It was questioned a lot and then it was eventually stopped. There was never any question of how I was spending my time because I was always visible. I worked five shifts a week the same shifts as everybody else so there was never any doubt as to where I was. It was just what I was doing when I was there. I felt it was evident because we'd take half a group of patients. Possibly she was jealous of the role or threatened by it. (20060719)

Not all of the CF team felt this conflict and senior CFSN 20060607 shared his theory that the reason his ward sister was supportive of the role was because he negotiated his actions with her, supported her role and that he was an existing respected member of the clinical team with eight years experience. He was aware that other members of the team had problems in this regard and felt this was because their sister was more controlling than his and because of lack of experience on the part of the CFSN. Lead CF 20060509 felt that on the whole sisters and matrons were supportive of the CF team and its objectives. However, she believed that within the NHS these 'middle-managers' themselves are relatively powerless and that the main threat to her team was from higher management who she feared would decide that CFSNs were an expensive luxury that they could no longer afford.

Case Study 1 Conclusion

The issues generated above by Case 1 were 'recruitment and retention'; 'role definition'; 'organisational change'; 'clinical skills improvement'; 'practice/theory divide'; and 'power and leadership'. These illustrate the themes generated from the pilot study data and from the text of the transcripts from the six participants selected. These would inform the further analysis of the three case studies and of the 2nd case's transcript analysis below.

Case Study 2 Rehabilitation Wards Community Hospital

Case 2 is a community hospital located within the same county as Case 1. This case has been selected as it is known to the author as another area recently utilising ward based CFs. In addition, the clinical area is a rehabilitation rather than acute medical area. Consequently, the reasons for and effects of CFs in this area may be different to those in medical wards in a general hospital.

Initial Analysis of Interview conducted on 02 04 2007

The data collection for Case 2 was conducted in a similar manner to Case 1. However, in this case only one key actor was selected. Her code is 20070402 using the same method of identification as Case 1. This actor was chosen as she was the first CF to be appointed by the community trusts in the area. Since her appointment there have been several more appointments but she has been central to this growth and therefore has a great deal of knowledge about the case to share with the interviewer. It was initially intended to conduct a sample of participant interviews amongst the CF team within case study 2 and case study 3 areas. However, further interviews were not conducted at this second case study area or at the final third area examined by the researcher. This decision was taken because it became clear during the 20070402 interview that a similar pattern had been followed to that undertaken by the CF team in the acute hospital. This was due to the links between her appointment and the previous installation of the team at Case 1. Consequently further investigation of case studies 2 and 3 were undertaken using the form of participant observation described in the previous section of this findings chapter and by the use of anonymised questionnaires. These will be explored in the later sections of this thesis. This form of adaptation of research method dependent on the results is in keeping with Glaser's ideas and of inductive reasoning in general (see the methodology chapter of this thesis). As a result of this, the individual CF interview conducted on the Case 2 site is particularly interesting.

20070402 was a nurse with many years of experience in acute medical nursing.

She was a ward sister at another acute general hospital in the region prior to obtaining her CF position. She had been the first person employed in a clinical education post in this PCT three years before the interview. During that time the NHS had been reorganised and the employer had changed from a small local community trust to a county wide organisation. Her post had been successful and two other CFs had been employed by her original employer within her community hospital. Unlike the medical directorate in the hospital described in Case 1 the CFs were managed by the wards or departments they were attached to rather than by a central CF manager. According to the participant this led to a lack of communication between the CFs. Since the merger the other PCTs had shown an interest in the CF role. In the years after the interviews CFs would be commissioned across the county PCT and a level of central co-ordination introduced. However, it goes without saying that 20070402 was not aware of this at the time of interview.

Transcript analysis Case Study 2

The analysis will be based around the themes generated for the first transcript analysis. These themes were ‘recruitment and retention’; ‘role definition’; ‘organisational change’; ‘clinical skills improvement’; ‘practice/theory divide’; and ‘power and leadership’. Again they will be examined in sequence. NVivo[®] software was used again to assist in identifying issues. This process uncovered several other preoccupations which emerged during this interview which were specific to the second case study or which were generalisable but had not been evident from the initial analysis of Case 1. These will be explored at the end of this transcript analysis.

Recruitment and Retention

Again 20070402 described her role as that of ‘supporter’. However, she did use the term teacher and teaching with a similar level of emphasis. When asked to describe her role she gave a list of objectives in order of priority. These were as follows:

- a. bridge the gap between theory and practice for the students. Think we do a good job of that.
- b. to support the mentors who are in post and to develop new mentors.

- c. then to start working with post-registration nurses.
- d. I do a lot of policy development and making sure that staff are signed up to it. Make sure PGDs [patient group directives]¹⁵ are up and running. Make sure documentation is OK. I do a lot of audit of post-reg stuff and general management of patients which doesn't include students. I have to action plan those and implement those. I focus this on [ward a] whereas the PDN does a lot of the same but she focuses on [ward b] and does a lot more huge project work than I do (20070402) [ward names anonymised].

This gives a much higher priority to the direct support and teaching of students than that given by the team from Case 1. However, this does not imply that she considers the role as primarily educational rather than a route to creating a supportive environment attractive to new starters and existing staff. Later in the interview 20070402 explains that the support of students is not just to provide the link between theory and practice described above but is also to encourage students to view her placement as a potential first post after qualifying. She has clearly considered this in some depth as she describes several possible scenarios which could lead to students choosing the community hospital as a job opportunity. These possibilities include that they see working for the PCT as a route to obtaining a post as a district staff nurse. This is understandable as traditionally students have been placed in predominantly acute general hospitals and have taken their first positions within either acute medical or surgical wards within the same hospitals that they trained. In recent years community hospitals have begun to be utilised by universities as placements in addition to general hospitals. This is in part the reason for the PCT employing CFs and it has also led to NQNs beginning to see these hospitals as possible employment opportunities. 20070402 also describes the need to not only recruit and retain staff but also to ensure that they are capable of providing the best care. Again 20070402 saw this as a big issue as not only were there insufficient numbers of nurses providing care but in her opinion the majority had been providing care which had not been updated for many years. This was partly due to a lack of students using the wards as placements,

¹⁵ PGDs are a form of group prescription allowing nurses to administer medications without an individual patient specific prescription being written by a doctor (Adam 2000)

partly due to it not being seen as a place for NQNs and partly due to consecutive ward managers being either dictatorial or too laissez-faire. This will be discussed later under ‘What it is to be a CF’ and ‘Power and Leadership’.

20070402 described her role as requiring a teaching qualification such as the ENB 998 and that she had obtained a similar qualification known as Facilitating Learning in Practice Settings (FLiPS). These were both versions of short courses set at professionally post registration but academically undergraduate level. They were approximately equivalent to a university module from a degree programme and covered basic teaching activities such as teaching and learning styles; Bloom’s taxonomy (1956); and assessment methods (Hinchcliff 1992). However, as she says “they didn’t want a cert. ed. or anything like that” (20070402). Similarly to the CFs in Case 1 she felt that current clinical expertise was most important rather than teaching ability or academic qualifications. As she said “[the employer] didn’t want a degree. They wanted current clinical knowledge” (20070402). This indicates that the ‘sitting with Nellie’ concept of nurse education remains strong at this trust as well and appears to be approved of by 20070402 similarly to the majority of those at Case 1. This may appear odd for a role which is predominantly focused on education. However, the explanation would appear to be that these are primarily skilled nurses and identify themselves as such. This is in direct contrast to Martin’s research in the 1980s which found that clinical nurse teachers identified themselves professionally as teachers rather than nurses (1989). It seems likely that this continued identification with nursing is due to their employment by the NHS rather than the school of nursing or the university sector and perhaps more importantly their embedded position geographical within the clinical ward area. As 20070402 says “I cannot sit in the office knowing that they are struggling. This is an advantage and disadvantage of being based on the ward. I’m sure that if I went off the ward and had an office elsewhere I wouldn’t have that rapport with staff.” This is something which the CFSN team at the primary case study identified with also. In other regions this close affinity with ward staff had led to the

CF role being subsumed back into the general ward nursing workforce (Doherty 2006; Staines 2006b and 2006c). This underlines the vulnerability felt by these staff as well as the value of their participation. Similarly to the previous case findings this leads to role definition.

Role Definition: What it is to be a nurse? What it is to be a CF? and Organisational Change

20070402 had clear ideas about what it was to be a CF.

I have a teaching plan in my head like the staff nurses have a plan of the day. I also have a plan of the patient care for the day but I'll also be thinking that will be a great time to look at the skin to see how it deteriorates or that will be an excellent time to focus on COPD¹⁶. If there is a lull time then I can take her off and she can go on the internet and we can start going through that. "Have we got a policy in place? What is Prodigy¹⁷ saying about peak flow monitoring and all that (20070402)?"

She sees her main role as a clinical educator of students on their ward placement.

Above this is spelled out in terms of creating a teaching plan around the activities which will take place during the normal nursing work day. This is a kind of modification of the 'sitting with Nellie' type of learning which it could be argued illustrates the most standard view of what CFs do.

However, this is not the full extent of her self view. She also includes management related duties including strategic policy planning and operational management activities. She shared an office with a PDN and was in constant communication with staff on the ward attached to this office. Consequently, she was continually comparing herself and her role with these other nursing positions. She made it clear that she felt her job was supporting staff in various ways and that in some ways this overlapped with the job of ward sister and PDN. However, in the three years she had been in post she had developed the job from a 'blank sheet of paper' to one which she felt was well defined and different to either of the other two senior nursing roles mentioned above in her area. She saw herself solidly in the role of supporting and

¹⁶ Chronic obstructive pulmonary disease which is an umbrella term for a range of long term chest conditions such as emphysema

¹⁷ A NHS database of evidence based treatment for medical conditions

educating. Despite this she felt that the position had been created by senior management in order to bring about progressive changes in the way in which the wards were managed by the ward sisters. As she says

that suppression has been huge and that has taken a good two years to shift. It is a culture we are moving here. It isn't just a mindset these things are ingrained in them. They have been dictated to them for so long and now the dictatorship has gone. It's like they go woo! They're going through that crazy phase. Now we've reorganised and now they've got to reform again. We've got to guide them the way we want them to go. People outside the ward must know about the role because people high up are trying to spread it further so we must be doing something right. (20070402)

As can be seen above this she is happy to comply with this direction of travel as she feels that it is removing a dictatorship of suppression. She makes it clear that her rationale for her enthusiasm to push this agenda forward is to improve patient care.

Basic care has improved because the ante has been up. I don't think it is just because of me. I think that society is asking more of them, the NHS is asking more of them and management are asking more of them. There is so much pressure on them that we have to implement tools to release that pressure sometimes. I don't think it is just down to me I think it's down to society as well (20070402).

This places her ethos in line with the usual focus of RNs as enforced by their professional body (NMC 2008d). Of course, improvement in patient care would be an objective which almost everyone would approve of. However, it is important to note that this is at the centre of the world of the nurse and 20070402 has maintained that focus along with her CF colleagues elsewhere. This is because of the role's potential split of emphasis between nursing, management and education. Similarly to the other case study she sees her role as improving patient care through improving the quality and quantity of the caring staff.

She had no direct line management responsibilities but her responsibilities at times put her in direct competition with the ward sisters. As she said ...

I think it is hard to distinguish between the CF, PDN and sister. I think that I do a lot of the sister's role. I can distinguish CF from PDN because I see that as doing work with post-reg staff who've been qualified and maintaining their professional development. (20070402)

She has seen a remarkable amount of change since taking up the post. Some of this change appears to have come about as a direct result of her interventions. She makes it clear that she has current problems with the ward sister stepping back and

letting her take control too much. She feels that the ward sister role is pivotal. In this most commentators would agree. Her view is that part of the reason why she was put into the role on that particular set of wards was to challenge the previous ward sister as can be seen below.

It's not always been like this. I've seen this ward through three matrons and two ward sisters. When I first started the ward sister felt threatened by my role. I used to get keys thrown at me and everything. I thought "oh what can I do" that was the dictatorship. Then this person went and the staff just blossomed. Now they have the opposite. They always say that the ward will reflect its management and it is now very laid back. People are not on tenterhooks. That is good in a way but not in others because discipline gets lapse. (20070402)

This is standard leadership theory which conceptualises types of management style in terms of political regimes. These range from the authoritarian, through democratic to laissez-faire with each having its own advantages and disadvantages (Mullins 2006). 20070402 has studied a range of professional update activities including an NHS leadership course. She has thought a lot about how to implement change in her workplace using these theories and her knowledge of NHS policy initiatives. This has led her to take planned action to make changes happen. She also has a historical perspective worked out to place her current activities into as can be seen below.

What happened was that staff were doing the same things all the time. They needed to branch out so that staff would do different things for the patients' benefit. They asked the local community [of staff] and they said they wanted the CF to do that but I don't think they truly understood what the facilitator was about. There were a lot of personalities about at that time who would stifle development and [senior management] needed to stop those or move them on before that could happen. Those people have now moved on and development is now starting to be second nature almost. The advent of KSF [the NHS Knowledge and Skills Framework¹⁸] has helped hugely. We've all had an impact on that but I think that the PDN and CF as well as one of the sisters/ward managers have had a huge impact and staff are taking notice of it. Development has come back to the forefront again. The KSF affects the paypacket and money makes the world go round. (20070402)

Her pragmatic belief that linking salary uplift to practice development gives staff an incentive to participate in it seems fair enough. It is also mainstream NHS management policy (NHS Employers 2009). Another aspect of this management speak is her view of her role as a strategic planner rather than a day to day operational

¹⁸ The KSF an HR mechanism to ensure that all staff are involved in continuing professional development and is part of the Agenda for Change NHS pay framework (NHS Employers 2009)

manager. As can be seen below she feels that despite her necessary interventions with the laissez-faire ward sister she is increasingly able to concentrate on long term objectives such as ensuring that all staff are receiving the required updates and that staff without existing formal qualifications such as auxiliary nurses are able to pursue them.

A lot of the work has been reactive “fire fighting”. As the PCTs have evolved and got bigger and they have become more commission based they have had to get a strategic plan to development and that has to incorporate the trust’s view of what the future is going to be and that is what generates a lot of our work. We haven’t been able to plan in the past but we are having to do that a lot more now. My role was a lot of fire fighting before. (20070402)

She sees her role as being practical, educational and managerial. This is similar to the CFs and CFSNs in the previous case.

As pointed out at the start of this section 20070402 felt that a major part of her role was teaching practical skills. This aspect will now be explored in more detail.

Clinical Skills Improvement

I think some people are just lost in the overwhelming scale of the changes around them and it is surprising that on the whole when they have that little bit of support they feel a bit better about themselves and manage to do the job right. (20070402)

In a similar way to the previous case 20070402 had believed that the role would be mainly about teaching clinical skills. As can be seen in the previous section, however, this turned out to be just a sub-set of the job. It did remain in her opinion though a central aspect. By the time of the interview she was beginning to have a wider role than just providing support on the wards to which she was allocated. There were several community hospitals in the PCT which she worked for and she was being asked to go to these to deliver clinical skills training “such as venepuncture, medical devices etc.” (20070402). These are skills associated with specific tasks which the trust policies require certificated training for before staff can undertake them. This definition does not fit with the wide view of skills described by the CFs in the previous case. However, 20070402 does perceive her role as improving all of those aspects of nursing care which the previous participants described as clinical skills. In fact she includes not only RNs and student nurses in the potential range of learners but all other health

workers involved in patient care such as HCAs and nursing auxiliaries.

20070402 also agrees with the previous case that skills are not sufficiently well taught in pre-registration training. This is a contentious issue as discussed previously and continuing Government and NMC policy is seeking to redress this perceived problem. Related to the lack of sufficient clinical skills the ‘theory/practice gap’ is also something which concerns 20070402. This can now be discussed.

Practice/Theory Divide

Similarly to Case 1 20070402 is keen to explain that her role is partly to bridge the theory/practice divide. She makes this clear in the quotation in the previous section where she describes having a teaching plan which will do this. It is also made explicit in answer to a question about what she believed her role to be prior to applying for it.

When I initially came over I thought that I would be working with a lot of post-reg nurses. About their development and innovations in practice. Because at that time they didn't have IVs [intravenous infusions and medications]. They rarely did blood transfusions and keeping people up to date with new medical devices. Then when I started researching for my interview for the presentation I had to do, I found that it wasn't about that at all. It was more bridging the theory to practice gap with students and not doing much work if any with post-reg, apart from the mentorship side.

She also goes on to explain that she believes the main reason why student nurses are not obtaining sufficient clinical skills expertise is that there is too much of a gap between the theory they are taught in university and the reality of nursing on a hospital ward. As she says

[student nurses] need to step out of the text book world a bit earlier than they are doing. They need to grasp the whole of what nursing is like in the real world. Once they do that they will settle down and enjoy it. I love my job and I really do think it is a cracking career. Text books will tell you so much and your actual nursing practice will tell you so much more. This is where CFs come in because I believe that they have closer links with the universities. That is the curricula outcomes then this is where the universities can do the theory and the CFs can do the practice. (20070402)

This approach fits in with the views expressed in the articles discussed in the review of literature chapter, that there are two sorts of nursing education, the theory which goes on in the lecture theatre and the practice which is learned by ‘sitting with Nellie’ on placements. Nevertheless, this is not the whole story as she makes it clear that she wants the student to link theory with practice while on placement and that she

facilitates this by having a teaching plan to ensure that part of the practical day with the student is spent researching an aspect of what was done by use of computer databases and discussion with an experienced nurse.

20070402 expresses frustration that she cannot spend more time doing this. She complains that she spends too much time in the office writing policies when she could be teaching and assessing students to ensure that they are achieving the best level of care at all times. However, it is implicit within what she is saying that the activity of practical teaching is considered by others to be of low value and that she is being coerced into fulfilling a higher management role. This position within the hierarchy appears to be an unwanted by-product of her success in achieving the goals she believes that senior management had for her. Throughout this single interview case study the disputes between senior role holders and hierarchical position have been central. With this in mind 'power and leadership' can finally be compared with the previous case study.

Power and Leadership

20070402 is more forthcoming with her portrayal of disputes with ward sisters than any of the previous study participants. She makes it clear that the first sister to be in post was despotic in her style and openly hostile to her role. The second ward sister was almost the opposite in handing over responsibilities for operational management which 20070402 felt was outside of her remit. On the other hand, 20070402's relationship with senior management appears cordial in that she believes that almost co-incidentally her and their goals are synchronous. As a consequence, she believes that her job is safe and that she can get on with supporting front-line staff with both lightening their workload and providing them opportunities to advance their professional education. This conjunction between the outcomes of the CF teams' activities and the aspirations of senior management is replicated in the previous case study. It would appear likely that despite the CFs' concerns that theirs is a luxury job it has remained safe for nearly ten years in these two organisations mainly because of

their usefulness to producing the outcomes that managers desire. These will be further outlined in the summing up of this chapter.

Final Summing up of chapter around the themes

On the whole the themes running through the case studies are repeated in both analyses. These are ‘recruitment and retention’; ‘role definition’; ‘organisational change’; ‘clinical skills improvement’; ‘practice/theory divide’; and ‘power and leadership’, all have a place in the lives of the CF teams involved. These themes were generated from the textual analysis of the interview transcripts. Nevertheless, they could just as easily have come out of a local or national policy document as they are a list of some of the major preoccupations of the NHS and its political masters. The CF either by accident or design is ideally situated to assist with the implementation of these policies in a way that other, more traditional, posts are not. It could fairly be argued, as 20070402 does, that “CFs are more essential than ward sisters”.

This contention that CFs are essentially the tools of management and the state to provide the motive power for the movement of the levers of policy is of course not the whole story. The majority of the CFs have taken on the role as an alternative to pursuing a management career in nursing. It is evident from their testimony that they are aware that they are providing this service but that they do so on their terms where possible and that they are uncomfortable with the implication that they are fulfilling a management rather than a straightforward clinical function. Nevertheless, by good fortune or by design they have exploited this position to both maintain and expand their position and to further their agenda of supporting front-line staff in providing good quality patient care. This has been solidly enough maintained to ensure that they have remained in post, while other specialist nurse post were lost, throughout the last few years of reining back of NHS spending.

One of the central ideological beliefs of the CFs running through all of the themes was that ‘sitting with Nellie’ was the best way for nurses to learn their trade. They never used this term of course. However, their descriptions of the way in which

they taught nurses and of how they felt that nurses should be educated were a modified version of this centuries-old method of apprenticeship training. They are not being contentious in this. The European Union (EU) directives on nurse education (EU 2006) state that all nurses must spend at least half of their 4600 hours of education in practice settings working alongside RNs with real patients. The radical aspect, for nurse education, is that they want this to be conducted using an educator as well as a student who is outside of the normal care provision workforce. In this way the work that they do and the real care that they provide is part of a formal teaching plan. Consequently, education is the primary purpose and care is the by-product. In the traditional version of this form of training the skill is learned by simply repeating the task as part of the working day and observing the skilled practitioner at work. This modified form uses the same format but ensures that learning is taking place rather than leaving it to chance.

The themes from the pilot study therefore stand and are supported by the data generated from the interview analysis. The combined hypothesis that ‘CFs improve patient care; improve recruitment; improve retention; and challenge existing authority’ is on the whole supported. The problem of quantifying the cause and effect of the imposition of CFs into a workplace and the outcome of the above is a difficult one. However, they are all central to the expressed beliefs of the CFs questioned. The additional theme generated by the second case is that CFs are an effective instrument for the implementation of policy. This at first glance appears oppositional to the concept of ‘challenging existing authority’. However, on closer inspection this is entirely appropriate as a policy instrument if the policy is being hindered by those people in positions within the hierarchy who are likely to be challenged by CFs. This of course assumes that their challenge is effective and that it is in line with the policy makers’ intentions. On re-examining the evidence from Case 1 this theme can fairly be said to run through all of the evidence provided. Consequently, it can now be added to the list of themes generated without requiring a further heading above. These are:

‘recruitment and retention’; ‘role definition’; ‘organisational change’; ‘clinical skills improvement’; ‘practice/theory divide’; ‘power and leadership’; and ‘policy instrument’.

In the next chapter the literature will be revisited. In this instance the data from the literature already discussed will be examined in light of the themes generated by the pilot and interview stage of the process. This will compare their findings with the findings from this study and either help negate or support those findings.

Chapter 7: Analysis of Literature Review

In the previous sections of the findings the following themes were generated: ‘recruitment and retention’; ‘role definition’; ‘organisational change’; ‘clinical skills improvement’; ‘practice/theory divide’; ‘power and leadership’; and ‘policy instrument’. These will now be compared with the themes generated during the literature review. In addition the initial hypothesis generated in the pilot stage stands. This states that ‘CFs improve patient care; improve recruitment; improve retention; and challenge existing authority’. This hypothesis will also be tested against the findings from the literature review. However, first of all it is appropriate to return to the review of literature to compare the analysis made from that with the case generated data analysis.

Literature Review

It is appropriate to revive the themes generated from the literature review chapter to compare with the evidence from the previous findings. These themes were: employers matter; short term funding; the CF as a solution to problems; researchers in this field are not objective; and the role is seen as transitional. As can be seen there is some overlap with the hypothesis and themes generated by the pilot and case studies. However, there are also additional preoccupations which the participants in this study did not have. In the first instance therefore these themes will be re-examined in light of the pilot and case study findings.

Employers Matter

In the literature a continuing theme was that it made a difference who was employing the CF. In the case study research this did not really come up as an issue. This is likely to be because all of the CFs were employed by the NHS trust and they all felt that this was appropriate. In the literature examined there were a variety of employers. In one case the CFs were employed by a HEI (Richardson et al 2001). In several of the others they were under joint contracts between the HEI and NHS trust. This had led the CFs to identify with the education provider rather than the placement

where the bulk of the CFs' work was taking place. This usually led to the CF focussing mainly on students rather than staff and could lead to the CF being pulled into teaching in the classroom as Martin had described in the case of CTs in the 1980s (1989).

The main aspect of this theme which had resonance with the CFs in the case studies was that they had problems with role definition due to their employers' main business being health care rather than education. This was the reverse of the effect related by the research articles for those employed by HEIs. In those employed by NHS trusts the CF was in constant danger of being pulled into providing direct care rather than focussing on education while delivering care. This sounds like a subtle difference but to many of the CFs in the case studies it was a central and continuing problem. As seen in the analysis of the interviews this could see them taken from teaching and supporting duties to undertaking a staff nurse or sister role. For staff employed by universities this problem with being taken from the duties prescribed for the CF into teaching in the clinical room of the nursing school is an equal issue. In both instances the problem appears to be that their role is not valued as highly as that of existing staff fulfilling a traditional task. Whether this is classroom teaching or delivering patient care does not appear to be the central issue. The fundamental problem is the same whether the employer is the trust or the university. That is the role itself needs to be seen as a reasonably priced essential service rather than an expensive luxury. While it is not seen in this way it will always be vulnerable at times when those services seen as essential are under stress. Consequently, the theme generated from the literature review that 'employers matter' is correct in that universities will remove CFs to classroom duties. Whereas, health service employers will remove them to patient care services. Nevertheless, this puts either employee in the same position as far as their CF duties are concerned. It does matter who is the employer because of this but for the CF whichever employer they have they must convince them of the same thing, that they are essential workers, who are just as valuable as their colleagues. Despite the deep embedding of the CF team in both trusts they were still seen as a sacrificable post

when staff were needed in direct patient care roles. This may appear sensible as this is the primary purpose of the trusts' business and the CFs are all qualified nurses.

However, other 'backroom' staff with nursing qualifications did not get asked to leave their duties to undertake direct patient care when the CFs were. Roles such as nurse managers and clinical nurse specialists would not be required to leave their duties unless a major accident protocol was triggered (Nottingham University Hospitals NHS Trust 2006). This plan would not be enforced unless an incident of the severity of a plane or train crash took place with multiple casualties. In the case of CFs the level of being called to provide patient care was that of a single member of staff calling in sick for example. Clearly there is a disparity between the perceived importance of the CF role and that of other nursing roles. Therefore this links in well with the role conflict theme. In the context of the two case studies in this thesis the hypothesis is generated that CFs are employed by NHS trusts rather than by HEIs.

Short Term Funding

One of the major issues within the literature was the short term nature of the CF posts. This was due to them being projects to test the effectiveness of the new role. This left the CFs feeling undervalued and at risk of losing their job. In the case studies the CFs and CFSNs were all on substantive contracts. In Case 1 they were part of a team which was deeply embedded into the structure and in Case 2 it was becoming embedded as CF 20070402 confirmed. Nevertheless, as stated above, this did not stop them from feeling vulnerable because of their concern that the job was 'too good to be true'.

Despite this continued feeling of vulnerability it is evident from the fact that both trusts have made these positions substantive that they are considered necessary and worthy of investment. As alluded to in the literature review the CF was employed as a solution to problems. This will be explored further in the section below.

The CF as a Solution to Problems

The problems that the literature review highlighted were a lack of skills by NQNs and insufficient supervision of students. The CFs were found to be capable of solving

these deficits but a question mark was left over the affordability of the CFs (Ellis and Hogard 2003). The trusts employing the CFs in the case studies examined for this thesis had decided to invest in the solution. They had evidence in recruitment and retention figures that they felt supported the continued use of these staff (Appendix 7).

This concept of the CF as a problem solver also fits in with the generated theme of the CF as a policy instrument. However, this has developed to the extent that the CF is not merely an experiment to solve two perceived deficits. They have become more of a trouble-shooter tasked with implementing policy in a changing environment. This is in part because in any given hospital trust a sub-set of ward sisters are seen as the most important agents of conservative resistance to policy change (Mackenzie 1998). The CF teams appear to be seen as change agents capable of challenging the sisters' hegemony at ward level. This is both a powerful and stressful position for the ward based CF or CFSN to be in. If they have the perceived support of senior management this allows them to challenge the authority of the ward sister while also being geographically present to observe and participate in the practical application of policy. If this does not fit with the CF's understanding of this they can challenge the ward sister over this with the authority of senior management behind them. This links into the 'Power and Leadership' and the 'Policy Instrument' themes.

Researchers in this Field are not Objective

This, at first sight, disapproving theme was generated by the self-identification of lack of objectivity by the articles' authors and from critical analysis during the review. This aspect is expanded in the 'Themes and Issues' section of the Literature Review chapter. This theme has also been dealt with in the methodology chapter. Consequently, there is little more to add here than to say that the research position in this thesis is similar to that of the authors of the articles reviewed. That is of a declared embedded participant. Nevertheless, in a similar way to the previously mentioned researchers this study has been carried out in an investigative and analytical academically structured way. That is it uses tools such as flow diagrams; memo forms;

question sheets; questionnaires and qualitative software to assess the data produced. As a result, the findings should be as synchronous with the illuminated material reality as it is possible to get from the position of an observer living in the same world.

Nevertheless, concerns regarding a lack of objectivity can fairly be levelled when considering the likely effect on participants of the recommendations from the final report. This leads to the next theme as in much of the reviewed literature the purpose of the research was linked to the livelihoods of several participants.

The Role is seen as Transitional

One of the central differences between the investigations undertaken for many of the reviewed articles and the research for this thesis is the purpose of the exercise. In the cases explored for this thesis the position of the CFs and CFSNs was essentially long standing and permanent. Even so, the participants often felt that their position was under threat for various reasons. Nevertheless, they had substantive contracts and the posts were part of the accepted structure of the organisations (Clegg 1990). This allowed the researcher to acknowledge any potential deficiencies without fear of the consequences for the actors involved. For the majority of the articles in the literature review the reasons for the research projects was to either support or deny further funding for a time limited project. This left the CFs in a precarious and stressful position of fearing for the continued existence of their jobs.

There is also much to compare between the literature and the evidence from this study with regard to the transitional nature of the roles themselves rather than the effects of this on the research outcomes. In the articles the roles were not only seen as temporary because of their short term contractual position. It was argued by, or evident within the text of many of the researchers that these were 'stepping stone' positions to a career as a classroom based university lecturer. The CFs interviewed did not appear to accept this hierarchical assumption of inferiority to either university or to clinical staff. When asked about their relationship with university colleagues they described an equal co-operative partnership. By the time of writing two of them have taken up lecturer

post with university employers as their chosen career path. One of these has taken a part-time post in the HEI while remaining in post as a CFSN for the remaining hours of the week. The other moved at first to a full-time secondment with one HEI then secured a full-time post at a different local university. Two have remained in the CF or CFSN post and report no desire to move to another position. Two others chose to move to more senior positions within the expanding internal NHS nurse education and training departments within their own trusts. The final one has emigrated to another country to undertake a similar ward based clinical training role there. Clearly the speculation that this was a short term springboard position to a 'proper' university post put forward by Rowan and Barber (2000) is not shared universally by the CFs and CFSNs in this study.

Could this just be another manifestation of the academic prejudice alluded to in the Ellis and Hogard (2003) section of the review chapter? The CF/CFSNs in their interviews all made it clear that clinical expertise had been a requirement of the job but not academic achievement. They were all required to have a RN qualification and post-registration experience. In addition they were required to have a teaching qualification. However, for most of the CF/CFSNs this was a single module at undergraduate level. The teaching in the clinical area element of the role would appear to take precedence at first glance. However, the most common description they all gave to their activities was that of 'supporter' rather than teacher or even facilitator. All of this puts the profession of education into a very subordinate position to the profession of nursing. Could this then be that the CF/CFSNs are prejudiced against formal education? In at least one case a CFSN expressed views which were specifically against the ability of university based lecturers to teach students useful knowledge (participant 20060607). In fact in all but one of the interviews the participant responded to the question about theory and practice to say that theoretical learning was of less value than the 'sitting with Nellie' method. In practice it appears that unsurprisingly both university and trust staff feel that their role is more important than the other's. Rowan and Barber's (2000)

hope that this role may lead to closer links between the two may have some merit. However, from the evidence of this study the linkage does not follow their model of the lecturer helping the CF/CFSN to become a better educator while the CF/CFSN merely allows access to the ward area. It would appear that CF/CFSNs have a variety of career plans in mind. This means that they see their links with other professionals such as lecturers as a part of an equal status network of useful others in an extension of the usual healthcare multidisciplinary team. To a certain extent the concerns brought up by Ellis and Hogard's (2003) questioning of lecturers are less important than the CF/CFSNs own prejudices. The universities require suitable and high quality clinical areas to place students. The NMC requires that students spend at least half of their course on clinical placements. The current system does not pay trusts and other providers anything for these placements while the university gets similar funding for a student nurse as for an HE student on a purely academic course. This puts the people responsible for the practice based education in a potentially powerful position as they are essentially providing placements on a voluntary basis. It is not quite as simple as that of course because the NHS nationally sets the numbers of students and pays for them to be educated to the required standard. Hence the reason why there has traditionally been no charge to HEIs is that the NHS would be essentially paying universities to again pay the NHS for their placements. Nevertheless, as an individual placement provider in this national framework the CF/CFSN can make a good case, should they so choose, to not have students for a period of time. There are no similar sanctions which the university as a whole nor which individual lecturers can call into place to balance this.

This more powerful position and their feelings of social equality with university staff can be traced to a much more robust position within the trust structure. The team has a straightforward management hierarchy in Case 1. In this there is no involvement with university structures at all and the lead CF is responsible directly to the directorate nurse manager. Apart from in exceptional circumstances this theoretically removes

pressures from both university and clinical practice to pull the CF/CFSN from their educational/supportive duties to either classroom teaching or ward work. It has been seen that at times this formal structure is undermined from the clinical side. At times CF/CFSNs have been moved into frontline care duties. Nevertheless, overall they have managed to maintain their separate position and this has continued in similar form for approximately eight years so far. This is a long time in the ever changing organisational environment of the NHS (Iles and Sutherland 2001). The NHS PCT in Case 2 were at the point of expanding to a PCT wide structure of support for CFs in their institution. This did not and has continued not to have as tight a management structure as the one in Case 1. However, they clearly have the support of senior management and again despite being moved into clinical duties at times they have retained their separate identity as CFs within the PCTs organisation. In both instances this points to the CF as an essential part of the nursing team within the evolving twenty-first century nursing and healthcare environment. It is now appropriate to briefly examine the themes generated by the pilot and interview stages of the case studies in light of the literature.

Interview Analysis Themes Re-examined

Recruitment and Retention

Issues relating to the recruitment and retention of nurses are not highlighted in the literature selected. This is surprising as this was a major policy issue at the centre of the goals of the NHS Plan (DH 2000). The literature reviewed is silent as to this aspect of the CFs role. Again this divergence between the findings of this study and the previously identified research is puzzling because the CFs in this study talked of their role in recruiting and retaining staff as part of their defining purpose. It is possible to speculate that this is due to the mainly university focus of the previous researchers and that the pilot projects examined were all designed to deal with increased student numbers rather than attracting or retaining new staff. In addition to this the case studies in this thesis were at a more mature stage of development than the pilot examples

examined previously. Consequently, the absence of data in the previous studies is not a significant challenge to the generation of this theme by the current study. There is certainly no evidence against the hypothesis that the supportive presence of CFs encourages recruitment and retention of staff. Importantly, in recent years it has been well demonstrated in a number of studies in the UK and elsewhere that patient mortality and morbidity levels are reduced consistently by the number of RNs available to care for them (Ford 2009a). This means that there is a direct incentive to increase nurse numbers in order to improve patient care. However, the role of the CF is to support the care givers rather than to provide care. When the CF is used in this way, to provide direct care, their effectiveness with regard to the products expected of CFs is likely to reduce. The concept of role conflict will now be discussed in more detail.

Role Definition

With regard to role definition there was a reasonable amount of concurrence between the findings from the previously published research and the accounts of the participants in this thesis. The arguments for this have been made above in the 'Employers Matter' theme from the reviews. Although the precise natures of these concerns are different it appears that the CFs in the previous studies were experiencing problems around role definition. This is also reflected in Martin's research into the experiences of CTs in the 1980s (1989). Consequently, this theme is positively supported by existing and current empirical evidence and can safely be inducted into the hypothesis that CFs suffer from problems with role definition due to their position between education and clinical patient care.

Organisational Change

The CF as a change agent is if anything more pronounced in the previous literature than in the current study. The thesis that CFs are ideal policy instruments will be explored below in greater depth. However, the idea that the CF is a product of organisational change is apparent in the titles of many of the reviewed articles as well as in their content. Titles such as 'a new way of working' (Rowan and Barber 2000); and 'Two Deficits and a Solution?' (Ellis and Hogard 2003) underline the

organisational change which has been perceived to have generated these roles. It would appear to be self evident that the CF role has not just started appearing around the country by chance. As discussed before they are the product of profound organisational change which was engendered by the move towards the New NHS brought about by the election of the Labour Government in 1997. This was made plain in the NHS Plan (DH 2000) and other policy documents. It was importantly supported by the Treasury and a period of expansion in service, salary and staff numbers ensued. Empirically, the numbers of nurses and other staff rose in line or even above the NHS Plan targets (The NHS Information Centre 2009). The direction of travel remains the same at present after a painful period of retrenching in 2006 (O'Dowd 2006 ; Staines 2006 a and 2006d). Initiatives such as CFs would have been almost unthinkable under the previous Conservative administration. This made major policy moves such as increasing student nurse numbers to boost overall nurse numbers essential. These increasing numbers of students and as an inevitable consequence the increase in NQN numbers required support. The obvious answer to this change was to employ a new grade of staff. In this case the CF. The other equally important organisational change happening at the time of the introduction of these roles was the move from Project 2000 to the new 'Making a Difference Diploma' courses. These new ways of training nurses were designed to produce nurses who were 'fit for purpose' when they qualified as RNs (Bradshaw 2001b). Again this organisational change was engendered by two clear-cut policy documents. These were the DHs 'Making a Difference' (1999) and the UKCCs 'Fitness for Practice' (1999). Both of these policy statements gave instructions to change the focus of nurse education away from the academic achievement of the award of the diploma in HE to the professional achievement of proficiency of the nursing skills required to be a functioning RN.

The findings from both the literature and this thesis supported by policy statements to the same effect provide sufficient evidence to support the hypothesis that these roles are a logical outcome of the organisational changes engendered to produce

more and better skilled nurses.

Clinical Skills Improvement

Only Ellis and Hogard's (2003) research from the reviewed literature made any attempt to quantify the skills improvement brought about by the CFs. Unfortunately this was unsuccessful. They attempted this firstly by assessing the outcomes from the existing assessment by ward based mentors. However, these were almost all assessing the soon to be NQNs as clinically competent. As the researchers were receiving reports that NQNs were not clinically competent they attempted to devise a more reliable assessment. However, the OSCEs they used were not well conceived and the comparison between the results of students, with CF support and without it, was not significantly different. As can be guessed from the wide ranging definition given, by the CF/CSFNs interviewed, the assessment of nursing skill is notoriously difficult. Nevertheless, this and other studies were keen to illuminate the effects of CFs on the improvement or otherwise of nursing skill. The more successful way in which this was inferred was from asking various staff whether they felt that CFs had an effect on this. This method was a lot more positive. This is also the method of assessment used in the research outlined here. It will also be part of the observational and questionnaire triangulation which will come later.

Despite the failure to provide solid, criterion referenced, assessed evidence of improved skill following CF contact there is large positive correlation from the opinions of staff in all of the research. Consequently, it is possible to hypothesise that CFs do help staff to improve their clinical skills. As a result of the implementation of these improved skills patient care should be higher quality.

The Practice/Theory Divide

The gap between theory and practice is explored by several of the research articles. The main finding there is that the CF supports the university in linking the theory taught in the HEI to the practice delivered on the wards. Some of the CFs concurred with this. However, several were less keen on providing a supporting role to the lecturer. On both sites the CFs described providing both theory and practice

education about what they saw as the necessary skills of the nurse. These were not necessarily the same as the things seen as important in the HEI. As a result it is a fair thesis that the CF provides a link between theory and practice. However, the important caveat is that they may want to do this independently from or even antagonistically to the authorised version dispensed by the university. It is possible that they may even be instructed to deliver a different message to the HEI by their line management within the trust. For example the NHS sets specific national training requirements for skills such as the aseptic non-touch technique (ANTT). Pre-registration nursing programmes have traditionally included the teaching of what is known as an aseptic technique. This uses the principles of asepsis as originally described by Lister (Wootton 2006). Routine audits had uncovered that these procedures were not always followed by nursing staff. Therefore, the NHS developed a training programme for staff to encourage them to follow the appropriate procedures. These became so prevalent that university nursing programmes had to take on the procedure taught in order for their students to be in line with existing best practice. This example is replicated in many other areas such as conflict resolution training; manual handling and adult protection training. This means that the concept of the origin of best practice being the school of nursing which was highlighted by Martin (1989) has been overturned in many cases. This brings us to the subject of where the power and leadership is perceived to be in the CF domain.

Power and Leadership

In only one of the reviewed articles did they see the CF as requiring a senior level of knowledge, authority and experience. This was Salvoni (2001). She described a model in which there was a hierarchical structure of practice education with each level providing a different service. This was designed to reduce the likelihood of a return to the two tier structure of lecturer and CT which was deliberately removed in the 1980s. The important aspect of this is that although there remains a hierarchy it is within the speciality of practice education rather than between the theory teacher and the practice instructor. This hierarchical relationship between the lecturer and CF was something

alluded to in several of the other studies and seen as a positive possibility for role development and joint working by Rowan and Barber (2000). However, the CFs in the case studies did not describe their relationship with university staff in a hierarchical way. They appeared to consider them as equal colleagues. The main issue for the CFs was that they may conflict with ward sisters. The structures of the organisations put them at times in direct conflict with the sister and at the same time provided them with varying degrees of managerial support. Therefore the issue of power and leadership can generate the hypothesis that CFs have varying status and power dependent on local factors often outside of their control.

Policy Instrument

The majority of the studies are explicit that the CF has been put into place in order to push forward a specific policy direction. On the whole this is supporting increasing numbers of NQNs and students in frontline clinical posts. The majority of the research studies are of projects designed to see if the CF is an effective way of doing this. In the cases examined in this research it is a more stable structure in which the CF was initially implemented to meet a specific purpose which most of the CFs identify as improving recruitment, retention and skills of NQNs. However, this has developed into a role which is not just to implement one aspect of change. Wherever new directions need to be brought about in clinical practice the CF/CFSN is employed to hasten the change. The CF can be seen as an ideally placed policy instrument for the implementation of change management. It could be argued that this is in part because of the perceived problem that they are not defined by a role in education or within clinical practice. They are employed by the trust but much of their responsibility is for education. Therefore they have the authority of trust senior management directly rather than through the intervening management of matrons and sisters. This is an important distinction as sisters and matrons have an overarching responsibility for day to day or operational management of patient care, whereas senior management tend to have a more strategic focus. This allows the CF to challenge existing authority at ward level

so long as they are standing on the firm foundations of engendering trust or national policy. It is therefore possible to put forward the hypothesis that ‘the CF is an ideally placed policy instrument for the implementation of strategic change management’.

Chapter Conclusion

The initial combined hypothesis generated by the pilot study and supported by the interview stage was ‘CFs improve patient care; improve recruitment; improve retention; and challenge existing authority’. The reviewed articles do not address the issues raised by this in any depth. This is not surprising as the hypothesis was generated from a case study which is quite different from the ones examined in these studies. That said, the literature reviewed does not negate the theory in any way.

In this chapter, attempts have been made to expand this hypothesis by making the themes generated into a further expansion of the theory. Therefore, it is now possible to state a fuller inducted theory to describe the deployment and behaviour of CFs. This encompasses all of the aspects of the original theory and expands them in line with the evidence. This approach to the description of a theoretical model by lists of attributes has a long history. For example in political science Friedrich and Brzezinski used this approach to describe the six traits or clusters which characterise totalitarian dictatorship (1956). This model is still used by political scientists to define the difference between totalitarian and merely authoritarian regimes. In this case the traits described are of course quite different from those describing totalitarian dictatorship. Nevertheless, they could be useful for determining the difference between CFs and other educational and clinical staff in health. This is particularly valuable when the lack of role clarity and even naming of the staff undertaking this role are taken into account.

The set of eight clusters describing CFs is as follows:

1. CFs are employed by care providers such as NHS trusts rather than educational institutions such as universities.
2. The supportive presence of CFs encourages recruitment and retention of staff which leads to improved nurse to patient ratios and better patient outcomes.
3. CFs suffer from problems with role definition due to their position between education and clinical patient care.

4. These roles are a logical outcome of the organisational changes engendered to produce more and better skilled nurses to provide better patient care.
5. CFs help staff to improve their clinical skills and thus to improve the quality of patient care.
6. CFs provide a link between theory and practice within an equal educational framework.
7. CFs have varying status and power dependent on local factors often outside of their control. Their position is better when part of an organisational framework designed to provide practice based education and support.
8. The CF is an ideally placed policy instrument for the implementation of strategic change management.

This list of traits is generated and supported by the evidence illuminated in the observational and interview stage of the research conducted for this thesis. They are in some ways triangulated by the previous studies above. However, the main purpose of this chapter has been to set the themes generated in the context of the previous studies and to start to solidify the theory emerging from these themes. This theory as outlined in the eight clusters will now be tested and triangulated against two more sources of data collection. Firstly a questionnaire and secondly further observations recorded by memo. Both of these additional sources deliberately encompass the third case study area as well as the already visited cases one and two. This third case will be described at the beginning of the next chapter in a similar way to the description of Cases 1 and 2 at the beginning of their CF interview analyses. The next chapter will be analysing a questionnaire completed by students and NQNs.

Chapter 8: Questionnaire Analysis

In this section a third case study area will be introduced. The data generated in this and the following chapter will be from all three cases. The NHS ethics committee terms insist on anonymity of location for all of the aspects of the study. Consequently, it is not possible to name the university in the text of this thesis. The cases in this section will be abbreviated in the following way: Acute Hospital Case 1 (C1); PCT Case 2 (C2); and another Acute Hospital Case 3 (C3). There will also be questionnaires for students who were placed outside of the case study areas, when referred to these will be designated as C4. To be clear C4 is not a case study but merely a convenient label for areas outside of the three areas under scrutiny.

This will be the first time that C3 has been introduced to the research process. Therefore the 3rd case study area will be outlined before going on to describe and analyse the data. This data will be in the form of a presentation of numerical and textual findings from a series of questionnaire surveys. These will make up the majority of the argument for this chapter. As explained in the methodology section it was decided to use a questionnaire approach in order to obtain information from a wider set of participants.

Case Study 3 Acute General Hospital (C3)

C3 is another acute general hospital located within the same county as C1 and C2. This case has been selected as it is an area familiar to the author through professional networks. It is chosen because it is in a similar geographical location but has used a different model to provide the support and education for ward staff to C1 and C2. Firstly, this model of educational support provided within this case study will be described.

The Learning Environment Manager Model of Clinical Education Support

The support is provided by LEMs rather than CFs or CFSNs. LEMs are ward sisters who have the usual ward operational management and clinical leadership responsibilities to be expected of the traditional ward sister role. As noted previously

the CF role has been given various titles throughout the health service. It has been noted for many other cases in the literature search chapter, that this is often more than a mere difference in nomenclature. This case is no exception to this observation. The LEM role is a commitment to ensure that learning and development take place on their ward. However, it does not give the post-holder any protected time to do this in. This is a fundamental difference between the LEM and the CF/CFSN. Nevertheless, in other ways they are quite similar models of educational support. The LEMs are coordinated by two people at trust level. These are the clinical placement learning advisor and a clinical placement learning facilitator. These two arrange regular meetings of the LEMs and ensure that they are provided with updates. Unlike C1, where the CFSN team is managed by a lead CF, they do not line manage the LEMs. As a result, in a similar way to C2, they are managed within the usual ward nurse hierarchy of matrons, sisters and staff nurses. However, unlike the CFs from C2 the LEM does not have a primarily educational focus but a clinical one. This responsibility within the ward structure and lack of protected education related time means that the LEM role is more similar to a traditional nurse mentor role. The LEM has a primarily patient care focus with student and staff educational responsibility attached, as an addition, to the job description. This is an identical position to the traditional mentor except that the educational responsibility is to the whole ward rather than to an individual student nurse. Therefore, the level of responsibility is similar to that of the CF/CFSNs in the previous case studies but without the time in which to fulfil the requirements of the role. To sum up the LEM has similar responsibilities to the ward based CF/CFSN but does not have the supernumerary status. They are more like a super-mentor in that they have responsibility for education across the whole ward rather than to a single student but similarly to a nurse mentor they do not have protected time in which to conduct this responsibility. Consequently, they are a pertinent case to examine as comparative as well as additional data. It is now necessary to elucidate the wider context of the case itself.

C3 The Broader Context of the Case Study

C3 is a medium sized district general hospital. In this it is similar too but somewhat smaller than C1. The hospital has the range of wards and departments expected of an acute trust. This includes medical wards. However, it also includes other nursing areas such as surgical wards; accident and emergency; intensive care; clinics and theatres. For C3 the whole trust was included in the case study. Consequently, at the level of product as well as process the reasons for and effects of LEMs in this area may be different to those on the wards in the other two studies which primarily focused on the medical ward areas. C3 will be examined alongside C1 and C2 in both this section and the final field observations in the next chapter.

Questionnaire Data Collection Method

The design of the questionnaire makes it possible for the researcher to identify the case from which each questionnaire has originated (Appendix 4). This will allow the overall numbers for each case to be displayed on the tables below. In the textual analysis this permits individuals' comments to be identified to their case study area and where the case is pertinent to the findings this will be made clear. However, where the case does not appear to have any effect on the outcomes the comments will be presented without reference to an individual case.

The comments made above regarding the questionnaires are also equally applicable to the observational study presented in the next chapter and to the other case study areas.

Triangulation

In an attempt to triangulate the data collected in the previous sections, student nurses and NQNs have been questioned using the questionnaires available in Appendix 4. The students are from a university department of nursing (HE11) which has placements at the trusts in the three case studies and elsewhere. The NQNs are all former students from the same department now working at those trusts. The questions are based on the findings from the CF interviews and analysis of the literature. The results of this exercise have been examined using themes generated from the

questionnaire process and the same criteria as the interview analysis.

Discussion of Distribution, Returns and Results

It is now possible to examine the data with some understanding of the context within which it was generated. Below the tables presenting the numerical data from students and NQNs questioned are shown. These are further divided into the numbers of answers given by cohort and case study area. This is done by providing three tables. Table one shows the distribution and returns by total; cohort and case. This table also indicates the numbers answering question one (Q1) from the questionnaire. This question crucially indicated whether a CF type role was present on their placement. Tables 2, 3 and 4 indicate the numerical breakdown of the answers to each of the six other questions (Q2 to Q7), and the numbers of participants giving a free text response. Table 2 presents this as total numbers of participants answering each question. Table 3 is divided by cohort/group of students or NQNs. Table 4 divides the participants answers by case study area.

Table 1 is presented first followed by a textual analysis of its findings. Each of the other tables will follow this and be analysed similarly.

Figure 22: Table 1 Distribution and Returns					
Participants (P)	No. distributed	Total No. returned	No. reporting being on CF placement	No. reporting being on non-CF placement	Don't know
first year student nurses (Y1)	112	85	12	65	8
final placement 3 rd year student nurses (Y3)	103	14	12	2	0
newly qualified nurses (NQN)	105	14	9	4	1
Totals	320	113	33	71	9
C1: Acute District General Hospital with CFs and CFSN team as full time staff and student support/education posts (C1)					
Y1	10	9	7	1	1
Y3	23	9	8	1	0
NQN	11	2	2	0	0
Totals	44	20	17	2	1

C2: County Primary Care Trust (Community Hospitals and District Nursing Teams) CFs as full time staff and student support/education posts (C2)					
Y1	28	22	3	15	4
Y3	40	4	3	1	0
NQN	18	5	3	2	0
Totals	86	31	9	18	4
C3: Acute District General Hospital with LEMs (teaching/support role combined with patient care and ward management responsibilities) (C3)					
Y1	0	0	0	0	0
Y3	42	0	0	0	0
NQN	37	3	3	0	0
Totals	79	3	3	0	0
C4: Students placed on placements outside of case study areas and NQNs obtaining posts outside of these areas					
Y1	74	54	2	49	3
Y3	8	1	1	0	0
NQN	39	4	1	2	1
Totals	121	59	4	51	4

Distribution

As can be seen in the table above, questionnaires were given to three sets of learners. These were 112 first year student nurses (Y1); 103 third year student nurses (Y3); and 105 NQNs. The Y1 questionnaires were distributed in the 2006-2007 academic year and the Y3 and NQN sets were distributed during the 2008-2009 academic year. This was in order to question the same students in their first year; third year and immediately after qualification. The differences in numbers between years are due to some students being back-grouped from previous cohorts and some leaving the course. This is why for example the numbers for NQNs and Y3 is lower than for Y1 and the number for NQNs is slightly higher than for Y3. The Y3 and NQN overall lowering is due to more attrition than back-grouping and the NQN rising is due to more back-grouping than attrition. There are two cohorts per year commencing their courses in May and September. In each instance both cohorts were questioned.

Low Numbers of C3 Returns

The distribution to the case studies was determined by where the students had been placed. Therefore, the lack of questionnaires sent to C3 in the Y1 set is straightforwardly because no students were placed there in the first year at that time. In the Y1 sample no students were placed in C3. Therefore the amount of questionnaires investigating that case for Y1 is zero. This is a quirk of the placement allocations for

this university and therefore needs no explanation. In Y3 and the NQN groups there were 42 and 37 questionnaires sent to C3 students respectively. Therefore, the zero returns for Y3 and only 3 returns for NQN are more difficult to explain. The overall number of returns at just over 13% for these email questionnaires was as will be noted below very poor. Three returns out of thirty-seven sent to NQNs for C3 is only just below the 13% average. It could therefore be just random chance that none of them were from C3 for the Y3 cohort. However, this seems unlikely on balance. Another explanation could be that as mentioned in the previous section the C3 model of education support is dissimilar to that of C1 and C2. As a consequence the unfamiliar name of CF rather than LEM may have led them to believe that this survey did not apply to them. This misunderstanding was predicted by the researcher before the questionnaire was distributed and consequently attempts were made to make it clear to participants that this included LEMs. Therefore, it remains unknown whether this was just a chance event or had some structural cause. Either way, the combination of the C3 Y1s not being available for questioning and the C3 Y3s not responding leaves only three answered questionnaires from NQNs to represent this case study area.

Unfortunately, this lack of representation of the views of participants from C3 is made worse by the lack of any free text contributions from this group. This lack of C3 evidence was part of the rationale for the inclusion of a final set of field work observations following this chapter.

Destinations of NQNs

The HEI which prepares the students under investigation was first commissioned to educate pre-registration student nurses in 2003. The course is three years in duration. Hence the first cohort to graduate was in 2006. Since then records have been collected regarding the employment destinations of the graduating RNs produced. Of these over 90% of the former students from this university dept have obtained RN positions within four weeks of qualifying (Whitehead 2008 and 2009). The year in which the email questionnaires were circulated was the 2008-2009

academic year. In this year many of them won posts with employers outside the region or in the private sector but 66 out of the 105 were in the three local trusts presented as case studies. Of these, 11 obtained positions in C1; 18 in C2; and 37 in C3 (Whitehead 2008 and 2009). The likely reason for the greater number being employed in C3 is that there is another university (HEI2) competing for placements in C1 and to a lesser extent in C2; whereas, in C3 the only university having placements there is the HEI from which the participants in this questionnaire hail (HEI1). The historical context of this is that C1 was entirely served by the other HEI from the region (HEI2) up until 2003. At that point HEI1 began to require placements in the same trust. However, HEI2 managed to protect the majority of their existing clinical placements to the detriment of HEI1. Consequently, HEI1 had to find student clinical placements in places other than their local acute hospital and this led to students from HEI1 having many fewer placements in C1 than those from HEI2. This as a matter of course leads to less former students from HEI1 obtaining posts in C1 than those from HEI2. This is because a student is more likely to choose an area to apply for employment where they have had a placement and the prospective employer is more likely to choose a former student who they have trained in their workplace and has experience of their policies and procedures. In addition to this, the nurse recruitment efforts at C1 are aimed at HEI2 for the same historical reasons that they provide more HEI2 placements. Whereas, in C3 their NQN recruitment is focused on HEI1 from which the participants of this investigation come.

Numbers of Returns and Answers to Question 1 (Q1) by Cohort Y1

In the Y1 set 85 forms were completed and returned. This high percentage return was obtained by asking the students to complete and return the forms during a lecture. This was done when the cohort of students was brought into university for a 'reflection day' which is a routine part of their clinical placement. Twelve had placements on wards with CFSNs and sixty-five who were at the same time on placements without facilitators. This ratio reflects the type of placements which the students are placed on

in their first year at this particular university. The majority of these are nursing home and community hospitals. The number allocated to areas outside of the case study areas is also due to this factor. In Y1 in particular the placements for students are a mixture of community hospitals which are mainly in C2; a small number of rehabilitation wards within the C1 acute hospital; nursing home placements; and NHS mental health ward placements. Of these one half go into nursing homes and a quarter go to NHS Mental health wards. This leaves only a quarter going to placements within C1 and C2.

Most of the CFs within the case studies are based on acute wards, a smaller number on community hospital wards and none in nursing homes or mental health wards. Therefore it is unsurprising that the overall majority of the students had not met CFs. However seven out of nine C1 respondents and three of twenty-two C2 participants reported being on a placement served by a CF. As made clear in the interview section of this research CFs were active in C2 at the time. However, they were only just being introduced to the C2 area. C2 is a large county wide PCT and the CF role was being introduced to community hospitals in the south of the county first. The majority of those responding that they were on a non-CF placement were on placements in the north of the PCT. Consequently this was unsurprising. Most students on placements on C1 and the CF active part of C2 combined were aware of CFs supporting their placement. It was already known as stated that CFs were in post at these placements. What the answers to these questions confirms is that students are aware of the presence of the CF. This is an important finding as it shows that the CF role is in place not just on paper but also as an active educational position. The numbers of students responding positively to the next few questions on the questionnaire indicate that they are not merely visibly present but are also doing a good job of supporting students in their areas. This will be pursued in greater depth later when discussing the results from each question.

Y3 and NQN

The same questionnaire was later emailed to 2 cohorts of in total 103 final

placement 3rd year student nurses and a former cohort of 105 recently NQNs. Email was used because reliable email addresses were known to the researcher for all of these participants and because of lack of opportunity to obtain a lecture based questionnaire from either of these groups due to structural issues. These issues were that the Y3s were on their final placement and would not return to university and the NQNs had already left the university. Unfortunately, only 14 were returned from each of these groups, making a total of 28 out of 208. This much lower percentage return than for Y1 (Y3 and NQN =13% in total compared to 76% of Y1) is likely to be due to the nature of email questionnaires compared to the advantages of having a group handing in their returns following a lecture. There are many known barriers to participation in email questionnaire research. This is even true in a population of experienced computer users who are all connected to the internet such as the subjects questioned in this survey¹⁹. The barriers to participation include technical and socio-psychological barriers. Technically the prevalence of spam and the nature of spam detectors make group emails less likely to be read or even to be received (Sheehan 2001). From a social perspective there is no individual advantage and a significant time penalty for the participant in an anonymous questionnaire. Consequently, given the time and space to refrain from completion an email questionnaire is at least as likely to be discarded as a postal one (Drummond and Campling 1996).

To some extent the Y3 and NQN groups could be said to be representative of the whole of their group because the students and NQNs in the final two groups of participants were more likely to have been placed on a ward where CFs were available. It is known to the author that the majority of placements in the three case study areas were supported by CF type roles by the 2008-2009 academic year. Therefore, the respondents are not likely to be the only ones from the group to have experienced CF support. Consequently, the majority of those who responded, (21 out of 28) had been

¹⁹ To complete their course of study at HEI1 the students and former students had used email to submit word-processed documents on a regular basis.

supported by CFs because the majority of those asked had been on wards supported by CFs rather than any self selection issues. Again this is an important finding because it indicates that students and NQNs in C1 and C2 are aware of the presence and support of the CFs that it is known are in place. It is also an important indication of the lack of visibility of the LEM role to students that despite the fact that there are LEMs on every C3 placement none of the Y3 students returned questionnaires to indicate this.

Nevertheless, it is necessary to be aware that these findings are inductive emerging data rather than any claim to statistical validity. The small numbers of respondents make the sample size insufficient for reliable statistical analysis as is outlined below.

Statistical Analysis?

According to Cochran's (1977) well accepted formulas as tabulated in Bartlett, Kotrlik, and Higgins (2001) the minimum sample size for reliable correlation would be 46 for each case. Therefore, Y1 would be possible to use for statistical analysis but Y3 and NQN would not meet the criteria. As stated above Y1 was different from Y3 and NQN because the majority of students were placed in areas which did not have a CF and the forms were collected by hand rather than by email. In addition to this the self selection implicit in analysing data from all of those who decided to respond for Y3 and NQN is a weak method for mathematical analysis of samples. Therefore, the decision made within the method section to refrain from formal mathematical analysis of data remains. However, as explained in the method section this does not preclude the use of this numerical data in a qualitative analytical framework. The data can be textually analysed in a similar way to the free text. Each of the numbers when regressed back to their origins represents the quantity of answers to a closed question similar to some of the responses within the semi-structured interviews. Consequently, the data generated by the closed questions for this aspect of the research can be analysed in a similar way to the others. The free text part of the questionnaire was designed to allow participants free rein to express their opinions on the subject. The numbers choosing to do so are indicated in the table but more importantly this resource is explored using a similar

thematic technique as the other aspects of this study.

Textual Analysis

The number of respondents choosing to make free text comments was reasonably high at 43 out of a total number returned of 113 or 38% (Table 2). This was an optional aspect of the questionnaire and completion indicates that a sizeable minority of participants felt it important to share their thoughts about this role. The amount of writing varied enormously from just one sentence to a two page letter which had been initially sent to a ward sister by the participant. This presents the researcher with another rich source of data from which to illuminate the subject matter. In a similar way to the semi-structured interviews this information can be examined and compared to extract themes and either to support existing theory or to create new hypotheses. In this case the words of the participants will be blended with the numerical data generated by the responses to the six remaining closed questions. Where the comments of individual participants are reproduced they will be identified by a code consisting of their group, followed by the case and finally an individual identification letter. For example the first student from Y1 at case C1 would be identified as 'Y1C1a'. This indicates the first participant for this group and case in the researcher's filing system rather than the first to be quoted in the text.

The results and their analysis will initially use the questions from the form to provide a format for presentation. Following that, the themes already generated and new ones emerging will be examined. Below are Tables 2, 3 and 4. The textual analyses of these results and the free responses will follow using Q2 to Q7 as headings. As made clear above 38% of those responding also provided further comments of their own. These will be examined and used to illustrate the answers within the structure indicated above.

Figure 23: Table 2 Total Cumulative Responses	
Questions	Numbers by participant grouping

1. Was there a Clinical Facilitator Nurse (CF) on your (most recent placement Y1 and Y3) or (first workplace NQN)?	See table 1 for a detailed breakdown of these numbers.			
2. Was the CF there to support ...	P Total	Students	Mentors or preceptors	Don't Know
	43	28	18	10
3. Was the CF there to teach clinical skills?	P Total	Yes	No	Don't Know
	36	25	6	5
4. Does the role of CF improve clinical skills on the ward?	P Total	Yes	No	Don't Know
	30	19	1	10
5. Would you rather have a placement with a CF?	P Total	Yes	No	Don't Know
	113	91	2	20
6. Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?	P Total	Yes	No	Don't Know
	113	97	2	14
7. Most mentors are Staff Nurses or Sisters. Would you prefer to have a CF as a mentor?	P Total	Yes	No	Don't Know
	113	47	22	45
8. The participants were provided with a free text box to respond to the following "If you have any further comments about the role or impact of Clinical Facilitators or similar supportive roles please write in the box provided below." The numbers choosing to do so are represented in the columns below.				
Numbers filling in text box ...	P Total	Yes	No	
	113	43	70	

Figure 24: Table 3 Cumulative Responses by Group

Questions	Numbers by participant grouping				
1. Was there a Clinical Facilitator Nurse (CF) on your (most recent placement Y1 and Y3) or (first workplace NQN)?	See table 1 for a detailed breakdown of these numbers.				
2. Was the CF there to support ...	P	Total	Students	Mentors or preceptors	Don't Know
	Y1	12	12	7	6
	Y3	12	12	8	0
	NQN	9	4	3	4
3. Was the CF there to teach clinical skills?	P	Total	Yes	No	Don't Know

	Y1	12	8	2	2
	Y3	12	12	0	1
	NQN	9	5	4	2
4. Does the role of CF improve clinical skills on the ward?					
	P	Total	Yes	No	Don't Know
	Y1	12	7	0	4
	Y3	12	7	0	1
	NQN	9	5	1	5
5. Would you rather have a placement with a CF?					
	P	Total	Yes	No	Don't Know
	Y1	85	64	2	19
	Y3	14	14	0	0
	NQN	14	12	0	1
6. Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?					
	P	Total	Yes	No	Don't Know
	Y1	85	70	2	13
	Y3	14	14	0	0
	NQN	14	13	0	1
7. Most mentors are Staff Nurses or Sisters. Would you prefer to have a CF as a mentor?					
	P	Total	Yes	No	Don't Know
	Y1	85	38	11	36
	Y3	14	5	6	3
	NQN	14	4	5	6
8. The participants were provided with a free text box to respond to the following "If you have any further comments about the role or impact of Clinical Facilitators or similar supportive roles please write in the box provided below." The numbers choosing to do so are represented in the columns below.					
Numbers filling in text box ...	P	Total	Yes	No	
	Y1	85	22	63	
	Y3	14	12	2	
	NQN	14	9	5	

Figure 25: Table 4 Cumulative Responses by Case Study Area (C)

Questions	Numbers by Case Study Area (C)				
1. Was there a Clinical Facilitator Nurse (CF) on your (most recent placement Y1 and Y3) or (first workplace NQN)?	See table 1 for a detailed breakdown of these numbers.				
2. Was the CF there to support ...					
	C	Total	Students	Mentors	Don't Know
	C 1	17	17	8	1
	C 2	9	8	3	4
	C 3	3	1	2	2

	C 4	4	3	4	3
3. Was the CF there to teach clinical skills?	C	Total	Yes	No	Don't Know
	C 1	17	14	1	3
	C 2	9	6	0	0
	C 3	3	0	1	0
	C 4	4	3	1	0
4. Does the role of CF improve clinical skills on the ward?	C	Total	Yes	No	Don't Know
	C 1	17	13	0	5
	C 2	9	6	1	7
	C 3	3	1	0	2
	C 4	4	2	0	4
5. Would you rather have a placement with a CF?	C	Total	Yes	No	Don't Know
	C 1	20	17	1	2
	C 2	31	21	0	9
	C 3	3	3	0	0
	C 4	59	49	1	9
6. Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?	C	Total	Yes	No	Don't Know
	C 1	20	18	0	2
	C 2	31	25	0	5
	C 3	3	3	0	0
	C 4	59	51	1	7
7. Most mentors are Staff Nurses or Sisters. Would you prefer to have a CF as a mentor?	C	Total	Yes	No	Don't Know
	C 1	20	10	6	6
	C 2	31	10	5	14
	C 3	3	0	0	3
	C 4	59	30	10	18
8. The participants were provided with a free text box to respond to the following "If you have any further comments about the role or impact of Clinical Facilitators or similar supportive roles please write in the box provided below." The numbers choosing to do so are represented in the columns below.					
Numbers filling in text box ...	C	Total	Yes	No	
	C 1	20	14	6	
	C 2	31	13	18	
	C 3	3	0	3	
	C 4	59	16	43	

As described in the section prior to the results tables, responses to each of the questions (Q2 to Q 7) will be discussed in turn. This will be followed by a discussion around the eight clusters theory of CFs generated from the previous stages of the

research process. Firstly, some numerical explanation is necessary to explain an apparent discrepancy.

Low Participant Numbers in Qs 2, 3 and 4

In total 43 participants answered Q2; 36 answered Q3 and 30 answered Q4 out of a total of 113 respondents. These may appear to be low numbers but those who were on wards where there was no CF, and answered 'no' to Q1, were instructed not to answer Q2, Q3 and Q4. There were only 33 reporting being on wards with a CF in total. This may appear to indicate an extra 10 answering Q2 and 3 extra for Q3. However, the explanation is twofold. Firstly, that many of the participants ticked both boxes to indicate that the CF was there to support both mentors and students. This of course doubled the number for each respondent taking this option. Secondly, that some participants ignored the instruction and answered despite being on non-CF wards. With these apparent discrepancies explained it is now possible to analyse each of the questions.

Q2. Was the CF there to support Students or Mentors?

As previously discussed, this whole questionnaire exercise was to find out what the student and NQN perception of the CF role was. The official answers to this question from the trusts' and the CFs' perspectives were already known. In all three case studies, to a greater or lesser degree, the CFs were allocated the duty of supporting both students, NQNs, mentors and preceptors in the clinical area. The numbers aware of this, when looked at across all cases and when sliced by group and case, make interesting reading.

The CFs interviewed all had a lot to say about supporting NQNs and felt it was an important aspect of their job. The wording of the questionnaire did not ask NQNs if CFs were there to support them. However, several of them wrote about this in their free text comments. One said that "nurses on the ward did not have the time needed to help me build my competence in this area. Also it is useful to have support from

someone who is not a staff nurse on your ward” (NQNC1k). This NQN had also had a positive experience of preceptorship which had been enhanced by the CF. It is also clear that although CFs are known to be present in some places they are not visible on the shop floor. As one NQN put it “I am aware that there is a CF for my area but am unsure who it is” (NQNC2h). It is hard to make a judgement as to why this is the case. It may be that the CF was engaged in other duties elsewhere. Whatever the reason, it indicates that the closer to the action and visible that the CF is the more effective they are. Other NQNs said that they would have benefitted from “student type support” as NQNC2b put it. The NQNs responses will be examined in more depth in later parts of this analysis but the main aspect of this question is the support from CFs to students and mentors.

Across all cases and groups 28 out of a total of 43 felt that CFs were there to support students. This should have been out of a total of 33 who were on wards supported by CFs. However, 10 additional people responded to this as well. For C1 17 reported a CF on their ward and 17 reported that the CF supported students. In C2, 9 reported having a CF covering their placement and 8 said that they supported students. This is a very positive finding in both cases. It is especially so in C2 as the newness of the role in C2 at the time of the Y1 sample was acute. They were arriving at the trust at the same time as this student cohort went onto placement. As one student put it “the CF started on the ward in my final week and was just finding his feet himself” (Y1C2e). In addition to this, at the time of writing, the role in C2 remains more dispersed than in the area of C1 under investigation. This is accurately assessed by Y3C2c who said “there was a CF between two hospitals”. This continues to be the practice in that the smaller community hospitals share a CF between them. Thus they will have less time to spend with individual students and tend to concentrate their efforts on supporting the staff and ensure that the educational environment is conducive to learning. Nevertheless there remains a strong identification of CFs with student support in these figures and this is supported by comments from the text box such as the following from a Y3C2 student.

My previous experience found that working with a CF meant they were there solely for you as a student and therefore had time to dedicate to your learning needs; this is in stark contrast to the time spent with busy ward staff which can be stressful for all participants and may also be detrimental for patient care. Without CF student nurses are often taught by health care assistants or other nurses willing to assist with learning needs and some students go through their entire training without having adequate opportunities to perform essential clinical skills. In my opinion this lack of consistency needs addressing to ensure quality care is maintained within the profession, it would also boost confidence within the individual student and enable them to be better prepared for the responsibility of the job once qualified (Y3C2b).

The third year student in this quotation makes a strong case for the universal implementation of CFs across all student placements. This is representative of several similar such comments and it supports the view of the CFs themselves. With a CF present the organisation can guarantee that clinical learning will take place. Without one, it is up to chance as to whether, or not, the staff have the time, energy or inclination to teach and assess students. As a consequence, as Duffy has pointed out in her seminal research (2003), some slip through the net without having learned sufficient skills by the time they qualify. Where the emerging evidence of this research is leading is that Duffy does not go far enough. She recommends that mentors are better prepared to deal with the responsibility of failing students. This is important but needs backing up by the educational support of dedicated staff employed within the clinical environment rather than the university. Only CFs can do this reliably and effectively because they are on site at the point of care delivery but not distracted by care responsibilities. They are employed by trusts and therefore part of the organisation rather than mistrusted outsiders. They are extra to numbers and have a primary responsibility for education. Whether this is done by working alongside the student as implied in the comment above or by providing a supportive educational environment to other staff to ensure this happens is down to local circumstances. Many made the case that not only did CFs support students but that they should be a universal provision. First year student Y1C4f was not alone in making the case that “[t]hey should be present at every placement to support the students.” On the other hand the lack of support perceived by students not receiving the advantages of a CF placement led to a feeling of injustice that they had been left out when she said “I have not seen

one on the CFP [Common Foundation Programme²⁰] and believe it is unfair that some students have access to one while others do not Y1C4". Some students alluded to the CF being a force for emotional support as well as theory and practice. For example Y3C1c proffered that

[t]he help of the CF during my placement was invaluable, she helped me regain my confidence and was instrumental in turning a negative situation into a very positive one. I would just like to add that the CF on this placement was absolutely wonderful and I don't know if I would have survived my placement without her help. (Y3C1c)

These comments from learners, back up the data emergent from the CF interviews, that the CF is active in all three of the Bloom's Taxonomy domains (1956). This is as noted in that chapter at variance with the usual perception of CF type roles as being purely clinical skills teachers and thus operative entirely in the psychomotor domain. This is an important issue for the status and pay of CFs as has been noted elsewhere (Field 1996) the teachers of manual skills tend to be lower paid and of lower status in educational culture than those who teach theoretical subjects. This issue will be returned to in the next section on clinical skills.

For C1 only eight and for C2 only three felt that CFs were there to support mentors. This could be an indication of the subjective perception of the student rather than an illumination of their overall role. It certainly does not fit with the CFs perceptions or with the job descriptions which guide them. In all other evidence the CF has a role supporting various staff and students educationally in the clinical environment. One of the Y1 students from the area of C2 which had not yet been provided with CFs made comments which were expressed in a similar vein by several others.

On this placement, all staff nurses have no choice about completing mentor training. I am finding that my current mentor does not embrace her mentor role, which most certainly has a detrimental effect on the students' learning objectives. To have access to a CF could only have a positive effect on students whilst also assisting a mentor in keeping their own clinical skills up to date (C2Y1n).

The student above had clearly felt that she was poorly served by her/his present

²⁰ CFP is the first year of a nurse education programme as stipulated by the NMC (2004)

mentor as a result of structural issues outside either of their control. The student believed that the RN did not want to be a mentor but the number of students on placements means that all available nurses must be utilised to fulfil this role as well as their primary caring duties. This concept of the mentor as a forced role which many RNs take on because their manager requires it of them is familiar in nursing. As a consequence nurse unions such as the RCN and the statutory body the NMC produce guidance and encouragement for their members/registrants to attempt to convince them of the benefits as well as the burden of this part of their duties (NMC 2008c, RCN 2007). Most of the respondents were keen to maintain the role of the practising nurse as the mentor as can be seen from the answers to Q7. This is in line with CFs and managers as well as the wider nursing community (Andrews and Wallis 1999). However, there appears to be widespread concordance with the idea that mentors are busy people who would benefit from support from a role such as the CF. Again this is in line with the views expressed by CFs and ward sisters in the observation and interview stages of the research.

In C1 and C2 there is a lower number who believed CFs had a mentor support role than a student support role, for C3 and C4 this was reversed. In C3 two respondents believed CFs, or LEMs as they are called in C3, supported mentors while one believed they were there to support students. This reversal could be due to the different emphasis of the LEM role locally but the numbers are not sufficient to form a conclusion even in the tentative textual analysis approach to numerical evidence adopted in this part of the study. C4 is even more difficult to assess in this regard. In any event these findings do not contradict the case that CFs are seen as supportive of students by the majority of students in the areas where they are placed with CFs. Their views regarding the support of mentors are likely to be a matter of perspective.

As alluded to earlier the issue of what CFs teach is important in determining their pay and status as well as effectiveness. Therefore the answers to the next question will now be examined.

Q3. Was the CF there to teach clinical skills?

A total of 25 answered yes to this question from a total of 36. Again this should have been out of a total of 33 who were on wards supported by CFs. However, a total of 36 responded to this question and the additional answers have been allowed. Several of the text comments also alluded to clinical skills teaching. The definitions of what clinical skills encompass have been discussed in the interview chapter and the wide definition used by the CFs is adopted by many of the respondents in this questionnaire as well. Nevertheless, this was not stipulated in the question itself. Consequently, this definition cannot be adopted when interpreting the numerical data. It must be assumed that some respondents considered this as a question about psychomotor skills and some about the broader set of educational objectives encompassing everything that a nurse knows and does which the CFs tend to adopt. Also the nature of the question was not exclusive. In other words so long as the CF teaches clinical skills the respondent can answer 'yes'. This does not of necessity imply that they do not do anything else. A Y3C2 student who answered that CFs were there to teach clinical skills included any form of training which may be required in the area in her comments.

I can say that her role on the ward was very visible, and she had no qualms about training both the students and the other staff on the ward should they feel that they needed it. That said she was also very pro-active when it came to organising other training sessions (Y3C2j).

This supports the concept that CFs are general educationalists and trainers who happen to be based in the clinical area. Another from C1 illustrates the holistic nature of clinical skills teaching. It shows that to a certain extent in many nursing skills the perceived split between theory and practice or between Bloom's domains is a false one.

I have found the role of the CF to be effective when teaching clinical skills on placement and also doing things like drug rounds with them as they ask you more questions and go in to more detail compared to when doing them with the staff nurse (Y3C1g).

The skill of drug administration is one of the more complex and demanding areas of a nurse's duties. This is not of course just a matter of handing out pills. The nurse must know what the safe route, safe dose, expected effects, side-effects, contraindications and other aspects of each medication is prior to giving it to the

patient. As the NMC say

The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council's register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner (now independent/supplementary prescriber). It requires thought and the exercise of professional judgement... (NMC 2008b:2).

As can be seen from the statement above, theoretical knowledge, practical skill and reflective, experience based judgement are required at an exacting standard. The reason for the professional regulator making this explicit is straightforwardly that errors in this as in many other nursing skills can lead to worsened patient morbidity or mortality outcomes. Along with other healthcare professional skills such as those of the surgeon there is a clear impetus to ensure that nurses get this right. This is especially the case as drugs get more powerful. According to the Audit Commission report 'A Spoonful of Sugar' the number of drug errors remained fairly constant between 1990 and 2000 but the number of deaths increased fivefold (2001). Their main recommendations were to ensure that clinical governance procedures within NHS hospitals included effective corporate management of medicines. The effect of this was often and certainly in the three cases studied here, to elicit advice from these committees to strengthen the education and competence assessment of nurses with regards to drug administration. CFs are clearly well placed to implement this sort of policy. As has been put forward in the previous chapter CFs are a good way to implement policies and procedures. This is a specific example in action.

Other areas of policy implementation which CFs have had a strong role in are mandatory or compulsory skills. This is another manifestation of the clinical governance structure of hospitals. Since the late 1990s clinical governance has been a central plank of the modernisation agenda for the NHS. Amongst other things this ensures that health and safety related training takes place. This training includes ensuring basic levels of manual handling and infection control skills. It also includes more demanding abilities such as those associated with aseptic wound dressing and the administration of intravenous regimens. As NQNC1k says the CF is

[v]ery useful and supportive in areas such as IV where perhaps nurses on the ward did not have the time needed to help me build my competence in this area. Also it is useful to have support from someone who is not a staff nurse on your ward (NQNC1k).

Again although this NQN is describing the education and training required to achieve competence in a specific assessed task she still says that support from the CF is useful. Again this is in concordance with the CFs' own view of themselves as providing support as well as education.

The key to all of this is not necessarily expertise in teaching. As has been made clear earlier the educational qualifications of CFs are mixed and in most cases only include the most rudimentary teaching qualifications. The main things which make CFs able to deliver this clinical skills teaching are clinical expertise, enthusiasm to pass on this expertise to learners and most importantly the dedicated time in which to do this. As a Y1 student who had not experienced a placement with a CF but who wished that she had said "[t]he CF may have more time to teach as the nurse has so many other responsibilities to undertake (Y1C4y)."

Q4. Does the role of CF improve clinical skills on the ward?

This may appear a superfluous question as the participants have just been asked if the CF is there to teach clinical skills. Surely, it follows that given this the quality of clinical skills practised on the ward must improve. However, this is not necessarily the case. In order to test this question empirically it would be necessary to devise a measure of clinical skills ability such as an OSCE and test the abilities of staff to a reliably assessed standard. Their OSCE results could then be cross matched against whether they were placed with a CF or not. This was attempted by Ellis and Hogard (2003) but they were unsuccessful. A similar attempt was considered in the case studies under examination for this thesis. The university in question has a well established OSCE assessment framework. Therefore it would be a simple task of cross-referencing the existing results data to their previous placements. However, after examination this was abandoned because the placements where CFs were placed also

tended to be the ones where the students could most easily practise their skills anyway. As one student participant from C4 said “I would have liked clinical skills to practise but there weren’t many” Y1C4I. Of course given the wide definition of clinical skills used this is not the case. Nevertheless, the point she is making is that in nursing home or mental health placements the type of skills employed by nurses are in many ways different to those used in general hospitals. Thus to fairly assess the CF against the non-CF placements a skill which was equivalent in both settings would be necessary to select. Unfortunately, the ones assessed by OSCE at this university were all of a kind which would naturally favour acute hospital placements. This leaves the informed opinions of participants as the method of illumination favoured by this research.

It is perhaps unsurprising that the respondents to the questionnaires found this a difficult question to answer. Numerically, a total of thirty people answered this question. Out of those ten could not make up their mind. However, only one felt that they had no effect on the level of skill and nineteen were convinced that they had a positive effect. This is of course the subjective opinion of students and NQNs. However, these categories of participants can be seen as particularly vigilant and inquisitive regarding the perceived quality of skill and care. Firstly, they are viewing the particular clinical workplace with fresh eyes as either recently qualified or currently learning to be proficient in the skills in question. Secondly, they are in a position where their own skills are under constant assessment and observation by mentors in the case of students and by senior staff for NQNs. It would appear sensible that people under assessment will attempt to match the skill level of those who are assessing them. Thirdly, students are asked routinely by universities to provide formal critical feedback of their placements. Invariably the quality of nursing skill and care on the placement is featured highly in the feedback (University of Nottingham 2007a). Consequently, the respondents questioned can be seen as better than average judges of the level of skills displayed. For those who could decide, the numerical data is strongly in favour of CFs being a positive influence on skills practised. However, the free text responses said

little about this. There was one strongly in favour of the CF because on their first job they felt the lack of support for new staff was likely to lead to unacceptably low levels of skill and thus poor quality care.

During my first job I was left to get on with things as all the staff were too busy to show me anything, this prevented me developing my skills and also put patients at risk. I feel that if there was a CF linked to the ward we would have got more input and therefore improve patient care (NQNC4a).

This would appear to be a safe bet. The NQN below also had a first job on a ward in one of the non-case study areas. However, in her case there was a CF type role in place. In this case she had previously had experience of a CF placement as a student and felt that the CF at her new job was not as effective.

This is a vital role which can be under-utilised. The staff nurses need this support in able to provide efficient and effective training of students and other staff (NQNC4h).

The number of students and NQNs who praised the CF in both these questionnaires and the routine feedback mentioned above was high. This praise was almost always because of their ability to give the learner their primary interest above patient care in order to improve the learner's ability to deliver better care.

The CF at [C1] was excellent, he spent time teaching us how to interpret ECGs etc., as well as offering assistance with assignments and reflections (found us loads of journal articles). (Y3C1f)

In this case the learner was alluding to the linkage of clinical learning to academic work. It is to this linkage between the demands of a placement and of the realities of providing real patient care at the same time that shall be examined.

Q5. Would you rather have a placement with a CF?

This question was linked along with the next question to the hypothesis that CFs lead to an improvement in recruitment and retention. The comments from students fall into two categories. The first type is like the third year below who relate the CF to improvement in learning. "This was the first time I had active support from the CF based in my work area. I enjoyed and appreciated the additional support. I feel strongly that this support greatly enhanced my learning (Y3C1d)." The second are those like the first year quoted here who talk about the general support that CFs can provide. "They

should be present at every placement to support the students (Y1C4f).” As noted in the interview stage these are both acceptable reasons for wanting to have a CF present. However, they are very different in their emphasis. With the first, the CF is there as an expert to teach the learner the skills of the trade or as a role model from whom to learn by ‘sitting with Nellie’ or working alongside the CF as they usually term this process. For the second the CF is a kind of emotional and practical support to the learner. In this way they ensure that the learner has the space and power to learn through working rather than just work. The implication here is that if there is not a specified person in the clinical area to ensure that learners have the supernumerary student status they are supposed to have then they will be coerced into the general workforce or otherwise mistreated. Unfortunately it is not possible to do more than to say from the free text comments that there are these two reasons for desiring a CF’s presence. The yes/no answers do not specify this dichotomy. However, it is interesting to note that ninety-one participants said that they would prefer a placement with a CF. Whether this is because of the support they are expected to give the student to be supernumerary or whether it is because they will teach the student is not specified. However, it is strongly favourable. It is also important to note that this question did not exclude those who were on non-CF wards. Therefore it appears that those who had been with and without CFs preferred the idea of having a CF present. Overall this shows that the learners themselves would like to have this role in place. The next part of the role is supporting and teaching NQNs. Would they prefer to have a CF present?

Q6. Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?

At 97 out of 113 participants agreeing that they would like to have a CF supporting them during their first job this was the most positively answered question. The transition from student to NQN is well known as the most stressful in a nurse’s career. Since the late 1980s the UKCC and later the NMC have advocated preceptorship for NQNs (UKCC 1990, NMC 2006b). This is because the period

immediately after qualifying can be a difficult transition from supernumerary protected student status to that of a registrant and an employee (Dimond 2005). The need for additional support during this period would seem like straightforward good sense. Nevertheless, this has often been seen as an optional extra by trusts. The government and NMC have finally in the last year accepted that this needs to be a requirement rather than a recommendation (Ford 2009b). This is a good thing but even so it may not go far enough. Many trusts do already have established preceptorship programmes. However, these good corporate policies do not always reach the shop-floor. This can be seen in the comment quoted below

I underwent a preceptorship program during the initial months of my first qualified post. However it is felt that more support would have been beneficial. It is felt that student type support would prove helpful making initial post registration posts less daunting. (NQNC2g)

This NQN was in a community hospital for her first job post qualification. She is not alone in finding the prospect of transition from supernumerary student to responsible and accountable nurse a daunting one (NMC 2008). The PCT for C2 does have a policy of providing preceptorship for NQNs. However, it does not have the kind of extensive programme of support of NQNs that both the hospital trusts in C1 and C3 have. The NMC recommendation for preceptorship is that the NQN should be supported by a nominated preceptor for a period of at least four months post-registration. This preceptor should be another RN working in the same area. Therefore, if this recommendation is put into place by the trust, and at the time of writing it remains just a recommendation, then the preceptorship partners have a similar problem to the mentor to student relationship. That is the preceptor is primarily a provider of nursing care rather than a teacher and supporter of NQNs. To a certain extent the problem is even greater for the preceptorship relationship than for the mentor as the NQN is not a supernumerary student but is part of the established nurse numbers as a paid employee of the trust. Therefore both NQN and preceptor are likely to have a full shift's worth of work to do before being able to have a supportive or educative relationship. The CF has a role which is primarily focused on the student or NQN and

as such can provide genuine support in the workplace during this ‘daunting’ time.

However, the NQN below makes the point that CFs are not necessarily in a position to do this either.

I am working in a community hospital which has had students almost constantly since I started in Sept 08. I've not seen the CF since I got here. I think they are a really good idea but need to be integrated more into everyday practice. It is my opinion that by better integrating CF's students and newly qualified staff would be more supported. (NQNC2h)

This is a good point and underlines the need for policy to be put into practice through creating a structure which enables the CF to fulfil their role. In C2 CFs are routinely spread much thinner than in the hospital cases. As a role which is often split between two community hospitals, it is not surprising that the NQN had not met hers. The C4 NQN below had not been on a ward which was supported by a CF as a NQN but had as a student.

I found as a third year student that CFs were really useful and learnt a lot as they had the time to teach, so as a newly qualified I think this would also be valuable. (NQNC4d)

She also felt that this would be a valuable addition to the support of NQNs.

Some NQNs felt betrayed by their trust in that they had been led to believe when applying for the post that they would be supported by a preceptor and have a period of supernumerary status for a period of induction. However, this promise sometimes did not translate into reality.

Although I was assigned a preceptor in my post, I only worked with her in my first week as a staff nurse and that was not supernumerary! I work as the only staff nurse on duty and I feel preceptorship programmes have a long way to go. (NQNC2g)

This is another case of policy not being put into practice on the frontline of care delivery. The practice of having just one RN on duty at many community hospitals remains. The PCT's policy is that this should not be the case for NQNs during their period of preceptorship. However, in this instance that was clearly not put into place. This theme of preceptorship as a good idea which is not always put into practice is a common one amongst NQNs. Another NQN was so traumatised by the experience of her first job at an acute hospital outside of the three case study areas that she looked for

and secured another post just a couple of months after qualifying. She felt the need to explain to the ward sister what had led to her resignation. The letter was sent to the researcher along with her questionnaire to act as additional comment. An extract is reproduced below.

I feel that the preceptorship period is not well organised and is not helping newly qualified nurses to gain adequate knowledge and skills in orthopaedics which is such a specialised area. I asked one of the nurses who should be helping me at this to fill something in, at which point she didn't know she was my preceptor until I told her. I feel it would help if during this time there was specific time set aside, even if it is 1 hour a month to discuss my progress and to see where I need to improve/develop my practice, as really I don't know how I am getting on. Although this should happen, the ward is that busy that people are not able to give us any time, I understand that everyone is busy and that patients come first. However in order to develop and become good nurses in orthopaedics, we need time to learn and be shown. If we are not given this then eventually the ward and patients will suffer, as when eventually we are looking after newly qualified nurses, if we do not receive a good preceptorship and adequate knowledge, then what are we going to pass on? And the cycle continues. (NQNC4f)

This cycle of repeated lack of support leading to reduced quality of care is the main logical concern for nurses. The nurse sees patient care as their primary reason for professional existence. Anything which reduces this is a problem. In general, nurses are prepared to put up with a less than comfortable working environment. If they were not they would not volunteer to do an academic course which is far from the usual student experience of 30 weeks of lectures a year. The nursing diploma or degree which leads to an RN includes 2300 hours of theory and 2300 hours of placement experience. This is enforced by an EU Directive (2006) which maintains the single market requirement of equivalence in member state qualifications. The outcome of this is that student nurses not only have the usual academic requirements but also have to work shifts including weekends and nights in line with the healthcare workers they are on their placement with. The job itself is so closely linked to the patient at the moment of their most vulnerable and dependent state makes it both a draining and privileged position. Consequently NQNC4f's assertion that her main concern is with the potential outcome that patients will suffer seems honest. Nevertheless, this lack of support at this crucial time is not universal. Another NQN also from an acute hospital in C4 had a much more positive experience of preceptorship.

Whilst there was no direct evidence of a CF on this ward, the mentor/preceptor role was fully utilized. I'm unsure as to whether a CF would enhance this. However you can never have too much support when newly qualified. (NQNC4b)

Despite her feeling that the preceptorship in this case was just as it should be she still felt that a CF could enhance this further. Again this would appear sensible. If a nurse providing support and education as a part of their role can do it well then a CF with this as their entire responsibility should be able to provide an even better service.

Given that almost all of the respondents who had an opinion either way voted in favour of the CF in support of NQNs and students in the last two questions maybe they could be further utilised to take over the mentor role for students altogether?

Q7. Most mentors are Staff nurses or Sisters. Would you prefer to have a CF as a mentor?

This question led to a far less positive response. Only 47 out of 113 respondents answered yes. Almost as many said that they did not know and 22 felt that this was a bad idea. Given the vast majorities in favour of having a CF to support learning and psycho-social needs, deduced from responses to previous questions, this may appear to be an anomaly. The respondents themselves clearly felt that this needed further explanation. The comment below is typical of their kind.

I feel that CFs have an important role, and they are very supportive. I don't feel it would be appropriate for CFs to be mentors, because from my experience they don't spend a lot of time on the wards or in the clinical area, which would make it difficult for students to gain ward experience. Y3C1

It is understandable that a student would prefer to have someone as their mentor who was more often than not working alongside them and the NMC require that mentors are present for 40% or more of the student's placement (NMC 2006c). The majority of these types of roles are based on wards as several of the respondents made clear. "The CF worked on the ward alongside other members of staff" (Y1C2i). Nevertheless, it is possible for students to have mentors who are not in a position to actually work alongside them for this 40% minimum. This has long been the case for community nursing placements where the primary mentor is often a district nurse and the student is often either visiting patients alone or accompanying another member of

the team. More recently trusts have experimented with 'pathway placements'. These are designed to reduce the number of students on traditional placement areas such as acute wards and to use areas which are staffed by RNs but have not been deemed suitable for student placements in the past such as clinics and departments. These students can then be mentored by specialist nurses or other RN roles who have not been utilised as mentors in the past (Whitehead and Bailey 2006). These RNs often include CFs who are ward based and lead CFs who may not be ward based. One first year student who had a ward based CF as a mentor had this to say

I had a CF as a mentor on this placement. Her knowledge and skill were invaluable to my learning and I am very grateful to have this experience. It has made me look deeper into the skills of nursing. (Y1C1c)

This deeper view into clinical skills is clearly a reference to the CF linking theory to practice as related by other participants. Some also said they felt that a CF as primary mentor would be too intense but most felt that a CF to support a 'normal mentor' was the right balance. "I feel that they are a valued member of the team especially in terms of supporting students and newly qualified nurses (Y3C1g)." It could be argued that CFs are capable of mentoring students but on the whole are better utilised to support 'traditional mentors'. This is not only because they are too few in number to mentor every student but because they could end up holding a monopoly on teaching and learning in the clinical area rather than providing a supportive resource. This would be a radical change and not without potentially detrimental consequences for nursing as a profession. The NMC have always been clear in their successive Codes (2002, 2004b and 2008d) that teaching and education of students and other staff is a central function of the RN. If it is sectioned off completely to experts then the core purpose of the nurse would be changed. This could lead to less impetus to remain up to date and perhaps more importantly a lack of ownership of the process of summative student assessment. This is an important function of any profession including nurses. The power of existing members of the profession to oversee the training and assessment of its students is of great import. Mentors are the assessors who decide

whether a student can progress to eventually become a registrant. This ownership of the entrance gates of the profession will be removed if mentors are not usually ordinary nurses but a separate body of specially trained members of the profession with a separate job designed specifically for education such as the CF. There could be a case for this but it is a route which should be travelled with some care and debate.

These questionnaires were designed to elicit information to either challenge or support the existing themes generated by the previous attempts at illumination. They have introduced the perspective of students and NQNs to a picture built up by the views of CFs, academics and managers. The main thing which this exercise has shown is the very high level of support which those on the receiving end of the CFs attentions have for them and their role. The eight clusters identified at the end of the last chapter stand as a result and some of the comments made by the NQNs and students can serve to illuminate them further.

The Eight Clusters

The set of eight clusters describing CFs will be briefly discussed with reference to the questionnaire responses below. These will be further examined in the final discussion section where all of the research methods used in this thesis will be employed. Now each of the clusters will be commented on in series.

1. CFs are employed by care providers such as NHS trusts rather than educational institutions such as universities.

This was clearly evident from the responses of students and NQNs in these questionnaires. The answers to whether or not a CF was present on the placement could be grouped into the case study areas easily. It was previously known where the CFs were deployed but this was a good method of checking that the professed policy of the employers was reaching shop-floor level. On the whole this was the case and the proximity of the CF to the placement area was noted approvingly by those students and NQNs who had a CF on their area. The further away the CF was the more disapproving the respondent. In none of these cases was there a similar role employed by a university. However, if there had been the likelihood is that they would have been

at times absent from the placement on university business such as teaching in the school of nursing clinical skills lab. This cluster is supported by this stage of the research.

2. The supportive presence of CFs encourages recruitment and retention of staff which leads to improved nurse to patient ratios and better patient outcomes.

One NQN (NQNC4j) related that she had applied for a post several hundred miles from the base area. When she went to visit she was reassured by being greeted and shown around by the ward CF. She then went on to describe how the CF had ensured her learning and psycho-social needs were catered to during her initial few months of work. Comparing this with the experience of NQNC4f, who had no effective support, it makes sense that NQNC4j would stay on the ward while NQNC4f could not wait to escape it. This is not just important to the particular ward but to the whole area of nursing represented by that instance. In this case one stayed in the hospital environment while the other left for the community. It also follows that if the second post was equally unwelcoming the NQN may decide to seek employment outside of nursing altogether. This welcoming and overt valuing of the new nurse could be done by any member of staff and would traditionally be the job of the ward sister. However, as related above regarding student support, ward staff have patient care as their priority. This often gets in the way of other duties such as properly inducting new staff. The CF is ideally situated to provide this service. However, CFs are not immune to the problem of role definition as they themselves have made clear in the interview chapter. This will now be looked at.

3. CFs suffer from problems with role definition due to their position between education and clinical patient care.

The students and NQNs did not appear to share the CFs' own concerns about this.

I feel the role of the CF is mainly to facilitate learners therefore they would have the time to give to students. Mentors have many other responsibilities so therefore can become frustrated at having to spend time with a student and this does impact on the student (Y1C4g).

Most of the participants had a clear enough idea of what CFs were there for even if they had not personally experienced them. Not only did they know what they were for they also valued their contribution. This came up repeatedly in free text answers

and in the quantitative responses.

4. These roles are a logical outcome of the organisational changes engendered to produce more and better skilled nurses to provide better patient care.

This particular group of respondents, as new members of the profession, have too short a perspective to judge whether this new role is a product of organisational changes. They will have experienced change since the beginning of their career as NHS reconfiguration is notoriously constant. However, the changes which have led to the introduction of this role took place several years before the most senior NQN commenced their nurse education. However, they will have been influenced by the staff around them and many of those will have harked back to a golden era of apprenticeship training and CTs which was subsumed by the supposedly unfit for purpose university education of Project 2000. With this in mind the CF appears a sensible reaction to the over-theory based education model. The CF puts education back into the clinical area and thus re-emphasises practical nursing. There can be no doubt that this has been the official direction of travel envisaged in Fitness to Practice (UKCC 1999) and Making a Difference (DH 1999) and this practical skills orientated policy direction remains dominant with the promises of guaranteed preceptorship made in Darzi (DH 2008a).

5. CFs help staff to improve their clinical skills and thus to improve the quality of patient care.

A majority of respondents believed that CFs were there to improve clinical skills and most felt that they were successful. It is difficult to ascertain for certain whether they have been successful in this but as many participants said it is not possible to have too much support in improving skill level. Improved nursing skills coupled to increased numbers of nurses working in an efficient way are the straightforward recipe for improved quality of patient care. CFs can improve the first two as we have seen and efficiency is being addressed by the Productive Ward initiative (NHS Institute for Innovation and Improvement 2008).

6. CFs provide a link between theory and practice within an equal educational framework.

That CFs link theory and practice was repeated several times by respondents.

The fact that CFs were there to support learners meant that many of them had to obtain the knowledge of the theory which underpins their nursing practice in order to fulfil their job. As one third year said “[t]he CF on ward [deleted] was supportive and knowledgeable” (Y3C1b). The other aspect to this is that the role of the practice placement based CF is not seen as inferior to that of the theoretical university based nurse lecturer. This is not clear from the learners’ answers. However, on the other hand none of them mentioned seeing CFs as in any way inferior to their university based counterparts.

7. CFs have varying status and power dependent on local factors often outside of their control. Their position is better when part of an organisational framework designed to provide practice based education and support.

Depending on the model of CF organisation the students and NQNs described the support received differently. Those in some of the C2 placements had a CF who was responsible for two hospitals. Some of those in this position had a positive experience. “The CF at [C2] is between two hospitals, she is there if you need her and can be contacted anytime” (Y3C2k). Others felt that this left them wondering who the CF was and with no practical manifestation of support. The one below had a clear idea of the structure within which the CF worked and was in favour of it

The role of the CF is managed by the Clinical Lead who works closely with the Team Leaders and information is cascaded throughout teams (NQNC2b).

Nevertheless, from the point of view of the learner the CF was best placed when as close to them as possible. The most positive responses were from those in C1 and one community hospital in C2 where there was a CF with specified time for the ward they were placed on. The enabling of the CF’s supernumerary status on the ward may well have been a product of the management structure within which they operated. Nevertheless, it was this proximity to the learner and the designated time and responsibility for teaching and supporting education which gained their approval.

8. The CF is an ideally placed policy instrument for the implementation of strategic change management.

The learner, as noted above, has too short a perceptual horizon to judge this and they were not asked directly about change management. However, it seems to make

sense that a practice based educator with no perceived management responsibilities can have a positive effect if they are behind organisational change.

Chapter Conclusion

The narrow perception of the learner is an advantage in checking that the intended policy of introducing CFs for various reasons is being adhered to at the care-front. The fairly wide base of participants over much of the geographical areas under investigation allows a wide view when piecing together the individual shop-floor experiences. However, it has the disadvantage of never lifting the line of sight above the ground floor. This is of course the most important test as it is at the point of delivery that policy implementation matters. Nevertheless, it is also important to take a more strategic view of this as the decisions which affect the point of delivery are more usually taken at a more remote management level. Therefore, it is necessary in completing the research phase to return to an overt observational fieldwork of a similar kind to that taken in the pilot study. However, this time it will encompass not only the meeting rooms of C1 but those of C2, C3 and elsewhere as well.

Chapter 9: Final Observations Analysis

Introduction to Chapter

This final chapter of the findings section will analyse the observations taken during the whole research project from Cases 1, 2 and 3. This encompasses the period from the beginning of the CF interviews in early 2006 to the time of final writing in mid 2009. Evidence from C3 has only been examined in the questionnaire phase of the research so far. Unfortunately, few responses were obtained from C3 in the questionnaire phase. The possible reasons for this have been discussed in the previous chapter. C3 is a somewhat different example to C1 and C2. Therefore, despite the lack of questionnaire evidence, it remains worthy of examination in the final observations stage. The overall outline of C3 has been given in the last chapter. Cases 1 and 2 were outlined in the previous chapters of this section. Consequently, it is possible to examine the eight traits which define CFs generated in the preceding parts of the process in light of the final observations.

As stated earlier the method of memo recording of ongoing observations adopted in the pilot study was maintained throughout the research process alongside the other aspects of the data collection. It is these memos (Appendix 2) which will be analysed in this chapter. The same method of coding for the memos was used for this stage of the research process as for the pilot stage. Memo numbers simply continued and dates and participant identification remain the same. The only required difference was the identification of case study area. This used the same method as that outlined in the questionnaire stage. That is C1, C2 and C3. Again, similarly to the questionnaire section, where memos were generated outside of the primary case studies these are identified as C4.

Justification of Cluster Model

The point of listing the clusters of CF functions is to argue that any position which has all of these traits is a CF as defined by this thesis. This is not merely

important because of the multiplicity of designated titles for roles which include education in the clinical practice area. It is mainly of interest because this thesis argues that the CF thus defined can make decisions based on this definition which will lead to him or her becoming the most effective means of improving education in practice. In effect, this is the identification of a route to an ideal type for education in clinical practice. This is specific to nursing but could apply to any health profession or conceivably to other educational purposes where there is a need for education in the practical arena. As can be seen from this statement, and from the eight clusters themselves, it is not an easy recipe to create identikit roles throughout nursing or healthcare practice. What it does is enable new and existing roles of this type to examine and improve their position based around a conceptual model. The justification of the eight clusters model and of its potential use as a method of improving effectiveness of staff in these roles will be examined further in the discussion section.

The Eight Traits of Clinical Facilitators

This chapter will now look at the eight clusters through the lens of fieldwork observations as suggested above. These are listed at the end of chapter seven. Each of these will now be examined in light of the data generated from the field observations from C1, C2 and C3.

Field Observations

CFs are employed by care providers such as NHS trusts rather than educational institutions such as universities

It is known that CFs in C1 and C2 and their closest equivalent LEMs in C3 are employed by the NHS trust. The observation which was repeatedly noted in this phase was that this was known and welcomed by the participants. The memo below records the outline comments from a ward based mentor.

Figure 26: Field Observations No. 103

CF Study Field Observation Memo Form Date 20071009 Time 1230 No. 103

C2 Meeting with mentor on community hospital placement	Mentor – explains the contribution to placement learning which CFs provide as essential. She explains that her CF works for the PCT but has two hospitals to look after. She assists with students who have greater needs and provides a schedule of induction goals for NQNs. She is easily contactable and frequently visits the placement to plan educational activities with the mentors, preceptors, NQNs and students.
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This is fairly typical of the observations on this theme. Some did feel that the university should pay for these services but on the whole the perceived ownership of the CF and the geographical proximity made the trust employment of the CF a good thing. Strategic managers also appear to be in favour of this model. In comments recorded in a field observation (FO) memo in 2008 a manager explained that she would have been unable to instigate her programme of preceptorship without her network of LEMs (FO20080621C3). If the LEMs were employed by a university this would not have been possible because the NQNs supported by preceptorship would be trust employees rather than university students. The use of education staff employed by the trust allows the flexibility to use these CFs to provide support to learners of any type so long as they are within the clinical area at the time. This is an important distinction as the learners most requiring facilitation at any given time could be students, NQNs, HCAs experienced RNs or any group of staff dependent on the extant circumstances. Strategic health authorities (SHA) provide funding to NHS trusts to support placement based education.

Figure 27: Field Observations No. 161

CF Study Field Observation Memo Form	
Date 20090702 Time 1000 No. 161	
C4 Regional Research Alliance Event	SHA Research manager – Discussion with the researcher about the funding for CFs and practice based education. She is investigating how the money allocated to trusts for the purpose of clinical education is spent. It is not transparent because students are placed in areas mainly responsible for care rather than education with mentors who have mainly caring responsibilities.

As can be seen in the memo above it is not always apparent that this funding is being spent on education directly. There is so much overlap between clinical education and patient care within the existing mentorship system that this is not surprising.

However, in order to provide permanence to the arrangement the funding for each CF is taken out of the general nursing budget for the ward. Where CFs can be shown to pay for themselves in improved quality patient care ward managers are prepared to accept them as a valued permanent member of the team. This can be seen as a positive structural position as the overall budget for care is less fickle than clinical educational funding. Nevertheless, it is fair to say that the CF is a clear way for trusts to show to funding agencies that they are providing specific frontline staff expenditure as well as putting the finance into the general care budget. Unlike more distant staff the ward based CF/CFSN can be seen to have a direct affect on students and other learners. The Darzi Report has promised a tripling of funding on NQN preceptorships over the next three years (DH 2008b). Existing funding for preceptorship is sent to trusts. It is not always transparent even to those delivering the service where the funding goes as can be seen in the memos below.

Figure 28: Field Observations No. 152

CF Study Field Observation Memo Form	
Date 20090408	Time 1300 No. 152
C1, C2 and C3 Telephone Discussions with Lead CFs and equivalents	All of those spoken to were the main organisers of preceptorship within their trust. No funding from the SHA has ever been specifically mentioned to any of them as funding the provision of preceptorships or CFs or CFSNs within the trust.

Nevertheless, the funding has been quantified in Parliamentary answers as £10 million as of 2008 rising, over three years, to £30 million on NQN preceptorship (Ford 2009b). Again the funding of CF/CFSNs will be a logical use for these funds.

The supportive presence of CFs encourages recruitment and retention of staff which leads to improved nurse to patient ratios and better patient outcomes.

This trait of CFs to improve recruitment and retention of all grades of staff has been repeated in multiple observation memos. It is perhaps most notable in conversations with clinical managers. Both of the acute hospital trusts have formal preceptorship programmes to support NQNs and both of these are organised and run by the lead CFs or equivalent. The continued high levels of recruitment of NQNs at both

trusts has only been sustainable by the use of ward based CFs. Lead CFs and there equivalents have made this clear on several occasions. For example:

Figure 29: Field Observations No. 133

CF Study Field Observation Memo Form	
Date 20080617 Time 1320 No. 133	
C1 Recruitment Group Meeting	Lead CF – There are so many NQNs that if we did not have the [formal trust] preceptorship programme it would not be possible to retain them all. Chair – Accepts this as uncontroversial fact.

The linkage of CF activity to trust maintained records on recruitment and retention has already been made. Therefore there is evidence that they do affect recruitment and retention and that this is recognised by the organisation. This is also alluded to in the staff magazine (Synapse 2007) and is clearly something which the organisation values.

CFs suffer from problems with role definition due to their position between education and clinical patient care.

This is an issue which has been highlighted in each section of the research. It is also evident in the memos. At a university based meeting a nurse academic who had previously had a CF type role admitted that she had moved into the university sector for this reason.

Figure 30: Field Observations No. 142

CF Study Field Observation Memo Form	
Date 20081127 Time 1100 No. 142	
HEI1 Practice Group Meeting	Nurse Lecturer – “The post [CF] was a difficult one because you felt that you were being pulled in two directions. Teaching learners on the one hand and looking after patients on the other”

Otherwise the former CF may have remained in the previous post. This is similar to the difficulties reported by LPs in their practice Leigh et al (2002). However, the organisations who have now been hosting these roles for almost ten years are not blind to this and have developed strategies to reduce this effect. At a meeting of CFSNs organised by a lead CF at C1 the following memo was taken.

Figure 31: Field Observations No. 91

CF Study Field Observation Memo Form	
Date 20070411 Time 1310 No. 91	
C1 CFSN meeting	CFSN3 – Notes that these regular meetings help to maintain the sense of teamwork as CFs and that otherwise they would fall into the general patient care activities of the ward.

At C3 a LEM during a ward educational audit explained that the trust provided four days per year for LEMs to fulfil their role (FO20090708C3). It could be argued that this is a small amount and less than is required but she felt it was important to recognise that her role had the requirements of time and energy to complete the duties attached to it. Within this time set aside the LEMs are required to attend centrally organised meetings and thus have recognition at trust level. It would appear from the lack of student and NQN evidence that perhaps LEMs have less recognition at ward level. Clearly this remains an issue but it is one which is being addressed by the organisations.

These roles are a logical outcome of the organisational changes engendered to produce more and better skilled nurses to provide better patient care.

The evidence for this cluster is strong from the previous sections and is backed up by the FOs. The organisations repeatedly use CFs to deliver training objectives. One example for this is the introduction of the ANTT training which many trusts nationwide adopted in 2007 (Randle and Clarke 2007). The C1 trust adopted this training and every RN across the trust was trained. CFs and CFSNs were used to facilitate this on the whole (FO20071005C1).

From a wider political policy construction perspective their will shortly be a move to make preceptorship a national requirement. This has mainly been a result of concerns about quality of patient care from a frontline workforce made up increasingly of recently qualified nurses (Duffin 2009, NNRU 2009, Ford 2009b). However, policy makers at the DH and NMC cannot do this without the means to ensure that their policy is put into practice on the ground. As the National Nursing Research Unit make clear in their comprehensive study, existing staff will be hard pressed to do this without

assistance (Robinson and Griffiths 2009). The CF is an ideally placed vessel to use for this purpose. Health and shadow health ministers are both aware of this as can be seen in the memos below.

Figure 32: Field Observations No. 148

CF Study Field Observation Memo Form	
Date 20090303	Time 1400 No. 148
C4 Memo of meeting with Anne Milton Shadow Health Minister at Portcullis House	Discussed preceptorship and ways to ensure it happens. Included discussion of CFs as a way of managing and facilitating supported preceptorship.

Figure 33: Field Observations No. 163

CF Study Field Observation Memo Form	
Date 20090720	Time 1100 No. 163
C4 extract from email from a student following her attendance at Students' Commission Day at Cowdray Hall RCN: London July 20 th 2009	The health minister agreed today that we need a separate type of mentor who's sole job is to facilitate a student on placement, and that this was also needed for [NQNs].

This need for identified staff to implement national policy logically follows from the decision to move to compulsory nationally required preceptorships.

CFs help staff to improve their clinical skills and thus to improve the quality of patient care.

The kind of clinical skills improvement noted in the preceding trait is straightforward to see. However, the majority of skills improvement and consequent quality of care betterment is more difficult to measure. Nevertheless, the participants in the case studies support the idea that CFs have this effect. The Practice Learning Teams (PLT) are a joint venture between HEI2 and placements (Chapple and Aston 2004). Part of the functioning of PLTs are regular team meetings between placement mentors, CFs and nurse lecturers. At these events the formal student feedback for placements is evaluated and discussed. One of the most repeated features of the student feedback is that CFSNs and CFs are always mentioned as supportive to the students (PLT1 2009). They also report similarly to the questionnaire answers that CFs help to improve clinical skills (FO20080213C1).

CFs provide a link between theory and practice within an equal educational

framework.

These PLT meetings cover several trusts. Some are chaired by university staff and some by trust staff. Where it is trust staff it is invariably CFs who do this (PLT 1 2008). In addition, all mentors are usually encouraged to attend these meetings but as it would be expected the CFs are the most regular attendees.

CFs have varying status and power dependent on local factors often outside of their control. Their position is better when part of an organisational framework designed to provide practice based education and support.

At C1, C2 and C3 the position within the hierarchy of staff is variable. At C1 there is a clear management line of accountability with a lead CF in charge and job descriptions showing this (Appendices 1 and 8). C2 has a similar clarity but with line management from clinical staff. This leads to a different power dynamic. C3 LEMs rely on their clinical status which is usually at ward sister level. As one said “I am in the enviable position of writing my own off-duty. So, if I need some LEM time I just write in a day as LEM.” (FO20090708C3).

The CF is an ideally placed policy instrument for the implementation of strategic change management.

The trust managers in all three cases see the CF as a way of linking educational policy to shop-floor level. This can be seen in the ANTT and preceptorship for two examples. Nevertheless, in the formal interviews with CFs they were all concerned that their job was potentially vulnerable. The majority of the interviews were conducted during a period of NHS cutbacks under the regime of Patricia Hewitt (Health Service Journal 2006). At a meeting with a lead CF in 2008 the issue came up as can be seen in the memo below.

Figure 34: Field Observations No. 136

CF Study Field Observation Memo Form	
Date 20080911 Time 1500 No. 136	
C1 Meeting with lead CF1	Researcher – During the time of the interview you felt worried that the trust would use CFs to staff the wards rather than as facilitators. Lead CF1 – They did take us into the numbers on wards for a while just after those interviews because of the jobs frieze due to cuts in funding but they still needed us. It was always supposed to be temporary and they never removed the role. When the next set of NQNs came along they needed us to induct them and to organise the

preceptorships. Since then there have been times when we've been put back onto the wards but the role carries on.

In this case the CFs were clearly seen by their managers as valuable conduits of policy implementation. They were seen even in a time of financial restraint to be worth more in their role as CF than as a senior clinical practitioner caring directly for patients and leading a ward directly. It is at around the time under discussion in the memo above that the photograph below was placed in the staff magazine of a trust which used CFs to organise preceptorship. The trusts in the case studies cannot be identified due to the strictures of the NHS ethics mentioned before. However, the scene below is very similar to pictures and articles in staff magazines at the case study trusts. From this single cohort of NQNs it is possible to see the wide influence that a few experienced CFs can have. There are more CFs necessary to support this number of NQNs in practice than the three lead CFs in this photo.

Figure 35: Welcome to Our NQNs! Photograph



(Synapse 2007)

At the time of writing the majority of these RNs remain in clinical positions and many have taken on academic courses and/or obtained more senior positions.

Possible Ideal Type Clinical Facilitator

It would probably be most prudent to leave the discussion at this stage. It is possible to be fairly confident based on the evidence gathered from the various sources that CFs exist within the properties outlined. However as Marx said “[t]he

philosophers have only interpreted the world, in various ways; the point is to change it” (1845). From these final observations it is possible to hypothesise a potential ideal type of CF. This will now be outlined below.

The Clinical Facilitator Ideal Type Definition

Figure 36: CF Ideal Type
1. The ideal CF should be employed by care providers such as NHS trusts.
2. The CF role should be defined clearly in their job description and include specific time to fulfil CF duties. These duties should include supporting all learners in the CF’s geographical area.
3. The CF status should be the same as a nurse lecturer and as a senior clinical nurse with similar levels of experience and qualification.
4. The CF should be part of a CF team with a supportive management preferably with an entirely clinical educative responsibility.
5. The CF manager should monitor the effects of the CF team with regard to skills improvement; recruitment and retention; and quality of patient care.

This is the ultimate expression of the ideal CF. Whether each of these conditions will ever be met in a real CF is an open question. However, the point of this is to express a goal towards which advocates of the CF project can aim. The specific qualities and criteria for the ideal CF have previously not been quantified. This has left those who felt a need for educators to be in practice with a problem. What exactly were they asking for? If it is to have a skilled practitioner able to teach learners in practice settings then this is arguably covered by the “sitting with Nellie”, or in nursing terms the mentor, approach. Having a specific set of criteria which have been generated from historical, logical and empirical principles provides a powerful and useful model for those who believe that osmotic learning is not sufficient for the complex practical skills defined and the emotional support required by learners described by the CFs in the interviews section. The final discussion of the issued raised in the context studies and findings will be discussed further in the next chapter.

Discussion of Findings

Chapter 10: Discussion

Introduction to Discussion Chapter

The results section has logically developed the theories generated from the data as it progressed and has been discursively critical of the data and theories throughout this process. However, it remains necessary to have a separate discussion chapter in order to gain a little analytical distance from the data and to return to some of the issues raised in the context study.

Each of the stages of the research has produced its own ideas and an attempt at synthesis has been made towards the end of the findings section. This has been a progressive process but there is now the need to look down on all of this from above to discuss the overall results. The theory generated thus far from the observed data is that CFs can be defined by a set of eight traits and that knowledge of this model can help them to achieve an ideal type. The observations in the three cases showed that in two of these it was in various stages of travel in this direction. These case study areas had taken these measures as a logical consequence of the operational demands of the role. Thus the existing structure in these two areas did not meet the ideal type envisaged but was travelling 'naturally' in that direction because of the existing circumstances within which they were operating. However, in C3 the LEM role was not currently appearing to be as effective for various structural reasons and when mapped to the clusters it was not at the right-hand end of the continua in the diagram below (figure 37). For the purposes of this discussion it will first be necessary to undertake a critical reappraisal of the position of the researcher within the organisation being observed; secondly, the effects of the introduction of CFs on the oppressed socio-political position of nurses will be discussed; thirdly an attempt will be made to justify the cluster model further; fourthly, it will be possible to discuss whether the proposed conceptual route to the ideal type is necessarily the best way to achieve this; fifthly, the ideal type will be discussed with a view to its claim to be the best method of producing skilled nurses who will remain in clinical practice and produce better quality patient care; sixthly, the

possible adverse affects of a move to adopting this role across health services will be evaluated; and finally a diagrammatic representation of the cluster model and ideal type will be described as a possible tool to assist with the implementation of the most effective CFs into practice.

Critical Reappraisal of Insider Research

The position of the researcher as an insider within C1 was made clear in the methodology and results chapters. The researcher's statement of situation was important to him for reasons of honesty, theory and practicality. These issues will be dealt with in turn.

Honesty was important from the outset. The research was conducted by a lone researcher albeit under the usual academic supervision expected of a PhD student and the usual research management department paraphernalia to be expected of any study involving the NHS. Despite the veracity guaranteed by this dual checking the single researcher has more to prove than a team. Simply put there is less peer pressure to maintain genuine data for an individual observer than for a group who can be expected to check each other's findings. Consequently, the need for utter transparency is that much greater in this case (Bogdewic 1999).

Research theory is discussed at length in the methodology chapter. In this instance this potentially controversial position was justified using feminist (Chapman 1995, Lorde 1994) theory and ideas borrowed from social historical research (Samuel and Thompson 1990). The advantages usually described of being a situated participant researcher include trust, access and depth of understanding (Samuel and Thompson 1990). These certainly held during this case as will be seen in the practicality paragraph below. The disadvantages include problems of maintaining academic objectivity (Mannheim 1936). However, this is tempered by the use of previously published data; data collected for other uses and constant comparison within the study. Even if this were not the case the researcher makes no claims to objectivity.

Conversely, the subjective position of participant is explained and celebrated. This has

both theoretical and practical advantages.

From a practicality point of view this research would not have been possible in this form unless the researcher was known and trusted by the participants. Identifying the most important actors and gaining access to these busy clinical professionals as a stranger would have been difficult to say the least. As a known and trusted colleague it was an easy task to identify and access the personnel required (Gilchrist and Williams 1999). When interviewing them it was possible to discuss topics which they would have felt less at ease sharing with an unknown researcher. This was not simply because the researcher was a colleague but because he had shown himself to be someone who would use the data collected for purposes of which they would approve. The meetings accessed during the field observation phases of the research would have been difficult to gain access to and hard for a non-participant to justify the commitment over several years to attend. The observations were overt in that the participants were informed of the researcher's activity. However, they behaved in a way that indicated no reference to the research activity being undertaken. The participants being observed were in any case used to audits and other forms of observation in their work routine. The majority of field observations were taken during formal meetings at which minutes are taken and distributed. Consequently, any change in behaviour caused by their knowledge of an observer would be part of the usual train of events for a constantly observed and recorded event. Despite this, the researcher made efforts to reduce any distortion by explaining in the text the overt and consensual nature of the observations. This allows the reader to interpret any findings with full knowledge of the data collection method and any distortions it may have induced.

It is now possible to move onto the political implications of this research.

Liberation from Oppression

Menzies study of a London Teaching hospital from the late 1950s (1960) described an oppressed profession unable to see beyond the limits of its reified reality (Lukacs 1923). Education has been posited as the solution to this by Freire (1972). Similarly,

academic achievement and status, it has been argued by many nurses and other professionals interested in the profession, is the route out of this for nurses (Abel-Smith 1960, Dock and Stewart 1938). Nevertheless, despite being a HE based profession since the 1990s and a move towards graduate status by 2015, the social status self-identified by nurses (Whitehead 2007) and identified by the ONS (2008) remains at a lower level than many other health professions. This is not surprising when considering the continuing hierarchical nature of health services management (Marcuse 1964); the overwhelmingly female profile of the profession within a continued patriarchal oppressive society (Plumwood 1994); and the socio-economic position of the woman-worker within contemporary society where caring is valued less than other work (Tschudin 1999). Against this social, psychological and cultural oppression the clinical nurse especially needs more than a HE diploma or degree to lift her from repression. As discussed earlier in this thesis, direct physical clinical care can be seen within the reified view of the profession as a socially inferior aspect of nursing to loftier academic, management or consultative roles (Bore 2004). This conception of physical care as basic and something to move on from within a profession, which remains mainly at the bedside in the public imagination (Kalisch and Kalisch 1987) and in empirical measurement (NMC 2007b) is a problem. The CF provides a clear link between the theory and practice of nursing. By their presence alone as a nurse whose primary purpose is education situated in the clinical area they indicate the value placed on the knowledge of the nurse. More importantly, their position outside of the ward hierarchy, as a part of the clinical team but managed as part of team whose primary purpose is supporting learning rather than providing care, is crucial. This indicates that they cannot be counted on to submit to the ever present oppressive requirements of patients over those required to care for them. As many of them stated within their interviews this takes the role outside of the confines of the nursing situation and makes the post feel like a “dream job”. This challenge to the status quo is empowering for the learners within the clinical area as well as the CF themselves. This was indicated

repeatedly within the questionnaires from students and NQNs. Unexpectedly to the researcher this challenge to the ward hierarchy is not merely permitted by senior management but is supported. This appears to be because, as the CF in C2 made clearest, managers see CFs as a useful policy instrument. This provides them with a way into the frontline of care which would usually be mediated by middle managing ward sisters and matrons. Understandably, this makes the CF a valuable resource and makes the challenge to authority which they also represent a price worth the organisation paying. Consequently, the managerial structure of the CF team indicated at the beginning of chapter 6 enables the CF to be a conduit for policy implementation and an autonomous challenge to the oppressive local hierarchy. In addition to the revolutionary potential that this gives the role it also encourages RNs at a stage to progress in their career to consider this as an attractive potential post. The alternatives to this are either remote from the frontline of care provision or a part of the oppressive management hegemony.

When all of this is taken into account the CF role can be seen as a radical agent of change within a continuing repressed profession. Given its position within the workplace structure it is hard to imagine a more conveniently situated agent to move the profession towards the valued, equal status that it deserves. It is now necessary to discuss the practical steps required to put these essential workers into place.

Justification of Cluster Model

In the preceding results section the eight clusters were justified. It is now possible to examine this and the hypothesised ideal type CF further. The eight traits hypothesis is grounded in the data which emerged from the case studies. The basis of this case study evidence is solid in C1 and C2. It is less so in C3 due to lack of formal interview text and a poor response rate from questionnaire participants. Nevertheless, the overall organisational picture from C3 is fairly robust as it is in the public domain as job descriptions and verified by field observation access. As a consequence, as argued in the findings section, the validity and reliability of primary research in

isolation can be relied upon as a sound basis for this hypothesis. Is this model generalisable to the wider population with regard to education in practice settings? This is of course less certain. However, the long history of adult education indicates that problems with linking education to industrious activity have been an issue in vocational subjects in general as well as in nursing. The traditional approach has been to simply put learners into the workplace and hope that they pick up the job as they go along. A refinement of this is the 'sitting with Nellie' approach adopted in many apprenticeships and in nurse training up to the present day. However, this must change, as jobs become more complex and especially in industries such as health care where a minimum benchmark of quality is required to ensure that acceptable levels of healthcare related morbidity and mortality are maintained.

The use of these professional educators in workplace settings is not a new one. In nursing it can be traced back to at least the period of CTs from the 1950s (Bradshaw 2001a and Martin 1989). In other industries the use of specialist industrial trainers in factories and apprentice training centres was commonplace in the 1970s (Field 1996). However, this has often been seen as an expensive option by employers and one which can be cut back in times of difficulty. In nursing the removal of CTs was specifically a result of the move to Project 2000. In other industries this has been mainly due to economic recessions. The pattern of introduction of the role and then removal during leaner times was repeated again between 2000 and 2006. Some NHS employers including C1 had taken on CFs when the new Making a Difference Diploma nurse education programme was introduced around 2000. Not all NHS employers had moved to the use of this role (Mallik and Hunt 2007). Nevertheless, those who had decided to employ CFs examined their necessity when the funding for NHS services was reined in under Patricia Hewitt, the then Secretary of State for Health, in 2006 (Health Service Journal 2006). Some decided to remove the whole CF organisational structure as a result. The trusts under investigation in the study did not choose to do this despite the concerns of the CFs themselves that this would happen. The reason for this would

appear to be that the CF team was meeting the needs of the trust at a level which outweighed their perceived cost.

If viewed through the lens of the eight clusters the CF role can first be identified as such. This is more important than it may at first appear. As many others have commented the titles given to these roles are so varied that it is not always obvious that it is a CF that is being described. In addition there are roles which sound similar to the CF but which have an entirely different focus. The PDF for example at C1 is a role with an emphasis on introducing changes in practice rather than supporting students and NQNs in practice. On the other hand, the LEM role in C3 is a direct comparator to the CF role in C1 and C2 in that it is identifiable on each of the traits. There can be no doubt that in many ways the CF/LEM roles in each of the three case studies are different. For example many CFs and CFSNs in C1 are undertaking the role full time for one ward. In C2 this is in some cases true but some of them are also required to cover two community hospitals. In C3 the LEM only has four days per year to conduct the role whilst also undertaking a full-time position as a ward sister or senior staff nurse. However, the point is that they are somewhere on the scale for each of the clusters with no exceptions. This is not the case for other similarly named practice education roles, such as the PDF at C1. Other roles involved in practice education such as link lecturers and many LPs can also be excluded because they do not fall somewhere in the spectrum of the eight traits. This does not mean that each CF is an ideal type of the role but it does put it somewhere in the conceptual model which can then be moved in the ideal type direction by a participant or team of collaborators cognisant of the model and of the ideal type goal.

Is the conceptual route to the ideal type the best way to put effective ideal CFs in place?

This question is central to the thesis generated by this research. Almost without exception the learners supported their use and managers even when under financial pressure found them invaluable. However, this depended not just on the presence of

someone in a clinical educative role but on their position within the eight clusters model. If for example they are too far away from the learners' everyday life due to structural issues then their effectiveness drops and their support with it. Therefore, it can be shown that it is necessary to maintain the CF within the known boundaries of its effective position within the organisation and its relationships with others. This is what the eight clusters model allows the sponsoring organisation to measure. It appears that it is not just having someone with a clinical educative responsibility present but a set of interdependent requirements must also be met to a greater or lesser extent depending on the outside circumstances. The historical precedent for this was the CT. As Martin (1989) showed these staff lost the support of educators, staff and students as their role was diluted by the movement to predominantly classroom teaching. Their link with direct clinical practice was broken. When the changes brought about by the introduction of Project 2000 came about this weakened position became untenable. The pressures which were brought to bear on this kind of role in 2006 were less than those in the mid 1980s. Nevertheless, many CF type roles were lost. It appears that the ones which remained intact were the ones with the strongest relationship to the ideal type. The organisations which took these paths were not following the eight clusters model. However, they had, through experience and good fortune, hit upon winning formulas which this research has been able to uncover and model. Future organisations can then build on the experience of those organisations who obtained good results by the use of the model mapped on their success. Then the organisation can build a structurally stable and long lasting team of CFs. Nevertheless, the goal of introducing and maintaining a team of CFs is only of value if those CFs can make a useful product. The ultimate product of nursing is patient care. No matter whether the nurse has direct patient contact or not the final produce can only be quality patient care. The only difference between the nurse who is close to the patient and the one who is distant is the number of steps between that nurse and the final product.

Is the CF ideal type the best method of producing skilled nurses who will remain in clinical practice and produce better quality patient care?

The findings of this research indicate that this is the case. They have a wide positive influence on large numbers of frontline care providing nurses. Consequently, in a similar way to other nurses with a less than obvious role with patients it can be argued that their overall influence on the quality of care provided is greater than that of the nurse who provides care directly.

In this thesis it was decided to investigate the affects of CFs predominantly through the eyes of staff and student participants. This was partly, as explained, because of perceived difficulties in obtaining other measures of their activities. Previous authors have agreed with this stance including Ellis and Hogard (2003) who failed in their attempt to measure improved clinical skills through OSCEs. It is possible to design better OSCE type assessments of clinical skill and this would make an effective measure of clinical skill. However, the central issue is not the skill of the nurse but the effect of the use of that skill and other factors such as increased numbers of staff to patient ratios. This effect is known to be better quality patient care. It is not the case anymore that this is difficult or controversial to measure as commented by Faltermeyer (1999). There are accepted tools such as the essence of care benchmarks (DH 2003). From the evidence uncovered in this research there appears to be a linkage between skills improvement and recruitment and retention and the introduction of effective ideal type CFs. This could be linked to local Essence of Care benchmarks and national clinical audit measures of mortality and morbidity levels (DH 2006b). For ongoing assessment and evaluation of the efficacy of this role then these are already existing tools which could be utilised by the DH to monitor its productivity. The introduction of ideal type CFs and CFs which were elsewhere on the eight cluster continuum could be measured against patient care benchmarks directly rather than against the intermediate effect of improved nurse numbers and clinical skill ability.

The affects of the CFs can be measured and they have been measured. In C1 for

example part of the lead CF's activities was to keep track of the numbers of NQNs commencing and staying with the trust. Ratios of RNs to patients are directly related to improved patient outcomes in a list of morbidity indicators and to overall mortality levels (Kane et al 2007, Lankshear et al 2005). Therefore by solidly evidence based inference if CFs are leading to more RNs remaining on wards then the quality of patient care will improve. However, to be absolutely sure of the best use of resources it would be necessary to attempt various methods of improving the care and measuring them against each other. If it is assumed that the only reason for having and keeping a team of CFs is to improve skills and to increase recruitment and retention then this would be the logical test for their efficacy. However, as stated above we can be sure that they improve these three measures. There are other advantages of the deployment of CFs in sufficient numbers such as the improvement of relations between trusts and HEIs which make their use sensible even if they are not the single most effective way of improving patient care. Despite this with the introduction of any new role there are likely to be adverse as well as positive affects. This will now be looked at.

Adverse affects of a move to adopting this role across health services

There can be no doubt that there would be beneficial affects of introducing the CF role across health services. However, there are also likely to be problems associated with this as with any other change. In the interviews and in previous studies there were several problems raised. These included power conflicts with senior staff on wards and with HEI staff. This would become one of the eight clusters and is an important consideration when deliberating the long term viability of the CF role. However, it is not the survival of the role which is in question here; rather, it is the side-effects of introducing the CF to an existing structure.

Both of the existing groups mentioned above are likely to see the CF role as an infringement on their territory. The support aspect of the role is part of the ward sister's role and the educative aspect of facilitation is part of the link lecturer responsibility (Day et al 1998). In part these issues, especially the conflict with ward

sisters, were responsible for the demise of the CT in the 1980s. However, given the appropriate support structures the CF can be seen as part of the ward team rather than as the sort of alien invader which the CT came to be seen as (Martin 1989). In Mallik and Hunt's study for example they found that the PE could be seen either as "a team member, guest or stranger" (2007:1852). If the CF is given the tools to make themselves an ideal type on the eight clusters scale they can be seen as a "team member" in each instance. As long as this does not mean that they abandon the educative staff focused role in favour of the patient care default of all RNs (Gerrish 1990), this makes them more likely to be seen as a partner and less likely to be seen as a threat to the overall business of the ward.

With regard to the CF's relationship with the HEI based link lecturer there are other issues to be addressed. In Ellis and Hogard's (2003) study the link lecturers were the only group which appeared to be hostile to the role. In some ways this is less of an issue to a trust employed CF than hostility from staff they are working in close proximity with. However, it remains a problem because the students who will be on placement and requiring support from the CF will be influenced by the lecturer's views. If they are sympathetic to the CF role then the student is more likely to be in favour. If the CF takes the position of attempting to link theory to practice then there is a role conflict with the link lecturer. However, in the observation stage of this research none of the hostility which Ellis and Hogard found was evident. This could be due to the amount of time which the CF role has been in place at the case study areas, which in C1 is approaching ten years. In this time the CF role has become seen as a part of the educational furniture and as a consequence they have shown themselves to be an important part of the team rather than a threat. The appreciation of students is shown in almost every evaluation form from placements where CFs are based (PLT1 2009). These evaluations are discussed at PLT meetings as described in the results section and in the published minutes of the PLT (PLT1 2008). Consequently, the link lecturers get to see the benefits from students' perspectives as well as having face to face

discussions at regular meetings (Brooks and Moriarty 2006, Chapple and Aston 2004,) with the CF/CFSNs who make up the majority of the representatives from practice at these events. The potential role conflict with these two groups of staff can therefore be influenced positively by CF activities. This can alleviate the adverse affects in favour of the beneficial.

Another concern is that by removing these experienced RNs from direct clinical patient care duties to the less direct clinical education role, care is left to more junior staff. As a consequence the overall quality of care could fall. However, the CF/CFSNs interviewed all said that they would have moved to another position if the CF role had not been created. Therefore, it is probably more likely that the CF role is retaining these RNs close to the business of patient care rather than removing them from it. During the time that CFs have been in existence the options for nurses to move to roles away from the traditional ward nurse have increased exponentially. This has been deliberate government policy (DH 1999 and 2006b). The introduction of nurse specialist roles of various kinds outside of the ward and often outside the hospital have been a factor amongst others such as the increasing age profile of nurses which have led to nurses leaving the ward area earlier in their career than may otherwise have been the case. This has left wards often understaffed and with an increasingly junior profile of RNs. The CF role in this overall picture would appear to give the experienced nurse a way to progress without leaving the frontline of inpatient care. Clearly, from the comments of the CF/CFSNs in the interviews this is a direction in which a significant number of nurses would like to travel. Consequently, the choice is not between becoming a CF and remaining on the ward as a direct carer. It is a choice between moving away from the ward altogether and remaining as a CF/CFSN. The choice of a nurse at a certain point in her/his career is to move to a nurse specialist role away from the ward team or to remain as a CF. Thus, if the CF team is correctly designed with sufficient CFs to be a “team member” rather than a “guest” or “stranger”, far from removing a valuable team member it is a method of retaining them.

The cost of CFs has often been cited as a reason for either not having them or for removing them from the workforce. This could especially be seen as an issue when considering that the ideal type suggests that they should be employed by service providers rather than educational institutions. This makes it a greater issue because the central purpose of the trust is patient care rather than education and the CF is focused on education of learners in practice more than the direct care of patients. However, the cases put for recruitment, retention and skills improvement have been used by CFs and their leaders to successfully support their retention despite often difficult economic conditions in the NHS. These are no longer short term funded experimental positions. They are now considered a permanent part of the healthcare structure in these institutions. In addition to this the argument that the CF role keeps experienced staff on the wards rather than it being an additional expense means that it can be seen as saving expenditure on re-training staff to replace the experienced staff who would otherwise leave. In C1 the CFSN in particular is closest to the model's ideal type. From the outset this role had no additional funding. As a result, despite the ward based CFSN having external management from a directorate lead CF, the funding came from the existing ward budget. This gives them the ability to remain outside of the day-to-day responsibilities of ward management without being removed entirely from the ward team. The direct linkage of ward budget to the CFSN's ability to produce the required ward outcomes of improved patient care provides a clear view of the benefits and detriments of the role to the team they are working with. On the whole, within this model, the CFs have been retained.

The funding for CF type roles has come directly from general trust, directorate or ward budgets for care provision. This does not mean that the NHS does not provide funding for practice education. Large sums are allocated to this purpose and dispensed by SHAs through the Multi-Professional Deanery (MPD) as discussed in the field observations section. This funding has been seen as provision for students rather than for NQNs. However, in the Darzi Report the promise has been made to make

preceptorship compulsory and to provide funding to support it (DH 2008b). The commitment to this support for NQNs appears to be followed by both political Parties as well as the NMC. This shows that far from being seen as an expensive luxury the CFSN is seen as an affordable necessity.

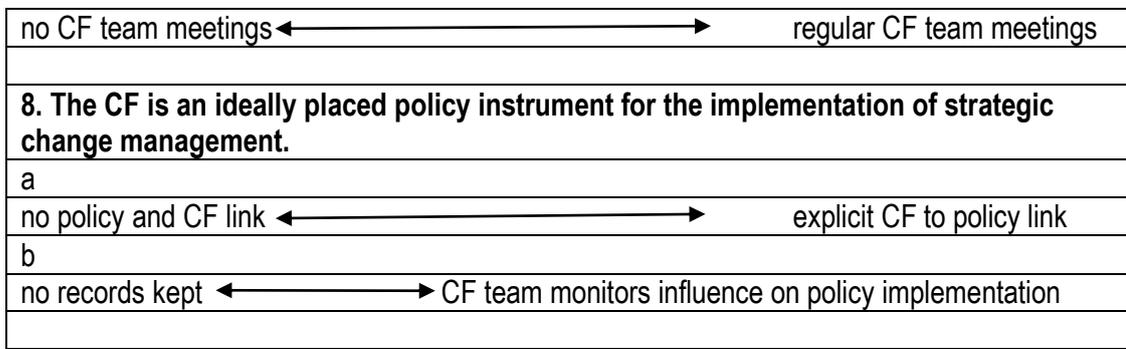
Overall, the adverse affects of CFs whether they are related to role conflict, attrition or financial detriment can be countered within the framework of the eight cluster model. This can be justified either from the position of supporting the CF role as something worthwhile in itself or from a utilitarian perspective of ensuring the maximum amount of good quality nursing care for patients throughout the health sector. This has been the goal of nurses since Nightingale’s time as was seen in the nursing context study. The support of skills improvement in the workplace by specified staff such as CTs in nursing and industrial trainers in other sectors is a logically, historically and empirically supported extension of the traditional “sitting with Nellie” approach to apprenticeship training. As such it is an uncontroversial move to devise methods for encouraging the deployment and maintenance of the modern CF. A suggested method for doing this based on the conceptual model and ideal type will now be discussed.

The Practical use of the Conceptual Model of CFs

The eight traits discovered to identify CF roles on a continuum has been generated from observation of existing circumstances. As previously discussed this is useful in order to provide a specific definition within which to place or exclude roles which are not otherwise universally identified. The model modified from this below is not merely to define or exclude CFs. It also places them on a continuum for each trait. Once the CF has been mapped to this diagram efforts can be made to move towards the ideal type.

Figure 37: CF Cluster Diagram
1. CFs are employed by care providers such as NHS trusts rather than educational institutions such as universities.

a	university employed	←	→	trust employed
b	short term funded	←	→	substantive
2. The supportive presence of CFs encourages recruitment and retention of staff which leads to improved nurse to patient ratios and better patient outcomes.				
a	purely educative role	←	→	learner support role
b	only students	←	→	all learners
3. CFs suffer from problems with role definition due to their position between education and clinical patient care.				
a	no clear role	←	→	facilitator job description
b	no specified time	←	→	all work set as CF time
c	patient care responsibilities	←	→	learner support responsibilities
4. These roles are a logical outcome of the organisational changes engendered to produce more and better skilled nurses to provide better patient care.				
a	no explicit link to organisational objectives	←	→	explicit link
b	CFs do not monitor activities	←	→	CF team keeps careful records
5. CFs help staff to improve their clinical skills and thus to improve the quality of patient care.				
a	no evidence	←	→	CF team monitors skills improvement
b	no specific training	←	→	CFs provide training sessions
6. CFs provide a link between theory and practice within an equal educational framework.				
a	CF seen as a helper to link lecturer	←	→	CF as equal partner
b	CFs not invited to educational meetings	←	→	CF act as Chair at joint meetings
c	no qualification requirement	←	→	post-grad teaching qualification
7. CFs have varying status and power dependent on local factors often outside of their control. Their position is better when part of an organisational framework designed to provide practice based education and support.				
a	no CF structure	←	→	visible CF team
b	no CF leader manager	←	→	lead CF as CF team
c				



The diagram above shows the use in which the cluster model can be put.

Identifying where the CF is on each continuum is a matter of observation and judgement assisted by the explanation in Appendix 10. The diagram is designed to be used as a tool for CFs and their supporters to map either existing or proposed models of CF organisation. Nevertheless, many of the criteria are objectively quantifiable and the ones which are not could be answered reliably by appropriate actors in the trust or HEI. Either way it can be used to encourage progress towards the ideal type identified below. The use of the diagram is explained in more detail in Appendix 10.

Once the CF or CF team is mapped to the diagram the most appropriate action can be taken to move them along the various continua toward the right of the spectrum. The point of this is to provide an evidence based model for those wanting to improve clinical education in order to enhance their argument. It is useful also to have the utopian aspiration of the ideal type but is not usually possible to move from an existing set of cultural, economic, social norms to those of an idealistic goal (Sargisson 2000). What is necessary for this teleological project is to be able to find the existing position of the actors within a realistic model. From that position it is possible to move the levers of influence in the direction indicated to reach the proposed destination. That final objective is easily articulated and is also evidence based as argued in the previous chapter.

The Clinical Facilitator Ideal Type Definition

Each of the identified traits of the ideal type (see Figure 36) is a projected perfection of those identified in the existing CFs and teams in the case studies and in the literature. This perfection is a logical extension of the aspects of their identified

cluster which could either be shown to produce results or which a convincing amount of participants believed were desirable. As stated in the previous chapter this is a less solidly based definition than the eight clusters model. However, if as argued, it is necessary to have a goal as well as a way to identify that a CF is present, then a definition of that goal is required. It should be noted that the ideal type is one as envisaged rather than a description of an existing state. Therefore, future changes in the real world may well modify this. Whether this is the case or not is less important than that an ideal type is identified, agreed and aimed for by those who seek to establish this role universally. This conceptual model of identifying existing CFs and the ideal type to aim for are offered as potential contenders for this position.

Chapter Conclusion

The concluding chapter will sum up the findings from the thesis. It will be followed by some recommendations for action based on the arguments presented.

Conclusions and Recommendations

Concluding Chapter

This chapter will summarise the thesis. It will be followed by recommendations for practice and research based on the findings.

Summary

The thesis consists of the following: a substantial two chapters of context studies which aim to situate the research subject in time and place; a literature review limited to a canon of research papers which are intended for later use in the multi-method research; the methodology which aims to justify and outline the use of an inductive multi-method approach from philosophical principles; a set of five research findings chapters which are structured around the inductive research process; and a discussion chapter which builds upon the debates generated in the research chapters to postulate a model of CF definition and encouragement. The summary which follows will mirror this format.

Context Studies

The CF is a product of over one hundred years of adult education and nursing education history. Therefore, it would not be possible to consider the effects of the role without first examining this backdrop. The first chapter examines the historical basis of adult education. It commences this exploration in the nineteenth century with the debates between liberal and vocational approaches which raged then and continued to feature throughout the twentieth century and the beginning of the twenty-first century. However, this historically based account is not limited to ideas of history as a dead backdrop to the present. The context is presented as a way of situating clinical nurse education into the wider social, political, economic, cultural and educational agenda. This includes current political policy discussions as well as those of the past. This remains a political issue of some importance not exclusively around the old issue of liberal education versus vocational training but also learner inclusiveness and the status of the education provided.

Many of these debates in adult education have been transgressive in the real sense of the word, challenging rather than modifying the liberal-capitalist hegemony. This has always been a well known aspect of continuing education. Whether practitioners have agreed with this aspect of the field, or been strongly opposed to it, they have accepted its presence as a force to be considered. Nursing has often been seen as a conservative profession or even that most submissive of descriptions, a vocation. However, this has never universally been accepted in theory or practice. The historical context study of nursing and nurse education provides evidence of continuous battles both within and outside of the official arena. The position of nurses and nursing within the hegemonic structure is of some importance as they are oppressed on at least the two fronts of sex and class as a group. This matters because it often leads to decisions being taken on nurses' behalf rather than by them. The opposition to this, when it is acknowledged, is often seen as a recent phenomenon. The study shows that there is evidence of this strain throughout nursing history as it is throughout historical investigation of most oppressed groups. Within nurse education specifically, the position of those who sought to provide education in practice rather than in the lecture theatre has been seen as socially inferior to that of classroom nurse teachers. This culminated in the removal altogether of CTs in the move of nurse education to HEIs in the 1980s. However, this is a complex area of social understanding as many nurses believe that clinical skills are the most important aspect of nurse education. These two social forces have been responsible for the fact that, during most of nursing history, up to the present, the majority of clinical education was done by the 'sitting with Nellie' approach. As explained in the adult education section this entails a student nurse observing and assisting a skilled practitioner as they perform their daily duties. The practitioner is unlikely to have any formal teaching qualification beyond the most basic permitted to perform the task. As a consequence the student's clinical education relies on luck, as to whether they come across an enthusiastic teacher, or whether they are just used as an extra 'pair of hands'. The context study concludes with the various attempts

to provide specifically qualified clinical practice teachers into the workplace. This culminates with the confusing current position where in some areas there is provision and in others not, and where there is a plethora of nomenclature for the staff who do perform these responsibilities and no agreement as to who pays for them or employs them.

Literature Review

The literature review chapter has a specific purpose separate to that of the historical context studies presented previously. A great deal of literature has been examined, described and evaluated in the historical process of the context studies. Nevertheless, the literature review chapter is a more focused attempt at examining a specific canon of recent articles which look specifically at the CF role in the UK. These are later used as source material in the third chapter of the results section. This is a slightly unconventional approach and efforts are made to justify this using Glaser and Strauss' GT approach to inductive research. The approach to the research was highly influenced by their ideas as was to become clear in the methodology chapter. Nevertheless, the literature review chapter begins to examine the specific origins of the CF role rather than adult education, nurse education, and clinical education in general. There is a detailed description of the technical methods of selecting the canon of literature to be discussed. Seven central articles are selected and these are described and briefly discussed as to their reliability and validity.

These seven previous studies have several issues in common. These include the short term nature of many of the roles; the concerns over role security which come with it; the difficulty of showing the effectiveness of the role; and concerns regarding status in relation to clinical and lecturing staff. These issues would also be evident in different ways for the primary case study research done for this thesis.

Methodology

Having set the scene, during the first three chapters, in which the research will

take place, the methodology section outlined the case for proceeding using a multi-method approach outside of any particular paradigm. In order to approach the research from such potentially uncertain footings it was felt necessary to gain a secure epistemological grounding. Therefore research philosophy and logical process is examined and discussed. This leads to discussion of what scientific research is and where the demarcation lines can be drawn between empirical scientific understanding and metaphysics. It is argued that the form of inductive theory generating research, external to any specific paradigm, is most appropriate when investigating a novel subject of this kind. It is apparent from the historical and contemporary literature that no dominant paradigm exists regarding clinical nurse education in general. Therefore research into the CF aspect of this is certainly in the arena of “extra-ordinary science” as described by Kuhn. This allows the researcher to develop theory from observation of the data rather than attempting to nullify existing theory. As CFs are a new phenomenon, they need to be observed and questioned with an open mind in order to allow their praxis to suggest theoretical models.

With the philosophical underpinning dealt with, the ideas of Glaser and Strauss are used as a guiding and justifying approach. Neither, Strauss and Corbin’s, nor Glaser’s specific versions of GT as expounded in the 1980s and 1990s are specifically adhered to. Glaser’s theoretical sensitivity approach is referred to but is not slavishly followed. Instead, a pragmatic methodological regime tailored towards the specific subject matter to be illuminated is designed. The research process undertaken could be more accurately, though less helpfully described as multi-method. This is a less useful definition than the earlier one of a modified GT because multi-method allows any collection of methodology to triangulate data to a theory. Whereas, GT is specifically inductive and qualitative as is the research within this thesis. Therefore to claim some resonance with GT, while not being tied to that specific grand theory is a more informative label.

Ethical, legal and bureaucratic considerations were described and discussed in

this section. The ethical and legal considerations of conducting a research project involving overt observation and questioning of consenting adults with full mental capacity may appear minor. However, the bureaucratic process of achieving ethical and research management approval was similar to that of a hazardous drug trial on vulnerable patients. This was because these were NHS case studies and as such all research has to be approved by NHS research management and ethics committees using the same format.

In line with Glaser's approach, that 'all is data', a wide overall geographical and historical study area is set. However, the bulk of the primary research is conducted within three case studies. However, data is used from the copious previously compiled resources which straddle two centuries and all of the UK.

The stages of the research process are described and justified. This encompasses the multi-method approach and uses the logical inductive process described earlier. In line with Glaser and Strauss' ideas of generating theory from the data the overall plan was not drawn up until after the research had been completed. In order for the reader to obtain a flavour of this process it is provided as a single page flow diagram.

Research Findings

The research findings are presented as five discrete chapters. These follow the stages of the flow diagram described earlier. Thus, they consist of pilot study; interview analysis; literature analysis; questionnaire analysis; and field observations analysis. These will now be summarised.

Pilot Study

The pilot study was an initial overt observation over a period of a few months at the beginning of 2005. This took the form of a series of memos taken immediately after observation while the researcher was embedded in the action. The researcher was at this time a lead CF within the trust. This allowed him to obtain observations at the most interesting and informative meetings and exchanges related to CFs. The data collected generated a set of themes and allowed the observer to construct an initial

hypothesis. These themes and this hypothesis would be used to design the next part of the process.

Interview Analysis

The interviews of seven practising CFs at Cases 1 and 2 were to be the centrepiece of the research project. Semi-structured interview questions were designed from the findings of the pilot study. The interviews took place between the beginning of 2006 and the middle of 2007. During this period considerable changes took place in the NHS landscape. The main feature was the reining-in of a period of several years of uninterrupted growth in health spending by the Government. Trusts were told to find efficiency savings at an unheard of rate and as a consequence staff morale fell dramatically. However, this external influence was taken into consideration when analysing the findings. The interviews were transcribed in detail and qualitative coding software was used to assist the selection of themes and similarities in evidence.

The initial hypothesis from the pilot study was supported and a set of themes was generated. The next stage of the research would be to test these against the existing literature as planned in the literature review chapter.

Literature Analysis

In this chapter the existing literature was set against the themes generated by the interview analysis. The process used was to present the researcher's own description and discussion of the previous literature as data from which to generate theory.

From this evidence an 'eight clusters model' to describe the CF was devised. This encompassed the previous hypothesis and thematic approach into a single descriptive hypothesis, that CFs could be defined or excluded by mapping eight descriptive clusters to them. This would be tested again at the next stage of the research.

Questionnaire Analysis

The questionnaires were devised from the findings of the previous three stages and especially from the eight trait model described at the end of the literature analysis section. The participants questioned in this case were student nurses and NQNs. These

were the main recipients of the CFs' facilitation and therefore were essential actors from whom to gain information. As there are relatively large numbers of them even in the limited case studies under investigation a questionnaire approach seemed sensible. Nevertheless, it was decided that in line with the rest of the research process the analysis would be done using a qualitative approach. This was achieved by using an interpretive method of analysis similar to the other stages. The outcome of this questionnaire triangulation was to support the eight traits model more securely. It was then decided that all other available first hand observable data should be collected and analysed by the researcher. This would be particularly useful in order to revisit the activities of the organisations' management.

Field Observations Analysis

The pilot study had generated useful results. Therefore when it ended the researcher took the decision to continue the overt consensual observation process alongside, and contemporaneously with, the other stages. Again, these observations and memo takings were done using the same forms and the same outlook of collecting data as it presented itself. Towards the end of this process it was possible, as the theories emerged from the other stages of the research, to be more selective of events to record as memos. In two cases it was also possible to negotiate meetings with national politicians in order to check data. The culmination of this phase was to hypothesise not merely a set of criteria on which to hang a definition of CFs but also to provide the utopian aspiration of an ideal type CF to aim for within the descriptive model. This became possible because of the level of certainty which the multi-method approach to the research subject could lend to the overall analysis. The final stage was to discuss these logically derived but complex set of analyses and hypotheses.

Discussion

The discussion chapter provides a place for reflection and overview of the data which has been collected, analysed, interpreted and used to generate theory, in a headlong logical dash of GT production. Each step has been logically based and

empirically grounded, but can it all stand up to overarching critical analysis? The approach that the researcher takes to the discussion chapter is to set a series of considered questions to the findings. These questions are generated by taking the whole series of research stages into account. As a result, some of the primary data is returned to and some new sources are examined, as well as the central purpose of examining the research analysis afresh. The summing up of the discussion is that the clusters model and ideal type are justified. However, this is now taken further in order to provide a working model of where a specific CF or CF team is within the cluster model, then to use this in order to provide a map along which to move them towards the ideal type. This solidly grounded teleological model is the final culmination of the thesis. The research presented is an evidence based addition to the existing body of knowledge. The CF mapping model and aspirational ideal type is intended to add to the existing body of practice. It just remains to suggest recommendations for further action and research in this area.

Recommendations

The recommendations for action and further research are inherent in the discussion and conclusion chapters. However, it is desirable to briefly lay these out in a recommendations section.

Recommendations for Action

The move to compulsory preceptorship, which will be implemented in 2010 (DH 2009), will make the use of CFs an even more attractive proposition to trusts than they are at present. The results of this thesis are important for those managers in a position to commission these staff and to those, such as trade unionists, who would seek to influence those in positions of power. It appears likely from the analysis of the findings that CFs will be useful to trusts in bringing about the required changes and in supporting front line staff in the increased workload that this new level of responsibility will bring about. Therefore, the use of the models devised in this thesis for identifying and implementing a successful CF role into an organisation's structure is recommended. This can be done by mapping existing or proposed roles to the diagram presented previously (Figure 37) and attempting to move the sliders towards the values on the right of the continua.

Ideally, the Department of Health and the professional regulator should recommend or stipulate the use of CFs in every trust. If this took place there would be no fear of being redeployed back into the direct-care workforce during times of financial pressure. This would enable an even more secure position for these valuable staff and encourage other equally highly qualified staff to join their ranks. The design of the role should be based on the ideal type identified in this research (see figure 36).

Recommendations for Further Research

There has been a reasonable amount of research conducted on the effects of this role. This set of case studies adds to that body of literature and puts forward a theory that these staff can be defined by an 'eight cluster model'.

The limitations of this thesis are that the primary research has been restricted to a

single English county. A repeat of the entire research project in another county or amongst a larger set of participants would be the usual recommendation following the scientific process for repetition to verify results. However, the inductive nature of this research would make repetition difficult to achieve. This is because the outcomes of this research would be known and the generation of theory from the data would be compromised by this knowledge. Nevertheless, it would be possible to repeat the data collection methods in other geographical areas. However, the field study aspect would probably be redundant because of its opportunistic nature. This was of great benefit for inductive research but for the deductive process which should follow it would be less useful. The semi-structured interview questions and the questionnaires could be repeated usefully. If similar results were obtained at other trusts this would add weight to the existing theory. However, nullification would not be possible by this method as the case is in its own context of time and geography which cannot be repeated.

A more useful approach would be to design methods to test the validity and reliability of the conceptual model and ideal type generated. This could be done by setting the cluster model against similar roles and testing their respective effectiveness. To test the ideal type it would be possible to design roles around this and collect data for the effectiveness of this model of CF against an area without a CF or with one which did not match the ideal type.

There is always possible further research which can usefully take place. However, this thesis is the culmination of six years of study which has considered the activities and effectiveness of CFs and their learners. It has questioned and observed the students, NQNS, CFs, their managers and other participants. It has taken into account the historical and contemporary political, social, economic, cultural and professional framework. The research is limited, as is all research. However, its conclusions can be counted on as solidly evidence based and reliable.

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Appendix 1: CFSN Job Description 2004

Name:

Job Title; Clinical Facilitator Staff Nurse

Reports to: Lead Clinical Facilitator Nurse

Ward / department:

Directorate: Medical Services

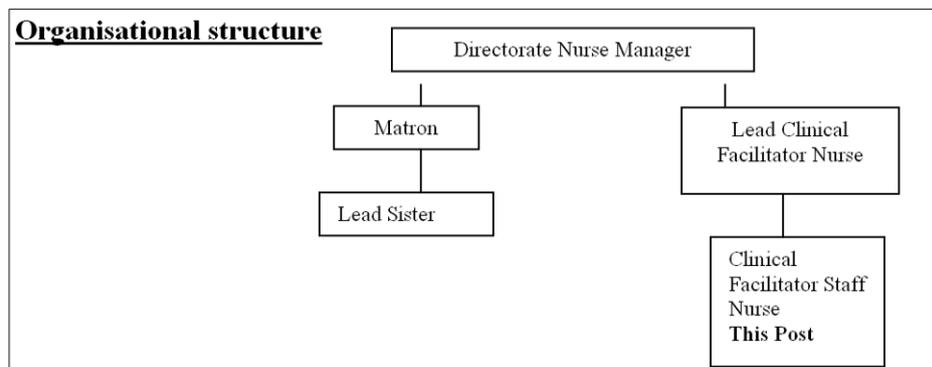
Job Purpose

To facilitate the development and assessment of students and nursing staff within the clinical area in order for them to achieve learning outcomes.

To provide advice and support to junior staff in the delivery of high quality care and actively support the Lead Clinical Facilitator in delivering educational programmes.

Dimensions

This post has no direct budgetary responsibilities, but there is an expectation that the individual will have an understanding of resource issues and how they are managed. The postholder deals with chronically ill patients within the hospital environment. There is a clinically and educational component to this post.



Key result areas

Clinical

1. Support and advise learners in the process of identifying the care needs of a patient with complex problems.
2. Assist junior staff in prioritising, implementing and evaluating patient care in accordance with Trust policies, procedures, protocols and guidelines.
3. Promote and develop the use of evidence based practice to improve the out comes of patient care.
4. Contribute to the development of health promotion /education strategies and take every opportunity to ensure they are implemented, making use of all available resources.

Professional

5. Initiate the introduction of new ideas and ways of working and act as a source of information and advice in specific areas of practice to the benefit of patient care and the development of the service.
6. In accordance with professional codes maintain own professional development and competence to practise whilst actively supporting other members of the team with their own development.
7. Has an understanding of clinical governance and is proactive in the development of a culture that is

committed to innovation and quality improvement through the use of research and audit.

8. At all times ensure that own actions support and promote equality, diversity and the rights of patients, the public and colleagues within the health care environment.

Managerial

9. Identify hazards, assess and categorise risks where appropriate developing and implementing control measures to prevent further risk.
10. Make use of all available methods of communication to monitor and contribute to the development of effective communication systems, taking action to resolve problems when communication fails within the health care team, including external agencies and with patients and their significant others.
11. Contribute to the development of networks and work in partnership with all members of the health care and educational teams both within and external to the Trust to ensure continuity of care for the patient.

Educational

12. Facilitate the development of staff in the ability to manage and influence effective use of available resources (people, equipment and stock) taking into account ongoing needs and potential problems.
13. Assist in the development for learners programmes of support taking into account both the needs of the service and the aspirations of the individual practitioner under the direction of the lead CF.
14. Work alongside students and identified staff in the clinical area to support their learning outcomes and understand the relationship between theory and practice.
15. Regularly visit all student and novice nurses in the base clinical area to collate information for the Lead Clinical Facilitator.
16. Provide advice to mentors and preceptors as required and refer to the lead CF.
17. Provide progress written reports on students and staff as required.

Internal and external relationships

Internal

Other Nursing Staff
Consultant and Medical Staff
Other members of MDT
Other hospital wards/depts
Nurse Specialists
Lead Clinical Facilitator Nurse
Practice Learning Team

External

Other Hospitals
Community nursing staff
Practice Nurses
Ambulance staff
Social Services
University Staff

This job description outlines the duties as currently required but may be amended by mutual agreement to reflect future developments in the service and the impact of new technology on the role. Appropriate training will be provided to support essential additional skills required.

It should be noted that this is a core job description and is the minimum required of a Senior Registered Nurse. It may be added to by the directorate in line with the requirements of an individual post.)

Signature of post holder.....

Date.....

Signature of line manager.....

Date.....

Appendix 2: Field Observation Form

CF Study Field Observation Memo Form	
Date	No.

(Bogdewic 1999:59)

Appendix 3: Semi Structured Interview Questions

Questions for interviews

What do you do? Or what is your role? [open ended]

The intention of this question is to gain an understanding of the facilitators own explanation of their job.

What led you to fulfil this current role? [open ended]

This is designed to firstly find some common or disparate answers. The extent of similarity or difference may be indicative of common sources of practitioner. This is intended to aid the researcher in interpreting their further answers.

Why do you think that your role was created? [open ended]

The researcher has some insight into the introduction of these roles. The drivers appear to have been mainly to do with the previously mentioned theory/practice gap and need to recruit more nurses. However, the participant may have other thoughts on this. If so what are they and are they or the researcher's explanations widely held by this group of staff as a "creation story".

What is the primary purpose of this role? [open ended]

Similarly this is to investigate the researcher's hypothesis that the primary purposes are recruitment, retention and skills development. Do the participants share these beliefs?

Does the role improve clinical skills? [closed] If so which ones? [open ended]

This and the following two questions are designed to discover the participant's views on the specific areas of interest to the researcher. These may be covered in previous answers or may not.

Do you think that the role affects the recruitment and retention of newly qualified nurses? [closed]

If so in what way? [open ended]

See previous. The question is specifically aimed at newly qualified as the researcher believes that the recruitment and retention of newly qualified practitioners is primarily reliant on support in practice.

Do you think that the role affects recruitment and retention of experienced nurses? [closed] If so in what way? [open ended] {possible supplementary questions: does it improve retention by support or by offering another route for senior SNs to aspire to}

See previous. This question is intended to find out whether there are any ways in which the role can encourage or discourage experienced nurses.

Does the introduction of this sort of role impact on the authority of the ward sister? [closed] If so in what way? [open ended]

There has been much debate about the hierarchy of nursing and the introduction of new roles. This question is designed to elucidate the debate from the perspective of the participant as a representative of new practitioners.

Which grades of staff do you support/facilitate/teach? [open ended] e.g. HCAs, SNs, NQNs, students.

This is to gain insight into the position of the participant within the organisation from another perspective. The role is diverse and changing. Therefore this is to examine where the focus of attention is for this participant.

What do you think of the quality of pre-registration nurse education/training? [open ended] e.g. does it provide nurses able to meet the needs of patients and service? Is it improving or getting worse?

One of the key reasons for this research is gaining insight into the debate about the preparation of nurses for practice. As these staff are involved in this process it is most important to find out their views on this.

Does the organisation provide sufficient resources for you to fulfil your role? [closed] If not then what should be provided? [open ended] E.g. do you have admin support or clinical assistants etc.

This is intended to discover how well the participant believes that they are supported by their organisation. This indicates whether they are in a position which has been stipulated by the Department of Health without the support of local management or which has grown from local need.

Current events move the focus from the recruitment and retention we've been discussing to cutbacks and redundancy. How does this affect what you do?

This question came as a result of changes in the socio-political climate away from recruitment and retention towards financial cuts and consequently a halt to recruitment as staff are the largest expenditure.

Appendix 4: Questionnaires Regarding Clinical Facilitators

Student Nurse Questionnaire Regarding Clinical Facilitators

Name of Placement

Please answer the following questions with reference to your own experiences on placement.

Questions	Please Tick (✓) Your Answers		
Was there a Clinical Facilitator Nurse (CF) on your most recent placement?	Yes	No If no please go to question 5	Don't Know
Was the CF there to support ...	Students	Mentors	Don't Know
Was the CF there to teach clinical skills?	Yes	No	Don't Know
Does the role of CF improve clinical skills on the ward?	Yes	No	Don't Know
Would you rather have a placement with a CF?	Yes	No	Don't Know
Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?	Yes	No	Don't Know
Most mentors are Staff Nurses or Sisters. Would you prefer to have a CF as a mentor?	Yes	No	Don't Know
If you have any further comments about the role or impact of Clinical Facilitators please write in the box provided below.			

Newly Qualified Nurse Questionnaire Regarding Clinical Facilitators and Similar Supportive Roles

Location and specialty of First RN Job

Please answer the following questions with reference to your own experiences in your first job. Where CF is referred to below please answer this with reference to any clinical educative support roles such as that of “Learning Environment Managers”.

Question	Please Tick (✓) Your Answers		
Was there a Clinical Facilitator Nurse or similar role (CF) covering your most first workplace?	Yes	No If no please go to question 5	Don't Know
Was the CF there to support ...	Students	Mentors or preceptors	Don't Know
Was the CF there to teach clinical skills?	Yes	No	Don't Know
Does the role of CF improve clinical skills on the ward?	Yes	No	Don't Know
Would you rather have a job with a CF supporting the students there?	Yes	No	Don't Know
Would you rather have a job as a newly qualified nurse on a ward with a CF to support you?	Yes	No	Don't Know
Most mentors are Staff Nurses or Sisters. Would you prefer to move the mentor role to CFs?	Yes	No	Don't Know
If you have any further comments about the role or impact of Clinical Facilitators or similar supportive roles please write in the box provided below.			



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DE22 1GB

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Participant Information Sheet

Study title

An Investigation into the Effects of Clinical Facilitator Nurses on Medical Wards

Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The study is being done at the behest of the medical directorate nurse manager in order to evaluate the introduction of a new nursing role. A secondary purpose is to compare provision at the Derby Hospitals Medical Directorate with similar acute environments in other Trusts. The author is undertaking the research as part of his PhD in Adult Education.

In recent years hospital Trusts across the country have introduced practice based teachers or advisors in order to support an influx of inexperienced nurses. The study will attempt to illuminate the effects of this change in practice.

Why have I been chosen?

You have been chosen because of your work role as a clinical facilitator or similar.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and a consent form to sign. If you decide to take part you are free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you take part you will be asked to participate in a 30-minute interview at your place of work at a venue of your choice. The interview will be based on a series of questions and this conversation will be recorded on audio tape and later transcribed.

Will my taking part in this study be kept confidential?

Your participation in this study will be confidential and anonymised. Any audio tapes will be stored securely.

What will happen to the results of the research study?

The research will be used as part of my PhD and academic publication of the results will be sought.

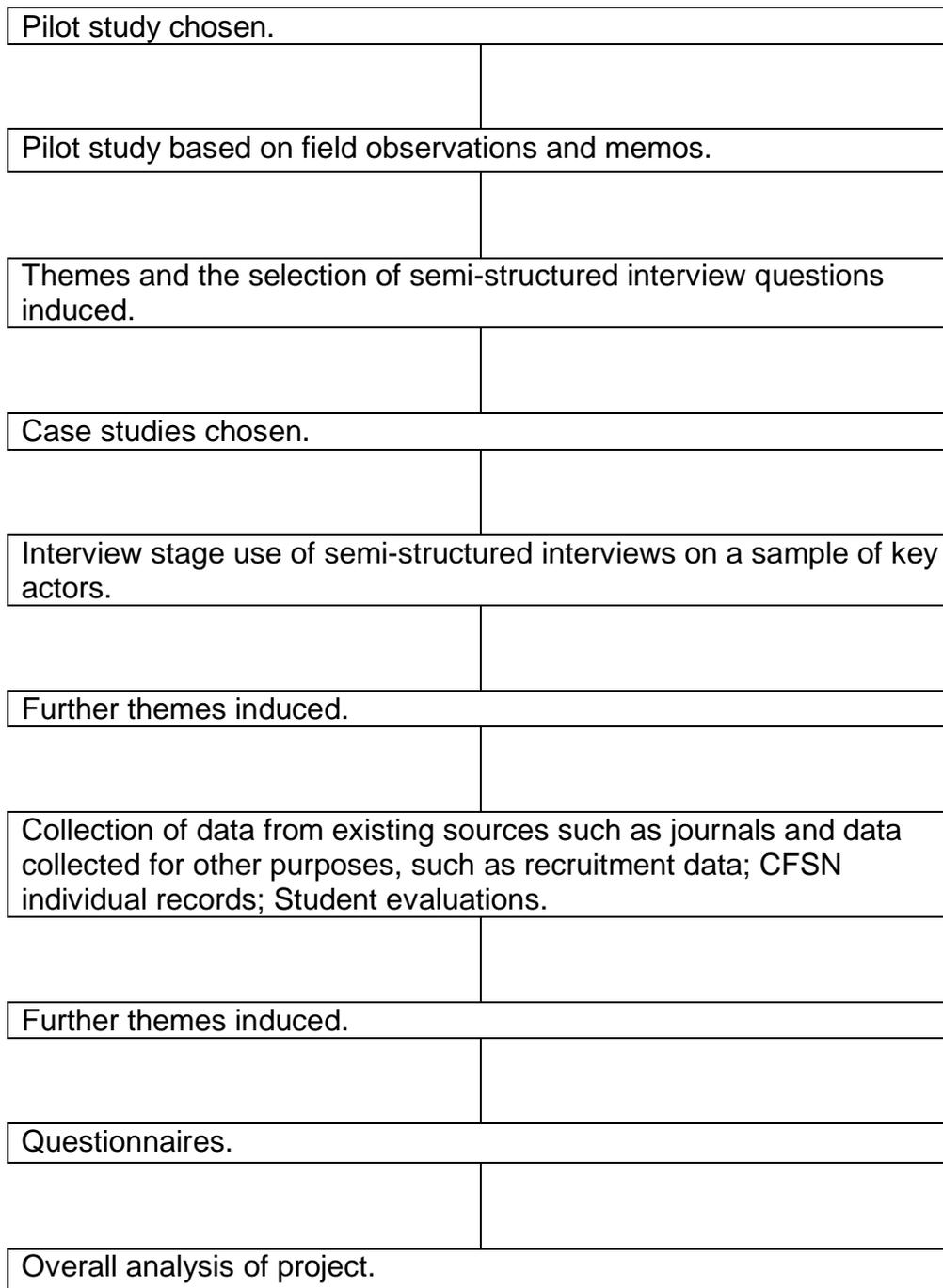
Who is organising and funding the research?

I am funding my own research and it is organised by me as part of my PhD study at the University of Nottingham School of Education.

Contact for Further Information

If you require further information do not hesitate to contact me as detailed above

Appendix 6: Study Design Flow Chart



Appendix 7: Recruitment figures for Mar. 2001 to Jul. 2004
(details of wards and hospitals removed for the purposes of this thesis)

6 monthly recruitment figures from clinical facilitator records.

During the last three and a half years we've recruited 181 nurses to ward based staff nurse posts.

33 of these have left the directorate, mainly to other directorates in the trust. That leaves 148 nurses at present with less than 3 ½ years experience on medical wards. 1 of these is now a sister/charge nurse and one is a CFSN. The rest remain ward based SNs.

Breakdown of the new starters is below:

91 were newly qualified, 11 returners, 37 overseas and 42 "experienced" (of which about 20 actually needed as much support as a returner nurse).

Breakdown of leavers is below

14 to other directorates within this Trust, 6 to community, 2 to nursing home, 8 to other trusts, 3 left nursing

There are about 300 staff nurses on the wards so approx ½ have less than 3 ½ years experience. This doesn't take into account the nurses who are experienced on paper (i.e. more than 3 years since qualified) but actually require support to a similar level as new/returner nurses.

Appendix 8: Lead CF Job Description 2004

Job Title:	Lead Clinical Facilitator Nurse
Reports to:	Directorate Nurse Manager
Ward / Department:	Medical Services
Directorate:	Medical Services

Job Purpose

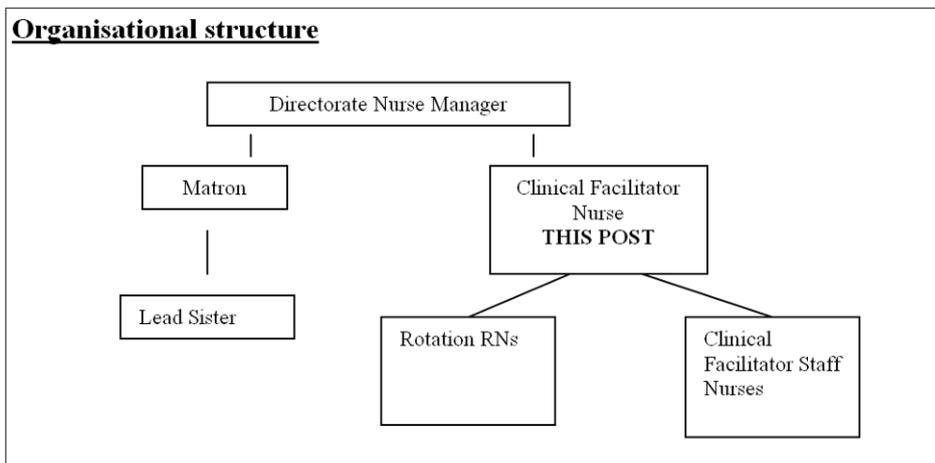
To lead, develop, implement and co-ordinate support and development programmes for student, newly qualified and experienced registered nurses within the Directorate for the purpose of recruitment, retention and skills improvement.

To provide professional nursing leadership and guidance, expert clinical advice and managerial skills which will ensure the delivery of a clinically effective service in line with local and national development plans, Trust policies and procedures.

Dimensions

This post has clinical, managerial and educational components for nursing staff.

This post does not have direct budgetary accountability, but the post holder is expected to influence the resource issues of the directorate. The clinical area deals with patients with acute and chronic medical conditions



Key result area

Managerial

1. Through the provision of good leadership and management, develop and sustain a culture within the area where the team works towards a philosophy of care that enables the delivery of a high standard clinical service whilst maintaining the privacy and dignity of patients.
2. Influence the development of the service and act as a change agent, where necessary leading staff and facilitating the change process whilst encouraging others to be innovative and adaptable in their approach to change.
3. Manage resources in an efficient and effective way, where necessary influencing budgets held by senior managers through the use of expert knowledge and judgement.
4. Takes some responsibility for the promotion of health and safety of patients, the public and staff within the directorate by identifying hazards, assessing risks, and ensuring that all trust policies are adhered to within the health care environment.
5. Facilitate the development of individual staff and the nursing teams within the directorate through the use of forums, appraisal and personal development plans taking into account both the needs of the service and the aspirations of the individual practitioner.
6. Make use of all available methods of communication to build and develop effective communication networks and processes both within and external to the clinical area / Trust.
7. Manages and co-ordinate post-basic education within the directorate.
8. To participate in the recruitment strategy and direct recruitment to the Directorate.

Education

- 9. Lead the development of an education strategy relevant to the directorate, making use of all available resources and encourage staff to be proactive in the implementation of the strategy.
- 10. Lead the development of professional, educational and rotational programmes within the directorate.
- 11. Lead, facilitate, develop and deliver teaching and induction programmes or training packages to meet both individual and corporate development needs of staff.
- 12. Support staff in developing the educational environment and extending the range of learning opportunities in the clinical areas.
- 13. Assist clinical staff with the assessment, mentoring, and support to all students and staff in the directorate.
- 14. Provide regular evaluation and progress reports on all staff and students as required.
- 15. Work alongside students and any nurse referred, in the clinical environment to assess and support their achievement of learning outcomes and to facilitate reflective practice.
- 16. To provide support and guidance for staff wishing to develop their careers/professional development.
- 17. Designs, completes and evaluates non-clinical audit projects to evaluate educational/training initiatives/programmes within the role and makes recommendations for change in practice.

Professional

- 18. In accordance with professional codes maintain own professional development and competence to practice.
- 19. At all times ensure that ones own actions support and promote equality, diversity and the rights of patients, the public and colleagues within the health care environment.
- 20. At all times ensure own work practices, conduct, behaviour and attitudes provide an example of professionalism for all staff.

Clinical

- 21. Provide expert clinical advice to the multi-professional team and taking into account all aspects of Clinical Governance to promote and develop the use of evidence based practice to improve the outcomes of patient care.
- 22. Ensures and facilitates the development and delivery of programmes of care when working within the clinical area.

Internal and external relationships

Internal

All clinical staff, in particular
 Ward Sisters and Matrons.
 Assistant Director of Nursing
 (Professional development)
 Professional Development
 Advisor (pre-registration)
 Directorate senior nurses
 Practice Development nurses
 Other Clinical Facilitators
 Recruitment Team

External

Schools of Nursing staff
 Lecture/practitioner networks
 Professional Bodies
 The Improvement Network

This job description outlines the duties as currently required but may be amended by mutual agreement to reflect future developments in the service and the impact of new technology on the role. Appropriate training will be provided to support essential additional skills required.

Signature of post holder.....

Date.....

Signature of line manager.....

Date.....

Date.....

Appendix 9: NViVO® Results

Node: /Search Results/recruit Paragraphs coded: 23 Passages coded: 29 Documents coded: 6	Node: /Search Results/redun wildcard Characters coded: 30 Paragraphs coded: 6 Passages coded: 6 Documents coded: 5
Node: /Search Results/retention Paragraphs coded: 21 Passages coded: 21 Documents coded: 6	Not mentioned by actor interviewed in January 2006
Node: /Search Results/recruit or retention Paragraphs coded: 27 Passages coded: 50 Documents coded: 6	Node: /Search Results/facilitate wildcard Characters coded: 225 Paragraphs coded: 22 Passages coded: 25 Documents coded: 6
Node: /Search Results/clinical Paragraphs coded: 57 Passages coded: 79 Documents coded: 6	Node: /Search Results/development Characters coded: 132 Paragraphs coded: 10 Passages coded: 12 Documents coded: 4
Node: /Search Results/skill Paragraphs coded: 43 Passages coded: 66 Documents coded: 6	Not mentioned by either practising CFSN
Node: /Search Results/skill or clinical Paragraphs coded: 72 Passages coded: 145 Documents coded: 6	Node: /Search Results/directorate Characters coded: 187 Paragraphs coded: 13 Passages coded: 17 Documents coded: 4
Node: /Search Results/practi wildcard (practice; practise; practical) Paragraphs coded: 44 Passages coded: 68 Documents coded: 6	Not mentioned by either practising CFSN
Node: /Search Results/theor wildcard Characters coded: 65 Paragraphs coded: 10 Passages coded: 13 Documents coded: 5	Node: /Search Results/lead wildcard Characters coded: 24 Paragraphs coded: 5 Passages coded: 6 Documents coded: 2
Not mentioned by one of the practising CFSNs	Not mentioned by any of the CFSNs
Node: /Search Results/education Characters coded: 207 Paragraphs coded: 18 Passages coded: 23 Documents coded: 6	Node: /Search Results/manage wildcard Characters coded: 192 Paragraphs coded: 20 Passages coded: 32 Documents coded: 6
Node: /Search Results/train wildcard Characters coded: 165 Paragraphs coded: 23 Passages coded: 33 Documents coded: 6	Node: /Search Results/support wildcard Characters coded: 700 Paragraphs coded: 62 Passages coded: 100 Documents coded: 6
	Node: /Search Results/facilitat wildcard Characters coded: 225 Paragraphs coded: 22 Passages coded: 25 Documents coded: 6
	Node: /Search Results/teach wildcard Characters coded: 380 Paragraphs coded: 35 Passages coded: 76 Documents coded: 6

Appendix 10: Explanation of CF Cluster Diagram

This document is to be used in conjunction with the CF Cluster Diagram.

In each case the evidence generated from the data suggests that being at the right-hand end of the line is the more secure and most effective place to be. The closer the CF can be moved towards that end the better. This can be measured by any appropriate method such as asking CFs, link lecturers, managers, students; and ward staff. It can also be done by looking at records such as meeting minutes; recruitment and retention data; educational audits; student evaluation documents; and quality patient care indicators such as essence of care.

Cluster 1

a. If the CF is employed by the HEI or trust then they are at one or the other end of the continuum; if they have joint funding they are in the middle. If they are seconded by one to the other then they are placed part of the way along in that direction.

b. Many CF roles have been initially introduced as short-term projects, the shorter term the funding for the role the closer to the left-hand end of the continuum. If the CF has a substantive open ended contract then they are at the right-hand end.

Cluster 2

a. If the CF role is purely teaching clinical skills or other educative tasks in an area remote from the clinical working area they are at the left of the continuum. Those who are based at ward level with a primarily supportive role are at the right hand end.

b. If the CF is limited to teaching one type of learner such as student nurses they are at the left-hand end. If they have a remit which encompasses all of the learners within their geographical area of influence they are on the right-hand end.

Cluster 3

a. The clearer the job description of the CF is the further along the continuum it is.

b. The CF who has all of their work time specified as doing CF duties is at the far end of the continuum. If they have only part of their work time set aside for CF duties then they move incrementally towards the left end.

c. If the CF has similar levels of patient care responsibility to that of RNs in their area then they are at the left end of the line. If they have no patient care responsibilities they are at the right end.

Cluster 4

a. If the CF role is explicitly linked to the objectives of the organisation they are at the right end. If the organisations links are not consciously linked by the CFs to their role they are at the left end.

b. If the CFs monitor and record their activities which correspond to skills and recruitment/retention improvement they are mapped at the right hand end. If they have less reliable linkage between these issues they move towards the left.

Cluster 5

a. When CF team monitors skills improvement by OSCE or similar criterion measurement they are placed at the right end. If they have no evidence of skills improvement due to their efforts they are at the left end.

b. If the CF provides specified skills or other training, whether this is as an identified session or as opportunistic teaching during the usual running of the day, they are placed at the right end of the spectrum. If there is no evidence of training then they are at the left end.

Cluster 6

a. If the CF is seen as the assistant to the link lecturer then they are at the left end of the scale. If they are the equal partner they are at the right hand end.

b. If the CFs are not invited to practice education meetings they are placed at the left hand of the continuum. Where CFs have senior organisational roles, such as chair, on clinical education committees they are at the right end. If they are invited as observer or for consultative rather than negotiation purposes they are further to the left.

c. If the CF is required to have a registerable teaching qualification then they are placed at the far right of the spectrum. If they are only required to have a professional qualification rather than a teaching qualification they are placed at the left. If they are required to have a lesser teaching qualification such as a single teaching module then they are placed part way along the line.

Cluster 7

a. If the CF team has a written structure which is well known by the team and by their colleagues they are at the right. If there is no formal structure they are on the left. If they have a structure in practice but no written constitution they will be part way along the continuum.

b. If the team has a CF manager with no other management responsibilities than managing the CF team they are at the right end of the line. If they have no leader at all they are at the left. If there is a leader in practice but nothing written or if there is a leader in policy documents but not in practice they are part way along the continuum.

c. If there are regular and frequent team meetings which all of the CFs have to attend then they are at the right. If there are no meetings of the CF team then they are at the left. If there are less regular or ad hoc meetings then they are part way along.

Cluster 8

a. If the CF team are explicitly linked to a policy such as the implementation of ANTT or providing preceptorship they are at the right. If there is no known link they are at the left. If they work out a link then they are part way along.

b. If the team documents and monitors their activities mapped to specific trust or national policy they are on the right. If they do not keep records of this then they are on the left.

Appendix 11: Acronyms and Initials

ANTT	aseptic non-touch technique
C	case study
CCU	coronary care unit
CF	clinical facilitator nurse
CFP	Common Foundation Programme
CFSN	clinical facilitator staff nurse
CLT	clinical liaison tutor
COHSE	Confederation of Health Service Employees
CPE	clinical practice educator
CPF	clinical practice facilitator
CT	clinical teacher
DH	Department of Health
EN	enrolled nurse
ENB	English National Board
EU	European Union
FO	field observation
GNC	General Nursing Council
GT	grounded theory
GTC	General Teaching Council
HCA	health care assistant
HE	higher education
HEI	higher education institution
ICU	intensive care unit
LEM	learning environment manager
LP	lecturer practitioner
NCVQ	National Council for Vocational Qualifications
NHS	National Health Service
NHSU	National Health Service University
NMC	Nursing and Midwifery Council
NQN	newly qualified nurse
NVQ	National Vocational Qualification
ONS	Office for National Statistics
OSCE	objective structured clinical examination
PDN	practice development nurse
PCT	primary care trust
PE	practice educator
PPF	practice placement facilitator
RCN	Royal College of Nursing
RN	registered nurse
RNT	registered nurse teacher
SEN	state enrolled nurse
SHA	strategic health authority
UK	United Kingdom
UKCC	UK Central Council for Nursing, Midwifery and Health Visiting
USA	United States of America
VAD	Voluntary Aid Detachment
Y	Year (indicates seniority of student nurses)