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FACILITATION SKILLS – THE CATALYST FOR INCREASED EFFECTIVENESS IN CONSULTANT PRACTICE AND CLINICAL SYSTEMS LEADERSHIP

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Introduction

The research reported here offers insights into the key facilitation skills required by consultant practitioners as clinical systems leaders to enable individuals, teams and organisations to be effective in transforming and sustaining cultures to ensure they support integrated health services that are person-centred, safe and effective (Manley et al 2011, Manley et al 2014)

The project, used collaborative emancipatory action research (EAR) to provide a support programme within the early implementation period of consultant practitioners (nurses, midwives and health visitors) across the United Kingdom (UK) (DH 1999a) between 2001-2003, and finally reported in 2012¹. Consultant practitioners were a response to a lack of clinical career pathway for senior nurses, midwives and health visitors, and later AHPs, aimed to strengthen their contribution to health care and keep expertise at the bedside (DH, 2000). This role is the pinnacle of the clinical career ladder in these professions, and builds on the qualities expected of advanced level practice within the National Health Service (NHS) Career Framework (Skills for Health, 2010).

Nurses and midwives practising at higher levels were seen as key to reforming the health service and particularly working across professional and organisational boundaries (DH, 2002). Simultaneously, a need for change in practice and team

¹ The delay in completion and publication resulted from one year's unforeseen sickness of the primary author and then changes to employment conditions that mitigated completing both analysis and writing of the final report.

culture was highlighted by the Bristol Royal Infirmary (BRII, 2001) in relation to developing a health service that is well led through programmes of training and support for clinicians. Fourteen years post Bristol, the need to address such issues continues as reports of health care failings and national media attention to poor/toxic organisational and workplace cultures challenge professions, health care providers, regulators and subsequent governments to act (e.g., Francis, 2010; Patient Association, 2009; 2010; Kirkup, 2015). Current political reforms, which some are conceptualising as ‘privatisation by stealth’ (e.g., BMA; Pulse, 2011; Tallis & Davis, 2013), are also likely to challenge the effective delivery of joined-up, person-centred services.

Whilst the focus of this research was on supporting newly appointed and aspiring consultant practitioners, to develop the holistic facilitation skills for enabling such cultures, we found that these skills were catalytic when combined with other consultant functions and leadership skills. So, although this original research was undertaken ten years ago, the insights resulting are extremely relevant to the quality, productivity and innovation agenda, today because it focuses on the facilitation skills that help prepare consultants as clinical systems leaders. The need for clinical systems leadership – characterised by the skill-set of consultant practitioners is vital across the health economy if a whole systems approach to health and social care is to be achieved (Kings fund, 2015; Manley et al, 2014) and quality health care developed, assured and sustained.

Background and Literature

The consultant role comprised four functions: expert practice; professional leadership and consultancy; education, training and development; and, practice and service development, research and evaluation (DH 1999a)

The number of consultants initially appointed was fewer than hoped due to a dearth of candidates with the required pre-requisites e.g. the research, evaluation, learning and development skills necessary to match clinical expertise. As a result, there was high interest at the project’s inception in preparing aspiring consultants, supporting existing consultants, as well as exploring the methods to achieve these purposes.

The only research predating the political initiative above was a three year study, within a Nursing Development Unit using EAR to operationalise the role. It clarified the concept of the consultant nurse², including its attributes, key processes and the time required in practice to achieve and sustain the cultural outcomes associated with quality care in the workplace (Manley 1997; 2000a&b; 2001; 2002, 2004, 2009), specifically: effective, person-centred care; empowered staff who maintain individual and team effectiveness; and continuing practice development.

² Consultant nurse and nurse consultant is used interchangeably within this report. Each term is associated with the same concept and meaning, although historically they have different associations: with nurse consultant linked to an external business orientated constancy role, and consultant nurse, an insider clinically based role that mirrors those of consultants in medicine (Manley 1996). All UK Departments of Health use the term nurse consultant but within the context of an insider rather than outsider consultancy model.

Consultants do not achieve success in isolation but through collaboration with others, so being able to facilitate as well as inspire others to achieve a shared purpose were key processes in her conceptual model, reflected in the concepts of leadership and facilitation (Manley 1997). These processes were identified as influential in achieving cultural change, practice and service development; development of a learning culture that enabled individual, team and organisational learning; the establishment of practice-based research approaches and evaluation; and, the dissemination of expertise to as wide a community as possible through advanced consultancy approaches (Manley 1997). Other practice leaders (Binnie & Titchen, 1999) were focussing on the contribution of external facilitation to insider roles. The role of facilitation was a key concept emerging at the time linked to the achievement of professional activities such as: critical companionship and learning in the workplace (Titchen 2000); research implementation and knowledge translation (Harvey et al, 2002); practice development (McCormack et al, 1999; Manley & McCormack 2003; Garbett & McCormack, 2004); and the development of expertise in practice (Manley et al, 2005; Hardy et al, 2009). This latter project also used EAR to provide insights into how to support individual and organisational effectiveness through enabling expert practitioners to become practitioner-researchers and facilitators of others. Although involvement of co-researchers was limited to nurses with clinical expertise being individual practitioner-researchers with support from critical companions.

Subsequent research on consultant practice developed in parallel with the project or subsequent to it; for example: the evaluation of consultant nurse/midwife roles (Guest et al, 2001; 2004; Lathlean & Masterson, 2004; Redwood, 2007; McIntosh and Tolson, 2008); exploration of the role's complexity (Woodward et al, 2006; Jinks and Chalder, 2007; McIntosh and Tolson, 2008); leadership (Woodward et al, 2006; Lathlean, 2007; McIntosh and Tolson, 2008; Manley et al, 2008); and the role's impact on patients and/or across organisations (Ryan et al, 2006; Redwood, 2007; Avery and Butler, 2008). No other research focused on developing the facilitation skills of consultant practitioners or supporting aspiring consultants either prior to or since the study reported here.

Research Aim

The aim of the project was to enable newly appointed and aspiring consultant practitioners to develop expertise across the full range of consultant functions (see above) so as to increase their individual and organisational effectiveness. An assumption made was that participants were already experts in their primary practice (nursing or midwifery) but required help with developing expertise in the other functions of the consultant role. Pivotal to these functions and impact on organisational effectiveness are skills in the facilitation of others.

This was to be achieved through a programme of support which exposed participants to a methodology and methods that would help them grow their facilitation expertise across all consultant functions and the themes identified in Box 1. The programme involved the project team accompanying participants as they became both individual practitioner-researchers of their own practice and members of a critical research community investigating what was important to them in their everyday practice, as well as supporting each other through the inquiry process.

Box 1 Programme themes

- Putting the role of the consultant into practice
- Developing effectiveness;
- Demonstrating impact;
- Developing the facilitation processes necessary for helping others to develop

Research Design

Consultant practitioner as a novel concept for both participants and organisations expected barriers to implementation. In addition, the consultant role involves developing effectiveness in others and building and sustaining effective cultures – both activities are vulnerable to internal and external influences (often including power structures) that would need to be overcome. Emancipatory action research (EAR) (Grundy, 1982), the philosophical and methodological framework underpinning both the support programme and research approach embraces the: recognition and dismantling of barriers; transformation of power structures that hinder the development of practice; facilitation of cultural change and effectiveness; and, enables participants to research their own practice individually and collectively.

Central to EAR is the concept of ‘critique’ which also underpins the facilitation skills needed to help others to become effective through reflection and transformation (Mezirow, 1981). Critique is a cognitive and artistic process (Titchen, 2009) in which underlying assumptions of historical, social, political and cultural contexts are surfaced, examined, debated and contested. Critique aligns with critical social science and the intention to bring about: enlightenment (self knowledge about how and why we act; empowerment (approaches, strategies and motivation from increased self knowledge to bring about better ways of behaving and working); and, emancipation (putting these strategies into practice) (Fay 1987). Developing skills in critique is therefore important for consultant practitioners in their multiple facilitation roles.

EAR is defined by three criteria (Grundy & Kemmis, 1981). Table 1 illustrates how these are linked to questions asked in the study and the tool used

Table 1: Criteria for EAR linked to action, questions and tools

Criteria for EAR	Focus of action	Examples of Qs or tools used
1. Social practice is susceptible to improvement through deliberate strategic action.	This is on improving something or implementing a change (See McCormack, Manley, Wilson 2004; Titchen & Manley 2007; van Lieshout, 2013).	How do we demonstrate our effectiveness? How do we support others to be effective? How do we develop effective workplace cultures?
2. A spiral of interrelated cycles involving planning, acting, observing, reflecting and theorising that are	These spirals can include individual and/or collective action (See Titchen & Manley 2006; Cardiff 2014).	Using an Action hypothesis framework to develop understanding across different practitioners experiences resulting

systematically and self-critically implemented		from interrelated spirals
3. The involvement of those responsible for practice in each moment of activity, widening participation as the project involves or touches others (stakeholders), maintaining collaborative control of the process (See Ollerton J (2012); Snoeren & Frost, 2011.	A commitment to the empowerment of different stakeholder groups and the sharing of information between them is explicit in the action research process. Stakeholder evaluation approach (Guba & Lincoln 1989) complements EAR by providing a practical tool termed claims, concerns, and issues for identifying what matters to them (Manley et al, 2005; Titchen and Manley, 2006, 2007). Eliciting and working with claims, concerns, and issues informs the direction of action as a facilitation tool.	<ul style="list-style-type: none"> • A claim is defined as ‘any assertion that a stakeholder may introduce that is favourable to the evaluand’ (p40). • A concern is ‘any assertion that a stakeholder may introduce that is unfavourable to the evaluand’ (Guba & Lincoln 1989:40), with the ‘evaluand’ in this study being consultant practice and the programme of support provided. • An issue ‘is any state of affairs about which reasonable persons disagree.’ (p40).

Participant recruitment

Recruitment was achieved through information provided to: a convenience sample – a group of 10 consultants in the Mid-Trent region who had previously approached the Royal College of Nursing (RCN) Institute for action learning support; members of a UK-wide nurse consultant network; all RCN members through RCN Bulletin; and the British Association of Critical Care Nurses with the largest number of nurse consultants.

Criteria for inclusion in the project were: voluntary participation; willingness to attend monthly active/action learning sets and collaborative workshops; willingness to join an action research study as a co-researcher; and support of their line manager.

All participants applying at the start of the programme joined one of three cohorts across England on a ‘first come first served’ basis. Later applicants were allocated to an informal waiting list. The research team intended to recruit consultants and aspirants from all four UK countries, but because of the dearth of nurse and midwife consultant posts in Scotland, Wales and Northern Ireland, participants were drawn predominantly from England.

Two cohorts comprised consultant nurses and one consultant midwife each. One of these cohorts was held in East Midlands and the other rotated around sites across South England, although membership was drawn from across England. The third was based in London and included nurses and one midwife who aspired to become consultants from across England.

Although deliberate attention was given to the commitments required to be practitioner-researchers, of the 20 consultants recruited to the project, one withdrew before its commencement and three never attended cohort meetings. These participants were replaced, subsequently, by two applicants who were drawn from the

waiting list. Of the 11 aspiring consultants, two never attended the project and they were also replaced from the waiting list. Of the 11 aspiring consultants who commenced the project, 4 withdrew either because of difficulty with travelling to either Nottingham or London or because of personal circumstances.

Consent

Participants consented to become practitioner- researchers, researching their own practice and participating in the project processes. Process consent was obtained at every stage of the research journey as well as consent to use the data emerging individually and collectively. Non-consent was respected and would not impact on participant's ongoing participation in the support programme.

Methods Used

Three methods supported co-researchers in researching their practice over 18 months, consistent with the research methodology to help them become aware of the influences on their own and others effectiveness through supporting them with the concept of critique underpinning effective facilitation:

- eighteen, monthly cohort meeting days including time for active and action learning (see below).
- Needs led workshops bringing all three cohorts together to analyse, interpret and make sense of project data. Four workshops included a two-day residential.
- Use of individual tools, such as the Claims, concerns and issues tool

The claims, concerns and issues tool guided the starting point for negotiating the work of each cohort meeting and workshop. Two other tools were used by a few co-researchers at the end of the study: qualitative 360 degree feedback (Manley et al 2005; Garbett et al 2007) and reflective review (after Johns 1995), to identify the learning and impact outcomes. The challenge of achieving ethical approval when using tools to develop effectiveness in practitioner research is described in Box 2 and explains why not all participants completed these methods.

Box 2: Ethical issues- the paradox in practitioner-research when obtaining stakeholder feedback

EAR is explicitly committed to acting morally and justly. This is reflected in the concept of praxis which is concerned with committed and informed action (Grundy 1982). In EAR the commitment is not just to act morally and justly but to change the systems that work against justice and equity. The potential for research facilitators to exploit and manipulate participants does exist (Grundy 1982), although this can be minimised through making explicit criteria for 'trustworthiness', working collaboratively, openly making explicit values and beliefs, and developing a critical community where critique, challenge and support are the norm.

The ethical issues are complicated when researching professional practice because by doing action research, professional individuals and groups are researching the effectiveness of their own practice and developing their practice in a way that can be argued as keeping knowledge and skills up to date, as well as developing competence and performance (NMC, 2008).

One challenge within this project hit at the heart of being a practitioner-researcher. Whilst by its nature, EAR is an ethical endeavour, the context in which such research operates may itself be an ethical constraint. Both ethical and professional practice is characterised as systematic and rigorous when developing one's effectiveness in daily practice, and that this includes theorising about practice, using and justifying different types of evidence and being involved in supervision. By using these very same processes as part of an EAR a paradox exists as barriers result that work against developing and researching one's own practice. This paradox is reflected in the 'research versus audit' debate where depending on whether some an activity e.g. patient stories, is called research or audit influences whether Local Research Ethics Committee (LREC) approval is required. The time and bureaucracy involved in obtaining research ethics approval then hinders practitioners in continuing to formally research their own effectiveness if trying to incorporate the views of other stakeholders.

One example in this study concerned the decision of consultant nurses to obtain feedback from their colleagues using a qualitative 360 degree feedback approach. Good ethical practice in day to day work, when using such a tool, includes respecting the choices of individuals if they decide not to respond or wish to remain anonymous. Given this ethical position, one chair of a LREC suggested that if the work was called 'audit' in the final report then LREC approval was not required. However, the researcher-practitioners making the request with this particular committee held their ground stating the study was not 'audit' but 'action research'. For this reason a Multi-Centred Research Ethics proposal was submitted with the result that it was almost impossible for the consultants to use the 360 degree feedback tool before the end of the project, although three did succeed through pure perseverance. The need for similar multi-centred research and local research ethics approval and research governance support was also acknowledged in Guest et al's study (2004) as a constraint that prevented the use of extensive stakeholder feedback within their study.

Active and Action Learning

*“Active learning is an approach for in-depth learning that draws on, creatively synthesizes and integrates numerous learning methods. It is based in and from personal work experience of practitioners. Being open to, engaging with and learning from personal experience are central activities in emancipatory and transformational practice development (PD) work and the purposes of PD; key to which is *transforming workplace cultures and individuals*” (Dewing, 2008, p. 273)*

Strategies included: reflection in and on practice; creative approaches to make sense of reflections, e.g. creative expressions and poems; presentation and critique of data gathered during the previous period; workshop activities around role and work; and allocating time for addressing negotiated needs, collaborative analysis, and action learning. Action learning was used extensively within the study and is described as, a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done (McGill & Beaty 2006). Structured reflection in and on practice is central to the action learning process and aims to uncover tacit

knowledge gathered through the person’s work experience that has previously been difficult to articulate and explain (Schon 1983).

Action learning is one way of enabling practitioners to take action in the workplace and to overcome the barriers that work against transformation. These emancipatory processes have been identified as central to the role of the consultant nurse in the achievement of cultural change (Manley 2001), as well as being influential in helping others learn from their experience through critical companionship (Titchen 2000). Table 2 outlines the primary data arising from the methodology and methods used.

Table 2 Methods, data and analysis

Methods	Data	Analysis
<p>Throughout the Study: Collective and collaborative methods:</p> <ul style="list-style-type: none"> • Active learning including action learning and other approaches to reflection on practice • Needs-led workshops 	<ul style="list-style-type: none"> • Claims, concerns & Issues held at every cohort meeting and workshop (x3 cohorts, 18 cohort meetings, 4 workshops) • Notes from cohort meetings and workshops (x3 cohorts, 18 cohort meetings, 4 workshops) • Notes from incidents brought to action learning across all cohorts (x 40 incidents) 	<p>Collaborative Analysis undertaken by all participants: Undertaken at various levels led to the synthesis of four themes:</p> <ul style="list-style-type: none"> • Role of the consultant nurse • Impact of the context on practitioner-researchers • Outcomes • Project processes <p>A final meta-analysis, undertaken by the research team in relation to the programme of support:</p> <ul style="list-style-type: none"> • Captured the starting points and end points of three significant journeys travelled by practitioner-researchers as they continually strived towards greater effectiveness:
<p>During and at the end of the study: Individual tools</p>	<ul style="list-style-type: none"> • Qualitative 360 degree feedback (during study) • Reflective Review (at end of study) 	<ul style="list-style-type: none"> • Becoming researcher-practitioners, integrating learning and inquiry into their everyday practice • Achieving greater effectiveness in their roles described by the metaphor ‘Sailing down the river’ • Achieving organisational effectiveness, described by the metaphor – ‘Wiring them in.’

Facilitation Approach

The research team modelled the facilitation of the methodology and methods (comprising the support programme) to enable participants become practitioner-

researchers and facilitators of others. The active and action learning set facilitators, as experienced facilitators of work-based learning, practice development and practitioner research, used holistic, enabling facilitation approaches that also involved the use of creative expression (Titchen, 2004; Rycroft-Malone, 2004; Manley et al 2005). They used ten principles for facilitating work-based learning (Box 3), derived from a concept analysis of work-based learning (Manley et al, 2009) to develop: facilitation skills, learning in and from practice, inquiry into own practice; and a learning and inquiry culture, but also participants' own praxis skills to sustain a commitment to the project.

These facilitation approaches influenced how co-researchers engaged with the methodology and methods in a way that was collaborative, inclusive and participative; were modeled by the research facilitators; and became evident in co-researchers as they progressed through a number of journeys

Box 3: Ten principles for facilitating work-based learning (Manley, Titchen, Hardy; 2009)

Principle 1: Developing a learning and inquiry culture

Principle 2: Negotiating the learning objectives and action to be taken to achieve individual and collective goals

Principle 3: Optimising the use of appropriate resources

Principle 4: Helping participants to learn opportunistically in the group learning situation

Principle 5: Role-modelling and articulating own professional knowledge about being an active learner, facilitator of active learning and practitioner researcher

Principle 6: Enabling the integration of knowledge and ways of knowing to develop professional artistry and praxis through using cognitive and creative approaches

Principle 7: Using a wide range of styles, processes and skills that match participants' level of knowledge and the context in which they are working

Principle 8: Enabling a working relationship/partnership built on mutual trust and high challenge and high support through paying attention to the whole person and processes as well as outcomes

Principle 9: Facilitating rigorous organizational, cultural and practice changes at individual and collective levels through practitioner research

Principle 10: Collaborating in project administration and management

Collaborative Data Analysis and Theoretical Development

The action learning part of cohort meetings involved individuals presenting, to the set, critical incidents important to them in their work. Set members actively engaged in

helping the presenter through providing high challenge and high support guided by a reflective model (after Johns 1995) to unpick the critical incident, identify the key question they wished to address; uncover the 'taken-for-granted' aspects in the incident; identify the internal and external factors impinging on the incident; and helping the presenter to identify strategies, explore consequences, capture action points emerging from the process, and identify learning.

Action learning produced significant data, in total, 40 critical incidents drawn from participants' reflection on their own practice presented across 18 months, 23 from consultants and 17 from aspirants. The analysis of incidents was later linked to the emerging themes from the meta analysis (See Table 3), but also became the focus of collective analysis by practitioner-researchers to theorise their practice and how to change it. This theorisation involved describing, explaining and predicting:

- relationships between practice concepts and developing evidence from their practice illustrating these
- action strategies that would move them from their starting points to desired end points.

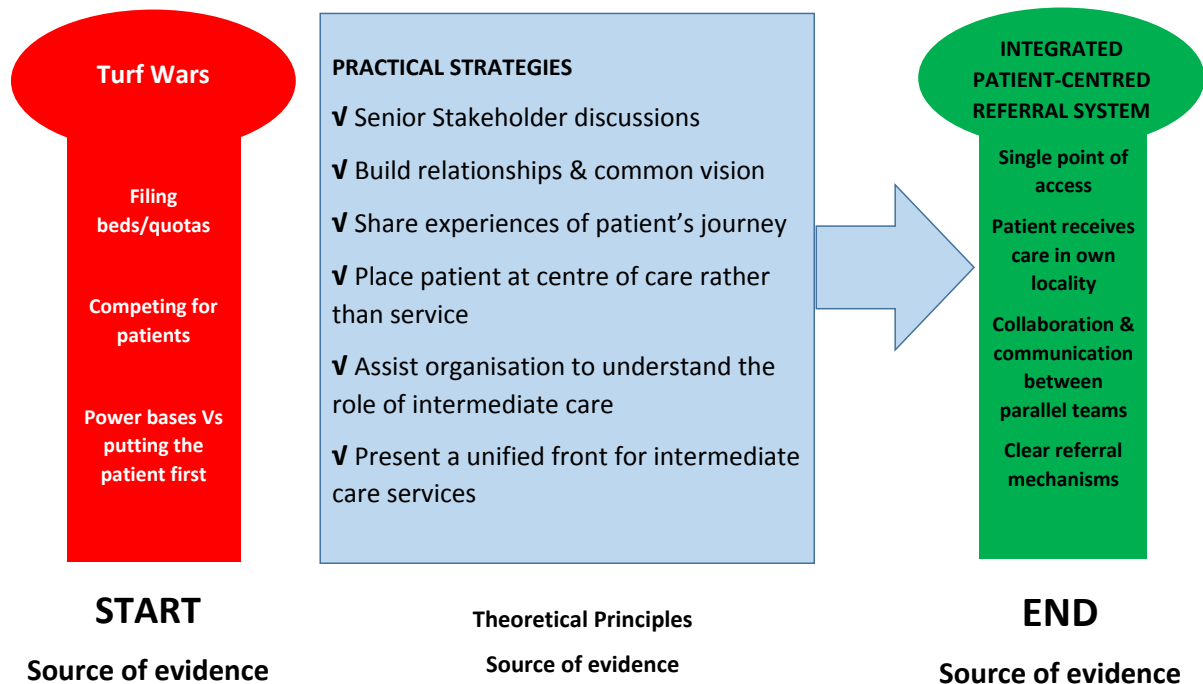
To achieve this theorisation, a framework was used, termed 'action hypothesis' developed in a previous action research study (Binnie & Titchen 1999). It was adapted with co-researchers for understanding how analysis of their own practice could contribute to theory and capture similarities or differences across different cohorts. The framework identified the relationships between: trigger concepts influencing the presenter's work; the goals they were trying to achieve; the strategies they undertook to achieve their goal; evidence of goal achievement and related published theory termed 'theoretical principles'.

Presenters of critical incidents reported back at later meetings their findings relating to the action they had taken, the impact of the action and how effective it had been. At subsequent meetings using the verified notes captured by the research assistant, the cohort group undertook a joint analysis of each action learning presentation (Kemmis & McTaggart, 1988; McTaggart, 1991; Prideaux, 1995;).

For each stage of the framework, evidence was collated from different sources that substantiated the issue, the strategies used and the outcomes achieved. In tandem, relevant theoretical principles in the literature were identified and considered by both the research team and the co-researchers to explain the concepts, strategies and relationships involved, either to strengthen understanding of the issue or to challenge the literature in response to practical experience. Figure 1, provides an example of how the framework was used in relation to one trigger, 'turf wars' and includes the strategies successful in addressing the trigger and the outcomes that arose from their use. Sources of evidence used to demonstrate triggers, strategies tried and outcomes included, meeting notes, action plans, stakeholder evidence. Theoretical principles in Box 4, refers to the evidence in the literature that support the strategy used, for example; practice development strategies that position person-centred care at the heart of health care (McCormack et al, 2013); approaches to developing a shared purpose and a transformational culture (Manley et al, 2011b) and, role clarity in intermediate care services (Nancarrow, 2004)

Figure 1:

Turf Wars



All data sets, of which the critical incidents were only part, were thematically analysed. Practitioner-researchers and the research team worked with data sets at cohort meetings and workshops to synthesise four overarching themes: 1) the role of the consultant nurse; 2) the impact of the context on consultants and aspirants; 3) the outcomes; and 4) the project processes. These themes were used to develop in-depth examples of the data with co-researchers, described more fully in the final research report (Manley & Titchen, 2012).

The final meta-analysis was undertaken by the research team subsequent to the project’s completion. Drawing on the four themes above, the starting points (at the beginning of the project) and end points of three significant journeys were identified across the support programme as practitioners-researchers strived towards greater effectiveness. Three journeys are identified and described: 1) becoming researcher-practitioners, integrating learning and inquiry into their everyday practice; 2) achieving greater effectiveness in their roles using the metaphor ‘Sailing down the river’ to describe how the journey felt; and lastly, 3) achieving organisational effectiveness described by the metaphor of ‘Wiring them in.’

Table 3 summarises the three journeys, starting point, strategies and endpoints achieved by participants through the support programme and the facilitation skills developed to achieve outcomes.

Table 3: The three journeys undertaken by practitioner researchers, their starting points, strategies and end points to describe the impact of the programme of support

Strands of the journey	Starting points	Strategies	End points
<ul style="list-style-type: none"> Enabling others to be effective <p>Becoming researcher-practitioners, integrating learning and inquiry into their everyday practice</p>	<p>Knowing that enabling others is an important aspect of the role.</p> <p>Not knowing how to enable others</p>	<p>Strategies identified, tried and tested for enabling others</p>	<ul style="list-style-type: none"> Skills developed in enabling others Others become more effective Greater team effectiveness
<ul style="list-style-type: none"> Enabling others to draw on what the consultant had to offer so that the role becomes embedded in, and supported by the organisation to achieve its potential <p>Achieving greater effectiveness in their roles – ‘Sailing down the river’</p>	<p>A context that didn’t know how to:</p> <ul style="list-style-type: none"> use consultants or seem to value them. embed consultants in the culture. support and develop consultants 	<p>Strategies identified, tried and tested for consultants to become embedded and fulfil their potential</p>	<ul style="list-style-type: none"> Credibility earned from others who began to recognise what consultant has to offer Contribution consultant is making is valued Consultant influences strategic agenda Consultant support mechanisms improved
<ul style="list-style-type: none"> Knowing what an effective culture is and developing this in the workplace for patient care <p>Achieving organisational effectiveness – ‘Wiring them in.’</p>	<p>Recognising Ineffective cultures</p>	<p>Knowing what an effective culture is Developing effective cultures</p>	<ul style="list-style-type: none"> Greater person centred focus Achievement of best practice Practice and patients’ experience influences strategic direction

Findings

The participant’s three journeys identified above illustrate the main outcomes in this paper.

Becoming Researcher-Practitioners, Integrating Learning and Inquiry into their Everyday Practice

A complex journey was identified in preparing participants for engaging in EAR. This included identifying their starting points, the facilitation of learning strategies used

and the outcomes, in terms of developing participants' knowledge, skill-sets and the professional artistry of integrated learning and inquiry

At the outset of the study, participants asked questions about action learning and practitioner-research that indicated unfamiliarity and uncertainty about integrated learning and inquiry. Whilst there were indications of gaps in knowledge, skill-sets and professional artistry of integrated and reciprocal learning and inquiry, participants were taking responsibility for the management of the project collectively. .

A haiku (a Zen poem), written at the beginning shows a clear understanding of practice development (PD) was not held.

*'Ideas evolving
PD processes unfolding
Practices transformed'*
(Workshop, June 03)

In addition to unfamiliarity with action learning, practice development and practitioner-research, most participants appeared not to have fully developed the skills for mindful, intentional action essential for any form of expertise.

"Action learning – it took a while for me to realise that it would not 'solve my problems for me' but provide a vehicle for reflection and planned action ... I was all over the place – in a real muddle at times, which did not facilitate the process. I tried to tackle too much and then found myself unable to sort out the wood from the trees. I took far too long in organising my thoughts into a coherent framework, finding it really difficult to explain what I did, or what the issues were for me [meta-cognitive knowing]. I wanted to blame the [action learning] process, or the fact that my role was 'different' and the concept difficult for others to understand, when, in fact, my behaviour mirrored what was happening in the workplace [reflexive knowing]."
(Practitioner-researcher reflective review)

Participants demonstrated evidence of becoming practitioner-researchers through becoming active learners and facilitators of others' learning. Through experiencing the ten principles of facilitation of work-based learning and developing expertise, co-researchers became able to use the principles in their own work;

'I have learnt about the importance of therapeutic teams and social processes being the key to change more so than organisational structures.' (Cohort 3, Reflective review).

'Action learning sets provides me with tools to facilitate others' role development.' (Cohort 1, Active Learning Set)

'I have learnt that role modelling is not enough. What is required is that we explicate our actions and our strategic thinking pathways to others: - a) so they can see its conscious activity, demonstrate our intentionality, and not just 'she's a natural/it's easy for her' and devalue these [praxis] skills; b) So

they can learn the strategies themselves; c) It also re-emphasises the need for *'practice with feedback'*. (Cohort 3, Reflective review 4)

'I learnt about action research... I learnt how to evaluate practice' (Cohort 3, Reflective review 5)

'We have engaged in genuine critical dialogue which has generated new thinking and theory' (Cohort 3, Active Learning Set)

'I feel that I have achieved some very real progress in terms of leading/developing practice but I am only just acquiring the tools (via the project) to demonstrate effectiveness.' (Collaborative Workshop)

We conclude that the strategies adopted by the facilitators to help participants on these journeys were effective. Despite the difficulties that participants had to surmount, at both individual and collective levels, the evidence suggests that facilitation strategies, imbued by the ten principles identified (Box 3) enabled rigorous practitioner research. Strong commitment to engagement in the action research and project management was shown. However, whilst participants felt supported and valued by the project, they raised concerns about the project coming to an end, in terms of where support for the future would come. This is a real concern and one that will have to be addressed if effectiveness of the consultant role is to be demonstrated.

Achieving Greater Effectiveness in their Roles – *'Sailing Down The River'*

This theme captures participants' experiences as they became confident in applying the attributes of a practitioner-researcher to their work and multiple roles described as *'sailing down the river'*. The key focus for the consultants was that of being a consultant, whereas for the aspirants, it was on becoming a consultant.

At the outset, consultants experienced two difficulties: operationalising the role, with concern about how to balance the roles, maintaining credibility and managing the lack of clarity about expectations of the role within their organizations. Although consultants were clear in theory, about their complex and interacting roles, their colleagues and their organizations were not. Consultants turned their attention to developing their knowledge, skills and capacities for demonstrating effectiveness in their multiple roles and gathered evidence, using a variety of tools, to show their organizations their achievements. For some, this was an arduous journey because their research skills were underdeveloped. Those who already had higher degrees were better able to demonstrate their effectiveness within the timescale of the project.

In contrast, the aspirants were not yet sure what a consultant did or how best to become one, they wanted to explore the components of the role. The starting point for them was how to become a consultant without a career development pathway already being in place. Through developing strategies for assessing themselves for the role, finding themselves a mentor and/or gathering qualitative 360 degree feedback on their role and areas for development, aspirants either moved successfully towards developing new consultant posts in their organisations, achieving positions in other organisations or further developing their skills for career progression.

For consultants, the first step was recognizing that multiple roles and their interplay required more development and balancing before the effectiveness of the role could be demonstrated to their organizations. Acting on this recognition, they addressed role ambiguity at service and strategic levels by clarifying the nature of this ambiguity and undertaking a sophisticated analysis, which enabled them to successfully clarify and negotiate the role strategically within their organizations.

A predominant focus within critical incidents was around the multiple roles consultants needed to fulfil. The leadership role, how this differed from management, and the research and evaluation role featured strongly in the consultants' critical incidents. Expertise in practice was the focus of the aspirants and developing the consultancy role was a lesser focus. The educational role was linked strongly to the processes of facilitating learning and effectiveness for both practice and service development.

The research, evaluation and developing effectiveness role was the most problematic to achieve and demonstrate due to resource and ethical committee constraints. Whilst the power of the interaction of multiple roles in relation to strategically influencing patient care has been shown, dilemmas remain about the level of focus at which consultants should direct their energy.

Both consultants and aspirants recognized that the post involved multiple roles, but the consultants initially struggled with finding time, support and resources to develop roles over and above their expert practice function:

'The consultant nurse role is more about evidence based practice, practice development and leadership ... I am overwhelmed by the workload. It's very unpredictable' (C1&3 Combined Active Learning Set)

Participants demonstrated through their practitioner research that they were able to achieve role clarity in their organizations, show greater effectiveness as a clinical, professional, political and strategic leader, educator and facilitator of work-based learning and as researcher.

'Being part of the action research project has helped me to understand others' perceptions of the role, develop strategies in order to articulate the complex nature of the role and to develop the role further. This has been achieved using 360 degree feedback, structured reflection and in particular being challenged in a safe environment, supported and nurtured by the group. It allowed me to have precious, protected time, away from the workplace to reflect on what I was trying to achieve (and often discover what a muddle I was in!). It has given me insight into how I perform and helped me identify areas requiring development. I would not have had the skills to operationalise this or have been disciplined enough to do this alone, which is why the support and facilitation from the group has been so invaluable.' (Cohort 1 Reflective review)

Consultants worked hard to successfully, in their view, influence strategically, for example the universities they were associated with, their Trust boards, Directors of Nursing, and their Nursing and Midwifery Committees. Over time, greater

effectiveness as a clinical, professional, strategic and political leader became apparent:

'I was pivotal in changing nursing strategy in the trust. Also supporting junior nurses in decision making in the new councils. This has been part of getting other people involved in what I am doing.' (C3 Active Learning Set)

'I have implemented actions from action learning and reflected on the issues I brought and the management of them. This has resulted in a number of positive outcomes, for example: regular review of supervision sessions with the result of colleagues wanting to continue to be supervised by me, a new member of staff approaching me to commence supervision and enabling colleagues to focus on the action points of their supervision.' (C1 Reflective review 3)

Consultants therefore developed an appreciation and recognition of the complexity of the role in terms of its multiple functions in practice;

'If I look at the document from the Department of Health (The Contribution of Nursing to Comprehensive Critical Care), I am [now] doing most of those things: strategic/organisational development; leading research projects; disseminating practice/educational initiatives; engaging in the political processes at local level and; trying to use facilitation processes to develop others'. (Workshop June 2003)

In respect of the aspirants' journey during the project, three applied for consultant posts and two had been involved with developing a consultant post at their own hospitals. One achieved a post at the end of the project and another achieved one in Australia.

Consultants' and aspirants' journeys towards greater effectiveness in preparing for a consultant role or working in multiple roles, have been demonstrated.

Having developed facilitation skills as active learners and become integral inquirers into their own practice (the first journey); participants were now able to focus on developing their own work effectiveness. This enabled them to further develop their facilitation skills to enable others to become effective. They earned credibility from others, who began to recognize what they had to offer. Through the complexity of their multiple roles they became valued for the contribution they made to services.

'My involvement in the project has provided the opportunity to identify the key attributes of a patient centred, evidence-based culture. To develop this culture within our own team I have met both individually and collectively with the team to identify their learning needs and how they can be addressed. Within the nursing team we now have two nurses undertaking their MSc in X (specialism removed to protect anonymity) nursing and four nurses undertaking degree level specialist X modules. These nurses are now challenging certain aspects of practice and using the evidence to develop a more patient orientated service, e.g., patients administering their own injections of X and devising information leaflets on aspects of self-management. A forum has developed where the nursing team can meet and share ideas and concerns.

This ensures that the team has a shared vision and engages in collective decision-making to improve the services for the patients, as well as supporting the needs of *team members.*' (C3 Reflective review 5)

Achieving Organisational Effectiveness – ‘Wiring them in.’

One of the aims of this research study was to help consultants demonstrate their impact. A key strategy (and metaphor) for achieving this organisational impact was termed by one practitioner-researcher as, ‘wiring them in’.

‘To wire them in is to engage them with a connection so there is enthusiasm for the process. They’re engaging in it even if they don’t agree. Wiring is an interesting image. Wires can get crossed so you have to check they are wired in.’ (C2, active learning set)

The following, Haiku builds on this metaphor which resulted from deliberations within action learning to capture these strategies:

Increasing the voltage.
Overcoming the resistance.
Give them a power surge.

The impact of this strategy on workplace cultures and services included a greater person-centred focus; achievement of best practice; and influence on the strategic agenda, to improve services to patients.

“I have developed an excellent service for the users and contributed to other services that affect the care/support the users receive. I feel I have also fulfilled the criteria for being a consultant nurse that is, expert practice, leadership skills, education/training and consultancy etc.” (Workshop 10/11 Jun ’03)

‘Participation in the Consultant Nurse Project has increased my ability to influence the strategic direction of services – I have been active in mapping services and developing strategies to address identified shortfalls, thereby ensuring that the Trust is in a position to deliver quality services to children, which reflect Department of Health requirements’ (Cohort 1 Reflective Review)

“I can demonstrate I have effected change by identifying issues within clinical practice and putting systems/solutions in place to improve practice/outcomes. Clinicians especially medics have moved from disliking a nurse in a position of expert/strategist to seeking guidance and support on clinical issues. This change has taken two and a half years and still has some time to develop.” (Workshop 10/11 Jun ’03)

For participants, workplace activity became the principle resource for learning, leading to greater individual effectiveness in their role demonstrated through the recognised impact and tangible changes achieved. To achieve positive outcomes for patients and the service as well as individuals, required practitioner-researchers to first develop facilitation skills as active learners and inquirers into their own practice to

develop their own work effectiveness. Then, shifting their focus to developing the effectiveness of others through enabling individuals and teams to be effective.

Summary of the Journey Themes

Taken as a whole and demonstrated in the quotes describing the participants' three journeys, it is clear that experiences of the programme of support underpinned by the research methodology EAR, related methods and the ten principles of facilitating work based learning were profound. Further evidence was provided at workshops and in reflective reviews:

'I have been part of the first action research project, which is co-operative and sophisticated in all stages ...Feeling positive for being part of something from beginning to end (Workshop 9/12/03)

'It provided the opportunity for professional development and self reflection on my role. I was able to ... explore my role in a challenging, supportive environment'. (Practitioner- Researcher, Reflective review).

This paper will now discuss the findings, new insights gained and limitations of the study.

Discussion of new insights

Facilitation – the catalyst for achieving effectiveness

This is the first time that facilitation exemplified by ten explicit principles (Box 3) has demonstrated a catalytic role to connect: how practitioners are supported; the positive impact on consultants' own effectiveness, the development of others' effectiveness; and impact on services and organisations. Although, other researchers have suggested this relationship, for example: Woodward et al (2006) researching organisational influences, identified consultant nurses gave and received support and acted to empower other nurses so building the relationships necessary for successful role integration; and Graham (2007), through narrative analysis described role transition of consultant nurses and concluded that to be effective and provide effective patient care, appropriate learning needed to take place and this was required before the real potential of the role could be realised. The connections between becoming effective as a consultant practitioner and enabling others to become effective are therefore recognised by others. This study has identified and tested the mechanism through which this may happen.

A systematic review and meta-synthesis, evaluating the consultant role concluded a number of studies implied active engagement in expert practice and leadership by focussing on specific service developments (Humphreys et al 2007). Whereas, in a cooperative inquiry of nurse consultants working with older people, it was recognised that it was important to understand how leadership (as one element) is reflected in a highly complex, multidimensional role. It was also established that there are links between leadership and enabling/facilitating, quality person-centred ways of working with Older People within rapidly changing, pressurized healthcare settings (Manley et al , 2009). McIntosh & Tolman (2009) argue that sociological and psychological research identifies difficulties in formulating a coherent theory of leadership, arguing

for better understanding of leadership processes. In their review of Scottish consultant nurses, with a focus on leadership, they concluded that nurse consultants require considerable technical expertise, cognitive and interpersonal skills, and the ability to take risks. Their data suggest that the leadership attributes required are transformational in nature, but that they also embraced more than transformational leadership in much of the literature. Greater exploration of the interrelationships between leadership and facilitation may provide greater understanding of both McIntosh and Tolan's findings as well as the study we are reporting here.

Methodological insight

New methodological insights and understandings have emerged from this study in relation to the use of EAR and the methods which build on the research team's previous experiences of enabling practitioner-research at the individual level in the development of nursing expertise (Manley et al, 2005; Hardy et al 2009). This insight relates to the degree of involvement in collaborative analysis undertaken by participants. All research participants contributed collectively, to full spirals of interrelated cycles involving planning, acting, observing, reflecting and theorising that are systematically and self-critically implemented (Grundy & Kemmis 1981), (although the final meta analysis was undertaken by the research team); as well as, being individual practitioner-researchers, which was the sole level of involvement in the previous EAR study (Manley et al, 2005). Other action research involving consultant practitioners or equivalent have predominantly focused on developing individual practice, quality, services or workplace cultures within a specific field collaboratively and collectively with key stakeholders (e.g., Gregorowski, et al 2013; Bellman et al 2011; Cardiff, 2014), but not, it appears, with a national community of practitioner-researchers, involved together in contributing to and facilitating all aspects of each research spiral, as described in this study.

Theoretical insight

This insight relates to the use of the theorising from practice framework. At the collective level, participants demonstrated evidence of becoming practitioner-researchers through becoming active learners and facilitators of others' learning, not only in the support programme, but also in their workplaces – they evidenced this through their collective action hypotheses. The rigour of collaborative analysis and theorisation from practice within this study was substantially greater than achieved in the earlier EAR study. Whilst an illustration of this is provided in Box 4, other examples are provided in the study's full report (Manley & Titchen 2012). It is proposed that this framework has potential for demonstrating social impact more convincingly, through illustrating the interrelationship between inputs, actions, outputs, outcomes and impact, whilst being cognisant of realist evaluation approaches which identify the links between contexts, mechanisms and outcomes (Pawson & Tilley 1997).

Subsequent studies completed by Kennedy et al (2011) and Gerrish et al (2013) have led to the development of an impact framework for consultant nurses through a comprehensive programme of work with in depth case studies. Three domains of impact have been identified - clinical, professional and organisational domains. Their findings suggest a largely positive influence of nurse consultants on a range of clinical and professional outcomes, which map onto the proposed impact framework. Kennedy et al's (2011) research is critical of the quality of the studies reviewed

identifying very little robust evidence and methodologically weak quality. They propose further robust research is required to explore nurse consultants' impact on patient and professional outcomes and that their impact framework could be used to guide future research and assist nurse consultants assess their impact. Whilst impact frameworks will enable effectiveness to be demonstrated, it is also important to understand the mechanism through which this impact is achieved if consultant practitioners are to be prepared effectively and if their roles are to positively contribute to future health and social care challenges. However, the programme of support presented here goes some way towards contributing understanding about the mechanisms that achieve the impact, providing insights about how future consultant practitioners can be developed and supported.

Limitations

Whilst there are new strengths in how this study has been conducted compared with our previous EAR (Manley et al, 2005; Hardy et al, 2009), there are also limitations, particularly around optimizing the support for participants in the workplace itself.

1. Lack of critical companionship support to assist with portfolio development
The lack of critical companionship support (Titchen, 2004) for practitioner-researchers within this study appears to have reduced the rigour of the practitioner research, particularly in relation to data gathering at an individual rather than collective level. Practitioner-researchers in this study did not seek or were able to find a critical companion in their workplace or develop such portfolios, even though it was an expectation of being a project member. This may have been because the roles were so new and there was little clarity about the roles by others in the workplace.

Critical companionship is the term provided for a 1:1 helping relationship focused on helping the individual to learn through a mutually supportive facilitative relationship (Titchen 2000; 2004). In the earlier study, the centrality of critical companionship to rigorous practitioner inquiry was evidenced through the completion and accreditation of portfolios of evidence of expertise. This finding suggests that critical companionship in the workplace needs to be built into supporting staff that are developing and preparing for the consultant role, a concern for participants. The need for support systems have been endorsed by other studies as it influences role achievement (Woodward et al 2006).

2. Focus on critical theory

The underlying premise of EAR is critical theory and its focus on identifying and removing barriers and challenging power structures. This may not be the most effective approach to transformation when placed in the context of movements, such as: positive psychology (Seligman & Csikszentmihalyi 2000) where the focus is on finding solutions, achieving personal growth and flourishing through optimum human functioning; transformational action research (Titchen & McCormack 2010) where the focus is on human flourishing as both end and means of research and creating the conditions for loving kindness and flourishing at all levels of being a person; or appreciative inquiry (Dewar & Sharp, 2013) where facilitation in action research is about identifying future actions that build on what is already done well. It is concluded that the EAR approach used in this study many of these elements. As can be seen from the evidence presented, the co-researchers flourished through their involvement in the EAR and the tool, claims, concerns and issues includes both a

focus on celebration through claims, and finding solutions as an endpoint of identifying concerns and issues.

There is much in common between the outcomes of this study and other studies researching non-medical consultants. Subsequent research has demonstrated; greater appreciation of the innovative nature, complexity and challenge of these roles across organisations (Woodward et al 2006; Jinks & Chalder (2007) McIntosh and Tolson 2009); much potential if more widely understood and actively supported by organisations (Woodward et al, 2006; Graham, 2007; McSherry et al 2007 ; Jinks & Chalder; 2007; Mullen et al, 2011); they cross traditional interfaces and different levels within and across organizations (Manley et al 2009); and are effective, flexible, responsive internally and externally locally, regionally and nationally (Mullen et al 2011). Mullen et al (2011) identified a key challenge is the small size of the workforce which can limit organization's experience of establishing and supporting the role. They recommend the importance of managers seeking to introduce new consultant roles provide support to retain existing consultants, so they reach their full potential. We conclude this study shows the need for actual and aspiring consultants to work collectively, using the strategies imbued by the support programme to collaboratively and strategically work across organisations and the health economy in clinical systems roles to support quality improvement, increased productivity and service effectiveness.

One major difference, in this study, with those above has been the use of EAR, which, combined with work based learning principles, has facilitated increased effectiveness and overcome the barriers to it. This has involved: learning to be a research practitioner; learning in and from practice; using active and action learning processes; and, using facilitation processes to increase effectiveness in others and transforming practice to develop improved services across organisations. We believe we have identified and shown the means through which consultants achieve improved patient services, that is, through developing the facilitation skills, based on the ten principles of facilitating work based learning (Manley et al 2009), that are necessary to enable others to become effective and for practice to be transformed. These insights are valuable for informing the development of future clinical systems leaders across the health economy, identified as essential for facilitating and achieving integrated whole systems approaches to health and social care (Manley et al 2014). Whilst these means have also been used with aspirants in practice and are deemed to have implications for succession planning of both consultant practitioners and clinical systems leaders, no studies have researched aspirants.

Conclusions

This study aimed to support practitioner-researchers as they grappled with new roles using EAR, related methods and the ten principles of work based learning. The research team helped participants grow the facilitation skills needed to develop and demonstrate their own effectiveness, foster effectiveness in others as a catalyst for transforming practice towards a culture that sustains effective person centred services – a quality required by clinical systems leaders across the health economy.

Participants demonstrated becoming practitioner-researchers, achieving greater effectiveness in their multiple roles through the facilitation skills developed to show their impact on others, the organisation and service.

Practitioner- researchers achieved role clarity in their organisations showed greater effectiveness as clinical and professional leaders, political and strategic leaders, educators and facilitators of work-based learning, and also as researchers. Increasingly they used critical incidents to integrate and use a complex array of evidence, including published research at executive and strategic level to benefit patient care.

The study concludes that the support programme based, EAR augmented by the facilitation skills and the ten principles derived from a concept analysis of work-based learning (Manley et al 2009) is central to achieving improved effectiveness and transformation of others, services and organisations. This happens when consultant practitioners use these principles within their multiple roles together with leadership that is transformational, strategic and political.

New insights achieved in this study encompass contribution to theoretical development at the community level, the role of critical companionship and portfolio development in further supporting practitioners in their journeys.

The research approach and the resulting framework for theorising from practice has potential for contributing new insights into social impact through making explicit the links between starting points, actions, outcomes and impact.

Recommendations

Many recommendations can be made about consultant practice and the actions required at the policy level in relation to service and organizational quality, as well as education and work based learning to enable these key professionals to develop the full set of skills required to be effective in their work (McIntosh & Tolsen's 2008). However, these are provided elsewhere (Manley and Titchen, 2012). Four specific recommendations are made in the context of facilitation, clinical systems leadership and consultant practitioner roles and action research (Box 4)

Box 4: Specific recommendations

1. Policy makers, governments and commissioners recognise the role of facilitation skills in achieving quality, productivity and person-centred services, individual, team and organisational effectiveness and commission programmes that develop these skills in senior clinical leader.

2. Commissioned programmes are developed by higher education to include the development of facilitation skills and associated leadership within post graduate courses and work to increase the number of work-based learning opportunities provided to develop the skills necessary to facilitate in the workplace across multiple roles.

3. Action researchers strengthen EAR by using: the principles of work based learning to guide the facilitation process; the claims, concerns and issues tool to

inform collective action spirals; critical companionship to support the rigour of researcher-practitioner activity; action hypotheses for theorising from practice; and portfolios to provide in-depth, multiple sources of evidence of impact.

4. Further research tests the ten principles of facilitation with other clinical leaders and within different research designs that compare the impact that the principles have with other approaches to transforming workplace culture.

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