

Section One

The Context

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1. From Artistry in Practice to Expertise in Developing Person-Centred Systems: A Clinical Career Framework

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Introduction

Throughout this book, we aim to provide a broad, interwoven vision of what is possible in nursing practice. This introductory chapter places nursing practice expertise within a clinical career framework that encompasses five interdependent domains. The first domain is about achieving professional expertise and artistry in the nurse–patient relationship. The other four domains are about developing expertise in implementing and sustaining person-centred systems. The development of person-centred systems requires expertise that includes the facilitation of individuals, teams, systems, learning, research, inquiry, evaluation and change in practice, so as to enable a culture of effectiveness to develop in the workplace. Other chapters of this book provide more detailed examples that illustrate expertise across some or all of the domains outlined in this chapter.

This chapter will focus on the following:

1. The domain of nursing practice expertise within the nurse–patient relationship.
2. The four domains associated with developing person-centred systems, namely,
 - (i) facilitating practice change and a culture of effectiveness in the workplace through leadership;
 - (ii) facilitating inquiry, evaluation and evidence use in practice;
 - (iii) facilitating learning and a work-based learning culture, where learning in and from practice is the norm and all learning feeds into practice transformation;
 - (iv) using consultancy approaches that foster self-sufficiency in problem-solving across teams and organisations.

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3. Identifying the relationships between various roles that encompass expertise in nursing practice and person-centred systems. For example advanced, specialist and consultant nurse practice and other clinically related career opportunities beyond the consultant nurse role.

The context of nursing practice expertise

Inherent in all nursing practice career frameworks is a spectrum of expertise that spans the range of domains above. This spectrum is necessary for practice teams and cultures to be experienced as person centred and evidence based. The establishment of person-centred systems enables patients and users to receive person-centred and evidence-based care, regardless of whether the most immediate provider of care has expertise or not. The reason for this is that such systems create cultures that enable a consistently high quality of nursing to be experienced by patients and users from the whole team. In other words, this spectrum or span of expertise is underpinned by an assumption that nursing is about both the relationship with the person who has health or illness needs, and also, the context in which nursing takes place (Manley, 2000) (Box 1.1).

The context for nursing practice therefore extends from that most immediate to the nurse–patient relationship, through to the health care team and onto the patient’s journey, which may cross a number of interfaces. It is at these interfaces that nursing practice expertise has most potential for developing person-centred systems (McCormack *et al.*, 2008a, 2008b). This is not to deny that nursing does and should not have influence at other levels, such as the organisational level – it does (Aiken *et al.*, 2002; McCormack *et al.*, 2008b), or that other levels of organisation aren’t important – they are (McCormack *et al.*, 1999) but the predominant focus here is on the workplace rather than the organisation.

Expertise: a lifetime’s journey

Although there is an interdependence in the development of expertise across the five domains, it is recognised that individuals follow different career trajectories

Box 1.1 Context for nursing practice (*Source: This box was published in *Surgical Nursing: Advancing Practice*, K. Manley & L. Bellman, p. 4. Copyright Elsevier, 2000.*)

Nursing is about

- caring values;
- focusing on relationships with individuals, groups and populations;
- managing/facilitating the context of care;
- enabling coordination and continuity of care;
- using knowledge of patients as people with concepts and implications of health and illness to inform assessment, interventions, evaluation, patient education and health promotion.

(Manley, 2000)

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and that these are not necessarily linear. By focusing on the different domains that constitute the spectrum of nursing expertise from that located within the individual nurse–patient relationship through to that related to implementing and sustaining person-centred systems, it is hoped that different starting points and professional experiences are recognised and greater fluidity in career progression is valued. Expertise doesn't develop overnight. It happens through using workplace experiences as the main resource for learning and inquiry. These experiences are combined with an impetus and desire for refining everyday practice, through structured and supported reflection that has potential to transform practice, the individual and the team, within an everyday culture that supports this transformation (Manley, 2004). This is a lifetime's journey within the context of lifelong learning, one that requires us working with others and exposing our practice to critique. Working with and exposure to critique were characteristics of the Royal College of Nursing's (RCN's) Expertise In Practice Project (EPP; Manley & Garbett, 2000; Hardy *et al.*, 2002; Manley *et al.*, 2005; Hardy *et al.*, 2006, 2007) in which participants, who were recognised by their colleagues as having expertise, were involved in trying to understand and articulate their nursing expertise and its outcomes. Through the process of portfolio development and with the help of a critical companion (Titchen, 2004), participants, by the end of the research, could explain not only why they had expertise, but also what the outcome of this expertise was on patients, colleagues and the service. This study led to the recognition that even experts needed help with unpicking and articulating their expertise, as well as the processes for developing it further in themselves and others. A set of standards emerged that would assist others in their development of not just clinical expertise but also person-centred systems (RCN, 2004a, 2004b). The four domains associated with developing these systems will be described later once the domain of person-centred expertise has been considered in more depth.

Nursing practice: person-centred expertise

Expertise in person-centred practice

The contemporary understanding of nursing expertise presented here (Box 1.2; Figure 1.1) is based on the findings of the RCN's EPP (Manley & Garbett, 2000; Hardy *et al.*, 2002; Manley *et al.*, 2005; Hardy *et al.*, 2006, 2007) and can be clearly traced to the original research of Benner (1984), Benner and Wrubel (1989) and Benner *et al.* (1996). Chapter 3 discusses these and other early works and sets out the literature landscape concerned with expertise in nursing and its development. This chapter focuses on the EPP which spanned a period from May 1998 and continued through to 2004. It included six cohorts of practising nurses working in four countries of England, Wales, Scotland and Northern Ireland. The project aimed to develop a deep and rich understanding of nursing practice expertise across diverse clinical specialities, through the identification and verification of its attributes and enabling factors. Derived from insights and augmented by a comprehensive analysis of the literature, these attributes and enabling factors formed the conceptual framework for the project (Manley & McCormack, 1997).

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Box 1.2 'The attributes of expertise'

Holistic practice knowledge is concerned with:

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

Saliency related to:

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

Knowing the patient is about:

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

Moral agency is concerned with:

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

Skilled know-how refers to:

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

Benner and her colleagues used phenomenology to interpret and illustrate nursing expertise through a number of paradigm cases and exemplars that showed overarching and specific aspects of expertise, respectively. In contrast, the EPP drew on emancipatory action research (Grundy, 1982) and fourth generation evaluation (Guba & Lincoln, 1989). The latter is an approach to social research that integrates action in the workplace with the concerns, claims and issues of

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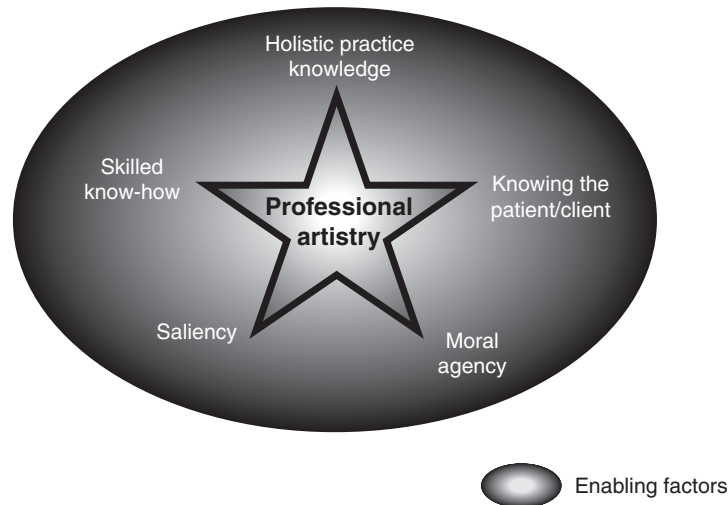


Figure 1.1 A conceptual framework for nursing expertise in the UK. (Source: Reproduced with kind permission of the Royal College of Nursing from *Changing Patient's Worlds through Nursing Practice Experience* (Manley et al., 2005).)

stakeholders. Schratz and Walker (1995) suggest that social research is about enabling practitioners to become more critical about their practice through identifying and evaluating their actions and decisions. Whilst supporting this notion, the EPP went way beyond it by inviting practitioners to become practitioner researchers who, simultaneously, investigated and developed their own expertise. To help participants to develop the necessary skill sets for practitioner research, participants and their critical companions were invited to join monthly action learning sets facilitated by two members of the research team. Participants also met regularly with their chosen critical companion (Titchen, 2001) in the workplace, in addition to collaboratively gathering evidence of and about the nurse participants' practice. The methodology of this study is further described in Chapter 3.

The outcomes of this project included a framework of expertise that offers a language for nurses to articulate and share with others what constitutes their practice expertise, thus providing a greater level of insight and articulation of what occurs between the expert practitioner and the people they care for. Table 1.1 sets out refinements and additions to the attributes identified in the original concept analysis conducted by Manley and McCormack (1997). Refinements and additions were established through an overall analysis of the nurse participants' portfolios of evidence and review of literature since 1997.

Analysis of the portfolios in the EPP also supported the three enabling factors of expertise identified in the original concept analysis, that is, reflective ability (reflexivity), organisation of practice (capacity to critically control all of their interactions to impact on the organisation through being able to see the bigger picture)

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Table 1.1 Support for the attributes of expertise since Manley and McCormack's (1997) concept analysis

Attributes (Adapted from Manley <i>et al.</i> , 2005)	Examples of empirical support in the literature since 1997
<p>1. <i>Knowing the patient/client/colleague/organisation</i> Seeing patients as people who are unique, recognising and respecting their view of their illness or situation; getting to know the patient as person in the context of their own life to enable unique interventions and care that meet the needs of patients and their carers as they see them; recognising patients' patterns of behaviour and understanding how they are likely to react; forming rapport easily, being accessible on a personal level and using one's own self to promote helping relationships; knowing when to relinquish control to patients/clients</p>	<p>Binnie and Titchen, 1999; Titchen, 2001; Titchen and McGinley, 2003; Bonner and Greenwood, 2006; McCormack and McCance, 2006</p>
<p>2. <i>Holistic practice knowledge</i> Integrating and using all kinds of knowledge in practice (e.g. theory, research, practical know-how, praxis, experiential, intuitive, aesthetic, personal); ongoing evaluation of, and learning from, new situations and embedding this knowledge for future use; using generic knowledge appropriately to individuals, groups, organisations or circumstances</p>	<p>Titchen, 2000; Titchen and McGinley, 2003; Donnelly, 2003; Judd, 2005; Kennedy, 2004; McCormack and McCance, 2006</p>
<p>3. <i>Saliency: knowing what matters and acting on it</i> Recognising intuitively and rationally what matters quickly and responding with immediate, seamless action; using skills appropriately and at the right time; listening and picking up verbal and non-verbal cues that can be missed by others; recognising patients', colleagues' and others' needs and reflecting these in action taken</p>	<p>Binnie and Titchen, 1999; Titchen, 2001 (skilled companionship); Taylor, 2002; Foley <i>et al.</i>, 2002</p>
<p>4. <i>Moral integrity</i> Consciously promoting others' dignity and individuality and respecting their values and actions without passing judgement; working and living one's values and beliefs without pushing them on others; providing information which enhances people's ability to solve problems and make decisions; being aware of one's own integrity and of setting the highest standards; aspiring to promote human flourishing for all involved in the clinical encounter through one's actions</p>	<p>Ersser, 1997; Binnie and Titchen, 1999; Titchen, 2000; Judd, 2005; Johnston and Smith, 2006; McCormack and McCance, 2006; McCormack and Titchen, 2006</p>

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Table 1.1 (Continued)

Attributes (Adapted from Manley <i>et al.</i> , 2005)	Examples of empirical support in the literature since 1997
<p>5. <i>Skilled know-how</i> Adapting and responding skilfully and with consideration to each situation; enabling others through a willingness to share knowledge and skills; mobilising and using all available resources; seeing a path through a problem and inviting others on that journey</p>	<p>Binnie and Titchen, 1999; Titchen, 2001; Titchen and McGinley, 2003; Judd, 2005; Bonner and Greenwood, 2006</p>
<p>6. <i>Acting as a catalyst</i> Creating harmony and understanding, enabling new ways of working, and influencing colleagues' practice for better patient care, through education and role modelling 'Being a catalyst' describes the activities undertaken and considered necessary to keep the momentum of development continuing as well as the personal communication with individuals that enabled inclusivity</p>	<p>Binnie and Titchen, 1999; Titchen, 2001; Manley, 2001; Titchen and McGinley, 2003; Manley <i>et al.</i>, 2005</p>
<p>7. <i>Creative, innovative and challenging behaviour</i> Pursuing person-centred improvement relentlessly; being willing to take informed risks, that is, working ethically in a non-standard way, to achieve the best outcome for patients/clients; challenging practices and organisations to improve practices; encouraging others to develop a shared vision</p>	<p>Binnie and Titchen, 1999; Manley <i>et al.</i>, 2005; Bonner and Greenwood, 2006</p>
<p>8. <i>Self-awareness</i> Exploring and recognising one's own strengths and weaknesses; recognising one's scope of influence and impact; seeking self-improvement; articulating one's expertise and passion for nursing Being self-aware and attuned to others</p>	<p>Manley, 2001; Manley <i>et al.</i>, 2005; McCormack and McCance, 2006</p>

and autonomy and authority (capacity for making decisions, taking responsibility for any arising consequences and willingness to challenge whole teams and senior colleagues if patient care was compromised). In addition, the EPP demonstrated that nurses with expertise effect change and facilitate both performance and organisational development.

Apart from Titchen's (2000, 2001) study, the processes of encouraging and supporting practitioners to deconstruct and then reconstruct their practice have not occurred before in an investigation of practice expertise. Indeed, the conclusion of other research undertaken to date (e.g. from our search of the literature related to

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practice expertise between 1996 and 2008) is that supporting nurses with expertise as practitioner researchers is puzzling and problematic. This study, therefore, makes another contribution in relation to setting out the practical know-how of enabling practitioner research. Thereby, it offers a unique framework for helping practitioners to inquire, critique and, perhaps most importantly, continue to learn from the process of investigating their practice, ongoing development and the articulation of their practice expertise as illustrated by participants in the EPP (e.g. Richmond, 2003; Titchen & McGinley, 2003; Brown & Scott, 2004; McCormack & Henderson, 2007).

Originally presented as a typology (as in Table 1.1), we concluded that the dynamic relationships between the attributes were not articulated and how nurses use them in a holistic way within their practice were not shown. So building on Titchen's (2001) and Titchen and McGinley's (2003) findings, we re-presented the typology as shown in Figure 1.1 and introduced professional artistry as the overarching enabling factor into our framework. Professional artistry enables the blending and melding of the attributes into unique configurations for each unique patient and context. The dimensions of professional artistry include, for example, different kinds of knowledge, ways of knowing, multiple intelligences, creative imagination and therapeutic use of self. These dimensions and the processes of professional artistry are described in Chapters 3 and 12. Whilst further research is required, we propose that professional artistry includes the reflexive and metacognitive processes that underlie the three enabling factors above.

Although the EPP primarily focused on what happened within the nurse-patient relationship, it was also evident that expert nurses impacted on their colleagues and the organisations in which they were located. This illustrates how expertise in nursing spans and is interdependent with expertise in the other domains necessary for developing person-centred systems. As nurses progress through the clinical career ladder, they develop expertise that extends beyond the world of the nurse-patient relationship to the immediate systems in which care provision is located.

Expertise in developing person-centred systems

Kitwood defines person-centredness as

a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.

Kitwood, 1997, p. 8

Person-centred systems are characterised in the workplace, regardless of setting, by the presence of structures, processes and patterns of behaviour that are embedded in the principles of person-centred care and are manifested in a culture that is person-centred (McCormack *et al.*, 2008b). These principles include maximising opportunities for enabling continuity and integration of services by keeping the person at the centre of decision-making, minimising discontinuity through

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systems re-design, helping individuals and teams to work effectively, and the building of social capital (McCormack *et al.*, 2008b).

Social capital refers to the connections between individuals and is located in the relationships and social networks identified by the norms of reciprocity and trustworthiness that arise from these connections (Putnam, 1993; Adler & Kwon, 2002). Just like economic capital, social capital can be accumulated for distribution among society based on the idea that the more connected a citizen is to his or her social networks, the more social capital or resource that is available for citizens to draw upon in order to improve their lives. The extent to which social capital exists in a given context critically influences the success of collective and collaborative work (Putnam, 1993). Social capital leads to greater potential for networking and commitment to cooperative action (Cohen & Prusak, 2001) and therefore contributes to creating workplace cultures where people flourish through trust, shared values, mutual understanding and respect. Manley (2000, 2004) and Manley *et al.* (2007) describe the culture arising from such principles as an *effective workplace culture*, one that is associated with specific attributes that include the values, patterns of behaviours, structures and processes necessary for achieving social capital, person-centredness, evidence-based care, and individual and team effectiveness.

Person-centred systems through their structures and processes therefore actively support practitioners and practice teams to deliver on key values. This characteristic is demonstrated well by the Magnet Hospital Programme and the outcomes it achieves (Aiken *et al.*, 2002). In Magnet Hospitals, nursing is highly valued and supported and this is reflected in the quality of care experienced by patients. Enabling person-centred systems to develop in practice requires a specific skill set that builds on nursing practice expertise located in the nurse-patient relationship. This skill set is outlined in Box 1.3, but for greatest effect, needs to be located as near to the interface of care between health care providers and recipients as possible (Manley & Webster, 2006).

These skills were derived from a set of methods, for example, agreeing ethical processes, analysing stakeholder roles and ways of engaging stakeholders, being person centred, clarifying the development focus, collaborative working relationship, continuous reflective learning, and developing a shared vision, among others known to be influential in developing practice (McCormack *et al.*, 2006). This

Box 1.3 The skill set required for developing person-centred systems (*Source:* From Manley and Webster (2006).)

- Working collectively with users and others, and representing different stakeholder groups.
- Developing an effective culture, including transformational leadership.
- Work-based learning encompassing approaches that include reflective practice.
- Using and developing knowledge and policy.
- Evaluating practice at individual and team levels.
- Helping individuals and teams achieve the above skill set.

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skill set underpins the following four domains necessary for developing person-centred systems:

- facilitating learning and a work-based learning culture;
- facilitating inquiry, evaluation and evidence use in practice;
- facilitating a culture of effectiveness through leadership;
- using consultancy approaches that foster self-sufficiency in problem-solving across teams and organisations.

The four domains build on the first – nursing practice expertise in the nurse-patient relationship – that captures the scope of the clinical career framework in nursing. Developing expertise in the four domains is now considered from the perspectives and the frameworks that currently exist to describe them.

Four domains of person-centred expertise

Facilitating learning and a work-based learning culture

Fundamental to the EPP and the development and articulation of nursing practice expertise was the creation of a learning culture that helped participants to learn from and in their practice, and in parallel for some, to re-create such a culture in their own workplace. This was achieved in two ways: first, through the nurse with expertise and their critical companion, and second, through action learning sets (McGill & Beaty, 2001) involving both nurse with expertise and critical companions so as to facilitate group learning about work and critical companionship (Titchen, 2004) that could be mirrored in the workplace. Both sets of learning processes were designed to help each participant to become more effective in their own work as well as develop the facilitation skills needed to help others with their learning and development in the workplace (Dewar & Walker, 1999; Ogrinc *et al.*, 2004).

Central to this approach is the concept of work-based learning with its potential to transform health care services so as to improve patients' and users' experiences, provide value for money, improve productivity and achieve continued modernisation (Manley *et al.*, 2009). Developing expertise in the facilitation of learning in and from practice, therefore, meets the needs of not only the learner but also the organisation (Flanagan *et al.*, 2000; Gallagher & Holland, 2004). Using experiential learning in health care organisations requires educators and managers to be aware of the need for skilled facilitation, and for that facilitation to be provided by practitioners who are prepared for their role (Green & Holloway, 1997; Walker & Dewar, 2000; Manley *et al.*, 2009) as an internal facilitator of it (e.g. Manley, 1997, 2001, 2002).

Work-based learning requires active learners who are motivated and have potential for learning and development. However, active learners span a continuum, and this continuum provides insights into practitioners' ability to learn themselves, as well as facilitate learning in others. Whilst it is possible to use active learning processes in practice to promote learning and a learning culture (Dewing,

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2008), developing expertise in the facilitation of others' learning and an ability to process learning, in terms of what is happening in the learning process, cognitively and metacognitively, is an additional asset. Manley *et al.* (2009), in an analysis and synthesis of the literature, develop a contemporary framework for work-based learning and identify a continuum that describes the journey of the active learner. At one end of the continuum, active learners may be recognised as listening and learning from others, taking the initiative in identifying self-deficits, setting their own learning objectives and goals, and learning from their own work experience. The development of professional artistry marks the other end of the continuum, one that characterises the pinnacle of professional practice, one that integrates and appreciates learning with inquiry and encompasses a number of characteristics described in more detail in Chapter 12.

Hence, within the domain of *facilitating learning in and from practice*, artistry in the practice of nursing provides the building block for developing expertise in the enablement of others' learning in the workplace. This expertise includes the ability to: recognise where individuals are on a continuum of active learner characteristics; deconstruct and reconstruct what is learnt in a meaningful way at several levels that integrate inquiry; and, simultaneously, develop a genuine learning culture in the workplace, one where work-based learning is valued and acted upon. Developing a learning culture requires that the characteristics of active learning and the skills to develop these be nurtured in and used by others, with regard to not only individual learning, but also group- and team-based learning (Manley *et al.*, 2009). A learning culture would therefore be recognised when the everyday work of health care, whatever a person's position, forms the basis for learning and inquiry in the workplace, and varied learning and development activities involving others are evident (see Chapter 12).

A set of evidence-based standards informed by frameworks, such as critical companionship (Titchen, 2004), have been developed to help practitioners to show their readiness for career progression with regard to facilitating others in their learning in and from practice both formally and informally, individually and in groups (RCN, 2004b). These standards are underpinned by a range of processes that would constitute the everyday repertoire of practitioners with expertise in facilitating, not only learning and development, but also person-centred systems (see Box 12.2). This range is important because these processes integrate and underpin all four of the domains identified for developing person-centred systems integral to nursing's career framework.

The domain of *facilitating learning and a work-based learning culture* is interdependent with *facilitating inquiry, evaluation and evidence use* – the next domain. This is because both domains require expertise in the same processes of facilitation.

Facilitating inquiry, evaluation and evidence use

Facilitating the integration of learning with inquiry, as argued above, is a characteristic that would be expected of those at the pinnacle of their career framework in practice. Some practitioners develop this expertise as a result of being exposed to the type of culture and processes described above; others come to this understanding from a different pathway that may have started with more traditional

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approaches to research. Practitioners at the pinnacle of their career framework, however, in addition to facilitation expertise, need expertise and an understanding in research approaches that cross different paradigms and inform different purposes. These purposes range from informing technical interventions through to developing practical understanding of patients' and users' experiences, as well as action-based participatory approaches in the workplace relevant to the context (Manley & McCormack, 2003). In addition, there are varying perspectives that extend from the use of evidence in practice, the development of evidence from practice and theorising from practice (Bucknall *et al.*, 2008) through to enabling others to contribute to the knowledge base through original practice-based research using a range of different research approaches.

Using the facilitation skills and processes referred to above (Manley *et al.*, 2009), and expanded in Chapter 12 (see Box 12.2), combined with an understanding of different research approaches as part of an action research study operationalising the consultant nurse role, Manley (2001) was able to make research real through using it in practice, facilitating research critique and application and helping practitioners undertake research and evaluation in their everyday work. The way the consultant nurse worked with and facilitated practitioners (as co-researchers) in developing research expertise resulted in not only a positive valuing of research by all, but also enabled care to be up to date, for example, through nearly all nursing interventions being informed by evidence-based standards. In turn, these results enabled the development of a strong research culture.

The practitioners, as co-researchers in the work, were able to contribute to a programme of research in the workplace (Manley, 1994; Manley *et al.*, 1996, 1997), informed further by masters and undergraduate theses. This research increased the staff's understanding of practice and the needs of patients and families within the workplace and helped them to use a range of different research approaches that led to benefits for patients, relatives and staff (Mills, 1993, 1997; Welch, 1993; Creasey, 1996; Cruse, 1996; Pinnock, 1998).

In another action research study (Down, 2004), the full range of research approaches, combined with facilitation expertise and work-based learning, were used to implement person-centred systems by developing, implementing and evaluating an organisation-wide practice development strategy. The skills involved in facilitating the implementation of person-centred systems drew extensively from those identified in the consultant nurse action research study but extended them to the organisational level. In the organisational study, practitioners were enabled to use work-based learning approaches, become practitioner researchers and develop research skills that augmented and strengthened their everyday practice. This resulted in research products, namely, research protocols developed by practitioners for patient stories, staff stories, observation of practice, qualitative 360-degree feedback, using the RiCH tool as a research culture benchmarking tool (Fox & Feasey, 2001) and the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (AGREE Collaboration, 2001) to enable the use of evidence from practice (RCN, 2007), thus improving practice through a climate of inquiry.

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The facilitation of transformational research that involves shared action drawing on critical and phenomenological approaches is a feature of research in the workplace that includes genuine involvement of stakeholders in the research process (Titchen & Manley, 2007). Facilitators of transformational research, that is, research that transforms individuals, teams and organisations through the process of the research, will need to develop expertise in a number of strategies, specifically:

- creating a transformational research culture;
- holistic facilitation that enables stakeholders to develop research skills and to sustain these (Binnie & Titchen, 1999; Manley, 2001);
- promoting authentic collaboration;
- overcoming the obstacles to genuine collaboration in the workplace so that decision-making is democratic and stakeholders are not marginalised.

Titchen and Manley (2006) identify a range of principles necessary to guide the achievement of authentic collaboration and also tools that can be used to enable it, such as, values clarification, claims, concerns and issues, thematic analysis and interpretation, and collaborative theory generation (Titchen & Manley, 2007); these are expanded further in Chapter 13.

The practitioner at the pinnacle of the clinical career framework would therefore be expected to develop expertise in using these tools in a range of different settings; different kinds of knowledge, using different methodological assumptions within action research for different purposes; and 'critical, creative communities that are mindful of the practicalities of being rigorous with audit trails, the critiquing of claims and findings, making explicit the many complex spirals of related activity that take place, as well as more consciously and collectively surfacing the barriers to action and promoting human flourishing' (Titchen & Manley, 2006, p. 345).

One repeated theme throughout this chapter is that of integration – and how the development of practice expertise is integrated with developing expertise in the other domains. Facilitation too has been an integrating theme with facilitation pivotal in the EPP (Manley *et al.*, 2005), and work-based learning (Manley *et al.*, 2009), helping others to both become inquirers of their own practice, as well as a prerequisite to achieving evidence-based practice (Rycroft-Malone, 2004). Three factors enable research to be implemented in practice: the quality of the evidence, the need for skilled facilitation and a context that includes a conducive culture, leadership and evaluation (Rycroft-Malone, 2004) highlighting again how the domains of practice expertise are integrated.

Facilitating a culture of effectiveness through leadership

Earlier, a culture of effectiveness was stated as the purpose of person-centred systems. A culture of effectiveness is recognised by five attributes (Box 1.4).

Whilst both organisational and individual enabling factors have been identified as influential in developing such a culture (Manley *et al.*, 2007), this chapter in

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Box 1.4 Five attributes of an effective workplace culture (*Source: Adapted from Manley et al. (2007).*)

1. Specific values promoted in the workplace, namely:
 - person-centredness
 - lifelong learning
 - support and challenge
 - leadership development
 - involvement and participation by stakeholders (including service users)
 - evidence use and development
 - positive attitude to change
 - open communication
 - teamwork
 - safety (holistic).
2. All the above values are realised in practice; there is a shared vision and mission and individual and collective responsibility.
3. Adaptability, innovation and creativity maintain workplace effectiveness.
4. Appropriate change is driven by the needs of patients/users/communities.
5. Formal systems and skilled facilitation exist to continuously enable and evaluate learning, performance and shared governance.

the context of the clinical career framework will focus on individual enabling factors as these are most relevant for developing expertise in facilitating an effective workplace culture. The individual enablers include transformational leadership, skilled facilitation and role clarification (Manley *et al.*, 2007). Skilled facilitation has already been identified as an important skill set for developing expertise in practice, learning in and from practice, as well as for promoting a culture of inquiry that is evidence based.

Role clarity with clear expectations and responsibilities is recognised as a prerequisite for enabling evidence-based practice and critical thinking (Davies *et al.*, 2000, Newman *et al.*, 2000), the implementation of Total Quality Management (Huq and Martin, 2000) and also an effective culture (Jones & Redman, 2000; Bevington *et al.*, 2004). Role clarity is something that can be achieved through using tools such as qualitative 360-degree feedback (see Chapter 13) and so the focus here will be primarily on leadership.

Leadership and practice expertise

Leadership has long been identified as the key to culture change (Bate, 1994; Brown, 1998) and the main approach to developing a culture of effectiveness in the workplace (Kouzes & Posner, 1987; Manley, 1997). Transformational leadership is a clear and well-researched concept that encompasses paying attention to culture (Jones & Redman, 2000; Manojlovich & Ketefian, 2002), role-modelling shared values (Haworth, 2000; Bevington *et al.*, 2004) and achieving a common vision through engaging hearts and minds (Davies *et al.*, 2000).

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Leadership and management are different activities that are related (Marquis & Huston, 1996), but it is leadership expertise that is essential for cultural change. Kotter (1990) identifies the specific mechanisms through which leaders achieve action:

- creating a perceived need to change;
- clarifying the vision of what change was needed;
- challenging the status quo but marshalling a lot of evidence to support this;
- communicating a new vision in words and deeds;
- motivating many others to provide the leadership to implement the vision.

As this chapter focuses on the clinical career framework, it is pertinent to consider both the advantages and disadvantages of including an operational management component to senior clinical posts (Manley, 1993). Whilst benefits include having legitimate power and influence to change practice through authority from position power (Handy, 1993), the disadvantages relate to the time and energy consumed in administration and operational management, reducing dramatically the time available for developing practice (Lathlean, 1995; Fulbrook, 1998). Past arguments are that without the position power of an operational management role, it may be more difficult to influence and change practice (Manley, 1997), although this is unproblematic if values and beliefs are shared (Manley, 1993; Fulbrook, 1998) and everyone takes responsibility for making values live. Within a culture that is collaborative, therapeutic and participative, sources of power are devolved. Credibility is from expertise, power of argument and critique, power to enable others, and shared values and beliefs.

Whilst it may be argued that formal management is not a core component of advanced practice (Fulbrook, 1998), there is an argument for emphasising the strategic aspects of management and management skills, rather than the operational aspects (Goodman, 1998). The need for strategic vision, having a good sense of direction and 'seeing the possibilities' (Manley, 2001) is integral to leadership expertise, with the ability to work within strategic frames of reference a necessity for developing practice (McCormack *et al.*, 1999).

Being a political leader is one of the five dimensions of cultural leadership (Bate, 1994) (Box 1.4). Bate argues that political leaders focus on interaction and assign meaning by putting ideas into words and giving ownership of the idea to the organisation or community; they bring about cultural change through changing people's frames of reference (see Box 1.4). For example, translating the concerns of practitioners who provide care at the interface with users to those responsible for executive decisions is a highly developed skill recognised in successful executive nurses who are described as translators and interpreters (Antrobus, 1999). At a micro-politics level, Ward *et al.* (1998) identify the importance of addressing stakeholders' concerns before undertaking practice development activity, identifying the need to consider the impact that activities will have on one's own work practices, as well as relationships with significant others. In addition, he identifies the need for strategies to deal with possible negative organisational attributes

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because lack of ownership of practice initiatives by all stakeholders negatively influences project outcomes. Political leadership aims to influence policy through positioning key ideas, getting stakeholders on board and developing and using influencing strategies that will have an impact on the development and uptake of local as well as national policy (Antrobus, 2003).

Effective cultures are characterised by being strategically appropriate and adaptable and involve leadership that mediates between a changing context and the providers of the service, constantly drawing this changing context to the notice of practitioners so that they can respond. An example of this is seen in advanced practitioner roles where nursing expertise is augmented by a specific set of competencies to enable changing health care needs to be met.

Bate (1994) comprehensively identifies the five dimensions necessary for cultural leadership, but considers not all would be present in any one person arguing, the need for balance between them at different times (Box 1.4). Expertise in this domain would include developing expertise in some areas whilst recognising how the expertise of others can complement the full range of leadership dimensions required.

Transformational leadership is emphasised in enabling a culture of effectiveness to develop (Manley, 2004), but leadership expertise at the pinnacle of the nursing career framework needs to integrate clinical and strategic leadership with transformational and political approaches (Manley, 1997, 2002; Redfern, 2003; Hayes, 2003).

In helping consultant nurses in older peoples nursing to explicate their clinical leadership role, through a cooperative inquiry, the need to appreciate leadership as influencing others was a focus. As practising nursing expertly may not positively influence others if there is no one to experience and observe nursing expertise other than the patient (Manley *et al.*, 2008). This inquiry set out to identify that which was taken for granted in the consultant nurses' everyday leadership practice. A complex picture emerged that was multifaceted and multidimensional, one that involved working across levels, seeing connections between teams, interacting policy strategy decisions with an impact on clinical decisions. Clinical leadership strategies at three levels of influence resulted and these were directed at the:

- *immediate care of the patient*, for example an active judgement was made to lead patient care because of the complexity of the patient, or, working across boundaries to benefit the patient;
- *team*, for example by being opportunistic and intentional in using any situation that emerged to work with staff to develop their practice, planting seeds, facilitating participation of stakeholders in developing a common vision;
- *organisation*, for example building relationships at a strategic level, developing networks for engaging in and building on at a later date, using governance frameworks to influence practice.

In this fourth domain, *facilitating a culture of effectiveness*, facilitation expertise, role clarity and a number of leadership dimensions have been identified that are essential requirements for nurses at the pinnacle of their career framework if both a

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culture of effectiveness is to be achieved in practice and nursing is to influence the broader health care agenda. The final domain focuses on consultancy approaches in clinical practice.

Consultancy approaches to foster self-sufficiency in problem-solving

The provision of specialised help reflects consultancy practice in its commonest form, that of, providing expertise and advice to a consultee. Growth in consultancy has arisen across society from increasing demand for social and technical knowledge and skills (Gallessich, 1982) also reflected in increasing specialism within nursing (ICN, 1999). Gallessich (1982) differentiates the role of consultancy from other roles considering it an emerging professional in its own right. She argues that innovative consultancy practice crosses traditional professional boundaries and spans three developmental levels, suggesting that the knowledge base informing consultancy practice is broader than the original focus of a discipline and extends to drawing extensively on knowledge from other fields such as organisational change, development and learning.

Caplan's (1970) consultancy model is health specific, was developed in mental health, and is driven by the assumption that consultancy is about disseminating as much expertise as possible to the widest number of people requiring access to it. Caplan's model includes both direct and indirect consultancy focused at either the individual patient or health care provider through to the system, programme or organisational level (Table 1.2). This model therefore provides a framework for understanding and developing consultancy practice and expertise across the career framework for nursing (Manley, 1996, 1997):

Expertise in nursing consultancy would include the ability to operate within all four types, so that, the potential of nursing practice expertise can be realised at strategic levels as well as clinical levels.

Manley, 1996, 1997

Consultancy is not about developing dependence on the consultant. Although, in the past, expert specialist nurses acting in a consultancy function may have unwittingly caused dependency. For example, in being asked to provide help and advice (client-centred consultancy) about a patient's leaking stoma bag, the specialist nurse would have attended to the challenge, drawing on years of experience to provide a completely leak-proof bag to the satisfaction of the patient, with the consequence that other practitioners became deskilled and dependent on the expert. In Caplan's model, the focus of the consultant is on enabling such expertise to develop in others. Helping others to become self-sufficient in their own decision-making and problem-solving, and continuing to be self-critical is essential to achieving a sustainable culture of effectiveness across any service. This approach to consultancy is termed process consultancy.

Schein (1988) differentiates *process consultancy* from other approaches to consultancy, namely, the *purchase of expertise model* and the *doctor-patient model*, where consultancy tends to be underpinned by the premise that the expert knows best and that others will accept their advice without question. Whilst there will be

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Table 1.2 Examples of consultancy activity using Caplan’s (1970) consultancy model

Type of consultancy	Direct/indirect	Focus of consultancy	Examples
Client-centred consultancy	Direct to the patient/client/user and sometimes the care provider	Focus is on the client (i.e. the patient/user) and their health and illness issues. Although the request may come from a consultee (the care provider)	Specific patient-centred issues, for example assessment, diagnosis, intervention, evaluation and review
Consultee-centred consultancy	Indirectly focused on patients/clients	The consultee (health provider – individual /team) is the main focus of attention and is helped with their own activity, knowledge and learning	Improving knowledge and skills of health care providers as individual practitioners and teams
Program-centred administrative consultancy	Direct focus on a programme of activity	The focus is on developing, implementing and evaluating a programme/system of activity across an organisation	Implementing and evaluating, for example, critical care outreach or infection surveillance systems across directorates or organisations Implementing directorate-wide and organisation-wide programmes of, for example, practice development, systems for monitoring and maintaining patient safety, clinical governance, clinical effectiveness
Consultee-centred administrative consultancy	Indirect	Focus is on supporting the consultee who is implementing a programme of activity	Helping individuals (consultees) to implement and evaluate programmes/systems across directorates and organisations through, for example, mentoring, coaching and supervision

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times when experts' advice and guidance are required, the importance of working predominantly within a process consultancy model is important. This is because it fosters individuals and teams to develop their own skills in problem-solving activities so that they become self-sustaining. Process consultancy is also consistent with the facilitation approaches previously described and would be necessary for both developing and sustaining person-centred systems. Process consultancy is underpinned by values about collaboration and how others develop. Successful use of process consultancy and also Caplan's model involves:

- being able to work in a truly collaborative way with others;
- helping others to become self-sufficient in their thinking, learning and development processes by using approaches that enable ongoing reflection and critique;
- drawing on a number of tools which facilitate the development of a common vision and the giving and receiving of feedback.

The consultant is often viewed by the consultee as an expert. He or she may be expected to pass along relevant information and knowledge to the person of lesser expertise. While such a perception may benefit the consultant by increasing the likelihood that he or she will be listened to, it also negates the strength of the consultee and ignores the need of the consultee for assistance in the diagnostic process. To achieve the best resolution to the consultee's problem the consultant must work in collaboration with the consultee.

Hansen et al., 1991, p. 31

Developing expertise in a consultancy approach that enables self-sufficiency in ongoing problem-solving marks the final domain linked to the clinical career framework. At the beginning of the chapter, it was stated that nurses will be on different journeys in their development across the domains of the clinical career framework and will have different starting points. Whilst this is the case, for those at the pinnacle of their clinical career pathway, expertise in nursing practice and expertise in the other four domains necessary for developing person-centred systems would be a necessary requirement.

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Differing emphasis of expertise

The clinical career picture in nursing has undergone a period of change internationally (Schober & Affara, 2006). Nursing practice has moved from one that has been uncoordinated, underdeveloped, undersupported, with little options for the practitioner beyond the clinical manager role, to a position where it is now possible to progress coherently within a practice-based framework that enables the expertise of practitioners to remain in practice but still grow and develop the scope of their expertise (Rolfe & Fulbrook, 1998; Manley, 2001). There is now a much

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clearer vision for practitioners in their clinical career pathways; where they can go, as well as how to get there.

During recent years, there has been an emergence of different roles linked to advancing the practice of nursing and health care in response to changing health care needs and demand, for example nurse practitioners, clinical nurse specialists, generalist health care practitioners, lecturer practitioners and practice development facilitators as well as consultant nurses – within an international dimension, these roles all have subtly different meanings. The challenge now is how these roles can be linked and integrated more clearly to the concepts of nursing expertise across the career framework in a coherent way that enables clear public accountability as well as transparent career progression, and an explicit contribution to a modern and effective health care service.

Currently, there are tensions between a focus on developing generalists and specialists. Increasing specialism is a movement pervading all activities within a growing technological society, one where there is a knowledge explosion with new knowledge, technological advances, and increasing public needs and demands (International Council of Nurses, 1999). On the other hand, there is political interest in having a more generic worker with flexible skills to work within any health care setting; however, there lies the dilemma if one is seldom practising the skills one has learnt, then competency becomes questionable (Eraut, 1994). Within nursing, it is possible to have both expertise in terms of a specific client group such as the older person with mental health needs, and also generalist expertise in leadership, facilitation of cultural change and the development of a learning and research culture. Therefore, the career framework needs to reflect these two parameters:

- *A growing expertise and specialism with a specific client group*, for example as seen in nurse practitioners who work in general medical practices, or emergency nurse practitioners working within a minor injuries unit, or clinical nurse specialist working with patients with acute or chronic pain. Such practitioners are associated with predominantly client-centred care in the majority of their professional role.
- *A growing expertise in the domains necessary to develop person-centred systems* where patients and users experience care that is both person centred and evidence based; for example team or clinical leaders and managers who develop their managerial and leadership expertise in addition to their practice expertise; practice developers who develop their skills in enabling service teams to provide person-centred and evidence-based care and may be working either across organisations or within particular clinical directorates; lecturer practitioners and clinical facilitators who work with specific client groups but are developing their roles as facilitators, educators and enablers; and some clinical nurse specialists who are developing teams and services across whole organisations and sectors. This parameter is associated with a split in the time spent directly and indirectly with actual practice, although all activities are practice focused and interdependent.

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These two parameters may have a different emphasis within any one job role, but one could argue that expertise in the primary role of practising one's discipline is an essential prerequisite to progressing through a clinical career ladder in nursing, although the achievement of expertise in practice of caring for one's client group may not be a prerequisite to progressing along other career pathways such as health care management, higher education and traditional research pathways. The focus of the clinical career pathway is the integration of the clinical aspects of these functions within practice and for some the first and second parameters run sequentially and for others they develop in parallel. Within the UK, the consultant nurse is the pinnacle of the clinical career ladder in nursing and requires the achievement of expertise in all the domains necessary to develop person-centred systems. The consultancy function of the consultant nurse role integrates consultancy on nursing practice and practice development with consultancy on research and education in practice settings as well as consultancy on consultancy itself (Manley, 1996).

Consultant nurses use their expertise in nursing practice combined with expertise in the other domains to develop a workplace culture dedicated to providing quality care across the patients' journey, regardless of who provides care (Manley, 2001; Manley & Dewing, 2002). Clinical nurse specialists, like consultant nurses, are also usually expert nurses for a specific client group; however, they may be on their own journey of developing expertise in the other domains expected of the consultant nurse. Advanced practitioner roles are growing in number, whether they are generic or specialist; these too have nursing expertise at their core. However, advanced practitioner roles are associated with a specific set of competencies that will enable health care services to 'mind the gap' in the patients journey. Such competencies are informed by the technical interventions previously associated with different disciplines and in the future will also be integral to other roles in the nursing career framework. However, there is a perceptual difference between demonstrating such competencies at a level that is safe and confident and integrating them into a pattern of behaviour that can be described as expertise. Through explicating frameworks, standards and skills across the five domains, it is hoped that there is greater clarity about how to both achieve and recognise nursing practice expertise with regard to both the nurse-patient relationship and the development of person-centred systems.

Pathways beyond the consultant nurse role: where next?

Once the pinnacle of the clinical career pathway has been reached, it is important to reflect on the opportunities that may be available that places nursing practice expertise at their centre. Can nursing practice still be a part of one's role beyond a consultant nurse post? To answer this question, those posts that would build on the clinical achievements of the consultant nurse rather than posts that take practitioners away from the world of practice and the provision of direct services to patients and users are highlighted. Such posts fall into three areas; all are currently immature but have the potential for further development and would appear to be a natural progression for those who have developed their expertise across all the

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key domains of the consultant nurse but wish to influence health care practice and services more broadly:

1. *Clinical chairs*. These are posts that bridge health care organisations and universities with most of the post's emphasis being based in the health care organisation rather than the university. Clinical chairs would be leading an organisation-wide strategic programme of practice-related research and practice development where they would be supporting consultant nurses, senior practice developers and practitioner researchers in a corporate way contributing to the goals of the health care organisation. Clinical chairs are likely in the future to be the main supporters, coaches and mentors of consultant nurses across the organisation and would be a resource to the university in ensuring that Higher Education Institutions provide programmes relevant to the world of practice. The clinical chair would continue to practise nursing with possibly a small caseload within a specific area but predominantly their generic expertise would be used to support organisation-wide activity and would be strategically focused.
2. *Executive clinical leads/directors*. These are posts that in the future would be occupied by people who have progressed through the clinical career ladder and who have considerable experience as consultant nurses or practice developers rather than through the general management route. Their role would encompass providing expertise in nursing and service development as a member of the organisation's executive team in addition to leadership. They provide a strategic executive opportunity similar to executive medical directors and would still continue with a small caseload, thus keeping them in touch with the realities of practice and service delivery at the patient interface.
3. *Clinical deans*. These posts again bridge the health care organisation and the university similarly to the clinical chairs, although the time in the university would be much higher in proportion than with their clinical chair counterparts. These posts would mediate between the Workforce Confederations, health care providers, strategic health authorities and the universities providing clinical educational leadership with a focus on clinical education.

Summary

This chapter has set out to help readers to develop a broad vision for a clinical career pathway that is focused on nursing practice expertise. It has provided a vision for a clinical career pathway that focuses on two parameters: the development of expertise in the practice of nursing for a specific client group through the nurse-patient relationship, as well as, developing expertise in all the other areas necessary for providing quality services to patients – the four domains required to develop person-centred systems, regardless of national context.

Through considering the frameworks presented, readers are encouraged to assess themselves and their readiness to proceed through a clinical career

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framework, to decide where they are, where they want to be and to have some understanding about what they need to do to move in the direction of their vision. Many of the contributors to this book have been on this journey and are shining lights for what nursing expertise can offer – they are living models for the impact nursing expertise can have on contemporary health care.

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