

**Professional Identity and the Advanced Nurse
Practitioner in Primary Care: A Qualitative
Study**

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Abstract

Background: Health professional roles are being adapted in response to increased demand and declining medical workforces, both in England and internationally. This is exemplified by advanced nurse practitioners (ANP) in primary care. However, evidence suggests ANP practice may lack acceptability and understanding, leading to underutilisation. Professional identity (how colleagues are perceived by themselves and others) may influence how professionals work together to utilise such roles. Previous research has explored ANP professional identity during transition and in isolation from workplace cultures. Less is known about relationships between professional identity and established ANP practice within primary healthcare teams, or how ANP practice is affected by workplace cultures. Wider societal level influences have not been fully explored. This study aimed to explore the relationship between professional identity and ANP practice in a context where ANP practice was established.

Methods: The study consisted of a qualitative cross-sectional study which explored professional identity of ANPs on a sample of general practice websites. Then the relationship between professional identity and ANP practice was explored, in-depth, in an ethnographic study of two general practices in England.

Findings: ANPs lacked visibility on general practice websites. Both studies found ANPs were framed within a traditional nursing identity. This impacted on ANP practice and has implications for how professionals and the wider public understand ANP roles. Individual characteristics and interactional relationships were central to acceptance and utilisation of ANPs within the workplace, but were limited by broader societal level understanding of professional identities. ANPs negotiated their place within the workforce by utilising established understanding of professional identity. Intra-professional tensions were identified between ANPs and nursing.

Conclusions: Professional identity is a useful framework within which to develop contextual understanding of ANP practice. Primary healthcare team members utilised shared understanding of professional identity to shape ANP roles, which both supported and inhibited ANP utilisation.

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Author's Declaration

I declare that this thesis is a presentation of my own original work, of which I am the sole author. This work has not previously been presented for an award at this, or any other, university. All sources are acknowledged as references.

1. Introduction

1.1. Background

In this thesis I aimed to explore the relationship between professional identity and the practice of advanced nurse practitioners (ANP) working in primary care in England. Increasing economic and demographic demands, coupled with a reduced medical workforce, have led to drives to alter working practices of healthcare professionals, both internationally and in England (Freund et al., 2015). This has led to non-medical practitioners expanding their practice into areas traditionally demarcated within a medical domain (DH, 2010a; McInnes et al., 2015; Por, 2008; Health Education England, 2015a; Rolfe, 2014). Furthermore, service delivery is increasingly shifting from secondary to primary care (NHS England, 2014). Advanced nurse practitioners working in primary care are one group of professionals whose role encompasses these issues (Kooienga and Carryer, 2015; Por, 2008; Rolfe, 2014; Schadewaldt et al., 2013). However, various barriers to ANP practice have been identified, which have the potential to limit ANP utilisation (Andregård and Jangland, 2015; Bryant-Lukosius et al., 2004a; Freund et al., 2015; Lloyd Jones et al., 2005; Lowe et al., 2012; McConnell et al., 2013; Middleton et al., 2011; Quinn, 2010; Schadewaldt et al., 2013). As a consequence, it is questionable whether such practice may be effective in addressing increasingly challenging healthcare service demands. There is an emerging body of literature suggesting professional identity may influence the level and effectiveness of ANP practice (Aranda and Jones, 2008; McNeil et al., 2013), but little is known about: the relationship between professional identity and established ANP practice; how professional identities of ANPs and other members of the primary healthcare team influence ANP practice; how wider social and professional influences affect ANP practice.

Professional identity can be characterised at micro (individual), meso (interactional /relational) and macro (group/societal) levels (Currie et al., 2010). This study aimed to explore how, and to what extent, each level impacts on ANP practice. Specifically, the study was informed by two identity frameworks, Social Identity Theory (Tajfel and Turner, 1986) and Positioning Theory (Davies and Harré, 1990), which consider identity a process of interaction between different levels. Consequently, a study strategy was developed to explore the relationship between professional identity and ANP practice in primary care, within this context.

Macro level identity includes the public image of a profession (Hallam, 2000; Wackerhausen, 2009). While nursing has a long established public image, little is known about the public image of ANPs, or how this impacts on ANP practice and utilisation. In England, general practice is a specific area of primary care which provides first point of contact care to patients (The King's Fund, 2011). Therefore, a preliminary qualitative cross-sectional study was carried out to explore how the outward-facing public image of ANPs was represented on a sample of general practice websites. This aimed to answer

- To what extent, and in what way, are ANPs presented and depicted to patients and the public on practice websites in relation to other professional groups?
- To what extent are patients able to make informed decisions/choices about their healthcare providers through information provided on general practice websites?
- How might the information provided affect how, and to what extent, ANPs are accepted and utilised in general practice?

Following this an ethnographic study of two general practices, within which ANP practice was established, was developed. The aim was explore in-depth the relationship between professional identity and ANP practice. The objectives considered

- How do professional identities of ANPs and other primary healthcare team members influence ANP practice?
- How do ANP interactions within the workforce influence ANP practice?
- How are ANP professional identities negotiated within a wider social and professional context?

This research is situated in the epistemological perspective of subtle realism (Hammersley, 1998). That is, no single absolute truth is claimed, but rather understanding is influenced by both the researcher and the researched. However, there is enough shared understanding so that useful and applicable conclusions can be drawn and utilised to inform healthcare contexts (Duncan and Nicol, 2004).

This study makes a contribution to knowledge in a number of ways. Firstly, it provides insight into to public image (macro) identity of ANPs on general practice websites, something which was previously unexplored. It found ANPs were primarily situated within a traditional nursing identity which did not adequately reflect ANP roles and levels of practice. This is important because it offers insight into how patients and the wider public may perceive ANP practice and, as a consequence, may influence how ANPs are regarded and utilised. Secondly, it addresses a gap in the ANP literature relating to how professional identity impacts on established ANP practice within workforces, and considers how different members of the primary healthcare teams' understanding of professional identity shape ANP practice and utilisation. Like the website study, the ethnographic study also identified ANPs were predominantly situated within a traditional nursing identity within which ANP practice did not neatly fit. This inhibited practice as ANPs were seen to be limited by their identity as nurses. Of note was that these perceptions did not change, despite long exposure to ANPs at the practice sites. This is contrary to previous studies of new ANP roles, which surmise acceptance will develop over time (Andregård and Jangland, 2015; Sangster-Gormley et al., 2013).

Consequently, individual ANP acceptance was achieved when ANPs were perceived as different from their professional group, both by themselves and others. Establishment of ANPs also depended on their personal relationships with decision-makers. This meant ANP roles were limited to the level of the individual, while ANPs as a professional group were less successful. In this way macro level professional identity subsumed lower order individual and interactional identities, which has implications for ANP practice and widespread utilisation. Because ANPs were trusted as individuals, but not as a professional group, the extent to which ANP practice can address workforce and demographic issues may be limited.

This study also contributes to knowledge by identifying that nursing as a profession does not always support ANP practice, while ANPs themselves may be unsupportive of other ANPs and nurses. The findings of this study are of significance, not only to the nursing workforce, but to clinical workforces and service delivery more broadly. This is because it highlights how fundamentally held beliefs and understanding of professional identity may inhibit different ways of working, which are increasingly recognised both nationally and internationally, as central to addressing increasing demands on healthcare delivery.

1.2. Origins of the study

My own interest in the subject stemmed from my experience working as an ANP in primary care. While my experience was overwhelmingly positive, when qualifying as an ANP in 2005, it appeared that numerous opportunities would be opened to ANPs. However, these did not always come to fruition and limited, rather than supported, ANP practice. For example, at that time non-medical prescribing was severely curtailed because nurses, unlike GPs, had to hand-write prescriptions and were restricted to prescribing from a limited prescribing formulary. When subsequently nurse prescribers were permitted to prescribe from the full British National Formulary, the local Primary Care Trust developed a document in which nurses were required to list items they would prescribe by prior agreement, which again limited this aspect of the role. Furthermore, other nurses and colleagues more broadly, appeared to differentiate between ANP and GP practice. For example, both myself as an ANP and GP colleagues were qualified to insert contraceptive implants. However, nurses would set up equipment for GPs and support the patient while undergoing the procedure, but did not do the same for myself as an ANP. Neither would I have considered asking for such support from my nursing colleagues. Reflecting on the behaviour of myself and others made me consider why such differentiation existed, when the roles performed were essentially similar. This led me to consider how my identity as a nurse influenced both myself and others and ultimately how ANP practice developed. However, it is of note that I could not specifically articulate this at the time, as professional identity as a concept was something I was largely unaware of until I started researching this PhD. Like the participants in this study, professional identity existed at a subconscious level and it is by raising it to a conscious level that deeper understanding of the processes which contribute to shaping ANP practice can be explained.

The remainder of this chapter provides a broad overview of the international literature pertaining to ANP practice, then Chapter 2 explores the nature of ANP practice within England. Following this, Chapter 3 sets out the rationale for utilising professional identity as a theoretical framework within which to situate the study of ANP practice. While broad study aims are set out in Chapters 1 and 2, Chapter 3 explores and identifies gaps in the professional identity literature relating to ANP practice, which this study aims to address. It is here research objectives are refined. Following this, study methodology and methods are set out in Chapter 4. Study findings are presented in Chapters 5-7. These are then

further discussed in relation to established literature, and within a theoretical framework of professional identity, in Chapter 8. Recommendations for future policy and practice are also set out and strengths and limitations of the study discussed.

1.3. An Introduction to Advanced Practice - International Context

Internationally changing demographics, ageing populations, increasing incidence and prevalence of complex and co-morbid chronic disease, financial austerity and new technologies, coupled with a shortage of physicians, has led to exploration of alternative methods of delivering healthcare (Donelan et al., 2013; Freund et al., 2015; Lowe et al., 2012; Martínez-González et al., 2014). While the shortage of adequately qualified healthcare providers is global, there is a disproportionate burden within low and middle income countries (WHO, 2007). Within higher income countries, recruitment of physicians is more difficult in deprived and rural areas (Nardi and Diallo, 2014). Physician shortages are projected to continue unabated, particularly within primary care (Freund et al., 2015; Kooienga and Carryer, 2015; NHS England, 2016; Martínez-González et al., 2014). One way of addressing this gap in healthcare provision is to utilise nurses and other healthcare professionals in practice traditionally understood as being within the remit of physicians (DH, 2010a; McInnes et al., 2015; Por, 2008; HEE, 2015a; Rolfe, 2014). Concurrently, within nursing there have been attempts to advance the scope and expertise of practice (Stasa et al., 2014) in order to improve care (Nardi and Diallo, 2014) and to enhance the professional status of nursing (Pulcini et al., 2010; Searle, 2008). Development of advanced practice is reflected within other professions, such as physiotherapy and pharmacy (Chartered Society of Physiotherapists, 2016; NHS England, 2016; HEE, 2015a), while physician associates are also becoming increasingly central to healthcare delivery (Drennan et al., 2015; HEE, 2015a).

Advanced practice nursing and specifically advanced nurse practitioners [ANP] are at the forefront of policies to modernise the healthcare workforce both internationally and in England. (DH, 2010a; HEE, 2015a; Kooienga and Carryer, 2015; NHS England, 2016; Por, 2008; Rolfe, 2014; Schadewaldt et al., 2013). However, in primary care, numbers of ANPs remain small (Freund et al., 2015). Moreover, research has identified that ANPs are not always utilised to their full potential (Bailey et al., 2006; Fletcher et al., 2007; McMurray, 2011; Middleton et al., 2016). It is the utilisation of ANPs in primary care, and related contributory factors, that are of interest in this study. This chapter reviews the

background to advanced practice and provides an international overview of its development, in order to contextualise the thesis. The focus then turns to the nature of advanced practice within the English National Health Service and primary care specifically.

A number of relevant themes were identified in the ANP literature

- Role clarity and consistency
- Safety and competence agendas
- Utilisation: Barriers and facilitators to practice
- Professional Identity

These are drawn together in a narrative synthesis (Pope and Mays, 2006) and considered within both international and national contexts. The majority of literature related to the first three themes, with much less attention paid to the fourth. Expert opinion, qualitative studies, literature/systematic reviews, policy analysis and narrative overviews related to role clarity. Safety and competence literature was characterised by empirical studies such as randomised controlled trials and observational studies, with subsequent systematic reviews. Utilisation of ANPs has also been the subject of qualitative studies and literature/systematic reviews. In contrast professional identity relating to the ANP role has attracted minimal research, with most focused on transition to advanced practice in isolation from the workplace and new role implementation. This is significant as evidence is emerging that professional identity may be implicated in the utilisation of advanced and novel nursing roles (Chulach and Gagnon, 2016; Currie et al, 2010; Maxwell et al., 2013) and this requires further exploration. Therefore professional identity is considered in Chapter 3. Literature relating to role clarity, safety and utilisation of ANPs is presented in the following sections of this chapter and is representative of the literature most salient to the context of the thesis, i.e. ANP practice in primary care.

It is of note that in the literature numerous nursing titles are grouped under the umbrella term of 'advanced practice nursing'. Stasa et al., (2014) suggest this essentially encompasses those providing a generalist advanced level of clinical expertise and practice (advanced nurse practitioners) [ANP] and those who provide specialist nursing skills within a specific clinical area (clinical nurse specialists) [CNS]. However, distinctions were not always clear and while the former is of interest this study, roles and levels of

practice were often conflated and unclear in the literature, which limits comparisons. The titles 'advanced nurse practitioner' and 'nurse practitioner' were used interchangeably and shall be referred to as 'ANP' throughout the thesis.

Much of the literature of interest was of qualitative design, making it challenging to access as such studies can be poorly indexed on electronic databases (Mays and Pope, 2006). As a consequence snowballing methods such as citation tracking, hand searching of references and identification of grey literature took place to ensure a comprehensive review. In addition the Association of Advanced Practice Educators [AAPE UK accessed June 2016], a collaboration of Higher Education Institutions providing advanced practice education in the UK, produce a list of significant literature on their website. This was used to assess for omissions. Consequently, although the aim was to be comprehensive this was not intended to be considered a systematic review.

Quality assessment recognised that studies included in this review differed in methodology, participant populations and presentation of findings. Assessment was based on clarity and relevance of research question, relevance and congruence of methodology and reflexivity (Mays and Pope 1995). This is congruent with an epistemological stance that there is no one correct way of conducting and understanding research and that contextualised research is of value. Initially the position of the ANP within an international context is explored.

1.4. International Workforce Development: Advanced Practice Nursing and the Advanced Nurse Practitioner

The aim of advanced practice is to provide a flexible, multi-professional workforce which utilises a variety of skills and knowledge across a range of healthcare professional roles (DH, 2008; Freund et al., 2015; HEE, 2015a). Within nursing this relates to ANPs who undertake work traditionally seen as the responsibility of medical practitioners, while aiming to advance nursing practice (DH, 2010a) and CNSs who provide specialist nursing skills. In a discursive paper highlighting international variation in advanced practice nursing, Stasa et al., (2014) differentiate CNS and ANP practice through differing scopes. They understand CNSs as working within a registered nurse scope of practice, while ANPs work within an additional expanded scope of practice absorbing elements usually considered outside a nursing remit. This includes differential diagnosis, clinical

examination skills, referral and prescribing. ANP scope of practice also encompasses management of complex co-morbidities as well as research and leadership roles (Ball, 2005; Mantzoukas and Watkinson, 2007; DH, 2006b; SGHD, 2008). There is a developing consensus that advanced practice is a level of practice rather than a specific role (DH, 2010a; SGHD, 2008; RCN 2012).

In the literature, what is meant by scope of practice is often unclear. Therefore, Stasa et al., (2014) provide a useful definition of:

*tasks and activities which a practitioner is **legislatively permitted** to undertake, and which are grounded in their education and training* (p357 original emphasis).

Legislation and education are useful starting points to explore advanced practice nursing. However, internationally ANP legislation and education vary considerably (Bryant-Lukosius et al, 2004a; Kooienga and Carryer, 2015; Lowe et al., 2012; Pulcini et al., 2010; Stasa et al., 2014). This has implications for an increasingly mobile global nursing workforce (Kooienga and Carryer, 2015; Lowe et al., 2011).

1.5. International Implementation of ANPs

An estimated seventy countries have implemented, or are considering implementing, advanced practice nursing. (Stasa et al., 2014). In 2008, The International Council of Nurses International Nurse Practitioner/Advanced Practice Nursing Network [ICN INP-APNN] identified membership representing 33 countries (Pulcini et al., 2010). While not representing all countries with advanced nurses, those identified are set out in Table 1 to exemplify the diversity of countries adopting advanced practice nursing.

Table 1. ICN Survey 2008	
Countries of Respondents from The International Council of Nurses International Nurse Practitioner/Advanced Practice Nurse Network International Survey (2008) on Advanced Practice Nursing Education, Practice and Regulation (Pulcini et al., 2010)	
Argentina	Netherlands
Australia	New Zealand
Botswana	Nigeria
Canada	Oman
China/People's Republic of China	Pakistan
England/UK	Portugal
Ethiopia	Saudi Arabia/KSA
Fiji	Singapore
Finland	South Africa
France	South Korea
Grenada	Spain
Hong Kong	Switzerland
India	Taiwan
Ireland	Tanzania
Italy	Thailand
Jamaica	USA
Japan	

Countries include USA, which is commonly credited with the inception of ANPs in the 1960's (Savrin, 2009) and other economically developed countries such as Canada, Australia, New Zealand, UK, as well as some Scandinavian and other northern European countries (Andregård and Jangland, 2015; Carryer et al., 2007; Freund et al., 2015; Sullivan-Benz et al., 2010). Canada and Australia are among recent adopters of the ANP model and consequently a body of literature is developing at pace in these countries (Lowe et al., 2013; MacLellan et al., 2015; Sangster - Gormley et al., 2013; Schadewaldt et al., 2013; Schadewaldt et al., 2016; Sullivan-Bentz et al., 2010). However despite the continued development of advanced practice nursing, the scope of practice, legislation and educational standards of those performing advanced roles lack clarity at both national and international levels (Bryant-Lukosius et al., 2004a; Lowe et al., 2012; Pulcini et al., 2010; Wong and Farrally, 2013). The following section considers how this has impacted on ANP practice.

1.6. ANP Role Clarity, Education, Legislation and Regulation

Internationally, ANP roles have developed on an ad hoc basis in response to local and national demands (Bryant-Lukosius et al., 2004a). Standards of training are variable and titling inconsistent (Freund et al., 2015, Lowe et al., 2012; Pulcini et al., 2010). There are also significant legislative and regulatory differences between and within countries (Freund et al., 2015; Kooienga and Carryer, 2015; Pulcini et al., 2010; Weiland, 2008). In a key and often cited review of international ANP literature, Bryant-Lukosius et al., (2004a) found confusion surrounding titles, role function and scope of practice and little appears to have changed over time (Barton and East, 2015). This is reaffirmed by the ICN INP-APNN international survey of advanced practice nursing (Pulcini et al., 2010). Key advanced practice nursing informants from member countries (Table 1) participated in a web-based survey which identified a proliferation of titles within and between countries, variation in scope of practice and prescribing authorisation, differing legislative and regulatory frameworks and differing political contexts. While accepting some limitations (respondents were a self-selecting convenience sample and may not represent broader ANP or national perspectives), the survey substantiates claims of inconsistency and lack of clarity, while providing an international baseline of advanced practice nursing.

These findings are supported by a range of literature suggesting unclear and disparate titling, education, legislation and regulation of ANPs contributes to underutilisation of ANPs (Bryant-Lukosius et al., 2004a; Lowe et al., 2012; Pulcini et al., 2010; Schadewaldt et al., 2013; Wong and Farrally, 2013). Indeed Gardner et al., (2016) suggest the extent of literature highlighting lack of clarity has itself heightened confusion. The impact of ANPs on healthcare provision may be restricted if ANPs themselves, their professional colleagues and patients are unable to form a clear understanding of what it is ANPs provide. Consequently, the International Council of Nurses [ICN 2002] have recognised the need for a clear definition of advanced nursing practice, describing an

.... expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level. (p1)

However, the breadth of this statement constrains its practical utility and consequently individual countries have developed differing educational standards and legislative regulations (Freund et al., 2015; Savrin, 2009). The ICN INP-APNN survey found that the most prevalent level of education for 50% of surveyed countries was a master's degree (Pulcini et al., 2010). However, level of educational attainment does not necessarily reflect the economic development of a country (Freund et al., 2015), nor correspond to the level of initial training required. For example, while the UK currently has no mandatory post-registration ANP education or level of qualification (Freund et al., 2015), initial nurse education is now at graduate level (Traynor, 2013).

Although it is necessary for countries to work within their own statutory frameworks, inconsistencies have been found to constrain the role and utilisation of ANPs. Therefore there is a consensus that it is crucial for nursing as a profession to unify its position (Bryant-Lukosius et al., 2004a; Lowe et al., 2012; Pulcini et al., 2010), although this is not universally supported. Marsden et al., (2010) suggest localised flexibility and adaptability are key to ANP role development, while attempts to standardise ANP practice may result in a less responsive workforce. However, a clear understanding of any healthcare role is essential for practitioners to integrate their individual understanding of the role with wider expectations. It is also important that ANP practice is clear and consistent in order to allow others to understand what ANPs provide. Failure to do this can result in lack of understanding and consequent underutilisation (Bryant-Lukosius et al., 2004a; Lowe et al., 2012; Pulcini et al., 2010; Stasa et al., 2014). Furthermore, why such lack of clarity persists despite the long establishment of ANP practice requires exploration and is one of the interests of this study.

Lack of role clarity and educational standards may lead to difficulties in gaining authorisation for advanced practice (Lowe et al., 2012). Authorisation and legitimisation are linked to societal acceptance which is, in part, associated with regulation and legislation. This is because, as identified by Abbott (1988), professions are authorised to perform a particular role by society and this authority is justified by a clear remit, demonstration of educational standards and the provision of public protection through regulation and legislation. In turn the public can expect clearly demarcated standards of practice (Evetts, 2013; McMurray, 2011).

There are several legislative and regulatory anomalies in relation to ANP practice both within and between countries (Bryant-Lukosius et al., 2004a; Freund et al., 2015, Kooienga and Carryer, 2015; Quinn, 2010; Weiland, 2008). For example Australia, New Zealand and Canada have clear regulatory and legislative frameworks within which ANPs are required to practice (Freund et al., 2015; Marsden et al., 2011; Middleton et al., 2011). This contrasts with the UK where there is no title protection or current formal regulation beyond initial nursing registration (Marsden et al., 2011; NMC, 2012). In the USA the situation is more complex. Although ANPs are highly regulated and their title protected in law, there are variations between individual States and this has been implicated in contributing to underutilisation of ANPs in some parts of the USA, despite its long establishment there (Mullinix and Bucholtz, 2009; Quinn, 2010; Weiland, 2008).

Consequently internationally, nationally and locally, lack of clarity across ANP roles, titling, education, regulation, legislation and regulation pose problems (Stasa et al., 2014) in that:

1. ANPs may be unclear about their role
2. Other healthcare professionals may not understand the level, extent and scope of advanced practice
3. Patients may not know how/why to access and utilise ANPs
4. Providing suitable preparation for advanced practice may be challenging for academic institutions

There is a growing body of empirical evidence and narrative literature suggesting ANPs are underutilised both in terms of number and scope of practice, and inconsistencies in ANP role, titling, scope of practice, educational standards, regulation and legislation may contribute to this (Andregård and Jangland, 2015; Bryant-Lukosius et al., 2004a; Freund et al., 2015; Lowe et al., 2012; Middleton et al., 2011; Niezen and Mathijssen, 2014; Quinn, 2010; Schadewaldt et al., 2013; Pulcini et al., 2010; Stasa et al., 2014). Therefore, clarification of ANP practice is not merely theoretical, but has practical implications for healthcare delivery. However, some commonalities have been identified.

1.7. Consensus, Commonalities and the ANP

While the majority of international ANP literature highlights inconsistencies surrounding advanced practice nursing, there is some evidence of consistency, commonality and

consensus. Mantzoukas and Watkinson (2007) thematically analysed international data in a narrative systematic review which identified seven generic features of advanced nursing practice, which the authors suggest provide role clarification to enhance ANP practice.

1. use of knowledge in practice
2. critical thinking and analytical skills
3. clinical judgement and decision-making skills
4. professional leadership and clinical inquiry
5. coaching and mentoring skills
6. research skills
7. changing practice

However, how this description differs from usual nursing practice, or from other professions such as medicine, is unclear. Indeed, Rolfe (2014) critiques advanced practice nursing descriptors as being neither advanced nor specific to nursing. While it is evident Mantzoukas and Watkinson's (2007) descriptors are not specific to nursing, it is increasingly accepted that it is the level of practice that is significant (SGHD, 2008). From this understanding, it is the *level* of critical thinking, clinical judgement etc. that is 'advanced'. It is necessary then for ANPs to clarify their contribution by articulating not only the level of practice, but also what sets it apart from, and what it shares with, other healthcare providers.

Savrin (2009) asserts that countries go through sequential developmental phases in order to successfully assimilate ANP practice and these commonalities can be used as an international blueprint. In this model the USA is considered a prototype from which other countries can learn, as it is attributed with having the longest experience in developing ANP practice. However, the assumption that the USA is the gold standard of ANP practice has been contested by those who argue that despite its longevity, ANPs in the USA are far from being fully utilised both in terms of numbers and scope of practice (Mullinix and Bucholtz, 2009; Quinn, 2010). Moreover, such a model requires the conflation of care systems which are quite dissimilar, while the task-shifting focus in countries addressing specific healthcare crises may be grounded in different motivations from the professionalising agendas of western healthcare. Therefore the validity of this model

remains unclear. More recent attempts have been made to delineate advanced practice (Gardner et al., 2016), although this is in its infancy and at present appears most relevant to its Australian origins.

Further commonalities include that the number of ANPs in primary care remains low in most countries, despite nursing being the main non-physician clinician workforce (Freund et al., 2015). The reasons for this are unclear. Additionally, most ANP development is in response to underserved populations, unmet need, decreased physician numbers and increased patient demand (Freund et al., 2015; Nardi and Diallo, 2014). As a result ANP practice is more successful in environments where there is little choice of provider (McMurray, 2011), the implication being that where there is choice, ANP practice is less accepted. In order for ANPs to gain acceptance, it is necessary to demonstrate competent and safe practice. The following section explores the literature relating to safety and competence of ANPs.

1.8. A Question of Competence - Empirical Evidence and ANP Competence

ANP practice has been extensively evaluated in terms of safety and competence. Since its inception in the USA in the 1960's, research has compared ANP safety and competence against physician practice (Mundinger et al., 2000; Prescott and Driscoll, 1979). Indeed, there has been such a plethora of primary studies that an international research synthesis exploring the utilisation of ANPs and physician assistants [PAs], identified 11 systematic reviews of primary studies which assessed the safety and competence of ANPs, of which 6 were related to primary care (Wong and Farrally, 2013). However, this has not prevented further systematic reviews (Stanik-Hutt et al., 2013; Swan et al., 2015; Martínez-González et al., 2014) relating to primary and acute care settings. There are two schools of thought in relation to production of such prolific research. Rushforth (2015) suggests there are significant methodological flaws in the current evidence base which necessitate continued investigation, while Quinn (2010) critiques focus on ANP safety and competency as exposing lack of trust and confidence in ANP practice. That many reviews were found to simply repeat earlier search strategies or reanalyse previously reviewed primary studies may support such assertions.

The number of primary studies and reviews does not indicate quality, nor definitively support ANP competence. This is exemplified by Wong and Farrally's (2013) integrative

synthesis. While the reviews identified appeared to support ANP safety and competency, neither the methodological rigour of the systematic reviews nor the primary studies were assessed by the authors. This is a major limitation as several included reviews had uncertain relevancy and deficiencies in methodologies. Therefore Wong and Farrally's (2013) synthesis, as well as other ANP safety studies, should be understood within the context of methodological rigour.

Also of note in many of the studies was that the evidence base conflates various nursing roles and levels of practice. Substitution of nurses for doctors does not necessarily indicate advanced practice. As we shall see, some primary studies focused on quite low levels of practice and role transference, but are used to substantiate claims of safety in relation to advanced practice. Therefore caution and careful evaluation of primary studies, as well as the veracity of systematic reviews, is necessary to understand and utilise the evidence base effectively. This is important not only for patient safety, but for acceptance of advanced practice nursing, as an uncertain evidence base leaves advanced practice exposed.

This review focuses on primary studies and systematic reviews that are frequently referred to in the ANP literature to demonstrate ANP safety and effectiveness. Key primary studies by Venning et al., (2000), Kinnersley et al., (2000) and Shum et al., (2000) in the UK and Munding et al., (2000) in USA, as well as a Cochrane Collaboration systematic review (Laurant et al., 2004) and a systematic review by Horrocks et al., (2002) are repeatedly referred to in the international ANP literature as confirmation of safety and efficacy of ANP practice. There then appeared to be a gap in the timeline until a further systematic review of nurse-doctor substitution in primary care was published by Martínez-González et al., (2014), while another assessed the quality of primary care provided by advanced practice nurses (Swan et al., 2015) and another compared ANP and medical practitioner practice in a variety of settings (Stanik-Hutt et al., 2013). All appeared to demonstrate support for the safety and competence of ANPs.

Horrocks et al., (2002) and Laurant et al.'s (2004) systematic reviews both compared standards of nursing practice to that of physician-delivered care and were rigorous in design. Five randomised controlled trials [RCTs] were included in both reviews (Chambers and West, 1978; Kinnersley et al., 2000; Munding et al., 2000; Shum et al., 2000 and

Venning et al., 2000). Horrocks et al's (2002) review of RCTs and prospective observational studies looked at same-day consultations in primary care. They found ANPs were safe and provided equivalent care to medical practitioners in terms of clinical effectiveness and had high levels of patient satisfaction. These findings were supported by Laurant et al's (2004), subsequent systematic review of RCTs, which looked at both first contact consultations and long term conditions management. Findings suggested appropriately trained nurses could provide a quality of care equivalent to that of physicians in roles which substitute nurses for doctors.

The reviews of both Horrocks et al., (2002) and Laurant et al., (2004) were transparent and systematic. However, although well conducted they were limited by the quality of primary studies. For example, of 11 RCTs included in Horrocks et al's (2002) review, six did not report power calculations and two (Mundinger et al., 2000 and Shum et al., 2000) did not have sufficient power to detect differences in rare outcomes or for sicker patients respectively. Furthermore, in Laurant et al's (2004) review all but one study was inadequately powered to assess equivalence between physician and nurse care. This is important because conclusions are drawn on the assumption that nurse-doctor substitution is safe if no significant difference is found. However, even in adequately powered studies there remains a chance that significant difference is undetected (Type 2 Error) and this increases in underpowered studies (Rushforth, 2015).

In addition, risk of bias assessment, allocation concealment and blinding was problematic in many studies included in Laurant et al's (2004) review, while possible selection bias and high refusal rate (Kinnersley et al., 2000) and high attrition (Mundinger et al., 2000) were also identified. Furthermore, primary studies had unclear or subjective outcomes, focusing for example on patient satisfaction rather than clinical outcomes, although studies such as Mundinger et al., (2000) address this criticism.

Martínez-González et al., (2014) updated the work of Horrocks et al., (2002) and Laurant et al., (2004) by conducting a rigorous and well planned systematic review and meta-analysis of the clinical effectiveness of the substitution of physicians by nurses in primary care. Their review included undifferentiated diagnoses consultations, as well as management of long term conditions and preventive care by nurses at various levels of education and training. The study was designed, conducted and reported using PRISMA

guidelines (Liberati et al., 2009). It also met the criteria for inclusion on the Database of Abstracts of Reviews of Effects (CRD, 2015, Issue 2) and as a Cochrane review is considered a hallmark of methodological quality (Rushworth, 2015). 24 RCTs and two economic studies were identified and included in the study.

Martínez-González et al., (2014) found that nurse-led care reduced hospital admissions and mortality and increased patient satisfaction. However concern remained that rare adverse events were unable to be suitably evaluated. The authors, like Laurant et al., (2004) previously, highlighted poor quality and lack of rigor in much of the primary research. However the volume of rigorous studies had gradually increased and consequently Martínez-González et al., (2014) concluded that the quality of research included in the review was of an acceptable standard. Again caution should be exercised when using this review to support advanced practice roles. Closer analysis of primary studies suggests that in some studies extension of the registered nurse role, rather than autonomous advanced practice, was explored. Out of 24 studies, only 7 identified nurses as working at an advanced level. One study claiming full nurse autonomy (Houweling et al., 2011) was an RCT comparing practice nurses with one week's training in diabetes management to usual GP care. Nurses followed a protocol which indicated when referral to a physician was necessary and as a consequence this cannot be defined as autonomous advanced practice. Therefore, this study's ability to demonstrate advanced practice is limited. Additionally, the study was underpowered and its primary clinical outcome was not achieved by either group. There was no significant difference in outcomes between doctors and nurses despite nurses consulting with patients for an average of 100 minutes longer than GPs. Patient satisfaction was, unsurprisingly, higher for nurses. Consequently, conflation of nurse-doctor substitution and advanced roles and levels of practice was apparent in some studies. Conflated interpretation and transference of findings have the potential to be inappropriately utilised.

Following Martínez-González et al., (2014), Swan et al., (2015) conducted a further PRISMA guided systematic review (Liberati et al., 2009) of RCTs comparing care provided to adults by physicians and advanced practice nurses in primary care. Of the seven RCTs identified, all but one appeared in previously discussed reviews. As a consequence, similar findings of nurse-physician equivalency were identified, with similar caveats as before. Another systematic review frequently quoted in newer ANP literature

by Stanik-Hutt et al., (2013) aggregated data from 14 RCTs and 23 observational studies across different settings. The only safety outcome reported was mortality and equivalency was suggested between ANPs and medical practitioners. This review was restricted to USA studies and therefore transferability to other contexts requires consideration.

Transparent, comprehensive and rigorous reviews (Horrocks et al., 2000; Laurant et al., 2004; Martínez-González et al., 2014; Stanik-Hutt et al., 2013; Swan et al., 2015) allow adequate appraisal of the evidence base. However, as highlighted by Rushworth (2015), quality of review processes appears to have been readily accepted as proof of ANP safety and effectiveness, despite limitations in primary studies highlighted by the review authors themselves. Furthermore, nurse-doctor substitution and autonomous advanced practice have been conflated with the potential for inappropriate application. However, despite acknowledged limitations, a significant body of evidence has been unable to demonstrate that nurses lack the competence to deliver safe care to at least a standard delivered by physicians. Although this is not analogous with safety equivalence, it does suggest nurses can provide care comparable with physicians in specific contexts. Evidence does, however, remain equivocal. As a consequence of methodological weaknesses and inappropriate transference of findings, research supporting ANP competence continues to be questioned. This is problematic, not only for patient safety, but for acceptance of advanced practice. Accordingly, the American Academy of Family Physicians (2013) cite methodological problems associated with ANP safety and effectiveness research as cause for concern and this is reflected in the UK literature (Coombes, 2008).

These views are countered by Quinn (2010), in a PhD thesis which critiques ANP competence literature. Quinn (2010) argues that views of physician organisations demonstrate lack of legitimacy and acceptability of the ANP role caused by wider cultural, social, political and historical issues which leads to the underutilisation of ANPs. She argues that the breadth of ANP research focusing on competence demonstrates that ANPs are safe and effective, while dominant positivist research practices are used to inhibit the development of advanced practice nursing. In Quinn's (2010) view, quantitative and physician-nurse comparison studies are inappropriate measures by which to evaluate ANP practice and consequently associated findings are inevitably limited and equivocal. Critics of organised medicine's views of ANP research see this as a deliberate mechanism to place formal and informal limitations on ANP practice, which they suggest is

underpinned by potential threats to medical hegemony (Mullinix and Bucholtz, 2009; Quinn 2010; Weiland, 2008). Mullinix and Bucholtz (2009) suggest research pertaining to ANP safety and risk is 'a substitute for meaningful debate about the maintenance of medical dominance over primary health care' (p94), while in a study exploring professional power, Currie et al., (2012) found that competency and risk were used by doctors to control and restrict the development of other professional groups. This has potential consequences for patients who require healthcare services in an environment of provider shortages and finite resources.

Consequently, how ANP safety and competency ought to be evaluated remains contested. Munding, a prominent ANP researcher in the USA whose positivist physician-ANP comparison research is widely regarded as credible (Rushworth, 2015), argues physician practice should not be the benchmark to which ANPs aspire, or be measured by (Guadagnino, 2008). As early as 1979, Prescott and Driscoll (1979) highlighted that standards of physician practice relating to clinical examination and history taking fell below expectations. Therefore finding ANP care equal to physician practice may simply imply that ANPs are 'no more deficient than' physicians (Prescott and Driscoll, 1979 p 399). More recently, Houweling et al's (2010) study of diabetes interventions in primary care showed neither nurses nor physicians significantly improved the primary clinical outcome investigated. Therefore, both medical and ANP practice ought to demonstrate their absolute contribution to patient care, rather than positioning themselves relative to each other. However, despite calls to seek alternative ways of demonstrate ANP competence (Quinn, 2010; Mullinix and Bucholtz, 2009), the extent to which this can be realised remains unclear while the positive paradigm of medical bioscience remains dominant. Anti-positivist counter-arguments are contested by those who argue higher quality, adequately powered and rigorously conducted studies are crucial to ensure patient safety and realise ANP practice (Rushworth, 2015). It is clear the rigour of all research should be questioned, evaluated robustly and findings applied critically. However, individual flaws are inherent in all research and to disregard an entire body of evidence, rather than to transparently highlight and account for such weakness, can be seen as unethical as it may unjustly limit practice and therefore healthcare provision. It remains that patients and the public are entitled to safe and competent healthcare and it may be necessary for ANP research to focus on methodologically rigorous RCTs which clearly define advanced practice and compare suitable measurable outcomes in order to

attempt to resolve debate. Simultaneously, additional methodologies ought to be utilised to enhance understanding of both ANP and physician practice in, for example, exploring how safety and competency narratives influence ANP practice.

In summary, research exploring ANP safety in primary care, despite limitations, suggests that in the appropriate context ANPs can make a valuable contribution to patient care and healthcare workforce reconfiguration. Research using various methodologies is required to enhance these assertions. Recognition of ANP safety and competence is highly relevant to the utilisation and acceptance of ANP practice because decision-makers, such as physician associations, utilise quality of the evidence base to frame ANP practice. However, research focused on risk and competency can be viewed through an alternate lens of medical hegemony. As McMurray, (2011) asserts the 'appeal to patient safety is a time-honoured defence against perceived competitive threat' (p805) The next section examines how safety and competency agendas play out in clinical practice.

1.9. The ANP in Practice

The sustained focus on competence and safety of ANP practice, along with the assumption that physician practice is the standard ANPs ought to be measured against, can be seen to influence the ANP role in practice. Bailey et al., (2006) conducted a qualitative interview study of thirteen physicians and five ANPs working in four family practices in the USA, in order to explore the relationship between physicians and ANPs in primary care. They found medical practitioners routinely questioned and closely monitored ANP competence, while ANPs expended considerable effort overtly proving their competence to others. Physician competence was accepted by all. Similarly, in a qualitative study of barriers to ANP integration in primary care in England, ANPs stated they felt the constant need to prove themselves (Main et al., 2007). These findings are reinforced by a small survey study of primary care practitioners (n=153) conducted by Fletcher et al., (2007) in a region of USA, which found ANPs were required to justify their position through overt demonstrations of competence. All physician and ANP providers (n=249) in the area were invited to take part in the survey. Response rates were 87% for ANPs and 49% for physicians. 58% (n=42) of responding primary care physicians expressed concerns that ANPs lacked the abilities to manage complex patients and only two thought ANPs were 'well qualified and competent for the tasks they were assigned' (p360). Furthermore some physicians were concerned that ANPs were unaware of their

limitations. While the study should be understood in its context of a small scale descriptive study in a specialised area of primary care, it provides insight into potential challenges for ANPs working in primary care. It also reflects a larger national incentivised postal survey conducted in the USA (n=505 physicians, n=467 ANPs) which found one in three physicians thought increasing numbers of ANPs might negatively impact on safety (Donelan et al., 2013). These primary studies are supported in the findings of an international systematic review of collaborative practice conducted by Schadewaldt et al., (2013). It found relationships between ANPs and physicians lacked reciprocity, with ANPs perceiving 'demonstrating competence was a one way process' (p6).

It is clear that ANPs should demonstrate competence, as should all healthcare professionals. However, by continuously overtly emphasising their own competence and assuming the competence of physicians, ANPs can be seen to be complicit in maintaining an unequal relationship between ANPs and medicine (Quinn, 2010). Gordon and Nelson (2005) argue perceptions of nursing are re-enforced through traditional nursing and medical identities, resulting in a dislocation between expectations and realities. This can be seen to be demonstrated empirically by Fletcher et al., (2007), who found there were discrepancies between acceptance of the ANP in the workplace and comments physicians provided in qualitative interviews. Despite expressing concerns about ANPs' competence, qualifications and ability to recognise their own limitations, physicians still employed ANPs, but controlled and curtailed their scope of practice. Fletcher et al., (2007) understood this as dissonance between practical necessity and perceived threat to their professional territory, indicating potential for professional conflict. In this way competence and safety narratives are played out in practice and can be seen to contribute to underutilisation of ANPs. Donelan et al., (2013) argue that in the USA policies aimed at expanding ANP practice both in terms of number and scope are unlikely to succeed unless such concerns are addressed. This is considered in the following section.

1.10. ANP Utilisation

In the context of this thesis, utilisation refers to both the number of ANPs and the extent to which they practice at an advanced level. Freund et al., (2015) describe full utilisation as working within full remit and capabilities. However, their international overview of primary healthcare workforces found advanced practice nursing was limited by both scope and quantity of practitioners (Freund et al., 2015). There is support for this in a growing body

of empirical and narrative literature suggesting ANPs are underutilised in number and scope of practice (Andregård and Jangland, 2015; Bryant-Lukosius et al., 2004a; Freund et al., 2015; Lloyd Jones et al., 2005; Lowe et al., 2012; McConnell et al., 2013; Middleton et al., 2011; Quinn, 2010; Schadewaldt et al., 2013), while a recent qualitative synthesis of advanced nursing in general practice identified that such nurses continued to struggle for acceptance (Jakimowicz et al., 2017). This is of importance if policy makers are to be successful in achieving their workforce aims of physician substitution and ANPs are to forge a professional space at an advanced level. The literature identifies practical and cultural barriers and facilitators to utilisation which are considered in turn.

1.11. Practical Facilitators and Barriers to ANP Practice

One of the major practical themes identified in the international ANP utilisation literature is lack of role clarity, as highlighted previously. This was consistently identified as a significant barrier to practice. In a case study exploring the introduction of ANPs in a primary healthcare authority in Canada, Sangster-Gormley et al., (2013) found that team members' acceptance of the ANP role was directly related to clarification and understanding. This is supported by a small exploratory qualitative study conducted in Sweden by Lindblad et al., (2010). Here new ANPs and their physician educators were interviewed, with findings suggesting successful implementation required clear demarcation and definition. In an integrative review exploring medical and ANP views and experiences of collaborative practice in primary care, Schadewaldt et al., (2013) found that of 27 empirical (qualitative and quantitative) studies conducted in seven countries, lack of role clarity was the most frequently highlighted barrier to practice. This was supported by a meta-ethnographic systematic review of 26 qualitative studies by Andregård and Jangland (2015), which was not primary care specific. It identified lack of information about ANP roles contributed to underutilisation in relation to scope of practice. It appears then that there is a growing body of evidence suggesting lack of role clarity limits the role of the ANP in primary care.

These studies concentrate on new role evaluation and workforce redesign and suggest longer term establishment of ANP roles will lead to greater understanding and consequently improved utilisation. Therefore, it is assumed barriers to practice can be rationally resolved over time. However, there is currently little evidence to suggest that role clarification in itself will facilitate role utilisation. One study that did follow ANP role

institutionalisation over a longer period was a qualitative interview study by Reay and Golden-Biddle (2008). Implementation of new ANP roles in secondary care in a province of Canada were explored over a five year period. This study found ANPs were able to make small gains by explaining their role and making working practices easier for others. However, progress was slow with ANPs still explaining their role years after implementation, while easing the workload of others in some cases led to ANPs being overburdened and did not necessarily lead to acceptance and legitimisation.

Evidence suggests even in countries where role and level of practice are established and clearly set out, ANPs continue to experience barriers to practice. Of particular interest is a qualitative study by Poghosyan et al., (2013a) in which 23 purposively sampled ANPs were interviewed from one state in the USA where primary care ANPs were well established. ANPs reported that colleagues lacked clear understanding of the ANP role, preventing ANPs from practising to their full extent. It was unclear why there was such a perceived lack of understanding, despite ANP establishment. Indeed exposure to ANPs may only have a limited effect on understanding and acceptance. In a validated survey of physician attitudes towards ANPs working in one USA State (response rate n=563, 23.3%), Street and Cossman (2010) found that while physicians working with ANPs were more likely to have more positive attitudes towards ANPs than those who did not, the effect was limited. Ultimately physicians felt that ANPs should not be allowed to practice independently (despite State regulation permitting this) and argued physicians should be responsible for supervising ANP practice. However, the response rate of this study makes its utility questionable as it represents the opinions of a small minority of the sampled population. The study findings are, however, supported empirically by Fletcher et al., (2007) and Poghosyan et al., (2013a). Both found the ANP role was circumscribed in the USA, resulting in underutilisation both in terms of scope of practice and number of ANPs, which consequently results in reduced healthcare provision for patients.

Other practical barriers to ANP practice were also identified. In an international systematic review exploring task reallocation from doctors to nurses, Niezen and Mathijssen (2014) highlighted that organisational issues such as team integration and appropriate workspace can impact on ANP utilisation, as can institutional issues such as regulation, legislation, funding and patients' perceptions. Other primary studies and systematic reviews identified clear legal liability, protected funding, clinical and managerial support, appropriate job

descriptions and protocols, protected non-clinical time and physical space as facilitating the ANP role (Andregård and Jangland, 2015; Lloyd-Jones et al., 2005; Main et al., 2007; Poghosyan et al., 2013b; Schadewaldt et al., 2013;). However, the ideal was not always reflected in reality, thus limiting the extent of ANP practice (Andregård and Jangland, 2015; Niezen and Mathijssen 2104; Wong and Farrally, 2013; Schadewaldt et al., 2013).

That underutilisation of ANPs persists despite government drives to structure provision of organisational and practical facilitators is reflected in a census study of Australian ANPs conducted by Middleton et al., (2011) and repeated in Middleton et al., (2016). While structural barriers to practice were identified, other issues such as lack of professional support also contributed to ANPs not being utilised to their maximum clinical capacity. Furthermore, some practical barriers to utilisation were thought to be underpinned by cultural ones and explicit themes of safety, lack of clarity and lack of organisational structure used to rationalise ANP underutilisation. The implication here is that broader cultural practices may partly be responsible for limitations placed on the ANP role. Both Aranda and Jones (2008) and Quinn (2010) criticise current ANP research for focusing on the rational and practical, while failing to explore and understand the complexities of cultural practices within professional workplaces. They argue that underlying deep-seated issues which contribute to the continuing ambivalence and contentiousness around ANP practice are being ignored. Therefore, cultural facilitators and barriers to ANP practice will now be considered.

1.12. Cultural Perspectives

Culture has been described as ‘the social heritage of a community’ (Hall, 2005 p188) through which values, traditions, customs, beliefs and attitudes are passed on to group members, but remain obscure to others. A number of studies relate restrictive practices to cultural issues (Fletcher et al., 2007; Main et al., 2007; Poghosyan et al., 2013a). In an international systematic review of barriers and facilitators to ANP practice, Niezen and Mathijssen (2014) identified two cultural themes which inhibit practice: i) knowledge and confidence ii) professional boundaries.

1.12.1. Knowledge and Confidence

Niezen and Mathijssen (2014) systematically reviewed thirteen qualitative and quantitative studies relating to barriers and facilitators to medical-nursing task reallocation. They found

some ANPs lacked both confidence in their capabilities and insight into their limitations, resulting in reduced autonomy through reliance on physician support. This consequently inhibited utilisation. Similarly, Andregård and Jangland (2015) found that on transitioning to advanced practice, ANPs lost confidence and felt alienated, which affected their ability to perform to the full scope of advanced practice. These findings are supported by a study exploring nurse prescribers' pharmacological knowledge and decision making. Offredy et al., (2007) used validated patient scenarios to assess knowledge and confidence of qualified nurse prescribers in the UK or those studying towards the qualification (n=25). They found the majority of nurses lacked pharmacological knowledge and confidence to make autonomous prescribing decisions. While it is appropriate to seek advice, the value to patients and the healthcare system is minimised if nurses lack the skills and confidence to practice autonomously or require frequent physician support.

In a qualitative grounded theory study of barriers to ANP integration in primary care in England, Main et al., (2007) identified that physicians saw ANPs' lack of confidence as a cultural nursing trait. A purposive sample of 21 participants comprising of medical practitioners, a nurse, advanced nurse practitioners and managers participated in semi-structured interviews. They found some general practitioners were frustrated by what they saw as cultural limitations ANPs placed on their own autonomy, while ANPs were unwilling to accept higher level accountability. This serves to highlight discrepancies between policy and realities of practice, which Currie (2010) suggests may be a consequence of failing to recognise wider issues influencing nursing roles. Indeed, the position of ANPs in Main et al's (2007) study does not reflect the ambitions of advanced practice nursing leadership, which sees professional autonomy as key to advanced nursing (Nardi and Diallo, 2014). It may indicate that the direction of ANP practice as promoted by advanced nurse leaders fails to reflect the experience of everyday practice. This perspective is supported by Hallam's (2002) assertion of a mismatch between aspirations of nursing elites and the more pragmatic approach of practitioners. However, the findings of Main et al's (2007) study may be cohort specific, as ANPs participating in the study had limited qualifications and experience. This was a limitation of the study because participants' experience and level of training may not reflect the depth of knowledge and skills required to work at an advanced level and may consequently account for ANPs' reluctance to accept a level of responsibility consistent with advanced practice. Furthermore, the requirement for ANPs to overtly prove themselves within a

medical paradigm, coupled with physicians attitudes towards ANP competence, may contribute to perceived lack of ANP confidence and requires unpicking. Lack of regulation, legislative protection and organisational support as described previously may also inhibit capacity for ANPs to practice confidently within a clear framework. Therefore it would be of benefit to study established ANPs who have undertaken the appropriate standard of education in order for the issues raised to be further explored.

1.12.2. Professional Boundaries

A further barrier to ANP utilisation identified by Niezen and Mathijssen (2014) occurred when ANPs were seen to cross 'traditional boundaries between medicine and nursing' (p152) and this is supported by Schadewaldt et al., (2013). According to the seminal Sociology of Professions work by Abbott (1988), professional boundaries are drawn when groups demarcate their sphere of work in order to protect and maintain jurisdiction over their role. From this power and status are derived. Professions are licenced and mandated to perform specific domains of work and more powerful professions claim a mandate to control less powerful professions (McMurray, 2011). Tensions may occur when boundaries are transgressed by those who seek expansion into jurisdictions perceived to be the domain of others. As professional boundaries become more fluid, the challenge for those working at such boundaries is to negotiate ways of working which are acceptable to all parties. In an ethnographic study of nursing practice in a hospital setting, Allan (2001) described how nurses negotiated professional boundaries at an informal level. There was an implicit expectation that nurses would perform elements of work outside a traditional nursing scope of practice, but this was not explicitly acknowledged and there was no overt challenge to role boundaries. Because advanced practice nursing is the formalisation of cross-boundary work, it may need to be negotiated differently and a growing body of evidence highlights that ANPs face professional and managerial challenges associated with dynamic, boundary-blurring environments.

Niezen and Mathijssen (2014) identified that ANP roles which remained within nursing domains were much more acceptable to physicians than roles traditionally considered within the remit of medicine. In New Zealand, Mackay (2003) surveyed physicians' perceptions of ANP roles. She found they viewed traditional nursing functions more favourably than those usually associated with medicine, such as prescribing and physical assessment. Similarly, in a UK study of a primary healthcare team's views on ANP roles,

Marsden and Street (2004) found ANPs were considered effective in social rather than medical interventions and GPs were comfortable with ANPs managing 'self-limiting and straight-forward illness' (p21). In this way the ANP role can be seen to be marginalised.

Despite this, in a national survey exploring ANP and physicians perceptions of primary care in the USA, 75% of ANPs stated they worked to the full extent of their scope of practice (Donelan et al., 2013). However, working at full capacity remains aspirational for some (Freund et al., 2015). In a study of emergency nurse practitioner' perceptions of their role and scope of practice in Northern Ireland, McConnell et al., (2013) found that while ANPs were working at a level substantially beyond registration, this could not be considered advanced practice as external control strategies such as protocols, restricted referral rights and prescribing issues inhibited fully autonomous practice. In this way practical restrictions were used by more powerful external professions to control advanced practice nursing.

There is evidence to suggest physicians retain ultimate responsibility and control over ANP practice. (Poghosyn et al., 2013; Fletcher et al., 2007; Niezen and Mathijssen, 2014; Schadewaldt et al., 2013). Schadewaldt et al., (2013) identified that physicians saw ANPs as doctor's assistants rather than autonomous practitioners and as a consequence 'ruled by delegation' (Andregård and Jangland, 2015 p7). Niezen and Mathijssen (2014) found that reservations expressed by physicians about medicalised aspects of ANPs roles resulted a low level of ANP independence. This inhibited ANP utilisation and increased medical control. This has been attributed to a response to perceived threat of the professional status of medicine (Andregård and Jangland, 2015; Schadewaldt et al., 2014; Wilson et al., 2002; Wong and Farrally, 2013).

Here again Main et al's (2007) study is informative in suggesting boundary protectionist behaviour of medical practitioners was a central cultural barrier to acceptance, recognition, utilisation and effectiveness of ANPs. As a consequence ANPs experienced difficulties in performing their role within the established culture. This is reflected in two separate large qualitative studies exploring novel nursing roles in hospitals in England (Currie et al., 2010; Powell and Davies, 2012) which found role protectionism and traditional professional hierarchies came into play when cross-boundary roles were introduced. This impacted on the ability of nurses to reach their full potential and fulfil

policy aims. In addition in a quantitative survey of ANPs, nurse managers and nurse policy makers again in Australia, Lowe et al., (2013) found lack of medical support was identified by ANPs as inhibiting practice. This was despite it not being a focus of the administered questionnaire, but rather expressed by ANPs in free text comments. While the response rates was 38%, this potentially offers insight into the strength of ANP feeling.

Conversely, in an evaluation of a pilot ANP role in a general practice in England, Reveley (2001) interviewed different members of a primary healthcare team (n=36) and found little evidence of conflict reported at the intersection of professional boundaries. However, the study was limited to the experience of one practice with one ANP and did not report the ANP's experiences. Therefore while these findings add to the body of knowledge, they should be viewed within this context. A more recent critical ethnography of the introduction of 10 ANPs in Australia also found that individual physicians were generally supportive of ANP practice (MacLellan et al., 2015). Although closer exploration of findings revealed that ANP roles were often unsuccessful as ANPs faced challenges from others, which physicians appeared to be unable or unwilling to support ANPs through. It is clear then that evidence around boundary protectionism is not well understood. Discrepancies in findings may be attributable to several issues. For example studies were context, country and time specific. Lowe et al., (2013) recommend further research to gain deeper insight into such barriers in order to understand their effect on ANP roles. This may identify strategies within which to sustainably integrate ANP practice into healthcare teams. Aranda and Jones (2008) assert that in order to gain a more nuanced understanding of the position of advanced nursing, it is necessary to move beyond empirical description towards theorising ANP roles in relation to broader social, political, gendered, historical and cultural processes. In this way instead of labelling some practitioners as boundary or role protectionists, deeper insight and understanding of why some individuals behave as they do not only raises such behaviour to a conscious level, but provides insight into how these issues might be addressed.

However, it is not only inter-professional boundaries which can be seen to be challenged by ANP roles. While the focus of much less attention and empirical research, intra-professional tensions may also constrain advanced practice nursing from achieving its full potential.

1.13. Intra-Professional Tensions

There is an emerging body of evidence indicating ANP roles may be influenced by the broader nursing community (Bonsall and Cheater, 2008). In Currie et al's (2010) study of novel nursing role implementation within a secondary care NHS setting, it was identified that such roles can be problematic for those who continue to work in traditional roles. They warn novel working is unsupported by the professional institutions of nursing, not only in terms of regulation and accreditation, but also because nurses are culturally conservative as a result of continued subordination. As a consequence the majority of nurses in their study chose not to undertake novel roles, while those who did experienced lack of intra-professional support.

Tye and Ross (2000) also identified tensions between ANPs and other nursing colleagues. In a study of the introduction of two ANPs in an emergency department, they found conflict occurred when ANPs asked other nurses to carry out tasks and attributed this to the challenge of new roles on professional identity. This was also borne out by Powell and Davies (2012), in a qualitative study of the introduction of nurse-led acute pain services in secondary care. From semi-structured interviews of 71 participants consisting of surgeons, nurses, managers and other health professionals, they revealed subordinate groups resisted change in order to defend the status quo. As a result, nurses working in new roles were mistrusted and hindered by nursing colleagues, as well as sometimes being subjected to open hostility. In a recently published study of ten newly qualified ANPs from diverse clinical backgrounds and geographical regions of Australia, MacLellan et al., (2016) found that ANPs reported resistance to ANP practice by other nurses. This manifested in negative conduct ranging from dismissive and secretive behaviour to what the authors describe as 'turf wars' (p5). MacLellan et al's (2016) study was situated within a turbulent political healthcare landscape in Australia at the time of the study and the authors attribute behaviour at least in part to a culture of competitiveness over finite jobs, with which the ANPs interviewed felt ill equipped to deal.

It was also found that those in novel nursing roles considered themselves different to the general nursing community (Currie et al., 2010). In a study of nurses transitioning to advanced practice in acute care settings, Woods (2000) found new ANPs saw themselves as different from other nurses as they settled into their role. This was corroborated by Piil et al., (2012) who, in a small qualitative study of an extended nursing role in an outpatient

department in Denmark, found participants saw themselves as elite amongst nurses. Indeed describing oneself as 'advanced' can be seen as automatically positioning others as subordinate. While Piil et al's (2012) small case study has limitations, such as a small homogenous sample from one site, unclear recruitment strategy and lack of input from other stakeholders, it adds weight to the findings of Woods (2000) and Currie et al's (2010) more robust studies. What they do not explore are the potential implications and consequences of this self-positioning of ANPs. They are, however, a useful starting point on which to build further research exploring how these perceptions may influence ANP roles in practice as well as gaining a theoretical understanding of the underpinnings on which of such perceptions are built.

More generally, Hart (2004) warns intra-professional differentiation may result in fragmentation of nursing identity as generalist nurses may feel undermined by advanced practice nursing. This is explicit in a critique of advanced practice which suggests ANP practice contributes to a new nursing dichotomy where academic and technical elitism is valued above other aspects of nursing (Hallam, 2000). The potential for advancing roles in primary care to create intra-professional tension was evident in a small qualitative study conducted by Carr et al., (2005) into practice nurses' perceptions of advanced practice. Short, semi-structured interviews were conducted with 16 practice nurses recruited through convenience sampling. While not a focus of the study, there were apparent tensions between the roles, with some nurses lacking understanding of advanced practice and expressing concern that advanced practice challenged the status of traditional nursing roles while devaluing experiential learning. However, the impact of these tensions on ANP practice and the role of nursing more broadly remains unclear and requires further exploration. Carr et al's (2005) study had some limitations in terms of methodological rigour, for example some participants were 'aware of the researcher's personal opinions' (p350) and findings should be viewed in that context. Nevertheless, it is a useful preliminary study on which to further explore potential issues raised in an area that has been little explored.

It would appear then that an emerging body of evidence implicates the profession of nursing in building cultural barriers to ANP practice. The potential for nursing to impact on ANP practice receives little empirical attention, particularly in comparison to medicine, and is seen by some as unpalatable or taboo (Evans et al., 2014; Lowe et al., 2013). It is

for this reason that explicit exploration of the impact of the profession of nursing on ANP practice requires detailed exploration.

1.14. Managerial Influence on ANP Practice

Like nursing, the influence of management on ANP roles has been the subject of limited study, although managerial controls have been implicated in inhibiting ANP roles. In a qualitative longitudinal study of the introduction of ANP roles into five secondary care sites Woods (1998) found that idealised concepts of ANP roles were disregarded as 'organisational governance' (p124) took precedence. The influence of managers and physicians subsumed that of ANPs, who consequently became marginalised. This enabled short term managerial aims, such as meeting staffing quotas, while elements of ANP practice were disregarded. In this way ANPs could be seen to fill gaps in service, but not fully utilise their expertise, knowledge and skills. While Woods (1998) initially found this created tension for ANPs, after a year ANPs acquiesced to the imposed limitations. Woods' (1998) study included interviews with key stakeholders, observation of ANP practice and self-reported diaries. He identified a three stage conceptual model within which early role implementation could be situated. However the study was unable to consider the longer term influences on the ANP role and it would be of benefit to explore the influence of hierarchical and hegemonic relationships in more established advanced practice.

In a qualitative study of physician-ANP collaboration in Australia, Schadewaldt et al., (2016) identified that managers' leadership skills ought to be utilised more effectively to support ANP practice. While in a single case study of new ANP role implementation in a province of Canada, Sangster-Gormley et al., (2013) found managers played a pivotal role in the introduction of new ANP roles. However, little is known about the relationship between managers, ANPs and physicians or the impact such relationships have on ANP practice. Furthermore the experience of ANPs beyond role transition and early implementation is little researched. Like others, Sangster-Gormley et al., (2013) surmise that exposure to ANPs mitigates barriers to practice. However, this has not been empirically explored in depth. In a recent review of Australian ANP literature, Masso and Thompson (2016) found most studies focused on role transition and early implementation. As a consequence studies lacked utility in informing future recommendations as those ANP roles studied had not yet been fully realised. It is therefore necessary to explore

established ANP practice in order to inform the evidence base beyond early role implementation.

1.15. Wider Healthcare Communities

While some research explores ANP-physician collaboration (Schadewaldt et al., 2016) and to much less extent managerial and nursing impact (Lowe et al., 2013; Sangster-Gormley et al., 2013; McLellan et al., 2016), there is little emphasis on other primary healthcare team members and patients in relation to ANP practice.

Patient acceptance of advanced practice is commonly equated with patient satisfaction and much of the ANP safety and competency research used this as an outcome measure. Venning et al., (2000), Houweling et al., (2011), Horrocks et al., (2002) and Laurant et al., (2004) found high rates of patient satisfaction relating to ANP practice. This was sometimes attributed to longer consultations and provision of more information. They are supported by a case study exploring patients' perceptions of a nurse-led service (Chapple et al., 2000) in a general practice in England, where an ANP took over clinical responsibility for a practice because physician recruitment was difficult. Chapple et al's (2000) study found the role was acceptable to patients as it addressed an unmet need. The receptionist role was considered pivotal in negotiating understanding and acceptance with patients, although the impact of non-clinical colleagues is little studied elsewhere. As a single case study of a single ANP, caution should be used in extrapolating Chapple et al's (2000) findings and more recently studies have presented a more nuanced understanding of patient in relation to primary care consultations.

In an integrative literature review of qualitative studies exploring the benefits and limitations of nurse-doctor substitution, Rashid (2010) concluded some patients saw nurses as subordinate to physicians, in some circumstances patients would prefer to consult with a physician and patients thought nurses may overlook aspects of care. Patients who saw a nurse rather than a doctor felt their reason for attending was not taken seriously. Similarly, in a qualitative study of patients' perceptions of same day care in UK primary care settings, Redsell et al., (2007) found patients preferred to consult with GPs for more serious symptoms, while Parker et al., (2013) identified that Australian patients expressed confusion about ANP roles. Niezmen and Mathijssen (2014) also found some patients preferred physician care because this legitimised their illness. This is something

that Charles-Jones et al., (2003) relate to cultural understanding. In a qualitative study of nine English general practices, they identified that patients were organisationally categorised by condition. Minor ailments were directed to the nurse and pejorative judgements were attached to such categorisation and consequently to nurse consultations. Charles-Jones et al., (2003) suggest this recasts patients in a way that labelled some as unworthy of medical attention, while redistribution of work retained physician dominance. However, there has been little exploration on how this relates to ANP practice.

This review has considered barriers and facilitators to ANP utilisation identified in the literature and considered the impact on ANPs working in primary care. In summary, the literature suggests that ANP utilisation is inhibited by both practical and cultural barriers, while practical barriers themselves may be culturally underpinned. This may help explain enduring tensions within advanced practice working and is valuable in developing understanding ANP practice. However, the evidence base is small and barriers underexplored (Niezen and Mathijssen, 2014). Furthermore, there is little empirical study exploring the effects of cultural underpinnings on ANP practice (Aranda and Jones, 2008). This is significant as in order for ANP practice to move forward, such gaps in knowledge need to be addressed.

Finally, a qualitative evidence synthesis protocol has been published on the Cochrane database (Rashidian et al., 2013) which aims to explore barriers and facilitators to implementation of doctor-nurse substitution strategies in primary care. However, despite planned publication in 2015, this has not yet published. The lead researcher was contacted and the review is due to be published later in 2017.

1.16. Summary and Identification of Gaps in the Literature

The literature in this review consisted of systematic reviews, integrative syntheses, randomised controlled trials, observational, qualitative, cross-sectional and mixed methods studies, narrative reviews and position statements. The quality of evidence was methodologically variable, although there was some evidence of methodological rigor and from a qualitative perspective all research has value. Significantly, many studies failed to clarify what was meant by 'advanced nurse practitioner' and 'advanced nursing practice' and conflated advanced practice with other nursing roles. This impacted on the utility of

associated findings. Specific limitations relating to individual studies were raised within the body of the review. Quality of systematic/narrative reviews was assessed by considering methodological quality, checking search strategies and comparing authors' findings to key primary studies identified in the review, which were obtained where possible in order to assess credibility. While some study methodologies and search strategies were explicit, others lacked clarity and this was considered in relation to analysis.

This overview of international literature suggests that the ANP model has been utilised in many countries to address demographic and workforce issues. However, lack of clarity relating to qualifications, educational standards, titling, legislation and regulation has been implicated in the underutilisation of advanced practice, both in terms of number of ANPs and scope of practice. While these issues have been highlighted for some time (Bryant-Lukosius, et al., 2004a), little appears to have been resolved at either national or international levels. The literature also highlights practical and cultural barriers to ANP practice, while ANP safety and competence evidence remains contested. These issues may be informed by medical hegemony. ANP practice may also be limited by the reticence of ANPs to function autonomously, thereby reducing effectiveness. Furthermore intra-professional tensions within nursing, as well as the impact of managers and other colleagues require further exploration.

Most research focuses on role transition and early implementation of ANP roles, while little research has been conducted in relation to established ANP practice. This is unfortunate as the experiences of established ANPs may provide greater insight into how such roles can be sustainably integrated. It is not enough to assume time and role clarification alone will result in increased utilisation of ANP roles, as evidence suggests the contrary. Therefore it is necessary to explore ANP utilisation through an alternate lens.

It has been theorised that professional identity underpins cultural behaviours (Aranda and Jones, 2008; Currie et al., 2010; McNeil et al., 2013) and there is emerging empirical evidence suggesting professional identity may contribute to reduced acceptance and utilisation of advanced nursing roles (Currie et al., 2010; McNeil et al., 2013). However, there has been little research exploring the relationship between professional identity and ANP practice (Aranda and Jones, 2008) and there is limited research considering the construction of professional identity between and within professional groups, particularly

within primary care. Aranda and Jones (2008) argue there is a need to explore how social and cultural processes shape advanced practice nursing, while framing this within professional identity may aid fuller understanding of ambiguities and ambivalence related to ANP practice, thus moving research beyond the descriptive. Currie et al., (2010) suggest that in order to gain understanding of the influence of professional identity on evolving healthcare roles, it is necessary to study the concept in a micro environment. This is because professional identity is an interactional process that occurs at the level of the individual, in relation to their interactions with others and wider social context. The literature relating to professional identity and ANP practice is discussed further in Chapter 3, but first, the local and national context for this study is set out.

2. The Advanced Nurse Practitioner in England

2.1. Introduction

This study focuses on primary care within the English National Health Service [N.H.S]. England has a nationalised healthcare service within which primary care is increasingly important, as set out most recently in the national policy documents *Five Year Forward View*; *The Future of Primary Care: Creating Teams for Tomorrow*; *General Practice Forward View* (NHS England, 2014; Health Education England, 2015a; NHS England 2016). Within primary care, general practice provides an ideal multi-professional micro environment to study ANP role utilisation in relation to professional identity (Curie et al., 2010). There is a gap in the literature exploring the relationship between professional identity and ANP practice within primary care a priori, (Aranda and Jones, 2008), in relation to established roles and within a multi-professional context (Andregård and Jangland, 2015; Messo and Thompson, 2016).

In the following sections, the national context of ANP practice is set out. Focus is on England, rather than the UK, because organisational changes are specific to the English NHS due to increasingly devolved government structures (Paul et al., 2015). However, healthcare systems within the four countries of the UK share some commonalities and, to some extent, reflect healthcare workforce policy in other countries such as North America (Taylor and Hawley, 2010) and Australia (Carryer et al., 2007). Therefore utility may be more broadly applied. The following section contextualises ANP practice within the English NHS, with specific focus on primary care and general practice.

2.2. Background

National healthcare organisation in England is distinctive. Originating from social reformist agendas, the N.H.S was formed in 1948 and is funded through a national taxation system (The King's Fund, 2011; Rafferty, 1996). It is structurally organised into primary, secondary and tertiary care, with secondary and tertiary care delivering acute and elective hospital-based services as well as specialist services. Primary care is an umbrella term for community-based services including general practice, walk-in centres, pharmacies and dental care (The King's Fund, 2011).

Reflecting international trends, the NHS in England is undergoing a protracted period of significant workforce and organisational change (Aranda and Jones, 2008; Currie et al.,

2010; Marsden et al., 2010; NHS England, 2014; HEE, 2015a; NHS England 2016). This is particularly salient within primary care where there is a significant shortfall of physicians and nurses (NHS England 2016; The King's Fund, 2011). Simultaneously, policies have led to a shift in focus towards high complexity care within general practice which, coupled with increased patient demand, has led to pressure on primary care service provision (Aranda and Jones, 2008; NHS England, 2016). The *Five Year Forward View* (NHS England, 2014) sets out proposals for change within the NHS, including plans to further expand primary care and to adopt a more integrated approach between primary and secondary care. Meanwhile the Primary Care Workforce Commission states new ways of working are necessary in order to address 'unprecedented pressures' on primary care (HEE, 2015a p6). Potential solutions include broadening the roles of nurses through development of ANPs and expanding the remit of practice nurses (DH, 2010a; McInnes et al., 2015; Por, 2008; Rolfe, 2014).

The *Five Year Forward View* (NHS England, 2014) recommends strengthening the role of nurses within primary care and developing nurse leadership, while both the *General Practice Forward View* (NHS England, 2016) and the Primary Care Workforce Commission's report *The Future of Primary Care: Creating Teams for Tomorrow* (HEE, 2015a) point to expanding utilisation of nurses, pharmacists, paramedics and others as well as developing new roles, such as physician associates, as a solution to some of these issues. However, as the Primary Care Workforce Commission (HEE, 2015a p5) warns, workforce developments which require 'cultural change and the development of relationships across organisational boundaries' may prove challenging. Regrettably, the report offers no solution as to how such issues should be addressed beyond acknowledging this will take time. It is here that exploration of the experiences of ANPs in primary care may prove illuminating. First it is necessary to consider the structure of primary care and general practice within which ANP practice is situated.

2.3. Primary Care and the English Healthcare System

Primary healthcare is central to the wellbeing of societies and is grounded in local communities. The World Health Organisation's global view of primary health care was described in its Alma-Ata Declaration as 'essential health care...made universally accessible to individuals and families in the community' forming 'an integral part of the

country's healthcare system' (W.H.O.,1978, pp1-2). While Greenhalgh (2007) more prosaically suggests it is

....what happens when someone who is ill (or thinks he or she is ill or wants to avoid getting ill) consults with a health professional in a community setting for advice, tests, treatment or referral to specialist care. (p12)

In England, general practices are considered the core of primary care. General medical practitioners take responsibility for first point of contact healthcare, act as gatekeepers to secondary care and specialist services and arbitrate some statutory sickness benefits (The King's Fund, 2011) In addition, services previously within the remit of secondary care are increasingly devolved to primary care and general practice specifically (NHS England, 2014; HEE, 2015a; NHS England 2016).

2.4. The Structure of General Practice

Since the inception of the NHS, general practices have been owned and run by physicians known as general practitioners (GPs), who are independent contractors providing services to the NHS (Peckham, 2003). General medical practices were initially single-handed, with most subsequently becoming partnerships of self-employed GP shareholders, (Greenhalgh, 2007). This continued until the introduction of the General Medical Services Contract in 2004 (GMS, 2004), which opened practice partnerships to non-physicians, such as nurses and practice/business managers, and also supported employment of salaried general practitioners and ANPs.

Simultaneously, greater scrutiny and performance-related incentives became the norm (The King's Fund, 2011). As a consequence general practice became increasingly managerialised, with business managers employed to maximise income generation. Other commercial and voluntary providers, such as social enterprises and private companies, have also begun to provide primary care services under the Alternative Provider Medical Services Contract [APMS] (DH, 2004b), particularly in areas where GP recruitment is difficult. However APMS uptake has been limited (The King's Fund, 2011), while nurse and other non-medical partners remain a minority (Imison et al., 2016; McMurray, 2011). It is unclear whether this is due to lack of opportunity, or whether non-GPs are reluctant to

take on strategic roles. However, The King's Fund (2011) found partnership opportunities were increasingly scarce even for GPs. It may be that in this competitive environment it is difficult for others to access such opportunities.

As well as providing NHS services, GPs are also involved in service commissioning. The 1990s saw the start of GPs' involvement in the commissioning of services with the advent of GP fundholding and later as part of Primary Care Trusts [PCTs] (The King's fund, 2011). Prior to 2013, PCTs commissioned the majority of NHS services and controlled 80% of the NHS budget. They have since been replaced by Clinical Commissioning Groups [CCGs], with all General Practices required to belong to a CCG local to their geographical area (NHS England, 2012). CCGs are currently responsible for commissioning NHS services at an unprecedented level (The King's Fund, 2011), assuming responsibility for £65 billion of the NHS's current £95 billion commissioning budget (BMA, 2015a). GPs hold the vast majority of seats on CCG commissioning boards, with lay representatives, nurses, managers and secondary care doctors in the minority. Therefore GPs play a dominant role in both the commissioning and delivery of a broad spectrum of healthcare services. This has potential implications for the types of services commissioned and is significant in the development of nursing (and by extension ANPs) and other healthcare professional services in general practice. Moreover, as nursing remains under the dual control of the GPs both as service commissioners and employers, this has implications for nurses and patients in relation to the services provided and choice of care provider.

2.5. The Development of Nursing within English General Practice

Community district nursing and health visiting dominated primary care nursing until the Cumberlege Report (DH, 1986) brought general practice nursing to widespread attention in the mid-1980s (Damant et al., 1994). Until then practice nursing had been considered niche and idiosyncratic, lacking a defined career structure or educational pathway. The direct employment of practice nurses by GPs divided them from other primary care nurses who were employed within the NHS. This meant educational and developmental opportunities were often unavailable (Damant et al., 1994) and pay scales inequitable. It also meant practice nurses had a distinct relationship with physicians because of the status differential between employer and employee.

Practice nursing developed considerably following the introduction in 1990 of a new performance-related General Medical Contract (DH, 1990) which allowed GPs to employ nurses to deliver incentivised care (The King's Fund, 2011). The further introduction of the 2004 GMS contract (GMS, 2004) advocated development of innovative and advanced nursing roles (Campbell et al., 2008) in order to support policies aimed at shifting services from secondary to primary care, reducing hospital admissions and addressing increased demand for first point of contact healthcare (Por, 2008). This also corresponded with directives aimed at improving physician work-life balance (Campbell et al., 2008). These changes resulted in a greater role for practice nurses, who 'assumed a range of responsibilities that would previously have been undertaken by GPs' (The King's Fund, 2011 p18). At the same time educational opportunities increased with the development of a specialist practitioner undergraduate degree and master's level advanced practice courses, while new roles such as the ANP offered a more formalised career structure (The King's Fund, 2011). In addition, legislative changes resulted in suitably qualified nurses gaining prescribing rights (Ward and Armstrong, 2015). Consequently, between 1999 and 2008 the proportion of general practice consultations conducted by nurses rose from 21% to 35% (The King's Fund, 2011) while by March 2016, 15,753 full time equivalent nurses were employed in general practice (NHS Digital, 2016). Practice nursing also established itself as central to routine management of long term conditions, while the development of nurse-led services meant a more autonomous role for nurses (Chapple et al., 2000). As a consequence, general practice nursing plays an important part of primary healthcare in England.

However, general practice continued to be predominantly owned and controlled by medicine. Despite increased opportunities for nurses, their principal positioning remained as employees and mid-level practitioners (McMurray, 2011; Drennan et al., 2014b). This, coupled with limited representation on CCG boards, may indicate nursing has not achieved its full potential. As well as the professional influence of medicine over nursing (Hart, 2004), newer managerial discourses are increasingly important in shaping primary care. This 'New Public Management' (Dopson, 2009 p37) has implications for practice nursing (McDonald et al., 2009), for GPs and for patient services (Charles-Jones et al., 2003). In a qualitative study consisting of semi-structured interviews of 20 practice nurses working in practices across England, McDonald et al., (2009) found nurses felt an ethos of surveillance and corporate income-generating agendas impacted on their professional

relationship with patients. They also felt that nursing was devalued through increased medicalisation and routinisation of care, computer template driven consultations, mandatory data collection and incentivised targets. Similar claims have also been made by GPs (Campbell et al, 2008). Charles-Jones et al., (2003) identified similar concerns regarding managerial influence on professional practice and increased focus on cost efficiencies, with managers specifying which patients were seen by which clinicians. This was considered to fragment care into tasks and limit both patient choice and nurses' responsiveness to patients' needs. Primary care nurses have also expressed concern at losing clinical roles to unregulated healthcare assistants as their role shifts towards more complex areas of care such as long term condition management (Campbell et al., 2008).

Consequently, medicine and management remain gatekeepers for the development of nursing in general practice. This is often led by the needs and limitations of the practice, as decided by GP employers and managers, rather than abilities of individual nurses or needs of patients (Carr et al., 2005). The introduction of GMS contracts in 1990 and 2004 have, however, significantly increased the opportunities for nurses working in general practice. This is exemplified in the role of the ANP. Consequently, the role of the ANP in England, and specifically within general practice, will now be explored.

2.6. ANP Development in England

The UK professional nursing association, the Royal College of Nursing [RCN], has had advanced practice on its agenda since the 1970s and Stillwell is credited with introducing the ANP role to England in the 1980s (Albarran and Fulbrook, 1998). It then appeared to be somewhat stymied by the so called maxi-nurse/mini-doctor debate, which was at its height in the 1980s and 1990s and which was grounded in tensions between differing philosophical perspectives underpinning advanced practice (Por, 2008). This led to a polarity between those who understood ANP practice as the advancement of nursing and others who saw it as moving beyond mainstream nursing into new domains, predominantly medicine (Rolfe, 2014). Such debates have never been satisfactorily resolved (Por, 2008).

New impetus for advanced practice nursing came in response to the introduction of policies such as *Making a Difference* (DH 1999); *The NHS Plan* (DH 2000); *Liberating the Talents* (DH 2003); *Our Health, Our Care, Our Say*, (DH, 2006a); *Modernising Nursing*

Careers (DH 2006b); *Advanced Level Nursing: A Position Statement*, (DH, 2010a); *Five Year Forward View* (NHS England, 2014); *The Future of Primary Care: Creating Teams for Tomorrow* (HEE, 2015a) and *General Practice Forward View* (NHS England, 2016). These policies have overseen acceleration in both number and level of practice of ANPs. Concurrently academic institutions developed specific advanced practice programmes, led initially by the Royal Collage of Nursing (Barton and East, 2015).

It appears then that ANP practice in England predominantly developed as a consequence of workforce policies which substitute nurses for doctors (Bonsall and Cheater, 2008; Rolfe, 2014). Instead of pushing the boundaries of nursing practice (Bryant-Lukosious et al., 2004a), ANP practice can be seen as a cost containment exercise in response to workforce shortages (Aranda and Jones, 2008; Bonsall and Cheater, 2008). This has dominated the advanced practice agenda in England (Rolfe 2014), although there continues to be considerable debate as to the nature of advanced practice nursing. Indeed, the doctor substitute concept of advanced practice nursing has been challenged both at philosophical and pragmatic levels.

Philosophically, it has been argued that ANPs should not merely perform tasks doctors have identified as basic or mundane, which Castledine (1998) suggests is intellectually wasteful. Rather they should demonstrate expert clinical judgement and synthesis of experiential and clinical knowledge, as well as a high standard of clinical performance (Mantzoukas and Watkinson, 2007). Furthermore, there is evidence ANPs work to keep a nursing identity central to their practice in the face of fiscal and time constraints (Brykczynski, 2011). It can, therefore, be argued that ANPs adapt knowledge and skills from other disciplines, in addition to high level nursing skills, in order to advance nursing. Conversely on a practical level, it remains that ANP roles are most prevalent where there are supply side shortages (McMurray, 2011), while Rolfe (2014) highlights a projected shortfall in qualified nurses estimated at nearly 50,000 by 2016 and argues plugging gaps in medical provision impacts negatively on the provision of core nursing care.

However, regardless of the continued debate within nursing it remains that, at a service level, doctor substitution roles continue to dominate. In a recent government commissioned report on workforce planning, Imison et al., (2016 p4) envisage advanced practice as 'filling in gaps in the medical workforce' and caution against developing

advanced practice in a way which creates supplementary rather than substitution roles. This can be seen to dismiss the underlying philosophy of advanced nursing and ignores evidence suggesting physicians are less likely to accept advanced nursing roles which encroach on medical domains (McKay, 2003). As doctors continue to be positioned at the top of the professional hierarchy (Imison et al., 2016) it is likely medicine will continue to impact on the nature and scope of ANP practice.

2.7. Defining Advanced Practice Nursing

Reflecting international literature, in England there remains no clear definition of advanced practice nursing (Imison et al., 2016) despite its long establishment. Like its international counterparts, in England it is now broadly accepted as a level of practice rather than a specific role (Barton and East, 2015; DH, 2010a; SGHD, 2008; RCN, 2012).

A number of national policy makers and key stakeholders have contributed definitions of advanced practice. In 2006 the NHS Career Framework (Skills for Health, 2006) recognised advanced practitioners as:

Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. (Skills for Health, 2006, cited in SGHD, 2008)

The clinical role of the ANP was set out by UK nursing's regulatory body, the Nursing and Midwifery Council, in 2005 in its proposed definition and framework document (NMC, 2005), which is reproduced in Table 2. Note there is no specified level of educational attainment. The definition was revised the following year with the intention of creating a more patient accessible definition (NMC, 2006) and current literature appears to preface the 2005 framework with the 2006 revision (Paul et al., 2015; McConnell et al., 2013; SGHD, 2008).

Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your health care needs or refer you to an appropriate specialist if needed (NMC, 2006)

Table 2: NMC (2005) Advanced Practice Nursing Descriptors

Advanced Practice Nurses are highly skilled nurses who can:

- take a comprehensive patient history
- carry out physical examinations
- use their expert knowledge and clinical judgement to identify the potential diagnosis
- refer patients for investigations where appropriate
- make a final diagnosis
- decide on and carry out treatment, including the prescribing of medicines, or refer patients to an appropriate specialist
- use their extensive practice experience to plan and provide skilled and competent care to meet patients' health and social care needs, involving other members of the health care team as appropriate
- ensure the provision of continuity of care including follow-up visits
- assess and evaluate, with patients, the effectiveness of the treatment and care provided and make changes as needed
- work independently, although often as part of a health care team
- provide leadership
- make sure that each patient's treatment and care is based on best practice

The Royal College of Nursing [RCN] published its own guidance on ANP practice in 2002. This was updated in 2008 stating ANPs should have at least a first level degree, then again in 2012 to reflect that 'consensus within the UK health departments is that ANPs in the future will have undertaken master's level educational preparation' (RCN, 2012 p4). Descriptors are set out in Table 3. The RCN's position reflects that of the International Council for Nurses (ICN, 2002) which recommend master's level education and a more general international movement towards postgraduate education (Bryant-Lukosious et al.,

2004a, Freund et al., 2015). However, as discussed in Section 2.8, in England educational standards remain discretionary.

Table 3: RCN (2012) Advanced Practice Nursing Descriptors (P4)

A registered nurse who has undertaken a specific course of study and is skilled in:

- making professionally autonomous decisions, for which they are accountable
- receiving patients with undifferentiated and undiagnosed problems and making an assessment of their health care needs, based on highly-developed nursing knowledge and skills, including skills not usually exercised by nurses, such as physical examination
- screening patients for disease risk factors and early signs of illness
- making differential diagnoses using decision-making and problem-solving skills
- developing with the patient an ongoing nursing care plan for health, with an emphasis on health education and preventative measures
- ordering necessary investigations, and providing treatment and care both individually, as part of a team and through referral to other agencies
- having a supportive role in helping people to manage and live with illness
- having the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate
- working collaboratively with other health care professionals and disciplines
- providing a leadership and consultancy function as required

Both NMC and RCN descriptors are similar in content and concentrate on clinical elements of ANP practice. Other stakeholders have focused on defining advanced practice more broadly. The UK-wide initiative 'Modernising Nursing Careers' (DH, 2006b) attempted to provide structure for the future nursing profession and from this an Advanced Practice Toolkit was developed (SGHD, 2008). This drew together prior definitions of advanced practice from the ICN (2002), the NMC (2005/6), the RCN (2008 version) and the Career Framework for Health (Skills for Health, 2006) in order to develop consensus. From this a proposal was developed (Table 4). This includes the key concept of four pillars of advanced practice: clinical; education; leadership and research. These have

subsequently been accepted as central to advanced practice by key stakeholders (HEE, 2015a; RCGP, 2015; RCN, 2016).

Table 4: Advanced Nursing Practice Toolkit (SGHD, 2008)

Advanced practice is a 'level of practice' rather than a role or title:

- The Career Framework for Health definition articulates advanced practitioners across professional boundaries
- Advanced practice in nursing can be broadly defined by the International Council of Nurses' definition
- The NMC definition articulates the clinical 'advanced nurse practitioner' role within the UK context
- Advanced practice is shown across four pillars:
 - advanced clinical/professional practice
 - facilitating learning
 - leadership
 - evidence, research and development
- These themes are underpinned by autonomous practice, critical thinking, high levels of decision-making and problem-solving, values-based care and improving practice
- The skills and knowledge base for advanced practice are influenced by the context in which individuals practice

Following this the Department of Health in England set out its position on advanced nursing in its document *Advanced Level Nursing: A Position Statement* (DH, 2010a). Again this has no specific definition, but rather states there are two levels of nursing practice: entry and advanced level, with advanced nursing characterised as 'working at a level well beyond initial registration using their existing knowledge and skills to inform and further develop their practice' (DH, 2010a, p7). Again what makes this advanced or indeed nursing is unclear (Rolfe, 2014).

In 2016, Health Education England drafted a cross-professional definition of advanced clinical practice and stated the intention to develop a competence framework to promote national consistency, reflecting its mandate to develop a flexible responsive workforce.

Advanced Clinical Practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level of autonomy and complex decision-making. This is underpinned by a masters level award or equivalent that encompasses the four pillars of clinical practice, management and leadership, education and research, with demonstration of core and area specific clinical competence. Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes. (HEE website accessed January 2017)

While stakeholders are actively contributing to defining advanced practice, in view of these numerous and generalised definitions and descriptors, it is unsurprising ANPs have difficulty articulating their role and level of practice, while others struggle to understand advanced practice and what ANPs actually do. Indeed the government commissioned workforce report, *Reshaping the Workforce to Deliver the Care Patients Need* (Imison et al., 2016) identified lack of clarity around advanced practice roles as challenging implementation. What is clear is that it remains difficult for ANPs and others to understand what is meant by advanced practice and what differentiates it from other levels of practice and other professions. This is particularly pertinent as ANPs in England are among the least regulated and standardised internationally (Freund et al., 2015). Because the NMC is the statutory regulatory body for registered nurses and midwives in England and Wales, its leadership is central to ANP practice. Therefore, the role of the NMC and other agencies in relation to ANP education, standards and legislative and regulatory frameworks requires exploration.

2.8. ANP Education, Standards and Regulation in England

In England ANP practice does not correspond with a specific level of qualification and is not recordable on the register of nursing's regulatory body, the NMC (Freund et al., 2015). However, as registered nurses, those practising advanced nursing work within the NMC Code of Professional Standards of Practice and Behaviour for Nurses and Midwives which applies to all registered nurses and midwives (NMC, 2015).

After consultation in 2004 (First and Tomlins, 2015) the NMC proposed nurses in advanced roles should be registered on a sub-part of the NMC nursing register and their title protected (NMC, 2005). By 2010, the Report of the Prime Minister's Commission on the Future of Nursing and Midwifery, *Front Line Care: The Future of Nursing and Midwifery in England* (DH, 2010b), recommended advanced nursing should be regulated to ensure competency. However, the government's response to this document highlighted that the Council for Healthcare Regulatory Excellence (CHRE, 2009) advised that additional statutory regulation of advanced practice was unnecessary (DH, 2011). Consequently, the government would only consider additional regulation proposals from the NMC if there was significant evidence that advanced practice was 'fundamentally different from that at initial registration and where risk to the public is evident' (DH, 2011 p10). The NMC then confirmed in 2012 it had suspended further development of its Advanced Level Practice Framework and associated registration (NMC, 2012). An online survey of RCN advanced practice forum members reported many ANPs were disappointed with the NMC's position, which they felt left them legally and professionally vulnerable and perpetuated public and professional confusion (Hall, 2012). Consequently, lack of clear leadership and regulation from the NMC can be seen to contribute to ongoing confusion and inconsistency relating to the extent and direction of advanced nursing roles and level of practice.

That UK nursing's regulatory body has not provided leadership in the development of advanced practice nursing can be seen as reflecting nursing's historic inability to define and create its own professional discourse (Rafferty, 1996). This positions nursing as professionally, politically and influentially weak (Hart, 2004) and may impact on the credibility and legitimacy of ANPs because others outside nursing are taking the lead in shaping advanced practice nursing (Ball and Cox, 2004). It can also be seen to demonstrate that nursing continues to struggle to be considered a profession (Hart, 2004)

because traditionally to be recognised as such, occupational groups are required to have control over their own work and to exercise governance and regulation over themselves and others. Consequently, professions play a civic role protecting society (Evetts, 2013). That ANP practice remains unstructured and unregulated beyond initial registration may indicate that nursing in general, and ANPs specifically, have yet to achieve professional status. It also provides insight into the position of advanced nursing within healthcare systems, in that it continues to reflect nursing's historical difficulty in developing autonomous, professional influence over its own work (Rafferty, 1996). This has been implicated in underutilisation and lack of legitimacy of the ANP role (Quinn, 2010).

As a consequence of the lack of specific advanced nursing regulation and unprotected titling, educational and qualification standards in England are variable. There have, however, been attempts at standardisation. The RCN has long been at the forefront of encouraging advanced practice competencies (Gaskell et al., 2015) and its more recent support of postgraduate level education responds to the Department of Health's position on advanced level nursing (DH, 2010a). This identified a minimum threshold for advanced level competency and the expectation that ANPs should undertake 'Master's level education or its equivalent' (DH, 2010a p6). Both the RCN (2012) and the Department of Health (DH, 2010a) stop short of requiring a master's degree, or stipulate a specific advanced practice qualification, but rather cite postgraduate certificates and diplomas (DH, 2010a). More recently, the Health Education England document *District Nursing and General Practice Nursing Service: Education and Career Framework* (HEE, 2015b) was produced as part of the Transforming Nursing for Community and Primary Care Programme in order to develop a consistent approach to primary care nurse education and career frameworks. It sets out minimum educational and professional requirements for ANPs working in primary care (Table 5).

Table 5: Advanced Nurse Practitioner Minimum Professional/Educational Requirements. District Nursing and General Practice Nursing Service Education and Career Framework (Health Education England, 2015b)

- Registered on Part 1 NMC register
- NMC Specialist Community Practitioner Qualification
- Meet RCGP/ RCN ANP competencies
- Postgraduate diploma to include level 8 high-intensity interventions
- NMC Mentorship training
- Master's degree in a nursing related subject
- Practice Educator Award if role focused in education
- Independent/ Supplementary Nursing Prescribing – V300
- May work towards:
 - Professional Doctorate (Clinical practice)
 - PhD (Research)
 - Educational Doctorate (Education)

In addition the Association of Advanced Practice Educators UK, a collaborative of UK Higher Education Institutions, is working towards educational standard setting across the UK (AAPE website accessed September 2016). However, despite work towards standardisation, it remains there is no minimum statutory standard of education, while unprotected titling and lack of regulation means that advanced practitioners are those who chose to call themselves such. Furthermore, aspirations of master's level education may not be reflected in the ANP workforce.

An online survey by the RCN ANP Forum found that from n=689 ANP respondents, 70% held a first degree while only 40% held masters level qualifications (Hall 2012, p40). However, the survey sample may not be representative of the ANP workforce as the RCN does not represent all registered nurses or ANPs, while practitioners with specific characteristics may be more likely to respond to online surveys. The level of academic qualifications among ANPs working throughout primary care in the English NHS remains unclear, while Freund et al., (2015) highlight that the experience of UK ANPs, as well as the extent to which they are working at an advanced level, remains unknown. This is likely to continue until the role is formally regulated and the title protected.

Bryant-Lukosious et al., (2004a) assert that while ANP roles and level of qualification remains unclear, competence of ANPs will continue to be questioned. This is countered by Marsden et al., (2010) who argue regulation may inhibit advanced practice nursing by restricting flexibility. However, deficiencies in healthcare highlighted by such inquiries as The Francis Report (2013) into failings at Mid Staffordshire NHS Foundation Trust, the public inquiry into children's heart surgery at Bristol (Traynor, 2013) and the Morecambe Bay Investigation Report (Kircup, 2015) have led to implicit trust in healthcare professionals and the reliance on self-regulation in maintaining standards being challenged (Elston, 2009). This has led to broader moves within healthcare towards demonstrating competence through monitoring and accreditation of all professions, including medicine, resulting in greater external managerial control of healthcare professionals (Dopson, 2009). Therefore it is increasingly necessary for ANPs to be able to demonstrate their credibility and competence in the delivery of care through educational standards and regulation.

The RCN recently announced its intention to credentialise advanced practice in order to 'give nurses formal recognition of their expertise and skills' (RCN, 2016 accessed December 2016). Those wanting a place on the voluntary RCN register will be required to demonstrate working at an advanced level, registration will be renewed every three years and there will be a cost implication. The process is currently being piloted. This appears to be a response to Health Education England's *Shape of Caring Review* (HEE, 2015c), which recommended advanced practice be recognised through membership and fellowship credentials based on medical postgraduate models. However, it remains there is no formal regulation by nursing's regulatory body and the RCN as a professional association might be more suitably employed lobbying the NMC and other decision-makers for formal regulation. This may allow the level of practice undertaken by ANPs to be formally recognised by the public, by patients, by health professionals and by nursing itself. In turn, this may contribute to legitimisation of ANP practice.

It may be that ultimately regulation will be taken out of the hands of nursing and subsumed by increased control of government and other agencies, as outlined in the White Papers *Trust, Assurance and Safety- The Regulation of Health Professionals in the 21st Century* (DH, 2007) and *Extending Professional and Occupational Regulation* (DH, 2009). The Royal College of General Practitioners has also recently developed its own

competency framework for ANPs in primary care (RCGP, 2015), with the aim of achieving *Five Year Forward View* goals (NHS England, 2014). This maps ANP competencies to the GP curriculum, although it is unclear who is responsible for assessing ANPs. While this can be seen as professions collaboratively working to deliver healthcare strategy, it can alternatively be viewed as an example of professional hegemony, with medicine adopting a leadership role over nursing through a space created by inertia in nursing leadership. It remains that until such a time as the ANP title is protected, educational levels are standardised and the level of practice/role appropriately regulated, ANPs will find it difficult to articulate the service they can provide for patients and their contribution to healthcare. This has been identified both nationally and internationally as a barrier to full and effective ANP healthcare provision and will now be explored within the context of English primary care.

2.9. ANP Utilisation in Primary Care

Utilisation is working at full scope of practice, skills and capabilities (Freund et al., 2015), while a critical mass of ANPs is required if full impact is to be achieved. However, the number of ANPs in the UK remains low (Freund et al., 2015). Data compiled by NHS Digital from approximately 7600 general practices in England estimated that as of March 2016 there were 34,914 full time equivalent [FTE] general practitioners and 15,753 FTE nurses in general practices in England, of which 2,304 FTE nurses were considered to be working at an advanced level (NHS Digital, 2016). This is a drop from the reported 3,507 FTE ANPs in 2014 (HSCIC, 2015). While the data collection tool changed between data collection points and is termed 'provisional experimental' (NHS Digital, 2016, p4), this raises questions of whether the ANP workforce is sufficient to provide sustained workforce reorganisation on the scale required in recent policies.

Utilisation of ANPs in terms of practising at full remit has been discussed in relation to the international literature in Chapter 1. It is reflected in the work of Main et al., (2007) in relation to English primary care, which indicated ANPs experienced cultural barriers to advanced practice as described previously. Furthermore an ethnographic study conducted by McMurray (2011) exploring physician acceptance of ANPs in a general practice in England found that while GPs outwardly supported ANPs, their roles were curtailed by the same GPs. ANPs in McMurray's (2011) study solved this by forming an ANP partnership, but this model is limited by the low numbers of ANPs working in this way.

It has also been found that nurse prescribing has not reached its projected potential. The NHS Plan (DH, 2000) expected half of registered nurses in England to be qualified to prescribe prescription only medication by 2004, but Freund et al., (2015) found the figure to be nearer 25%, while Hall (2012) states only 9% of NMC registered nurses hold a prescribing qualification. Of note is that many nurses qualified to prescribe choose not to. In 2010 only 43% of UK primary care nurses with a prescribing qualification prescribed more than one prescription annually, while the number of items prescribed by nurses accounted for only 1.5% of the total items prescribed in primary care (Drennan et al., 2014a). These studies demonstrate discrepancies between policy and practice, which Currie (2010) suggests may be a consequence of failing to recognise wider cultural issues influencing advanced nursing roles. Similarly, in a literature review of the impact of primary care ANP roles Bonsall and Cheater (2008) identified that the current research base failed to explore general practice culture, organisation and service maturation and highlighted this as a significant gap. Consequently, such aspects and their underlying tributaries require further exploration.

While the ANP role in primary care in England is becoming increasingly established, there appears to be a considerable way to go before ANPs are fully utilised, both in terms of scope of practice and critical mass. Potential reasons for this have been explored in previous sections and a rationale for further study developed. Full utilisation of ANPs is important if policies such as *Five Year Forward View* (NHS England, 2014), *The Future of Primary Care: Creating Teams for Tomorrow* (HEE, 2015a) and the *General Practice Forward View* (NHS England, 2016) are to be achieved. Additionally, the NHS Workforce Review Team (2014) forecast increased demand for primary care services, coupled with an aging GP and practice nurse workforce which is set to seriously challenge future general practice provision, while many GPs and nurses are choosing to work part time and more flexibly (The King's Fund, 2011). In England the government has sought to address these issues by developing a more flexible, multi-professional workforce, of which ANPs play an important part. Other healthcare professions are also developing advanced roles and new practitioners such as physician's associates are beginning to be used as primary care providers. Within the profession of nursing, changes to education and workforce policy mean new roles and levels of practice across skill mix are set to develop further (Willis Commission, 2012; HEE, 2015c). All have potential implications for general

practice. First the future of nursing and then other professional roles are considered in the following sections.

2.10. The Future of Nursing

The RCN commissioned a report exploring nurse education's ability to meet present and future healthcare needs (Willis Commission, 2012). It recommended all registered nurses should be educated to graduate level post 2013 and this was subsequently adopted. The following year Traynor (2013) cautioned that employers may use degree level registration to rationalise the registered nursing workforce, resulting in fewer qualified nurses supervising care delivered by others. Subsequently the *Shape of Caring Review* (HEE, 2015c), also overseen by Lord Willis, recommended an increased role for healthcare assistants and the creation of a higher level care assistant role. The assistant practitioner role, which enabled some non-registered practitioners to take on work previously undertaken by registered nurses, had already been introduced. However, in 2015 the government announced its new nursing support role (Gov.UK, 2015) as a consequence of Health Education England's response to the *Shape of Caring Review* (HEE, 2015d). The new nursing associate role encompasses apprenticeship-style training in practice leading to a foundation degree and will potentially allow a different access route to registered nursing. The NMC have recently agreed to regulate this role (NMC, 2017), which may be seen by some to reflect the previous two tier education system which was phased out as part of nursing's professionalisation agenda in the 1980s and 90's. The *Shape of Caring review* (HEE, 2015c) also predicts a future nursing workforce based predominantly in primary care and suggests that in order to cope with increased and complex demand, advanced practice will need to develop further. The recommendations of *Shape of Caring* (HEE, 2015c) and HEE's response (HEE, 2015d) and well as other policy directives including the *Five Year Forward View* (NHS England, 2014) will necessitate adapting to new ways of working, both within nursing and amongst the wider healthcare workforces. However, while some policy recommendations acknowledge cultural change is necessary, there is little in these policies which engage with cultural and professional responses to change.

2.11. The Future of General Practice

Organisationally, skill mix is changing and healthcare hierarchies extending within general practice (Charles-Jones et al., 2003; The King's Fund, 2011; HEE, 2015c; NHS England,

2016). Pharmacists, physiotherapists and other health professionals are developing primary care advanced practice roles from within established healthcare professional frameworks (Chartered Society of Physiotherapists, 2016; Royal Pharmaceutical Society, 2013). The physician associate [PA] role has recently been introduced to the UK following long establishment in USA (Drennan et al., 2014b). PAs undertake two year postgraduate training based on a biomedical model and work under supervision of medical practitioners. Their remit is first contact consultations and less complex health needs. At present they are not authorised to prescribe medication and are unregulated. A recent mixed methods study of the safety and effectiveness of PAs in UK primary care (Drennan et al., 2014b) found they were safe and provided equivalent care to medical practitioners for patients who predominantly consulted with minor problems, were younger, were from more deprived areas, had fewer chronic diseases, sought consultations infrequently and took fewer prescribed medications. PAs were acceptable to other healthcare practitioners and patients, with the caveat patients wished to continue to choose who to consult. There was no significant difference in satisfaction rates between GPs and PAs, unlike studies of ANPs, which identified higher satisfaction with ANP than GP consultations (Venning et al., 2000). PAs were also found to be cost effective, although supervision costs were not accounted for and consultation duration, as for ANPs (Horrocks et al., 2000) was longer than for medical practitioners. Drennan et al's (2014b) positive evaluation of PA roles may precede larger scale adoption in the UK as set out in the *General Practice Forward View* (NHS England, 2016). However, broader introduction may mean PAs and other advanced healthcare professionals experience some of the issues encountered by ANPs within primary care. Therefore, the experiences of ANPs should be utilised to inform healthcare policy and develop strategies to encourage full utilisation of mid-level and advanced roles.

2.12. Organisational Considerations

Primary care roles remain dynamic and a variety of clinicians contribute to the future of primary care and general practice specifically. However, the organisational positioning of GPs as leaders and experts remains explicit. The Royal College of General Practitioners' document *The 2022 GP: A Vision for General Practice in the Future NHS* (2013) highlights that GPs expect to adopt a leadership position within general practice (RCGP, 2013 p9). Furthermore, the same document indicates GPs will continue to define their own educational requirements, as well as influencing the education and training of others. This view is supported by the government commissioned report, *Reshaping the Workforce*

to Deliver the Care Patients' Needs (Imison et al., 2016) which asserts in the future 'care will be supplied predominantly by non-medical staff' while doctors 'will act as master diagnosticians and clinical decision-makers' (p4), thus following a well-worn path where medicine retains dominance over other healthcare professions. In this context, it is even more important to explore how attitudes, behaviours and cultural underpinnings influence advanced practice. As highlighted previously, it has been suggested that professional identity may be a useful framework within which to situate such study (Aranda and Jones, 2008; Chulach and Gagnon, 2016; Currie et al., 2010; Monrouxe, 2010) and workforce issues (Currie et al., 2010).

2.13. Summary

This overview of ANPs in general practice in England indicates that ANPs can contribute an important resource in present and future healthcare delivery, while current national healthcare policy promotes the utilisation of flexible, multi-professional workforces. However, the literature suggests ANPs are underutilised both in terms of number of ANPs and scope of practice. There is growing evidence to suggest professional identity may be implicated in underpinning some of the longstanding issues relating to ANP utilisation both in England and internationally. However there is little research focusing on professional identities within primary healthcare teams in relation to established advanced practice. Therefore the aim of this study is to use professional identity as an a priori concept in order to explore its influence on ANP roles within primary healthcare teams. This addresses a gap in the literature exploring ANP roles within healthcare teams (Andregård and Jangland, 2015); established ANP practice (Bonsall and Cheater, 2008; Messo and Thompson, 2016) and the relationship between ANP practice and professional identity (Aranda and Jones, 2008; Currie et al., 2010; Matykiewicz, 2011) By exploring this at a micro level, it is anticipated deep insights will be gained (Currie et al., 2010) in order to move the ANP literature towards understanding how these practices and behaviours are developed and maintained, so they may be addressed more usefully in the future (Lowe et al., 2013).

The following chapter explores professional identity within advanced nursing practice, nursing more broadly and within a wider healthcare context. It then identifies a theoretical framework within which to situate the study and concludes by setting out specific research aims and objectives.

3. Professional Identity

3.1. Introduction

The following chapter sets out what is meant by professional identity and its potential impact on ANP practice. Initially professional identity is defined and its influence on nursing situated within wider historical, political and social contexts. The evidence is then related to ANP practice and relevant theoretical frameworks identified within which to situate the study.

3.2. Conceptualising Professional Identity

Professional identity is a value and belief system constructed to shape and legitimise the behaviour of individuals within professional groups (Wilson et al., 2013). It leads to the internalisation of professional behaviours and ethics, development of self-regulation and adherence to appropriate behavioural norms (Hamilton, 2008). Professional identity also allows the presentation of appropriate actions and acceptable demeanour to society, thereby instilling confidence and respect. In this way the public has a level of protection because actual behaviour can be measured against recognised expectations (Hamilton, 2008). Furthermore, society holds perceptions of a profession's identity which constitute its public image and which may or may not be consistent with realities of professional practice (Hallam, 2000). In this way professional identity is not simply formed by the profession in question, but is influenced by official recognition, related professions, public opinion, technological and scientific developments and economics amongst other influences (Wackerhausen, 2009). Therefore, it is necessary that a strong, coherent professional identity is developed in order to structure the roles of professions and to provide a framework within which the expectations of society are created and managed (Monrouxe, 2010).

In the literature, professional identity is often viewed as synonymous with professionalism (Wilson et al., 2013). The concepts are not the same, but inextricably linked (Willetts and Clarke, 2014). Professionalism refers to the control of work and workforce distinct from hierarchical or managerial control (Evetts 2013), through which self-regulating professionals act with autonomy underpinned by shared professional identity and ethics. It traditionally seeks to protect jurisdictional boundaries and demarcate spheres of practice in relation to other groups (Abbott, 1998; Evetts, 2013) and can be seen as the performance of behaviour, norms and values which represent a particular profession or

occupational group (Wilson et al., 2013). Professional identity is the process through which behaviours are assimilated, internalised and made meaningful (Monrouxe, 2010). It is how group members talk, think and behave (Rodriguez and Pozzebon, 2010) and is underpinned by various historical, social and political influences (Chulach and Gagnon, 2016). Therefore, professional identity is distinguished from professionalism by understanding it as underpinning professional practice and behaviour (Sluss and Ashforth, 2007). It is because professional identity influences behaviour that its study is of relevance to practice (Monrouxe, 2010). By gaining a more profound understanding of how professional identity becomes meaningful to individuals and professional groups, valuable applications to practice may be developed (Aranda and Jones, 2008).

Burford (2012) describes professional identity as a process of becoming, which brings together personal values with professional norms. In this way professional identity is considered to be constructed through the interaction between the individual and the social, through participation in common workplace practices (Wackerhausen, 2009; Willets and Clarke, 2014) and enduring throughout a professional lifetime (Johnson et al., 2012). Indeed a function of professional identity is to ensure individuals become, be and stay 'one of our kind' (Wackerhausen, 2009, p460), As Monrouxe (2010) explains, professional identity is a developmental process which should be understood not as something one has, but which one does.

Within nursing, Öhlén and Segesten (1998) define professional identity as an internalised 'feeling of being a nurse as opposed to working as a nurse' (p722) while Wackerhausen (2009) describes it as the tacit enculturation of 'what it takes to be a nurse' (p459). To be fully accepted as a member of a profession requires assimilation that goes beyond formal learning to the embodiment of rules, beliefs and habits consistent with views and accepted values of the profession. These are learned and demonstrated informally through ways of talking, questioning, telling narratives, dressing, explaining and understanding which are recognisably associated with the professional group (Wackerhausen, 2009). It is through this shared understanding that standards, behaviours and expectations are formed.

While there are many ways of conceptualising identity, Social Identity Theory offers a useful perspective by which to explain how group level identity is assimilated. From this conceptualisation, professional identity forms group cohesion which creates a sense of

belonging (Willetts and Clarke, 2014). Group membership is seen as emotionally valuable (Hogg, 2006) and consequently self-worth is developed through perceived group status, while the individual's status within the group creates self-esteem (Willetts and Clarke, 2014). However, as a consequence, groups see themselves as distinct from others and may use strategies to compete for prestige (Hogg, 2006). This results in privileging the values of the individual's group above others (Hongwei and Brown, 2013). In this way, professional identity influences how professional groups perceive and behave towards each other. McNeil et al., (2013) suggest this may influence how professional groups, and individuals within them, interact with each other within workplace environments and consequently how effectively they work together. Accordingly, the utility of professional identity as a means of understanding and influencing behaviours within and between professional groups is becoming increasingly recognised (Clandinin and Cave, 2008; Currie et al., 2010; Monrouxe, 2010; Sluss and Ashforth, 2007; Willetts and Clarke, 2014; Wilson et al., 2013).

However, despite many references to professional identity in the healthcare literature, the concept is often poorly defined, clarified and understood and lacks rigorous empirical study (Aranda and Jones, 2008; Johnson et al., 2012; Willetts and Clarke, 2014). Furthermore, little professional identity research within healthcare, and specifically within nursing, focuses on professional identity development beyond discrete educational development phases or early role introduction/transition (Johnson et al., 2012; Willetts and Clarke, 2014). This is reflected in the ANP literature (Masso and Thompson, 2016). While this is valuable, professional identity is beginning to be understood as an ongoing process which occurs throughout a professional lifetime (Johnson et al., 2012; Monrouxe, 2010; Wackerhausen, 2009). Furthermore, nursing does not exist in isolation, but within a multi-professional healthcare context framed by expectations of other professions and wider society. This is historically, socially and politically influenced so that nursing fits into a framework of professional healthcare identities and structures (Chulach and Gagnon, 2016; Rafferty, 1996; Traynor, 2013). Consequently the study of professional identity in relation to ANP practice would benefit from being situated within multi-professional healthcare contexts (Aranda and Jones, 2008; Matykiewicz, 2011) and beyond early role transition (Messo and Thompson, 2016). Willetts and Clarke (2014) argue it is necessary for professional identity research to pay 'specific attention to the workplace settings

where, and the social actions through which, nurses meet the daily demands of their profession' (Willetts and Clarke, 2014 p168).

In view of this, the following sections consider how professional identity may be used to explore cultural underpinnings which affect the utilisation of ANPs in a multi-professional primary care context. Initially, however, it is necessary to situate nursing identity within a historical and socio-political context. This is because such contexts continue to influence contemporary nursing identities (Nelson and Rafferty, 2010) and consequently may underpin some of the challenges encountered by ANPs and nursing more broadly (Chulach and Gagnon, 2016).

3.3. Professional Identity and Nursing: Historical Background and Socio-Political Context

While there are some differences in perceptions of nursing identity internationally, there are many commonalities. In particular Anglo-European, Australian and North American nursing identity share some cohesion as a consequence of shared roots (Nelson and Rafferty, 2010). Therefore, although the UK context of professional nursing identity is explored because this underpins my research environment, this conceptualisation of nursing identity remains influential more widely (Nelson and Rafferty, 2010).

For nurses their high profile, but low status within society has led to enduring notions of what it means to be a nurse (Hart, 2004). As a consequence, exploration of nursing identity cannot occur without setting it within a social, historical and political context, as this continues to influence how nurses view themselves and are viewed by others (Chulach and Gagnon, 2016; Rafferty, 1996; Wackerhausen, 2009). Davies (1980) argues that professions deliberately utilise and manipulate professional histories in order to develop underlying professional identities, while implicit assumptions of power underpin traditional social, historical and political ideologies, which Chulach and Gagnon (2016, p53) term 'colonialism'. These are retrospectively normalised in a way which continues to hold influence (Miró-Bonet et al., 2013) and underpin current healthcare structures (Chulach and Gagnon, 2016). In order to explore the impact of the social, political and historical construction of nursing on the identity of the nursing profession, and the potential implications for ANPs, the development of nursing is now considered.

3.3.1. Vocational Identity

In the UK, modern concepts of nursing originated from 19th century social reformist agendas (Hallam, 2000; Mortimer and McGann, 2005) and remain prominent in relation to contemporary nursing identity (Nelson and Rafferty, 2010; Hallam, 2000). This brand of nursing developed a specific identity based on societal norms which presented nurses as conscientious, obedient, gentle and subservient (Godden, 2010). Historically, character was linked to social class and gender, with nursing idealised to reflect societally held values and beliefs about femininity and class. Good character was seen as inherent to females of higher social class and the predominantly working class nursing workforce underwent quasi-religious and military style training in order to instil these perceived virtues (Rafferty, 1996; Abel-Smith, 1960). This led to the view of character, rather than knowledge, as central to nursing. This 'knowledge-virtue dichotomy' (Nelson and Rafferty, 2010 p8) remains pertinent today with both public and professionals concerned that intellectually proficient nurses may not be sufficiently caring (Hart, 2004; Scott, 2004). However, the inference that academic ability negatively correlates with care and compassion is unsound (Willis Commission, 2012) and appears specific to nursing. As the *Report of the Willis Commission for the Future of Nurse Education* (Willis Commission, 2012) asserts, professions such as medicine and law do not experience such anti-intellectualism discourses. While it is clear that care and compassion are central to nursing, these characteristics are not counter to knowledge and education (Gordon and Nelson, 2005). Despite this, an innate character-driven focus continues to inform present day nursing identity (Hart, 2004). Indeed, it has been argued that nurses continue to derive benefit from identifying with vocational identity because it creates a strong sense of moral identity from which pleasure is derived (Traynor and Evans, 2014). The contemporary nature of nursing's vocational identity was demonstrated as recently as 2013, when the Royal College of Nursing debated whether nurses were born or made at its annual conference (RCN, 2013) and through its recent 'This is Nursing' campaign. (RCN, website accessed June 2015).

Historically, grass roots nursing was predominantly female and working class. This and the subservient nature of nurse training contributed to a subordinate identity of nursing within healthcare hierarchies and society more broadly (Rafferty, 1996). This is in marked contrast to the social positioning of medicine, which was dominated by men from higher social classes and was quicker to mark out its own professional jurisdiction and mandate

(Lane, 2001). In addition, medicine quickly established a mandate of control over nursing (Hart, 2004), something which Abbott (1998) and Freidson (1970) suggest is a hallmark of dominant professions. While medicine identified with professionalism, the dominant view of nursing remained predicated on notions of vocation and self-sacrifice (Hallam, 2002). This led to nursing being positioned as subordinate to the flourishing patriarchal medical profession (Abel-Smith, 1960). It continues to inform current concepts of identity (Traynor and Evans, 2014) and confers expectations of behaviour in the eyes of nurses, other health professions and the public (Hallam, 2000; Lane, 2001). That nursing failed to develop its own coherent strategy for professionalisation is held by some as contributing to the continued subordinate status and identity of nursing in contemporary society (Rafferty, 1996). For this reason, the professionalisation of nursing became an important part of nursing identity.

3.3.2. Professional Projects

Nursing has long been concerned with professionalism and professional acceptance. In order to uphold professional status, professions require state legitimisation and legislation (Abbott, 1988; Currie et al., 2010). This is often demonstrated by professional registration and regulation (Evetts, 2013). Historically, nurse regulation was opposed by doctors and other powerful decision-makers, as well as some within nursing (McGann, 1986), who argued focus on professional and technical aspects of nursing, rather than character, was counter to the core identity of nursing (Rafferty, 1996). Rafferty (1996) saw this opposition as a direct response to the perceived threat to gendered societal roles and registration continued to be stymied until the nationalisation of healthcare in the UK in 1948, when state registration and standardisation of training was eventually secured (Carpenter, 1993).

That reform was established through external controls did not resonate with nursing's ambition to be accepted as a profession (Hallam, 2002) and despite regulation and standardisation of education, nursing continued to struggle for professional acceptance. This was in part due to the position of nursing within a medically dominant healthcare hierarchy (Carpenter, 1993). Characteristics inculcated during traditional nurse training meant that nurse education lacked critical perspective, which is considered central to professionalism, so hindered nursing's professionalising ambitions (Traynor, 2013). Consequently nursing engaged in a further professionalisation project aimed at raising the

academic status and professional profile of nursing, resulting in the development of *Project 2000* in the late 1980's (Traynor, 2013). This moved nurse education from schools of nursing attached to hospitals to universities where nurses were educated to diploma level within a more critical paradigm (Traynor, 2013). Concurrently, in order to further demonstrate a professional contribution attempts were made to strengthen the scientific basis of nursing, resulting in the adoption of nursing models (Allan, 2001) and evidence-based nursing (Traynor, 2013). This fitted a growing move towards evidence-based medicine and research-based healthcare more generally, suggesting the forging of a degree of commonality between healthcare professions. These developments challenged perceptions of traditional nursing identity as a semi-skilled occupational group and attempted to align it with professional aspirations (Traynor, 2013).

Attempts to professionalise and move away from a subservient professional identity were only partially successful, not least because diploma level qualification did not achieve academic parity with other professions. Consequently, nursing is now moving towards all graduate status (Willis Commission, 2012). However, the professional identity of nursing can also be seen to be challenged by non-registered healthcare assistants, clinical support workers, assistant practitioners and latterly nursing associates, who increasingly perform traditional nursing roles (McDonald et al., 2009, HEE, 2015d). Consequently, nursing not only struggles to be accepted as a profession but also faces a challenge to core nursing work from non-regulated assistants. This has been argued to lead to fragmentation of nursing identity (Hart, 2004) and may result in protectionist strategies similar to those employed towards nurses by others (Williams and Sibbald, 1999).

However, while there is concern about losing core nursing roles, policy has also developed to support registered nurses to keep their clinical role central to practice. The introduction of clinical grading in the 1980's (Gavin, 1995) and subsequently *Agenda for Change* (DH, 2004) focused on rewarding clinical expertise. This allowed development of expert clinical roles, such as the ANP, which aimed to keep experienced and highly skilled nurses at the front line of patient care, and can be seen to support the identity of nursing as patient-centred. However, the adoption of practices considered outside mainstream nursing, such as advanced practice, may challenge traditional perspectives of nursing identity and have been implicated in creating tensions not only in relation to nursing identity, but to the identity of others working within healthcare hierarchies (Currie et al.,

2010; Hart, 2004; Powell and Davies, 2013). Furthermore, the success of policies in developing expert nursing roles to their full potential is questionable (Currie et al., 2010; Gavin, 1995; Main et al., 2007) and it remains to be seen whether nursing can fully achieve its professional aspirations.

That nursing continues to be in some ways highly regarded while at the same time undervalued remains a paradox which nursing has attempted to address through professionalisation (Nelson and Rafferty, 2010). However the extent to which this has been successful is contentious, with nursing considered by many to remain a subordinate occupational group or semi-profession (Hart, 2004). The development of all graduate education may go some way to challenging this, as might advanced practice. What is clear is that nursing has developed a specific dominant professional identity which has created expectations about what it is to be a nurse. However identity is not a cohesive entity, but multiple, complex and sometimes disparate.

3.3.3. Disparate Identities

The preceding sections explored socio-political and historical discourses in relation to nursing identity and its influence on current nursing identity and practice. However, it should be acknowledged that identity is multifaceted and to understand its development as linear negates the complexity of differing nursing identities (Hart, 2004). Some argue corporate policies and managerial practices have seen nursing become less associated with professional identity and more aligned with principles of organisational identity (Hallam, 2002; Maxwell et al., 2013). That is, identification with the employing organisation is privileged above identification with the profession. While potentially beneficial in challenging protectionist behaviours linked to professional identity (Mitchell et al., 2011), this has been associated with negative consequences for patient care if professionals identify with detrimental corporate aims which override professional principles (Monrouxe, 2010).

In addition, history is not absolute, but an interpretive process in which some aspects are promoted and some suppressed, thus allowing specific identities to dominate (Davies, 1980). Critiques of traditional nursing identity have challenged the validity of a dominant nursing identity per se. For example, Hallam (2000) argues traditional non-threatening nursing identity allowed females to advance their contribution within the constraints of a

patriarchal society, while Hart (2004) asserts nursing historically had a strong political identity which has been hegemonically concealed, so nurses now feel powerless to adopt more radical identities. Alternatively, Traynor and Evans (2014) assert the profession of nursing itself utilises traditional nursing identity to create a sense of powerlessness and victimhood evoked through historical concepts of duty, servitude and self-sacrifice. This allows nursing to avoid confronting perceived failures and responsibility. It has also been suggested that vocational identity and its modern counterparts, holism and patient-centredness are 'golden age myths' (Dingwall and Allen, 2001 p64) because, although promoted as values inherent in nursing, they can alternatively be seen as tools utilised by nurses to protect their professional identity, jurisdiction and role boundaries. Indeed, it is unclear how closely nursing ever reflected its vocational identity, as incongruence between ideal and actual nursing identities were apparent at the earliest points in modern nursing (Abel-Smith, 1960; Hallam, 2002). It is clear that nursing identity can be experienced and interpreted in numerous ways. Nevertheless, an idealisation of nursing identity remains central to the lay view of nursing (Hart, 2004).

This is significant as the public image and identity of nursing centres on populist dominant views. It influences how nursing sees itself, how it is viewed by others and ultimately affects the ability of nursing to influence and deliver healthcare to patients (Hart, 2004). Therefore it is useful at this point to explore how the prevailing professional identity of nursing has remained prominent.

3.4. Nursing Identity and the Public Image of Nursing

Nursing has a distinct public image (Hart, 2004) developed through perceptions of professional identity transmitted through media images and portrayals, as well as experiences and interactions between the public and nurses. This outward-facing public identity is important in two ways:

1. It provides a cultural framework by which nurses learn what it is to be a nurse and against which they can measure themselves.
2. It allows wider society including the public, neighbouring professions and other colleagues to hold expectations of nursing practice and to adjudicate the fit of practitioner to expected practice.

However, it has been suggested both professional and patient understanding of the knowledge of the capabilities of nurses may be limited by assumptions and preconceptions underpinned by a traditional public image and professional identity of nursing (Currie et al., 2010; Hallam, 2002; Quinn, 2010) within which current nursing roles do not neatly fit. In a study of media images of nursing, Hallam (2000/2) found nurses were stereotyped as self-sacrificing angels, silent handmaidens, petty authoritarians or sex symbols. They were also predominantly characterised as doctors' assistants, with the ideal nurse principally seen as young, female, middle-class and white (Hallam, 2000/2). This is important because for potential nurses professional identity begins pre-nursing, through society's understanding of nursing (Hallam 2000). Identity dissonance may occur if idealised professional identity and realities of practice are not compatible. This has been negatively associated with recruitment and retention (Gordon and Nelson, 2005; Hart, 2004), poor practice, inappropriate behaviour and stress (Monrouxe, 2010).

Kramer (1969) first identified a disconnect between idealisation and realities of nursing practice, supported in a later study by Cohen (1981). A more recent study by Duchscher (2009) also found many of Kramer's findings continued to resonate within contemporary nursing. While in relation to ANP practice, a qualitative study focusing on the introduction of ANP roles in acute settings established that new ANPs experienced dissonance because the realities of ANP practice did not match ideals (Woods, 1998). Woods attributed this, in part, to the publication of unachievable ideals about ANP practice in the media, which meant ANPs were 'set up to fail' (Woods, 1998, p124). Thus, incongruence between ideal and actual nursing identities continues to impact on practice.

Gordon and Nelson (2005) contend that the public image of nursing is underwritten by a 'virtue script' which 'sentimentalizes and trivializes the complex skills, including caring skills, nurses must acquire through education and experience' (p63). They suggest the continued privileging of character above education and intellect is so pervasive that a social feedback loop (p66) has been created. Through this, nursing projects an image which is accepted by society and is then re-projected back on nursing. As a consequence nurses are then required to match this created image. This is problematic because dominant idealised public images and perceptions of nursing identity may fail to reflect the realities of modern nursing (Hallam, 2002). However, deviation from this expected idealised identity is judged harshly by society (Hart, 2004). Furthermore, practice beyond

mainstream perceptions of nursing may be difficult to understand because there is no established framework by which to measure such practice.

While dissonant and outdated public images of nursing are attributed by some to the hegemonic control of medicine and management (Hart, 2004), others view nursing itself as a central contributor both actively and through attrition. Hallam (2002) found nurse leaders manipulated the public image of nursing in order to project specific values and ideals which did not match grass roots experiences, while Gordon and Nelson (2005) suggest nursing is implicated in reinforcing traditional stereotypical views in media recruitment campaigns. That outdated images of nursing endure can be seen as a consequence of contemporary nursing's lack of visibility, which Sullivan (2000) argues results in the public remaining unaware of the extent to which nursing roles have evolved and expanded over time. A recent literature review found that unrealistic public images of nursing were partially self-created by an invisible and silent nursing profession (Hoeve et al., 2013). As a consequence the authors call for nursing to increase its visibility as highly skilled professionals in order to make the public image of nursing more relevant and congruent to contemporary practice. This not only applies to traditional media sources, but is a consideration for web-based and other new media. While there has been little research examining how nursing is represented on other platforms such as healthcare websites (Chen and Liu, 2010), the limited number of studies conducted internationally found an absence of nursing information on healthcare provider websites and concluded this constituted a lost opportunity to promote the professional image of nursing and effectively communicate information about the contemporary nursing roles (Boyington et al., 2006; Chen and Liu, 2010; Kasoff, 2006).

The public image of nursing directly impacts on the professional identity of nursing, both as societal perceptions and as internalised by nurses themselves (Hoeve et al., 2013). As the outward-facing representation of the profession, its congruence with reality is of importance and outdated representations of nursing may contribute to an unrealistic nursing identity within current healthcare contexts. Indeed, the role of the ANP appears to challenge traditional notions of nursing identity and it has been suggested that the professional identities of ANPs and others within the healthcare system may contribute to cultural barriers to the utilisation of ANPs (Currie et al., 2010; McNeil et al., 2013). The role of website representations of the public image and professional identity of nursing in

general, and ANP practice specifically, is little understood and not well explored. The following section considers healthcare website representations of nursing and ANP practice.

3.5. Internet-Mediated Public Images of Nursing – Website Representations of Practice

Websites have become an increasingly popular source of information. Worldwide the number of healthcare providers using websites to promote their services has grown exponentially over the last decade (Chen and Liu, 2010). Public utilisation of website information in order to make decisions about healthcare providers is increasing (Rafe and Monfaredzadeh, 2012). In England a growing number of hospitals and other service providers have developed websites through which information is conveyed to patients and the public. However, Smith et al., (2003) found that general practices in England were slow to appreciate the potential for information technology to provide information to patients. Consequently general practices spent little time and expenditure on developing and maintaining websites. However, there is increased recognition of the need to utilise information technology in general practice (BMA, 2015b).

In a 2011 study of general practice website availability in England, Jones et al., (2011) found that two thirds of general practices had a website easily accessible via a popular search engine, although they observed most were little more than ‘electronic nameplates’ (p663). Despite this, it remains that healthcare provider websites are increasingly being utilised by the public in order to inform decisions about care and services (Rafe and Monfaredzadeh, 2012). Consequently, it is necessary for the information presented on such websites to be fit for purpose. However, there is limited research relating to healthcare provider websites and even less pertaining to general practice websites and the roles depicted within them.

Because general practice websites offer the opportunity to present a public image of professional roles, websites are a suitable means of exploring how professional roles are promoted, explained and depicted in relation to other professions. Carty et al., (2000) suggests healthcare provider websites have the potential to promote and widely disseminate the professional image of nursing to the public, while Kasoff (2006) asserts that the presentation of nursing on websites may have a significant impact on public

perceptions of nursing. Consequently it is useful to explore how nursing roles are represented on websites as they become an increasingly relevant source of information.

Internationally, there has been little research examining how nursing is represented on healthcare provider websites (Chen and Liu, 2010). Those that do are specific to secondary care (Boyington et al., 2006; Chen and Liu, 2010; Kasoff, 2006). In a study of the websites of the top 50 hospitals in the USA, Boyington et al., (2006) found that nursing content was minimal and difficult to access. A similar study by Kasoff (2006) analysed the websites of 72 acute care hospitals in the USA and highlighted similar findings. Nursing content was found to be inadequate and difficult to locate, resulting in lack of visibility. This prevents patients and the public from gaining an understanding of nursing roles, resulting in a lack of knowledge about the services nurses provide. In a later study, Chen and Liu (2010) examined nursing information available on 50 hospital websites globally. The top 10 hospitals were selected from countries which were considered by the researchers to represent continental leadership in nursing: Australia, China, South Africa; UK and the USA. It was found that nursing did not have a strong presence on hospital websites in any of the five countries, although Australian and USA websites provided more information than others. It also identified that information about advanced practice nursing was 'rarely present' (p171) on any of the websites analysed. This is significant because, as described earlier, advanced practice nursing has been highlighted as an area of nursing where there is substantial confusion and lack of role clarity.

Boyington et al.,(2006), Chen and Liu (2010) and Kasoff (2006) concluded that the websites in their studies constituted a lost opportunity to promote the professional image of nursing and effectively communicate information about the role of nurses in patient care and service provision. Kasoff's (2006) study analysed a specific form of USA healthcare, while Boynington et al., (2006) and Chen and Liu's (2010) studies focused on acute hospitals which were considered to be the highest status and best performing, the implication being that websites of less prestigious hospitals may represent nurses even more poorly. However, this assumption has not been tested, nor have the website representations of nursing in other healthcare contexts been explored. It is unclear whether the findings of website studies of acute hospitals are reflected in other healthcare arenas, such as general practice websites, as there is a paucity of research in this area.

Studies relating to primary care and general practice websites are scarce, with none focusing on the representation of clinicians or nursing specifically. In a study of English NHS general practice websites, Howitt et al., (2002) developed a website quality assessment tool and used it to critically evaluate a random sample of 108 general practice websites. They found that while websites offered a broad range of information to patients and public, the overall quality of that information was poor. There was also a lack of information about nurses, with 54.8% of practices naming individual nurses on their websites, while only 19% of practices provided details of nurses' professional qualifications. This is in contrast to the 92.9% of practices which named general practitioners on their websites and the 73.8% which provided their professional qualifications. This information was collected in 2000 and the use of websites has become more prominent in recent years. Moreover, the representation of clinicians on general practice websites was not the focus of this or any other study of general practice websites in England, and no website studies have researched the representation of advanced nurse practitioner roles in general practice. Because of this, it is relevant to explore in detail how general practices contemporaneously choose to represent and position professional roles, including that of the ANP, to patients and the wider public.

The public image of nursing informs patients' and the public's perceptions of nursing and ANP practice. This includes new ways of representing nursing, such as websites. The outward facing public (macro) identity of nursing and ANP practice is only one element of professional identity, which includes internalised and interactional understandings of identity. The following section considers the literature associated with professional identity in relation to ANP practice.

3.6. Professional Identity and the Advanced Nurse Practitioner

3.6.1. Introduction

This section focuses on literature associated with the relationship between professional identity and advanced practice nursing. It centres on ANPs in primary care where research is available. However, this is limited and therefore advanced practice nursing research more broadly is drawn on. In a narrative review of English, USA, Canadian and Australian literature exploring new advanced practice roles in primary care, Aranda and Jones (2008) established few studies relating to advanced roles considered identity specifically or explicitly. Of note is that most research centres on early transition,

educational inculcation of professional identity and new role introduction as discrete processes set apart from multi-professional workplace contexts. However, there remains a paucity of research even in this area (Poronsky, 2013) and less is situated within multi-professional clinical contexts, or related to the experiences of established ANPs (Aranda and Jones, 2008; Messo and Thompson, 2016).

The literature relating to the professional identity of ANPs broadly follows four themes:

1. Identity loss, retaining a core nursing identity (defined as holistic and patient-centred), forging a new identity
2. Research focus on early educational inculcation of professional identity and new role introduction
3. Potential for both inter and intra-professional relationships to influence the success of advanced and novel roles
4. Potential for professional identity to underpin cultural practices related to ANP roles

Presentation is split into literature related to early role implementation and educational inculcation, followed by literature related to clinical context.

3.6.2. Early Role Implementation and Educational Inculcation

The literature suggests professional identity is of importance to student ANPs. Illingworth et al., (2013) conducted a qualitative study of fifteen registered nurses undertaking specialist and advanced courses at one university in England. The study consisted of two focus groups and individual interviews with four students. It found participants were primarily concerned with identity and belonging, while knowledge and skill acquisition was a secondary consideration. In a study of nurses adjusting to new roles in primary care, Holt (2008) used observational, interview, focus group and documentary methods to explore role transition in 11 primary care nurses. He found that 'centring identity' (p122) was one aspect of role transition. However, the paper did not explore this further. While it stated advanced nursing was being explored, demographic data suggested most nurses were engaged in traditional nursing roles with six being at staff nurse level, and none with masters education, making its application to roles outside traditional nursing practice unclear.

In research pertaining to early role transition and professional identity, concepts of identity loss and forging a new identity were central. An ethnographic study of UK student ANPs within an educational environment (Barton, 2007) found students experienced identity uncertainty. This manifested over the course of their training in stages i) separation from original nursing identity; ii) transition [characterised by feelings of uncertainty and dissonance between previous and current role] and iii) incorporation [finding a new role]. Barton's (2007) qualitative study took place longitudinally in an academic setting over the course of a two year part-time undergraduate degree and participants consisted of a convenience sample of 10 student ANPs, 5 medical mentors, 3 educators and 3 senior academic nurses. Barton (2007) found ANPs assimilated a new and coherent identity at around the time of completion of the academic course. However, the extent to which a new professional identity can be coherent at the end of an early educational phase is unclear. In a study of newly qualified ANPs Woods (1998) found that ANPs experienced dissonance between ideals and reality long after initial transition. Indeed, Woods (1998) implicates unrealistic expectations of nurse educationalists and leaders in unsuccessful ANP role implementation. Furthermore, in a narrative review of ANP role transition in the USA, Poronsky (2013) concluded that 'some new FNPs [family nurse practitioners] continued to perceive themselves in a state of disequilibrium many years after graduation' (Poronsky, 2013 p353).

It was also evident that ANPs and their educators worked to keep nursing identity central to their new role. In a qualitative study exploring transition from registered nurse to ANP conducted in the USA, Spoelstra and Robbins (2010) found 'the essence of nursing' (p5) was central to student ANPs during throughout the educational process. This was perhaps unsurprising as the intervention being explored involved 'didactic content' (p2) relating to the essence of the ANP role. Meanwhile, a qualitative study by Brykczynski (2012) explored how nurse educators inculcated a care ethic in the face of efficiency demands. 24 nurse educators from various academic institutions in the USA were interviewed about how they taught ANP students to focus on care and it was found that strategies such as holistic narratives and role modelling were used to situate holism and patient-centeredness within advanced nursing practice. Unfortunately, students' views of faculty teaching were not explored so the impact this had in practice was unclear. However in a study of ANPs working in various specialties the USA, Kleiman (2004) found ANPs identified with a professional identity that maintained perceived core values of nursing.

The study consisted of unstructured interviews with six ANPs who used holism discourses to differentiate themselves from physicians.

Albarran and Fulbrook (1998) suggest that ANPs are at the forefront of developing holistic and patient-centred care. However, as described earlier, this has been critiqued by those who suggest these concepts are a device by which differentiation is created to demarcate nursing from other roles (Dingwall and Allen, 2001), while the assertion that patient-centeredness is inherent and unique to nursing identity has been challenged. Greenhalgh (2007) argues holism is central to the work of general medical practitioners, while in a recent qualitative study, Chew-Graham et al., (2013) audio-recorded long term condition consultations between patients and primary care practitioners (practice nurses and general practitioners). They found instead of working in partnership with patients, most practitioners engaged in a biomedical agenda while ignoring patients' concerns. Deviant cases identified as meeting patients' needs were physicians rather than nurse participants. Consequently the claims of nurses as skilled collaborators in care remains contested, while it is questionable whether ANPs' assertions that they uniquely focus on keeping the patient central to the consultation are accurate. However, retaining the perceived values of nursing seems central to the professional identity of ANPs, with professional identity predicated on differentiating one's own group from others (Wackerhausen, 2009) and with holism and patient-centred discourses being one way of achieving this aim.

Brykczynski (2012), Barton (2007), Illingworth et al., (2013), Spoelstra and Robbins' (2010) and Woods' (1998) studies focused on identity transition within educational and early implementation settings. Like Kleinman's (2004) study, most were conducted in isolation from other healthcare team members. However, such studies conclude before longer term findings and conclusions can be drawn (Masso and Thompson 2016). Furthermore, the majority of professional identity assimilation takes place outside formal educational contexts and within hidden and informal socialisation processes embedded in workplace interactions (Currie et al., 2010; Hafferty and Franks, 1994; Wackerhausen, 2009), while current prevailing theories of professional identity consider it a complex, dynamic lifelong process (Johnson et al., 2012; Monrouxe, 2010; Willetts and Clarke, 2014). Although it is necessary to explore educational and early ANP transition, as these remain under-researched (Poronsky, 2013), it is within this broader context of ANP

practice, and within a multi-professional environment, that the potential relationship between professional identity and utilisation of ANPs may be more fully realised. Accordingly, in a narrative review of predominantly theoretical and narrative professional nursing identity literature, Willetts and Clarke (2014) call for professional identity research to be situated within the workplace, as they argue it is ultimately through social action and interaction that identity is formed and reformed. Rather than being understood as a discrete, time-limited accomplishment, professional identity can be understood as a career-long project (Willetts and Clarke 2014). However, both Johnson et al., (2012) and Willetts and Clarke (2014) highlight the paucity of in-situ workplace identity research in relation to healthcare in general and nursing specifically. Currie et al., (2010) support this, arguing that, in particular, micro-level study of professional identity in the multi-professional workplace is necessary in order to develop a deeper understanding of evolving roles and relationships in practice. This gap is important as little is known about wider contributory factors or longitudinal impact of professional identity. Therefore, the utility of professional identity in influencing utilisation of the ANP role is not well understood.

3.6.3. Professional Identity and the ANP Role in Context

One study exploring professional identity issues related to advanced nursing within a clinical setting was conducted by Piil et al., (2012). In a qualitative case study they describe the experiences of nurses working in expanded practice in a specialist secondary care outpatients department in Denmark. This consisted of interviews with 5 nurses, a focus group with the same nurses and the observation of 8 consultations lasting 5-14 minutes. Again they found participants felt they preserved their core professional nursing identity and values, but there was also a shift from traditional nursing roles resulting in enhanced self-esteem and creation of an identity different from other nurses and distinct from doctors. This appears to exemplify how professional identity can be positively utilised to promote advanced practice roles. However, while not the focus of Piil et al's (2012) study, medical and managerial hegemonic control of nursing work was acknowledged as impacting on the role and professional identity of the participants.

In a larger study, Currie et al., (2010) explored professional identity relating to novel nursing role introduction within a multi-professional healthcare context. They conducted a large qualitative study across six sites over a two year period of introducing a traditionally

physician-led nursing role to acute care settings. Interviews were carried out with nurses working in the new role (n=14) and other stakeholders (n=34) including 6 doctors. Currie et al., (2010) found professional identities of nurses and other healthcare professionals were implicated in the formation of barriers to practice, particularly at an institutional level. That is, professional structures such as medical hegemony and conservatism within nursing hindered nurses entering a new role, establishing the role and progressing from the role. A particularly relevant finding was the indication that professional level barriers to practice overrode person-based relationships. Therefore, competency of the individual nurse was less influential in role acceptance than long-held assumptions relating to the professional identities of all parties. Currie et al., (2010) suggest active, but invisible, work goes on to protect established identities and hierarchies and this impacts on the ability of nurses working in novel roles to reach their full potential. This further informs debate around professional identity and boundary work by arguing new nursing roles cannot be understood as 'boundaryless', but rather as 'less bounded' (p946), as organisational and professional barriers continue to restrict new models of working, within which nursing remains subordinate. This is relevant as failure to consider the potential impact of professional identity jeopardises the utility of advanced practice roles.

Currie et al's (2010) identification of an association between professional identity and barriers to cross-boundary working is supported by Powell and Davies (2012). Their study explored how professional boundaries impacted on a new secondary care pain service within which nurses developed an expert role traditionally undertaken by anaesthetists. This relatively large, representative purposive sample consisted of in-depth interviews with 71 participants consisting of surgeons (n=5), anaesthetists (n=19), nurses (n=33), managers (n=9), and other health professionals (n=5) across three acute UK hospitals of typical size. Like Currie et al., (2010) they sought deviant cases, but found few. Powell and Davies (2012) found professional boundaries were hindered by health professionals who resisted role change and impeded the development of working practice. This was achieved through strategies including doctors making knowledge claims in order to take jurisdictional control of the service and other nurses who 'significantly hampered' (p813) the practice of specialist nurses. In this way status quo was maintained. As described previously, Powell and Davies (2012) highlight the paucity of research in the important area of intra-professional issues related to nursing.

Maxwell et al., (2013) explored how new nursing roles achieved jurisdiction – that is the recognition of the legitimate right to undertake particular workplace practice. They conducted case studies in two acute NHS hospitals in England where new specialist nurse roles were introduced. The study consisted of semi-structured interviews, participant and non-participant observations and documentary analysis. Participants were new specialist nurses (n=4) and other key informants (n=17). The study found that four social identities - professional, speciality, relational and organisational - impacted on the types of roles developed, role acceptance and the extent of jurisdictional mandate. Counter to the findings of Currie et al., (2010) and Powell and Davies (2012), Maxwell et al's (2013) study found inter-professional relationships between and within professions played a significant part in role acceptance with personal characteristics engendering more support than technical expertise. However, this was often in the form of medical patronage which can be seen to continue to demonstrate a medically dominant healthcare hierarchy and potentially left the position of specialist nurses unstable as patronage could be withdrawn. Consistent with the findings of Currie et al., (2010) and Powell and Davies (2012) other nurses appeared to impede these roles. Maxwell et al., (2013) acknowledge these findings may be context specific and further study is necessary to explore other contexts and the influence of social identities over time and in established roles.

A PhD study by Matykiewicz (2011) uses the concept of identity to explore the introduction of a new clinical nursing leadership role, that of the modern matron. Unlike the other studies which focused on nursing roles which work at the boundaries of medicine, modern matrons work across nursing and management boundaries. The study draws mainly on semi-structured interviews with modern matrons in one English NHS Trust and explores identity development from their perspective. Findings indicate the role is contradictory and modern matrons utilise different identities at individual and social levels to create a unique role and identity. This study adds to the literature on identity development in early role implementation. However, as Matykiewicz (2011) acknowledges, lack of exploration of the perspectives of other stakeholders is a limitation of this study. Therefore, Matykiewicz (2011) suggests researching professional identity through 'multiple perspectives of the many actors involved in the social identification processes' is of value while 'in-depth accounts of lived experience within a longitudinal ethnographic study, allowing for a greater depth of understanding of the deep-seated values and beliefs which are the essence of identity construction would be beneficial' (p191).

While potentially having application to ANP roles in primary care, the studies of Currie et al., (2010), Powell and Davies (2012) Maxwell et al., (2013) and Matykiewicz (2011) all focus on new nursing roles introduced as part of a specific innovation in practice delivery in secondary care environments. Although they explore professional identity within a multi-professional context and may inform understanding of ANP role utilisation in primary care, they are not necessarily applicable to primary care, and moreover, were not intended to be. Furthermore, like the studies of Brykczynski (2012), Barton (2007), Illingworth et al., (2013) and Woods (1998), they do not consider the longer term impact of professional identity on advanced practice roles.

There is a paucity of empirical work exploring professional identity in relation to ANPs within primary care. Commentators such as Aranda and Jones (2008) highlight this as a significant gap. One anthropological study which did consider the relationship between professional identities and changing professional roles in primary care in the UK was conducted by Williams and Sibbald (1999). The study did not explore the role of ANPs in practice, but rather the shifting of roles between general practitioners, nurses (practice and community) and health visitors. The study consisted of interviews with various key stakeholders, which included several professional leaders as well as one manager, three general practitioners, two practice nurses, two health visitors and one district nurse. Williams and Sibbald (1999) concluded the culture of primary care was threatened by uncertainty which led to a breakdown of professional identity. This was manifest in feelings of loss in relation to changing roles, leading to low morale. Williams and Sibbald (1999) highlighted that reframing roles was not simply an inter-professional issue, but created tensions between different groups of nurses. The potential for nurses to be disproportionately affected was understood on two levels: i) the erosion of traditional nursing roles by unqualified assistants and ii) the failure of nursing to secure a mandate to challenge the traditional jurisdiction of doctors. This study provides useful insight into the relationship between professional identity and changing roles. However, data collection took place in 1996-97 and the structure of primary care has significantly evolved since then, although how these changes impact on the current culture of general practice is not fully understood.

A more recent study evaluated a combined postgraduate medical and ANP training programme in one of five Centres of Excellence in Primary Care pilot sites in the United

States Department of Veterans Affairs Connecticut Healthcare System (Meyer et al., 2015). This explored how the professional identities of ANPs and physicians changed during their first training year and how group identity developed. Six ANPs and twelve resident physicians were interviewed. Findings indicated individual identities had to first be developed before group identity could be created. Group identity then supported inter-professional working. Both ANPs and physicians were able to articulate their own professional identities, but while physicians felt confident in their abilities, ANPs were less so. Meyer et al., (2015) attribute this to the newness of the role and this appeared to resolve by the end of the twelve month programme. This study provides insight into how professional identity has the potential to influence ANP practice. However, it is a highly specific environment where new recruits develop their roles at the same time, while self-selecting participants had actively sought this workplace environment.

3.6.4. Summary

The empirical literature relating to professional identity and advanced nurse practitioners has been presented. The studies broadly demonstrate credibility in terms of theoretical grounding, methodology and analysis of findings (Mays and Pope, 1995). The literature is limited but suggests identity work goes on amongst ANPs during transition to ANP practice. While such research has utility, some literature suggests that transitional identity outcomes do not match the realities of advanced practice (Woods, 1998), while focus on new role implementation fails to consider the longer term issues. It also suggests perceived core nursing paradigms such as holism and patient-centeredness play a dual role in supporting nursing identity. It preserves aspects of identity which may be challenged by transitional processes and it allows categorisation of nursing as a unique discipline while demarcating nursing boundaries to exclude others. Within the current ANP professional nursing identity literature, there is a lack of research focusing on ANP roles within multi-professional healthcare contexts beyond early role implementation and specifically in primary care. A significant gap exists in relation to longer term utilisation of ANP roles and consequently exploration is required beyond early career development and the introduction of new roles. Therefore the aim of this study is to explore the relationship between professional identities within primary healthcare teams and its influence on established ANP roles in primary care. By exploring this at a micro level, it is anticipated deep insights will be gained in order to understand how cultural practices are developed and maintained, and so they may be addressed more usefully in the future.

The following section explores salient theoretical frameworks which underpin professional identity and are applicable to the thesis' aims and objectives.

3.7. Identity, Professional identity and Theoretical Frameworks

3.7.1. Introduction

This section is concerned with the theoretical frameworks utilised to underpin this study. Firstly, professional identity is set in the context of identity more broadly, then forms of professional identity construction explored.

Identity is considered a highly complex concept (Monrouxe, 2010), reflected in the range of theories of identity presented in the literature and underpinned by a variety of philosophical assumptions (Torres et al., 2009). Divergent epistemological views cover a spectrum from functional to interpretivist to critical, dependent on whether identity is considered to be a relatively fixed, linear developmental process, or rather fluid, dynamic and socially constructed and reconstructed (Matykiewicz, 2011). By definition, professional identity is derived from social and interactive processes, because identification with the professional group is key. Simply put, it is about how we see ourselves, how we see others, how others see us and how we think others see us (Monrouxe, 2010). Therefore professional identity is characterised as non-linear and socially constructed (Monrouxe, 2010), although critically, ANP professional identity research has focused on discrete, time-bound processes of identity formation which are considered to have an end point (Barton, 2007; Woods, 1998). It is necessary, then, for identity theories utilised in the exploration of professional identity to reflect its socially constructed nature (Willets and Clarke, 2014).

However, it is argued identity is not simply a social construct, but derived through the dynamic interaction between cognitive, interactional and social processes, through which perceptions of self and others are utilised to make sense of the world and through which individuals create their place within a collective (Monrouxe, 2010). In this way self is conceptualised relative to others and meaning is derived from that relationship (Davies, 2002). This interpretation of identity is embedded in symbolic interactionism, which forms a major facet of psycho-sociological theory and is highly influenced by the work of Mead (Stryker, 2008). Symbolic interactionism assumes meaning is negotiated through

subjective symbolic interpretation of social interactions, from which social bonds evolve (McCall, 2006). The key principles are:

- identity is socially constructed through interaction with others
- self is defined by how we want to be perceived by others
- others are a reference group by which we judge standards (McCall, 2006).

Based on this, Stryker's (1968) seminal work conceptualising identity suggests self is constructed from discrete identities which are situated and relational. That is, we hold multiple identities which become more or less salient dependant on contextual and individual drivers. Therefore professional identity is one of a number of identities an individual holds and the salience of this identity differs within and between contexts and individuals.

Chulach and Gagnon (2016) critique research pertaining to ANP professional identity, arguing it rarely considers identity from a critical standpoint. They use Postcolonial Theory to highlight that identity is shaped by traditional ideologies and structures which 'have constructed and entrenched social power imbalances and infrastructures so that they are made to appear inevitable and natural' (p53). They suggest it is because these perspectives go unnoticed or forgotten that they are not questioned and as a consequence status quo is maintained. From this perspective, it is necessary to consider how these ideologies and structures contribute to interactional identity formation so that such perspectives can be challenged.

3.7.2. Levels of Identity

Currie et al., (2010) suggest it is useful to conceptualise professional identity across three levels. Macro (social/institutional/group) level concerns public image, status and ethical obligations and is influenced by professional associations, academic environment, workforce culture, wider society (McNeil et al., 2015), and from Chulach and Gagnon's (2016) perspective, dominant but hidden discourses and structures. Micro (individual/cognitive) level relates to personal meanings and cognition which influence individual values and norms. By drawing on both, nursing identity may be influenced by how an individual perceives themselves as a nurse (micro) related to the extent to which this fits with their understanding of the broader (macro) image of nursing. In addition,

Sluss and Ashforth (2007) identified a meso (interactional/relational) level between the two, whereby identity is created through the negotiated agreement of social membership by the individual and by others through role and relationship enactment. From this perspective, professional identity can be understood as the interaction between micro, meso and macro levels of identity and it is this stance which is adopted in this study.

3.7.3. Professional Identity Construction

As identified earlier professional identity involves embodying rules, beliefs and habits analogous with a profession (Wackerhausen, 2009). Four interconnected mechanisms for achieving this have been identified in the literature: performance, reflexivity, narrative and socialisation.

A) Performance

It has been suggested professional identity evolves through performance (Willets and Clarke, 2014; Torres et al., 2009). In a concept analysis relating to the professional identity of medical students, Monrouxe (2010) asserts that when assimilating a professional identity, first individuals act (perform) as if they were a professional and subsequently begin to internalise this identity to become professional. Therefore professional identity is the embodiment of habitual practices ascribed by the profession which become normalised over time and accepted without question. In this way internalised values become tacit and subconscious (Wackerhausen, 2009). Consequently, the outward performance of professional identity indicates internalised values and the study of social performances and habitual practices may, therefore, allow greater understanding of underlying values and behaviours so that professional identity can be better understood. This suggests practitioners act without thought or reflection. However reflexivity has been highlighted in the literature as a mechanism through which professional identity is assimilated.

B) Reflexivity

Wilson et al., (2013 p373) recognise that through reflexivity the 'individual is an active participant in the construction of their professional self'. Through a process of enculturation from the perspective of the profession, individuals learn to reflect in the way their professional group reflects, thinks in the way the group thinks and value what the group values (Wackerhasuen, 2009). So a nurse might draw different conclusions than a

doctor about the same patient problem and this difference demarcates identity. This is because defining who one is may be based to a large extent on clarifying and dis-identifying with what one is not (Fiol et al., 2009). This, however, may become problematic when the perspective of the profession is so entrenched that group members lack the capacity or awareness to reflect from the perspective of others. As a consequence, professional identity threat and conflict may occur (McNeil et al., 2013; Wackerhausen, 2009). One way in which professions differentiate themselves from others is through the narratives they tell.

C) Narrative

Clandinin and Cave (2008) assert that in order to achieve a sense of who we are, stories are told and retold about who we want to be and how we want to live. In developing professional identity, group members tell narratives about themselves as a group member and the group to which they belong, as well as telling narratives which demonstrate typicality to the group (Wackerhausen, 2009). Furthermore, how narratives are told, what is added and omitted and the meanings, motives and characterisations attributed in narratives are central to identity formation (Garcia and Hardy, 2007). Narratives involve positioning self in relation to others (Garcia and Hardy, 2007) or professional group in relation to other professional groups (Wackerhausen, 2009). This is discussed further in section 3.7.6 relating to Positioning Theory, however, others (including other professional groups) are often presented in a negative or biased way, while one's own group is valorised or depicted as unjustly suffering at the hands of others (Garcia and Hardy, 2007; Wackerhausen, 2009). Indeed a key component of a group's identity is based on negation of other groups because a salient part of one group's identity not being a member of the other group (Fiol et al., 2009) In this way narratives are utilised internally in the stories individuals tell themselves, are projected in the stories told to others and are a device through which to construct identities of others (Garcia and Hardy, 2007). Audiences are used to test narrative legitimacy, through which identities are either reinforced or challenged.

Frank (2010) suggests that when narratives are retold consistently the story becomes unquestionable as a result of emotional investment. When this happens at a group level, such as in professional environments, cultures are formed. Conversely, disruption occurs when there is no normative narrative framework through which to interpret events, which

may contribute to feelings of professional uncertainty, disequilibrium and threat. In addition, group members are expected to understand the shared story in the same way and if they do not, conflict may occur (Frank, 2010). This is significant to the understanding of group behaviour in situations where group meaning is altered, reinterpreted or misunderstood, such as when novel professional working practices are introduced, or when there is a perceived shift or challenge to professional identity. Coherent narratives at a group level are realised through a process of socialisation, which has been a subject of large body of work, both within and external to healthcare.

D) Socialisation

The interactional processes of performance, reflexivity and narrative-telling can be seen as central to identity development, because they form the basis of professional identity construction and are enculturated into professional education and professional practices through socialisation. Like professional identity, socialisation processes are understood as fluid and continuous (Lai and Lim 2012, Rodts and Lamb 2008), beginning as lay ideas and developing throughout a professional lifetime (Hallam, 2000; Johnson et al., 2012).

Socialisation can be viewed as both structural and cultural (Lai and Lim, 2012). Structural elements consist of prescribed rules for example policies, formal hierarches and job descriptions, while cultural elements refer to language and symbols which represent ideas and values. There may be dissonance between the two and this may have utility in explaining why role implementation is sometimes unsuccessful despite organisational support (Currie et al., 2010). Cultural and structural aspects of socialisation influence professional identity and consequently behaviours. Hafferty and Franks (1994) suggest formal socialisation processes predominantly explore structural socialisation whereas cultural influences are often informal or hidden, and it is these cultural practices which are largely responsible for professional identity assimilation (Wackerhausen, 2009)

Hafferty and Franks (1994) suggest professional identity is predominantly constructed within hidden practices. Their work exploring medical students' professional identity construction characterises three levels of socialisation: formal, informal and hidden. Formal socialisation refers to taught curricula and overt professional practices which aim to instill professional identity and consequently professionalism. Informal socialisation is where formal directives are translated into practical application through learning from

colleagues. Hidden socialisation accounts for the transference of cultural practices that are outwith formal educational and professional aims. An example of this would be the enculturation of gallows humour amongst healthcare practitioners which, while considered a culturally recognised coping mechanism, is hidden from formalised socialisation agendas. Informal and hidden socialisation processes are considered to have greater impact on professional identity than formal processes (Hafferty and Franks, 1994; Wackerhausen). Therefore, exploration of informal and hidden elements of socialisation within the workplace are relevant in gaining understanding of professional identity.

3.7.4. Summary

Professional identity literature indicates identity is constructed through performance, reflexivity, narrative and socialisation. These processes are commonly enacted within practice environments. At a group level, they can be seen to result in the formation of a cultural identity which informs group behaviors. However, identity dissonance may occur when group norms fail to match individual ideals and this has implications in practice. Professional identity has been found to begin prior to studentship and can be viewed as a continuous lifelong process of personal and professional growth. It is influenced by formal, informal and hidden processes, with the hidden and informal considered most influential and which usually occur in workplace settings. It is therefore necessary to study these processes in-situ. Willetts and Clarke (2014) argue that understanding professional identity construction at a social level within the workplace leads to greater understanding of how and why professional identity and social behaviours are constructed and enacted in practice. The following section presents two theories of identity which reflect different, though overlapping, aspects of the processes described above and as a consequence underpin this study. It is the assertion in this study that by drawing on elements of both theories deeper understanding the phenomena of study is gained.

3.7.5. Social Identity Theory

Social identity is the concept that individuals identify with a social group to which they feel they belong. This results in formation of group alliances, standardisation of group behaviour and development of individual and group self-worth (Burford, 2012). Social Identity Theory is an explanatory framework which focuses on the individual as part of a collective (Willetts and Clarke 2014). It integrates both social and individual levels of

analysis. Burford (2012) argues its strength as a theoretical framework is in its ability to explain, understand and clarify, rather than being purely descriptive.

Social Identity Theory was originally conceptualised by Tajfel and Turner (1986) to explain the motivations underpinning group behaviour that cannot fully be explained by personality traits or interpersonal relationships (Hogg, 2006). Established principles of Social Identity Theory are that

1. belonging to a group is significant
 2. group membership is emotionally valuable
 3. self-worth is developed through perceived group status
 4. individual's status within the group creates self-esteem
- (Hogg, 2006; Willetts and Clarke, 2014).

Social Identity Theory is premised on the concept that social identities are developed and maintained by inter-group comparisons. In this theory, groups, and individuals within them, positively differentiate themselves from other groups. Strategies are used to compete for group prestige through a process of self and social categorisation (Hogg, 2006). This is an active process which is beneficial to the group, because it results in cohesion (Hogg, 2006). Consequently, this facilitates conformity, establishes norms and influences behaviour at a group level. These traits are not superficial, but are internalised so that 'conformity is not surface behavioural compliance but a deeper process whereby people's behaviour is transformed to correspond to the appropriate self-defining group prototype'. (Hogg, 2006 p124). As a result, values and behaviours become internalised and culturally accepted. However, as well as creating a cohesive professional framework, categorisation can also create partisan in-group behaviour and group membership is characterised by positive attitudes towards in-group members and negative attitudes [biases] towards out-groups (Burford, 2012). This results in an out-group homogeneity effect, where out-group members are seen as standardised, while in-group variability is promoted. The effect is linked to stereotyping and the meta-contrast principle (Hogg, 2006), in which in-group differences are minimised and out-group differences maximised (Burford, 2012). As a consequence the values of the individual's group are privileged above others and this may be reflected in behaviour towards other groups (Burford, 2012). Social Identity Theory therefore provides an explanatory framework within which to

explore group behaviours and has particular resonance in explaining tensions between groups who are seen as being in competition with each other to gain and maintain group status (Fiol et al., 2009).

Social Identity Theory has been further developed by McNeil et al., (2013) who use it to underpin the concept of Professional Identity Threat. In a concept analysis, they suggest professional identity is key to team working, with difficulties in engaging in effective collaborative working attributed to threats to traditional professional identities and hierarchies. McNeil et al., (2013) suggest that due to the nature of their role, ANPs in particular can be perceived by others to pose a threat to professional identity. They have developed specific professional identity triggers (Table 6) underpinned by the work of Chrobot-Mason et al., (2009), who theorised threats to identity were triggered in response to specific circumstances.

Table 6: Potential Identity Threat Triggers (McNeil et al., 2013)

1. Differential treatment, when one (usually dominant) group receives preferential treatment.
2. Differing values (e.g. biomedical/holistic models).
3. Assimilation (where the dominant group expects the subordinate group to assimilate the dominant culture).
4. Insulting behaviours (where groups devalue each other)
5. Simple contact (anxiety of working together triggers conflict)

That professional identity becomes more salient when identity threats are triggered is supported by Fiol et al., (2009). They argue that the extent to which one's own group is perceived as secure predicts the extent of tolerance of another group. Furthermore, when a group's identity is insecure, gaining security is predicated on the other group's demise. Fiol et al., (2009) also add to McNeil et al's (2013) triggers by suggesting identity threat

may be triggered when group distinctiveness is threatened. Therefore, how this may play out in relation to ANP roles, which can be seen to challenge the distinctiveness of both nursing and medicine, is of interest.

However, critics of Social Identity Theory suggest the framework is limited. This is because it theorises the relationship of the individual (at the micro level) with the group (the macro level), but only to the extent that each individual group member is considered interchangeable and that any group member would act within a predictably similar way given the same role (Currie et al., 2010). This is because a key principle of Social Identity Theory is that individuals within the collective are interchangeable prototypes predicated on role (Hogg, 2006), so that if one individual leaves the group, they are replaced by another prototype individual ensuring group equilibrium persists. Consequently the roles individuals perform are considered of central importance, rather than person-based attributes.

Critics argue identities are not only a consequence of roles performed, but of the individual's characteristics and their relationships with other group members (Currie et al., 2010; Monrouxe, 2010). Sluss and Ashforth (2007) term this interactional (meso) level of professional identity 'relational Identity' (p9). This focuses not only on the individual and the collective, but on the relationships and interactions between group members and between members of different groups. In order to function successfully in the workplace, both role and person-based characteristics are required to be viewed positively by others. Therefore it is necessary to explore all three levels of identity - individual (micro), relational/ interactional (meso) and social (macro), as set out in Section 3.7.2 - in order to develop theory and to gain greater understanding of how professional identity is utilised (Currie et al., 2010).

However, professional identity is not the only identity relevant to workplace contexts. Organisational and other identities may also play a part (Maxwell, 2011). Roccas and Brewer (2002) have developed Social Identity Theory to consider how individuals negotiate multiple identities. They consider professional identity is only one of a number of identities an individual may hold and view multiple identities as cross-cutting, so that they can be evoked in several ways at any one time. Examples of cross-cutting social identities include gender, race, class, familial, organisational and professional amongst others.

Depending on the salience of a particular identity, an individual may identify with another because they hold a shared identity. For example a female doctor and female nurse may identify with a shared gendered identity, but not with a shared professional identity, while a female nurse may identify with a male nurse professionally, while not sharing a gendered identity. In the case of the female nurse, whether she identifies more closely with the doctor because she is female or the male nurse because they share a professional identity depends on how salient and important those identities are to her at that time.

Roccas and Brewer (2002) suggest how individuals assimilate, manage and prioritise social identities depends on the amount of perceived overlap between identities and the individual's cognitive responses (Monrouxe, 2010). These responses are associated with the individual's cognitive abilities to identify with others and are achieved in a number of ways, ranging from low to high complexity (Roccas and Brewer, 2002). Low complexity identity formations are seen as easier to assimilate, but may create greater intergroup tensions. While the converse is considered of high complexity formations. This has significance in theorising both how and why individuals position one identity in relation to another. It also has utility in informing future practice by identifying how high complexity identities can be accomplished and low complexity identities minimised.

Social Identity Theory is an established theory of identity which conceptualises how individuals develop group identity and the subsequent impact on behaviours, although its use in healthcare research has been limited (Burford, 2012; Willets and Clarke, 2014). It offers a useful theoretical framework within which to understand the impact of identity on the behaviours of professional groups working within multi-professional contexts. By extending Social Identity Theory through the work of Roccas and Brewer (2002), McNeil et al., (2013) and Sluss and Ashworth (2007) a more contingent understanding of professional identity may be developed. Willets and Clarke (2014) assert that theoretically underpinning the study of professional identity in this way develops deeper understanding of the phenomenon. While Social Identity Theory has limitations, theoretical developments have led to a framework within which it may be useful to develop the exploration of professional identities within the workplace.

3.7.6. Positioning Theory

Positioning Theory was developed by Davies and Harré (1990) and in this theory identity is understood as being influenced by the individual and by the relationships and interactions they develop within wider social, historical, political and cultural contexts. It is underpinned by the concept that individuals and groups are positioned by themselves, by others and by wider society. The positions assigned to individuals and groups influence how they understand themselves, how they are perceived by others and how they behave (Georgakopoulou, 2013). A benefit of Positioning Theory is that it can be used to understand identity processes at individual, interactional and broader institutional and social levels. Therefore, it is useful in the study of professional identity within healthcare environments, as it considers identity construction at micro, meso and macro levels, the interaction between which is poorly understood within contemporary healthcare settings (Currie et al., 2010). It also offers a usable and practical analytical tool which links interpretation of local events and experiences to wider social identities and structures (Georgakopoulou, 2013)

Positioning Theory regards identity as created through narrative plotlines which are developed, organised and omitted in order to give meaning to events (Harré et al., 2009). Monrouxe (2010, p81) suggests these narratives are 'powerful social tools that we use to construct an identity for ourselves in the world: who we are, who we were and who we wish to be'. A key principle of Positioning Theory is that identity is created through the interaction between the stories people tell themselves and others within local contexts (Garcia and Hardy 2010) and broader social, cultural, historical and political discourses, which have been termed 'master-narratives' (Georgakopoulou, 2013 p89). Examples of master-narratives would be the societal level perception of what it is to be a mother, or a teacher, or a patient. Individuals draw on master-narratives to position themselves and others within storylines in order to claim rights and duties for themselves and to ascribe and challenge rights and duties to others (Georgakopoulou, 2013; Harré et al, 2009). In this way a teacher may claim certain rights over their pupils, while accepting certain responsibilities. Such master-narratives are often tacit and undisputed (Chulach and Gagnon, 2016). Therefore, their analysis through Positioning Theory raises them to a conscious level, allowing assumptions to be explored and contested.

Similar to Social Identity Theory, identity construction through narration involves positioning one's own group in relation to others in order to explain, excuse and promote specific outcomes. In this way narratives are not neutral but performative and creative acts with specific identity aims (Garcia and Hardy, 2007). Positioning Theory has the benefit of facilitating the explicit exploration of structural and cultural positioning, which has utility when exploring the nature of relationships between neighbouring professions and in multi-professional contexts.

Unfolding storylines are commonly narrated in conversation and consequently analytical steps have been developed in order to interpret such narratives (Bamberg, 1997; Bamberg and Georgakopoulou, 2008; Georgakopoulou, 2013). This provides a framework within which to develop understanding of interaction as a way of negotiating identity and linking everyday narratives to wider social, political, historical and cultural identities. Bamberg's (1997) three level positioning analysis explores the narrator as a character in relation to other characters in the narrative, and analyses how this relates to social categories [types of actions, motivation for actions, character tropes]. It then analyses how the narrator positions him/herself in relation to the audience they are telling their story to, as this reflects culturally embedded identity narratives. Analysis then focuses on how the narrator positions him/herself in terms of past events and pre-existing master-narratives in order to achieve a sense of self and identity i.e. how narrative fits with wider societal discourses. In this way identity can be explored as interactive, cognitive, social and structural processes.

Positioning Theory also has utility in terms of scale, as it can be applied to micro level interactions and to larger scale positioning (Harré et al., 2009). For example, it can be used to frame interaction and identity work within small clinical teams, or may be utilised to understand how professional groups, organisations or institutions position themselves in relation to others on a larger scale. In addition, it has gained prominence in the study of conflict resolution and may have utility in exploring associated concepts such as conflict exacerbation and alliance formation (Harré et al., 2009).

However, Positioning Theory is predominantly focused on narrative and this can be seen as a limitation of the theory because professional identity can be demonstrated, and interactions can be carried out, in many ways (Czarniaska, 2013). Positioning and identity

work may be demonstrated in different ways within workplaces, for example through car parking and workspace allocation; presence and positioning on websites and information boards; invitations/exclusions from meetings; dress codes etc. Consequently, while Positioning Theory predominantly focuses on narratives as a way of understanding identity, broader and more novel approaches are also beginning to emerge (Bamberg and Geogakopoulou, 2008; Monrouxe, 2009). Interactive narratives which take place within the social context in which they are performed (i.e. everyday conversations and social situations) are increasingly considered to be of importance in Positioning Theory, because it is through everyday habitus that identity claims are made (Bamberg and Geogakopoulou, 2008). Czarniaska (2013) suggests Positioning Theory can extend its application beyond narrative. She proposes identity may be shaped by the positioning of symbols such as dress and physical acts and this may have utility in the exploration of professional identity within the workplace. Positioning Theory can therefore be extended in a number of ways, for example through use of observation to explore how individuals position themselves and others within some formal and informal workplace interactions, (e.g. in meetings); by exploring how positions are symbolically assigned in practical/structural ways (e.g. room allocation, dress codes, website structure) and through exploration of how positions are ascribed within documentary and institutional/organisational frameworks.

Positioning Theory has utility in exploring professional identity because it has the potential to explore individual, interactional and social levels of identity. It has the potential to address, and raise to a conscious level, tacit beliefs and behaviours situated within invisible social structures (Chulach and Gagnon, 2016; Currie et al., 2010). This is necessary in order to gain a clear understanding of how, why and in what way identity may contribute to ANP practice.

3.7.7. Summary

While sharing some similarities, Social Identity Theory and Positioning Theory have specific characteristics beneficial to my research environments and study context. Both allow exploration of micro, meso and macro levels of identity and have utility in the exploration of multi-professional workplace environments. Both utilise the relative positioning of groups and individuals within them. Furthermore, both have potential to be extended beyond traditional contexts to other environments and forms of analysis, such

as website analysis. This is particularly relevant in relation to Positioning Theory, when website structure and content is considered as a different way of narrating identity. However, they also have distinct benefits which serve to highlight different aspects of identity formation. For example structural and cultural positioning is explicitly embedded in Positioning Theory analysis, while by extending Social Identity Theory to consider identity threat and relational aspects of identity formation allows a more nuanced and deeper understanding of interactional behaviours and their applicability to practice. As a consequence, both frameworks were used to underpin the research process with the intention of gaining a more in-depth, nuanced and explanatory understanding the relationship between professional identity and the practice of ANPs, than would be gained from utilising a single framework.

3.8. Research Strategy

As a consequence of identifying gaps in the literature set out in Chapters 1 and 2, and the subsequent review of professional identity literature relating to ANP practice presented in this chapter, a two part study strategy was devised to explore the relationship between professional identity and ANP Practice. The research was underpinned by a priori concepts drawn from Social Identity Theory and Positioning Theory.

An ethnographic study of primary healthcare teams, within which ANP practice was established, was developed. The aim was to explore in-depth the relationship between professional identity and established ANP practice in two general practices in England. The objectives were to explore the following questions:

- How do professional identities of ANPs and other primary healthcare team members influence ANP practice?
- How do ANP interactions within the workforce influence ANP practice?
- How are ANP professional identities negotiated within a wider social and professional context?

To address a gap in knowledge relating to new media representations of public image and macro (societal level) identity of ANP practice, a preliminary cross-sectional study

exploring the outward-facing public image and professional identity of ANPs on a sample of general practice websites was developed. Specifically this aimed to explore:

- To what extent, and in what way, are ANPs represented and depicted to patients and the public on practice websites in relation to other professional groups (GPs and practice nurses)?
- To what extent are patients able to make informed decisions/choices about their healthcare providers through information provided on general practice websites?
- How might the information provided affect how, and to what extent, ANPs are accepted and utilised in general practice?

The website study identified a priori themes which informed the subsequent ethnographic study. The following Chapter describes the methodology and methods relating to the research process, before findings are explored and discussed in relation to existing literature.

4. Methodology and Methods

4.1. Introduction

In this thesis, qualitative methodology and methods were used to explore the identified research aims and objectives. The term methodology describes the conceptual approach to the research process, while methods are the practical techniques utilised to generate and analyse data. Methodology and methods used in this study are described in turn in this chapter. First the philosophical framework within which the thesis is situated is discussed.

4.2. Philosophical Framework

Research paradigms are shared philosophical beliefs about how problems should be understood (Holloway, 2008) and consist of ontology, epistemology and methodology (Duncan and Nicol, 2004). Ontology and epistemology are fundamental assumptions about knowledge which inform methodology and methods (Holloway, 2008). That is, beliefs about the nature of reality and how this can be known underpin the approach and procedures used to acquire knowledge, which in turn informs the techniques used (Patel, 2015, accessed January 2016). These range from the Positivist standpoint that there is one single reality which can be objectively measured (usually quantitatively), to the belief that multiple realities are constructed and require interpretation. In this way realities are relative and subjective and this is known as Constructivism/Interpretivism, with qualitative methods usually utilised (Bowling, 2009).

While such knowledge claims are often presented as oppositional, the concepts are enmeshed (Holloway, 2008) and extremes of both stances have been described as naïve (Hammersley, 1998). As a consequence Positivism has been critiqued as more subjective than claimed and Constructivism/Interpretivism challenged in terms of trustworthiness and utility. In relation to Constructivist and Interpretivist standpoints the question is, if taken to the extreme and there is no reality or truth except that which is constructed in different contexts and through differing - but equally legitimate - lenses of interpretation, to what extent can such research contribute to knowledge (Hammersley, 1998)? This is particularly pertinent to applied health research where applicability and quality assessment is necessary (Duncan and Nicol, 2004).

Hammersley (1998) counters this by asserting there is an underlying shared reality that can be studied, but this is interpreted from the perspective of the researcher and while 'no knowledge is certain...knowledge claims can be judged in terms of their likely truth' (Hammersley, 1998, p66). He terms this subtle realism and in this way the aim of research is to represent reality, while acknowledging this is through the perspective of the researcher (and the researched). Veracity and value of knowledge claims can be made in terms of plausibility, credibility and relevance. That is how likely knowledge claims are to be accurate based on wider knowledge, the capacity of the research to add to existing knowledge (Mays and Pope, 2006) and whether the phenomena of study may reasonably be considered relevant to practice (Hammersley, 1998).

By contrast, subtle realism has been critiqued as having no ontological basis (Duncan and Nicol, 2004), which can be seen to limit research creativity and quality (Patel, 2015, accessed January 2016). However, it is increasingly utilised in applied health research where applicable outcomes are necessary to justify research (Duncan and Nicol, 2004). Consequently a subtle realist approach is adopted in this study.

4.3. A Qualitative Approach

Qualitative research is an umbrella term describing an approach to research focused on understanding and interpreting experiences and behaviour within complex social settings (Holloway, 2008). Qualitative approaches allow in-depth understanding of the situation being explored. It questions fundamental concepts, assumptions and explanations and unpicks how experiences, interactions and behaviours are constructed (Pope and Mays, 2006). Its strengths are in gaining in-depth understanding of a particular context, in interpreting why phenomena may occur and exploring underpinning meanings (Pope and Mays, 2006). In order to gain deep understanding, qualitative research usually focuses on specific settings or a particular area of interest (Hammersley and Atkinson, 2007; Holloway, 2008). Because of these characteristics, qualitative research has a range of applications within applied healthcare research and the study of healthcare organisations (Bowling, 2009). It is with these considerations that a qualitative and specifically ethnographic approach to exploring the influence of professional identity on the role of the advanced nurse practitioner in primary care was taken.

4.4. An Ethnographic Approach

An ethnographic methodology was adopted to allow for exploration of how ANP practice is negotiated within the culture of primary care. It was informed by a theoretical framework focused on concepts and theories drawn from the professional identity literature set out in Section 3.7. Ethnography is interested in social group cultures within a natural setting and is rooted in the researcher's exposure to, and prolonged participation in, the setting (Holloway, 2008). It centres on exploration of 'thoughts, values, norms and behaviours of members as well as the meanings they give to their experiences' (Holloway, 2008, p88). However, ethnography is not merely a reflection of the experiences of others, but is the interpretation of these experiences from the perspective of both group members and researcher (Savage, 2000). In this way knowledge is shaped (constructed) by interaction between the researcher and the researched. While more Positivist stances critique ethnography for just such subjectivity, others consider it is this insight which creates deep understanding of the phenomena of interest (Hammersley and Atkinson, 2007).

A variety of methods and data sources are involved in ethnography, but primary focus is on participation in the lives of a specific group through watching, listening and asking (Hammersley and Atkinson, 2007), for example through observation and formal/informal interviews. Additional ethnographic data sources include analysis of documents, settings and artefacts. However, ethnography is not merely the processual collection and analysis of data, but rather a process of writing through which data are interpreted and meaning emerges (Van Maanen, 2011).

There are several strands of ethnography. Conventional/descriptive ethnography describes cultures and uncovers patterns through analysis, while critical ethnography critically examines hidden agendas and assumptions framed within social structures (Holloway, 2008) with the aim of bringing about change (Hammersley and Atkinson, 2007). Focused ethnography is increasingly utilised in applied healthcare research because prolonged engagement in the setting and participant observation are less feasible than a more focused approach (Knoblauch, 2005; Savage, 2000). Focused ethnography remains grounded in ethnographic principles and uses short, but intensive, periods of fieldwork. It has particular utility when the researcher has some knowledge of the research environment (Knoblauch, 2005) because professional and other experiences can enhance insight (Engward and Davis, 2015). However, all aspects of ethnography are

open to critique. Because conventional ethnography focuses on describing what is happening, criticism centres on the extent to which it can be purely descriptive, because the values of both researcher and researched are central to interpretation. It also relates to utility, as knowledge is of little value unless it can be applied (Hammersley and Atkinson, 2007). Critical ethnography makes assumptions about social structures and raises questions about whose agenda is being explored (Davies, 2008), something that can be countered through transparency and reflexivity (Hammersley and Atkinson, 2007). Focused ethnography can be seen to counter the central tenet of ethnography, that of protracted emersion within a research setting (Knoblauch, 2005), although pragmatic balancing of duration and intensity of ethnographic study is necessary if such study is to be feasible within healthcare settings (Silverman, 2013). Prior experience of the research environment by the researcher has also been criticised as potentially inhibiting different understandings and explanations of a phenomenon (Engward and Davis, 2015). However, most researchers have some familiarity with the research context and it is necessary to question implicit cultural assumptions, something that can be addressed through reflexivity (Engward and Davis, 2015; Holloway, 2008) and associated positionality (Bourke, 2014).

While exploration of cultures is central to ethnography (Holloway, 2008), the notion of culture has been challenged (Savage, 2000). Whitehead (2005) characterises culture as having multiple attributes. It may be seen as real by participants, or may alternatively reflect an ideal. Culture can also be explicit or implicit, the former being easier for participants to articulate than the latter. Savage (2000) asserts that rather than assuming culture reflects homogenous shared beliefs, it has instead been recast to recognise differences within groups, which may reflect unequal power within social organisations. Therefore, ethnography has particular utility in informing understanding of healthcare organisations by identifying

the ways that an organisation's formal structure (its rules and decision making hierarchies) are influenced by an informal system created by individuals or groups within the organisation (Savage, 2008 p1402).

In this study ethnography was underpinned by the concept of construction. It attempted to explore not only what was happening, but how and why (Silverman, 2013). It was intentionally focused for practical reasons (i.e. access to study sites and PhD time constraints) and because of my prior experience of primary care. As the study progressed it became clear from the data and its interpretation that structural influences were an important aspect of participants' experiences. Therefore, focus shifted to a more critical perspective.

Ethnographic projects require careful management in order to ensure quality (Hammersley and Atkinson, 2007; Knoblauch, 2005). Quality in qualitative research will now be considered in relation to this study.

4.5. Quality

There are a number of ways of ensuring and evaluating quality in relation to qualitative research. These centre on credibility and trustworthiness, which is sometimes referred to as validity (Holloway, 2008). This is not analogous with validity in a quantitative sense, but rather the 'extent to which the findings of the study are true to its aim and that they accurately reflect the purpose of the study' (Holloway, 2008 pp237-8). For Hammersley (1990) quality can be assessed through establishing consistency between findings and wider knowledge, the credibility (recognisability) of the account to readers, the extent to which findings are relevant to those in similar settings and reflexivity. Relevance relates to the study's contribution to knowledge, while reflexivity is a sensitivity and self-awareness of how both the researcher and the research process impacts on findings (Mays and Pope, 2006 p89). Holloway (2008) suggests rather than adopting a checklist of all possible procedures, quality assurance should be pragmatic and relevant. The following sections describe the measures taken to ensure quality appropriate to this study.

4.5.1. Transparency

By making transparent the methods upon which evidence is gathered and conclusions drawn, judgements can be made about the credibility of qualitative research (Silverman, 2013). Transparency refers to being explicit about: research processes; underlying philosophical assumptions; past experiences and decisions made. Consequently, others can make sense of the interpretation, even if they do not share it (Maxwell, 2011). In this study professional experience and philosophical assumptions were made explicit at the

beginning of the thesis. A clear and complete account of research processes is provided within this chapter.

Linked to transparency is the concept of thick description, which was developed by Geertz (1973) in relation to ethnography. Thick description 'builds up a clear picture of the individuals and groups in the context of their culture and the setting in which they live' (Holloway, 2008 p229). It goes beyond superficial or merely factual accounts, to the interpretation of meaning and abstraction. In this study thick description was achieved by making detailed accounts of field experiences which combined observation and impressions/early interpretation with the aim of capturing underpinning meaning. This was then theoretically developed through further analysis. As a consequence interpretation can be judged in relation to the data. Below is an example from field notes of a multi-disciplinary team meeting showing attempts to contextualise data:

GP reg asks his queries. Nurse then puts her hand up (no one else does this) [child-like/subordinate positioning] and says 'I've got something', but senior GP starts taking at the same time. Nurse defers to him, but he lets her go first [doctor-nurse game; benevolence; subordinate; gendered?] She talks about a patient's clinical issue, Manager tells her how to respond from a practice perspective, but then after the meeting nurse goes to 'friendly' GP and asks him to look at notes/meds anyway [Nurse-manager game? circumventing or advocating?]
[Observational Field Notes Moorfield, line 736]

However, transparency does not solely refer to the clear and accurate presentation of research methods, or the demonstration of thick description. It also refers to a critical recognition and exposition of the role the researcher plays in shaping the data, the initial choice of research topic and the complete research process.

4.5.2. Reflexivity and Positionality

A central tenet of ethnography is that the researcher is integral to all aspects of the research process (Hammersley and Atkinson, 2008). Therefore it is essential researchers

reflexively consider their impact on these processes. Reflexivity is the recognition and explication of implicit and explicit influences on the research process (Engward and Davis, 2015). This requires the researcher not only to critically examine their direct shaping of research data, but to consciously consider the impact of a priori ideologies, assumptions and experiences (Mays and Pope, 2006). Engward and Davis (2015) suggest reflexivity should consider the influence of the researcher on data generation, analysis and selection, power relationships between researcher and participants, and construction of research text. Meanwhile Davies (2008) cautions against reflexivity becoming a spiral of self-absorption which inhibits the production of knowledge.

Related to reflexivity is positionality. This is the concept that the researcher's position within the research process, and in relation to research participants, is linked to relevant aspects of their identity, political stance, cultural background, professional and socioeconomic status (Bourke, 2014), all of which may impact on research processes and outputs. Positionality can only occur in relation to others. In this way whether, and to what extent, the researcher is considered to be an insider or outsider is relevant to interactions within the research process (Bourke, 2014). For Brunero et al., (2015) researchers who are also clinicians are never fully insiders or outsiders and their position often shifts dependent on context. It is therefore necessary to reflexivity consider the ways in which positionality may affect the research process and its impact on others, as well as how the researcher positions themselves and the extent to which they are considered an insider or outsider. In this study reflexivity and consideration of positionality were facilitated by keeping a reflexive diary and making notes, alongside field notes, about both the practicalities of potential researcher impact (e.g. the direct physical presence of the researcher on the researcher environment) and cultural, professional and ideological influences which may impact on the research process.

It first should be acknowledged that my professional background as an ANP in primary care initially provided insight, and focused interest, in the phenomena being studied. A priori concepts of identity had been developed from the literature which informed the research process and raised awareness of my own professional identity as a nurse to a conscious level. Furthermore, as a nurse for over 25 years, my socialisation within nursing, its relationship to other professional groups, the culture of healthcare and wider social perceptions about where nursing is situated, undoubtedly informed my underlying

views of the nature of nursing and its position within a wider healthcare context. As a consequence, it was necessary to reflexively and critically challenge these views throughout the study and careful consideration was given to the context within which data were generated and analysed. This was achieved, in part, by looking for disconfirming cases and alternative explanations. Supervisory meeting discussions provoked further reflection and questioning of analytical ideas.

My professional experience also proved a factor in gaining access to study sites, with participants at both sites generally appearing comfortable with my presence from an early stage. My background of working in general practice provided me with a broad understanding of general practice organisation and enabled me to talk to members of the healthcare team in a culturally appropriate way. It facilitated the development of rapport and allowed me to anticipate, for example, when might be the best time to talk to a particular participant, or what might be relevant to observe. However, Holloway (2008) advises caution as familiarity with similar contexts may prohibit recognition and thorough exploration of a phenomenon. Despite having knowledge of general practice and experience as an ANP, I was not previously known to participants, nor had I any awareness of the sites prior to recruitment. This meant I was, to some extent, able to balance familiarity with the general environment with being a stranger in the specific setting.

My background may have impacted the data in a number of ways. It may have led participants to make assumptions about my views of ANPs within primary care and this could potentially influence their decisions around sharing information. There were also times when I felt I was told idealised notions of what should happen, in contrast to what I actually observed. This may have been because I was expected to recognise good practice. The Hawthorne effect is where participants change behaviour in response to being studied (Bowling, 2009, p174). It was apparent in this study when a participant said they had researched ANP qualifications as they had anticipated this might be an interview topic. Another incidence was when a clinician said they would wash their hands because they were being observed. However, in general, participants did not appear to find being observed intrusive and this may be because they were used to working in an environment where clinicians were familiar with being observed, where the team changes regularly (e.g. locums, trainees) and where there is a tradition of medical and nursing training. In

the main participants appeared generally candid in interviews and informal discussions. Furthermore, as Whitehead (2005) suggests, expressions of idealised culture can be as informative as those that are perceived to be real and were interpreted within this context.

Participants may modify what they say and do in order to manage audiences' impressions of them (Hammersley and Atkinson, 2007). The researcher, and others with whom the participant interacts, can be perceived as audiences and impressions managed accordingly. Indeed, a premise of Positioning Theory is that individuals position themselves in relation to other characters, other audiences and within social contexts (Davies and Harré, 1990). In this way impression management by participants is an important source of data, and analysis using Positioning Theory was used to explicitly focus on how participants positioned themselves within social contexts and in relation to myself and others as audiences.

Careful consideration was given to my potential impact on participants and to impression management, which includes self-presentation, personal characteristics and roles (Hammersley and Atkinson, 2007). During field work, the decision was made to dress in an unobtrusive way, reflecting how I would dress when working as an ANP. This was in order to fit with the setting and professionals I was shadowing. My gender and age also reflected usual ANP characteristics and the setting. When making observations, I always carried my notebook to make it clear I would be making notes and participants became used to this. However, the process of notetaking was quite unobtrusive because of my position in the research setting. For example, in meetings I sat around a desk with several members of the practice team who also had notebooks and jotted down notes, while administrative work was common in the reception office. ANPs themselves often had notebooks in which the jotted down jobs they needed to complete and others, such as medical students, regularly made notes. Field notes were taken contemporaneously except where this might adversely influence field relations, for example in informal conversations. In these instances key words were jotted down where practicable and more detailed notes were written up at the earliest opportunity.

Researchers hold multiple identities which come to the fore during different parts of the research process and these may be utilised to develop rapport (Hammersley and Atkinson, 2007). For ANPs in the study it was clear they identified with me predominantly

as an ANP and this was perhaps underpinned by my professional empathy with them. For example, I would make them a coffee when they would otherwise be too busy to get one. When interacting with practice nurses, previous experience as a practice nurse was drawn on, while for other members of the team, my identity as a primary healthcare worker was emphasised. However, I also highlighted my identity as a researcher in some instances, to gain understanding from an outsider perspective.

It is also necessary to consider power relations within the research environment (Engward and Davis, 2015). This was particularly relevant in relation to non-clinical team members, such as administration/reception team members, and others such as health care assistants who may not be as used to formally talking about their experiences. This is where ethnographic methods are helpful because I became known to participants through spending time in the practices, particularly in communal areas. I consequently developed rapport with different team members prior to interviews. The other consideration was the power dynamic between myself and GPs and managers. From my perspective, both my experience as a nurse and my inexperience as a researcher shifted the power balance towards others, because I was sometimes nervous about my interview technique and was aware that qualitative research does not fit bio-medically accepted notions of research. For their part, while I aimed to minimise my nursing identity, GPs often referred to nurses as 'you' when talking to me, for example 'nurses have always had this view and it's beat into you right from the start' **[GP3 interview, line 690]** implying that my position and identity as a nurse was more cognisant than as a researcher. However, this did not appear to deter candour and GPs and other participants appeared comfortable expressing forthright and sometimes negative comments towards nursing in both formal and formal situations, 'That's because you're nuts you see!' **[GP3 Interview, line 685]**

Reflexivity and positionality also require consideration in relation to how research text is constructed, or as Bourke (2014, p2) describes it, 'the expression of voice that results in the reporting of research findings. Through this voice, the researcher leaves his or her own signature on the project'. This is important in ethnography because writing is considered an integral element and there are various ways of presenting texts (Van Mannen, 2011). Furthermore, it is through coherence, insight and recognition that qualitative research is believable (Bourke, 2014; Hammersley, 1998). Consequently, decisions about what, how and why ethnographic texts are presented are central. In this

study, themes emerging from the data were presented through the analytical lens of Social Identity Theory and Positioning Theory in order to form a coherent narrative which, because it is applied healthcare research, was intended to lead to recommendations for practice. Specific quotations were chosen in relation to coherence and relevance to the narrative, while disconfirming findings were also presented.

4.5.3. Triangulation

Triangulation is a way of exploring comprehensiveness and consistency by allowing investigation of a phenomenon from different perspectives (Holloway, 2008). Amongst qualitative researchers, triangulation is not generally regarded as a method for verification of findings, as incongruences between different forms of data do not necessarily invalidate findings, but rather can add valuable insight (Hammersley and Atkinson, 2007; Mays and Pope, 2006). Indeed Jerolmack and Khan (2014) highlight a recognised inconsistency found between ethnographic methods. They emphasise that self-reports of attitudes and behaviours such as found in interviews are often inconsistent with what actually happens, and they term this 'attitudinal fallacy' (p1). By using different methods of data collection and different data sources, such inconsistencies can be illuminated and further explored. Therefore, in this study, triangulation was used to ensure that the account was rich and comprehensive. This was achieved through comparing more than one method of data collection (observations, interviews, document analysis), more than one data source (two different research sites, informants from different professional groups) and theoretical triangulation (Social Identity Theory, Positioning Theory).

Research quality is imperative and its demonstration necessary in applied health research. The following sections describe methods and processes used in this study in order for this to be clearly assessed.

4.6. Study Design

A qualitative cross-sectional study exploring the public image, representation and positioning of ANPs on a sample of general practice websites in England was conducted prior to the main part of the study. The methods for this are set out in section 4.13. Following this an ethnographic study was designed to gain in-depth information in relation to cultures and behaviours influencing ANP roles within two general practice sites. The primary methods of fieldwork were participant observation, interviews and analysis of

artefacts and documents (Hammersley and Atkinson, 2007). Data generation focused on how ANPs worked with colleagues within primary healthcare teams. The study was designed to gain maximum information about the focus of the study by utilising three intertwined methods and triangulation as described in section 4.5.3. The majority of data were collected over a six month period.

4.7. Recruitment

Although ANPs work in various areas of primary care, a purposive decision was made to focus on general practice. Other settings include walk-in/urgent care centres, out-of-hours services and specialised roles such as community matrons. General practice was identified as a useful research environment because it encompasses a wide range of professional groups and primary healthcare team members within a contained environment. This facilitated the ethnographic study of the culture of professional groups.

Recruiting a small number of study sites is common in ethnography to allow in-depth study of the specific aspect of interest (Hammersley and Atkinson, 2007). It was felt that two case sites would be appropriate for this study in order to achieve in-depth rich information relating to how ANPs participated in general practice across two different sites. The aim was to achieve variation across the sites in terms of practice size, number and experience of ANPs as well as site exposure to working with ANPs. This was in order to explore what was common to both sites and what was specific to the particular context. Given the focus of this study, it was anticipated ANPs would act as gatekeepers to the study sites. Therefore, a complementary recruitment strategy consisted of the following approaches

- A voluntary ANP group who organise educational updates and informal support was contacted and asked to distribute a letter via email to their members. Time was negotiated to present study information at an educational weekend and participation was sought. However, while some ANPs expressed interest in the study, no recruits were gained through this method. Organisers fed back that some ANPs thought their employers would be unwilling to participate as there was no remuneration attached to the study, while others were reported to have commented they felt uncomfortable with being observed.

- Concurrently, ANPs in a specified region were identified through practice websites listed on the NHS Choices website. ANPs and practice managers/senior partners were sent a letter via email explaining the study. Four separate practices (one practice manager and three ANPs) made contact expressing interest in the study. Of these, two agreed to take part. As they had significant variation in terms of site size, number and role of ANPs and experience of working with ANPs, recruitment was concluded at that point. Sites were given the pseudonyms Oakcroft and Moorfield.

4.8. Within Case Sampling Strategy and Participant Recruitment

Prior to starting the research, both study sites were visited and a presentation made at each site's team meeting in order to explain the study to the primary healthcare team. This was both to encourage interest and to address any issues or concerns. Within case sampling rationale and recruitment of participants were as follows.

Qualitative sample sizes are generally small in order to focus on information-rich data. The aim is to gain deep understanding of complex research questions (Bowling, 2009). While general applicability across contexts in a quantitative sense is not claimed, 'knowledge of the concepts, instances and conditions about a phenomenon under study' (Holloway, 2008 p108) can be transferred to other situations. Theoretical generalisability and transferability of findings to other contexts may be achieved through thick description, connecting results to current theory, comparing findings to existing work and allowing the reader to situate evidence within existing experiential knowledge (Holloway, 2008; Smith et al., 2009). When a heterogeneous group is being studied, such as different professional groups within an ethnography, sample size should be large enough to encompass this variety and diversity, but allow for depth of information and thick description (Holloway, 2008). Sampling should continue until 'the same stories, themes, issues and topics are emerging from the study subjects' (Bowling, 2009 p410), while allowing for evidence that contradicts potential explanations (Pope and Mays, 2006). This informed the sampling strategy and a pragmatic balance between the breadth and depth of data was developed in order to ensure the both sample size and the data generated were manageable as well as comprehensive (Pope and Mays, 2006).

The study followed a purposive sampling strategy to facilitate collection of rich data allowing maximum knowledge of the phenomenon studied within a given context

(Holloway, 2008). Participants were selected because they had experience and knowledge relevant to the research aims and objectives (Bowling, 2009). Hammersley and Atkinson (2007) suggest sampling consists of time, people and context. In relation to time, observational fieldwork took place at different times of the day and different days of the working week in order to explore variations in activity and behaviours over differing timeframes. A broad range of participants were sought within each site both during observation and interview in terms of profession, role, gender and experience. This was in order to gain insight into the culture within which the ANP role sits. Contextual sampling refers to the different behaviours participants may display between different contextual settings. For example behaviour in the reception area may differ from that in the staff room of a general practice, as may attitudes displayed in conversation between ANPs and within multidisciplinary groups. Therefore several different settings and contexts were observed in order to maximise exposure.

Given the central role of ANPs, the aim was to recruit as many ANPs as possible within each site. Shadowing of initial gatekeeper ANPs led to recruitment of further ANPs and all ANPs working at both sites agreed to take part. A further ANP based at another practice was identified by one of the participants as a key informant. I was invited to contact the ANP who subsequently agreed to be interviewed.

While observing ANPs, I came into contact with other members of the primary healthcare team. During this time interactions between team members relating to the ANP role were observed within each practice. This was explained to primary healthcare team members before the research started and no members of the team declined to take part in the study. Opportunities for participation were on-going and sought as they arose. Processes of data collection and informal discussions led to the purposive identification of key informants who were considered to be able to offer valuable insight. Individuals were both invited and volunteered to take part in the interview stage of the study. A total of 30 key informants were formally interviewed across both sites. Participant characteristics are detailed in Section 6.3.

4.9. Ethical Considerations

Ethics approval was granted by the University of York Department of Health Sciences Research Governance Committee on 16th March 2015. Informed consent is a tenet of

ethical research (Pope and Mays, 2006). To explain this and all aspects of the study to potential participants a package of study information was provided, reflecting the different components of study participation (Appendix 1)

1. General information for all members of the primary healthcare team
2. Detailed information for those taking part in interviews
3. Specific information for ANPs taking part in interviews and/or observations

All information leaflets contained details of the consent process, which is set out in further detail in Appendix 2. Data management was compliant with the Data Protection Act (1998) and the Department of Health Sciences Data Security Policy (2014) and is described in Appendix 3. All data were anonymised by assigning a unique identification code to each site and participant. This was recorded on the participant's consent form in the case of ANPs and interview participants. For other members of the primary healthcare team, an identifier was assigned at the time of recording observations, ensuring field notes were anonymised at source. Consent forms were the only document linking identifiable information to the assigned unique identifier. These were stored in a locked filing cabinet in a restricted access room at the University of York. All study data were securely stored on a password protected University of York computer, which was again located in the locked restricted access room.

Qualitative inquiry necessitates a small number of sites and participants, as well as in-depth contextual detail, which may make protecting the identity of participants problematic (Goodwin, 2006). As there were only two sites in the study and a limited number of participants who were differentiated by role, care was taken to present information which minimised potential for identification of participant and sites. Practices were given pseudonyms and descriptions were presented at a level which minimised recognition. Specific titles of managers, practice nurses and specialities of ANPs were not detailed. Although one ANP was male, this was not identified in the study output. In addition, participants were made aware of both the nature of the study and the potential for identification in the study information leaflet.

4.9.1. Specific Ethical Considerations

In this study my position as an ANP created specific ethical considerations, not least because the nature of ethnography meant that rapport with participants developed throughout the study, particularly with ANPs. ANPs would often ask my opinion about specific aspects of ANP practice or clinical issues. Because they often worked in relative isolation from other ANPs, it appeared that a chance to engage with another ANP was welcomed, 'perils of being a lone worker, when I get someone to talk to I can't stop' **[Observational Field Notes Oakcroft, line 910]**. Some ANPs considered we would have a shared agenda, 'I hope your article will be published widely and I hope that it will promote the role of nurse practitioners' **[ANP1 Interview, line 493]**. While this aided rapport and consequently helped elements of the study, including access and candour, it was in some ways a difficult position to be in. This was because I was only in the field for a finite, relatively short amount of time and the study was my main focus, with my position as researcher predominating my experience as an ANP, at least from my perspective. Furthermore, overfamiliarity can lead to loss of critical perspective (Hammersley and Atkinson, 2007). I was grateful to ANPs as gatekeepers and informants, while looking for detail which would be of value to the study. Engward and Davis (2015) suggest doctoral research may place greater focus on successful completion of the study than it does on study participants. Therefore it is necessary to reflexively consider the impact research has on participants. Moreover, tensions may occur between the researcher's drive to uncover data and developing underlying human relationships (Habermas, 1984). This was exemplified when other participants presented negative views of ANP practice, or ANPs specifically. My relationship with some ANPs made this uncomfortable and difficult to write about, but was a significant part of the study. Decisions needed to be made about whether, and how, this should be included in the study, as duty towards all study participants, not just ANPs, and public responsibility for the research ought to be balanced. While this is a well-documented phenomena in ethnographic and qualitative research generally (Coffey, 1999; Hammersley and Atkinson, 2007) it still took me by surprise. Such tensions were addressed in my reflexive diary and were discussed at regular supervision meetings, with the aim of presenting findings and analysis transparently and accurately in a way which would reduce specific negative impact for those involved.

4.10. The Process of Data Generation

Whitehead (2005) observed that because ethnography is interested in learning about cultures, methods of learning should mirror the way children learn culture. That is through observation, asking questions of key informants, participation and interpretation of information. He uses Spradley's (1980) method of observation to move fieldwork from descriptive, to focused, to select. Descriptive observation is a broad approach which aims to record as much information as possible about what is happening. This is achieved in the first instance by engaging in 'grand tours' of study sites (Whitehead, 2005, p15), where the researcher observes the broad setting and gathers as much data as possible by asking who, how, where, when and why questions. It is through these broad descriptive observations that persons and topics of interest are identified. Ideas are then refined by conducting more focused observations, leading to the selection of key informants. Similarly, descriptive informal interviews are used to identify broad areas of interest and it is through this process that participants are selected to participate in more probing formal, semi-structured interviews. This method of moving from broad to specific was adopted in this study. The following sections describe data generation in relation to observation, interviews and documentary analysis.

4.10.1. Observations

The study was designed to facilitate observation of interactions between ANPs and others, for example in meetings, liaising with team members, during supervision, in clinical settings and in informal discussions with colleagues. Organisational structure, for example room allocation, dress codes and meeting structure were also observed. Data were also generated through informal conversations between participants and the researcher (Hammersley and Atkinson 2007). In this way the researcher becomes both observer and participant. The extent to which an ethnographic researcher participates in the field is variable. Adler and Adler (1987a) identified membership roles in participant observation

- Complete-member-observer
- Active-member-observer
- Peripheral-member-observer

The extent of participation depends, in part, on the context of the research setting. In this study peripheral membership was considered desirable because it allowed 'an insider's

perspective on the people, activities and structure of the social world' (Adler and Adler, 1987b p37) while remaining ethically compatible with the research setting. As Holloway (2008) suggests, when the observer role predominates the participant role, the researcher can ask questions and become accepted, but does not become an active member of the workforce. In practical terms this constituted, for example, sitting around the table with team members at team meetings and participating peripherally in informal conversations, but not making professional nursing contributions to the meeting.

A considerable amount of time was spent in each practice observing ANPs during their everyday work and in interactions with others. In total 127 hours were spent across both sites. Observation of ANPs involved spending time with them during part of their usual working day. It consisted of blocks which occurred within the timeframe of the ANPs' routine working practices and was designed to encompass different aspects of their working day, over different days of the working week and in different settings, in order to capture the maximum range of activity. This included informal interactions such as tea breaks and casual chats, as well as more formal meetings and negotiations. Time was also spent in communal areas – predominantly the staff room at Oakcroft and the reception office at Moorfield, which allowed observation of, and participation in, informal interactions.

Duration of observations was dependant on the ANP's timetable and negotiated with each individual ANP. It was initially anticipated observation would be carried out in blocks of two hours, however much of the work being observed lasted longer, for example at one practice the multidisciplinary team meeting routinely lasted for three hours. Therefore this was renegotiated as this became apparent and observation was usually carried out in half day blocks.

At Oakcroft, 6 ANPs were observed over 18 blocks of work. Sometimes more than one ANP was observed at one time (e.g. at meetings) and this resulted in a total of 27 observational opportunities. Individual ANPs were observed between 2-10 times (Table 7). Six multi-disciplinary team meetings were attended, as was one nurse team meeting and one full team learning event. At this site, focus was initially on shadowing the ANP who had originally agreed to take part in the study, as she was considered a gatekeeper

and key informant. Spending time with this ANP not only generated data, but led to introductions to other ANPs at the site and their engagement in the study.

Table 7: Oakcroft Alliance Observation Schedule	
ANP	Number of Observational Sessions
ANP1	10
ANP3	6
ANP5	4
ANP6	3
ANP7	2
ANP8	2

At Moorfield Practice, two ANPs were observed for between 6-13 blocks of work (Table 8). Five multi-disciplinary team meetings were attended, as was one nursing team meeting and one full practice team meeting.

Table 8: Moorfield Practice Observation Schedule	
ANP	Number of Observational Sessions
ANP2	13
ANP4	6

The research was designed so that while observing the ANP and more generally at the study site, a range of other healthcare team members were encountered and observed. This was used to both gather contextual information about the setting and focus on interactions with, and talk about, ANPs. Practicalities of how the practice worked were explored. For example, how appointments were booked, how work was organised and

how support of ANP roles compared to other clinicians. Details of primary healthcare team participants are set out in Section 6.3.

4.10.2. In-depth Semi-Structured Interviews

Semi-structured interviews with ANPs and their colleagues were conducted throughout the timeframe of data collection. This was in order to gather a variety of data exploring the relationship between ANP roles and professional identity and the influence this may have in practice. Each ANP was interviewed once. Interviews were informed by a topic guide which was developed iteratively using data gathered during the observational parts of the study, as well as by the literature including a priori theoretical concepts relating to Social Identity Theory and Positioning Theory. This part of the study explored the nature of ANP roles within the practices, how the ANP perceived their role and how this related to others within the practice. Focus was on how participants narrated and performed their role to make sense of their identity and the interviews were semi-structured in order to probe issues highlighted by ANPs themselves. This allowed for the exploration of theory, but also for emergent themes. ANP interviews lasted on average 60 minutes. Some minor points were followed up or clarified after initial interview.

Representatives of the primary healthcare team including administration/reception team members, the wider nursing team, general practitioners, practice managers and other clinicians including medical/nursing students and a physician associate student, were purposively identified during the course of the study. These individuals were invited to participate in interviews on the basis that they had knowledge and experience of value in addressing the research question. An interview topic guide was developed iteratively and conducted as described previously. Interview duration spanned from less than 20 minutes to over an hour.

4.10.3. Document Analysis

Study design included document analysis. Practice documents relating to ANPs such as job descriptions and specifications, protocols and strategy documents were requested. Practice websites were analysed and policies and statements from the Nursing and Midwifery Council, the Royal Collage of General Practitioners and the Royal College of Nursing, were used to inform the wider social and professional context. It was explained to both sites, at preliminary meetings and in the introductory letter, that documents would be

sought which illustrated the roles of ANPs in the practice, or related to ANPs and their position in the practice. Requests were made to both ANPs and managers during the course of fieldwork to provide appropriate documents. Practice website data was also collected both to provide background information about the sites and to allow exploration of how ANPs were presented on practice websites. However, practice documents collected relating to ANP practice were minimal, despite numerous requests, which may demonstrate the visibility and recognition of ANPs. While in itself a relevant finding, it remained that there was little material to analyse.

Oakcroft Alliance provided information about its structure, hierarchy and potential leadership roles. There was no specific information about ANPs in these documents and arrangements referred to GPs, but the practice manager informed me similar arrangements would apply to ANPs. A job description for the hybrid ANP role was also supplied by the practice. Individual ANPs supplied a job offer letter and a protocol they had authored. One ANP said she had never had a job description.

At Moorfield the practice did not supply any documentary information, despite several requests. A manager assured me that there was a job description and specification for ANPs, but did not provide one. An ANP informed me there was not a job description or written strategy for ANPs specifically, or nursing in general. The ANP who was an associate partner provided me with practice documentation relating to her role as an associate partner and her curriculum vitae.

The study was designed to generate and analyse data concurrently. The processes of data analysis are now described.

4.11. Data Analysis

Data were analysed thematically based on framework analysis described by Pope, Ziebland and Mays (2006), which follows a five stage approach based on Ritchie and Lewis (2003, 2nd Ed 2014). This approach is increasingly used in applied healthcare research. It is both grounded in the raw data as well as being informed by a priori conceptualisations and study aims and objectives. Data from each study site were initially analysed separately, then compared and contrasted.

Data analysed consisted of

- Transcripts from observational field notes
- Transcripts from audio-recorded qualitative interviews
- Relevant documents
- Researcher notes, memos and reflexive diary

Field notes and interviews were analysed separately initially, then compared and contrasted. Familiarisation with all the collected data and the relevant documents was established by listening to recorded information and reading and re-reading written and transcribed data. All data were then analysed using a constant comparative approach, with data within each study site being collected and analysed concurrently to allow for the development and testing of emergent themes and relationships. Data was then coded according to a priori concepts outlined in Social Identity Theory and Positioning Theory, which situates an individual's identity within social and cultural contexts. Specifically, Bamberg's (1997) three level positioning analysis allowed data to be coded at character, audience and societal levels, while Social Identity Theory considered data at individual, relational and group levels. However, the process was also iterative and data collection and analysis allowed for emergent themes to develop from the data. A reflexive approach to data analysis was followed with awareness that interpretation of data may be influenced by the personal attributes of the researcher. A diary was kept to support reflexivity and to create an audit trail of the analytical process. The stages of analysis are described below following Pope et al., (2006).

STAGE 1. FAMILIARISATION

Immersion in the data was developed by listening to recordings and reading transcripts, in order to list key ideas and recurrent themes. 'Intensive reading' is necessary to adequately and accurately analyse the data (Gibbs, 2007, p41). This means paying close attention to data, with emphasis on common and ordinary occurrences. Memos were used alongside field notes during initial stages of analysis to provide an audit trail as analysis moved from raw data to production of findings.

STAGE 2. DEVELOPING A THEMATIC FRAMEWORK

At this stage, ideas and themes identified during the process of familiarisation were developed into a thematic framework drawing on the study objectives, theoretical insights and emergent issues raised by participants, such as vulnerability. A list of thematic

headings, or codes, were created in order for them to be systematically applied to the original data. Coding is 'how you define what the data you are analysing are about' and is 'a way of indexing or categorizing the text in order to establish a framework of thematic ideas about it' (Gibbs, 2007, p38). It is the initial building block through which analysis is conducted in a systematic and transparent way. This facilitates development of analysis from a descriptive to a more analytical level. Discussion of a priori and emerging codes took place within the supervisory team at regular intervals.

STAGE 3. INDEXING (CODING) THE DATA:

Field note and interview transcript data were systematically indexed by applying codes from the thematic framework (Appendix 4). The process included the constant comparison method to check and compare each item with the rest of the data to establish appropriate analytical categories. This is a way of checking consistency and accuracy of code application, and of analysis more generally. It is an iterative process where codes are developed, then other occurrences across the data are sought, these are then compared to the original application and the code is then revised if necessary (Gibbs, 2007).

STAGE 4. CHARTING:

Charting involved the reordering of data under the appropriate code, or thematic heading. A chart was created for each code with summaries of participant views and experiences and/or verbatim text from individual cases. For interviews, charts were developed per individual participant and were divided into Bamberg's (1997) three levels of analysis (e.g. Appendix 5):

- How the narrator is positioned as a character in relation to other characters in the narrative
- How the narrator is positioned in relation to the target audience
- How the narrator is positioned in terms of wider societal discourses

This allowed comparative analysis to be conducted, in which data from individual participants and sub-groups were compared and contrasted within and across themes (Appendix 6). Analysis included searching across the data set for negative cases i.e. evidence that contradicts, or appears to contradict, the explanations being developed. In this way, alternative ways of explaining the data were considered. This was used to

enhance study quality, to allow consideration of alternative explanations and to support a richer, inclusive and more nuanced analysis (Holloway, 2008). For example, personal characteristics and interpersonal relationships were found to have a strong influence in whether ANPs were employed by practices. However, for one ANP several practices had rejected their approaches for employment despite them having previous positive relationships with the practices. While this appeared contradictory to the developing explanation that personal characteristics and relationships were important in ANP acceptance, it ultimately supported the further finding that underpinning societal level perceptions of the ANP role overrode person-based characteristics.

STAGE 5. MAPPING AND INTERPRETATION:

This allowed examination of associations between themes and presentation of results. Themes developed at Stage 4 were converted to a diagrammatic representation (e.g. Appendix 7) in order to find associations and to map the nature and range of phenomena identified. This supported subsequent findings.

Gibbs (2007) asserts good quality analysis of qualitative data requires attention to intensive reading, writing and record keeping, systematic and analytical coding and exploration of relationships and patterns. It requires transparency and openness and the use of tables, constant comparison and referral back to the data. This ensures analysis is exhaustive and balanced, and findings are supported by the data.

4.12. Summary

This section has described the methodological approach and methods utilised in the ethnographic part of the study. Study design is necessarily complex and requires an in-depth contextual understanding which qualitative research provides. The rationale for a qualitative ethnographic approach has been explored, ethical considerations discussed and steps to enhance quality assurance highlighted. In Section 4.13, methodology and methods relating to the preliminary website study are reviewed.

4.13. Website Study Methodology and Methods

4.13.1. Study Purpose

The purpose of this part of the study was to examine how ANPs were represented across a contemporaneous sample of general practice websites in England, in order to gain

insight into the outward-facing public image and professional identity of ANPs. The study explored how ANPs were described and positioned on websites in their own right and in relation to GPs and practice nurses. It also considered to what extent information provided about ANPs would be useful in informing patients and the public about the role of the ANP in general practice. The ANP was of primary interest, but this study also simultaneously generated information about the representation of practice nurses and GPs. As well as providing a reference with which ANP representation could be compared, this was of interest as there has previously been little research conducted on the representation of these professional groups on healthcare websites. In analysing the data, particular attention was paid to:

- Visibility of ANPs, practice nurses and GPs on general practice websites
- Clarity of information about these professional groups
- Qualitative differences/similarities in how professional groups were represented
- The positioning of ANPs on general practice websites relative to GPs and practice nurses

4.13.2. Study Rationale - Analysing Public Documents

Documentary analysis has been used in diverse areas of healthcare research (Shaw et al., 2004; MacLean, 2015; Monrouxe, 2009), although little consideration has been given to healthcare provider websites as a form of public document. Hewson et al., (2016) suggest document analysis is a little used method of internet research, but highlights its potential in exploring cultural identities, while Evans (2014) proposes it is a useful first step to further in-depth research. This is because documentary data are relatively accessible, cheap and quick to collect and can be utilised to identify gaps in knowledge and areas where further study would be beneficial. Consequently, conducting a study of the representation and positioning of ANPs on general practice websites helped inform the wider ethnographic study of ANPs in general practice. This was through contextualisation and insight into the outward-facing public image and identity of ANPs in relation to other professional groups.

Documents can be created with the intention of providing data for analysis. Alternatively pre-existing documents, such as policies and websites, can be analysed (Bowling, 2009). Analysis of pre-existing documents is minimally intrusive in terms of data collection and is not dependent on co-operation and response of participants (Shaw et al., 2004). As they

are authored and made available prior to the research being carried out, authors are not influenced by data collection or interaction with the researcher. Although as discussed previously, collection, analysis and interpretation of data are influenced by the researcher.

Another benefit of documentary analysis is it is considered relatively straightforward to compare data across similar organisations and identify commonalities and deviant cases, particularly if standardised templates are used. Such cross-referencing of information and omissions are seen by Freeman and Maybin (2011) to allow an in-depth level of understanding. However, Shaw et al., (2004) found documentary data collection and analysis were much more labour intensive than anticipated, particularly where deeper levels of interpretation and analysis were required. Comparison across apparently similar documents may also be challenging due to changing contexts and different presentation and organisation styles (Elston and Fulop, 2002). Further considerations in relation to documentary analysis include the potential for omissions, incomplete or superficial data, or aspirational rather than actual representations of the subject of interest (Shaw et al., 2004). However such data, including omissions and gaps, can serve to highlight hidden assumptions and ideologies which may underpin the construction of the document.

Despite these cautions, documentary analysis remains a useful tool to provide a rich data source, when conducted in a systematic and transparent way and when sufficient consideration is given to the level of analysis required (Freeman and Maybin; 2011 Hewson et al., 2016). While there is growing evidence indicating rigorous internet-mediated research achieves study quality comparable with offline research (Hewson et al., 2016).

4.13.3. Ethical Considerations

Evans (2014) suggests there are few ethical issues related to consent, confidentiality and anonymity in the study of pre-existing public documents, because they are authored and published with the explicit purpose of communicating information in the public domain. However when conducting research via the internet there are specific considerations. Much ethical focus surrounding internet research emphasises the extent to which online publication can be considered public (Hewson et al., 2016). Most literature and guidance relating to ethics in internet research is related to tweets, chatrooms and blogs which can be seen to blur public-private distinctions. However, it is acknowledged that documentary

analysis of existing documents is less contentious than more obtrusive or interactive forms of internet research. Consequently there is consensus that internet research should be individually and contextually judged (Hewson et al., 2016).

Hewson et al., (2016) consider internet research can be categorised on a spectrum ranging from obtrusive to unobtrusive, with documentary analysis lying at the least obtrusive end, particularly in relation to pre-existing documents. This can be utilised to inform research ethics, particularly where documents may reasonably be considered within the public domain. Public does not mean readily accessible (British Psychological Society, 2013), but rather that information is published for a public purpose and where 'there is likely no perception and/or expectation of privacy' (BPS, 2013 p7). Consequently, Hewson et al., (2016, p133) contend

in many cases published online documents may reasonably be considered to be in the public domain, and authors may be considered to have expectations that these documents will be widely viewed, shared, discussed and cited.

These statements are pertinent to the study of general practice websites, where the primary purpose is to provide information to patients within the public domain and where it is unlikely website authors would consider the information to be private. Indeed such websites can be considered to be explicitly produced to provide public information. However, copyright restrictions may apply meaning they are technically not considered public documents (Hewson et al., 2016), although there are criteria through which researchers may legitimately utilise copyrighted material as set out in *Exceptions to Copyright: Research* (Intellectual Property Office, 2014). This study was considered to fit these criteria when reviewed by a copyright specialist at the University of York.

Ethical considerations of internet research extend to consideration of confidentiality and anonymity and is particularly pertinent in dissemination and publication of study findings. This is because traceability and accessibility may be considered greater for online sources, especially when using verbatim quotations which may be linked to sources via search engines (Hewson et al., 2016). In this way anonymised information may be more

easily identifiable. The British Psychological Society (2013) suggest it may be necessary to paraphrase rather than directly quote from internet sources. However, it can be argued that when the data source is a website intended to provide public information and where information is professional rather than personal or sensitive, that the potential consequences of such traceability is minimal. Conversely, as Hewson et al., (2016 p114) indicate, qualitative research necessitates 'insight and interpretations, which go beyond just using what is already in the public domain' and this may potentially have implications in relation to the dissemination of such interpretations. Sixsmith and Murray (2001) highlight the importance of ensuring accurate representation when shaping material for an academic audience. Misrepresentation can be countered by thorough data collection and contextualisation, as well as transparency of process and analysis. In this study this, and how the data was presented, was considered in this context.

4.13.4. Study Design

A cross-sectional design was used to gain a snapshot of information available on a sample of general practice website documents. There are several potential methodological approaches to documentary analysis (Evans, 2014). Freeman and Maybin (2011) recommend the method should be flexible rather than prescriptive, however, the process should be systematic and transparent (Bowling, 2009). The dynamic nature of websites meant it was necessary to capture data in as comprehensive way as possible and it was necessary to adapt documentary analysis to suit this particular form of document. Initial data collection took place May-June 2015, with a further period of data collection undertaken in September 2015.

4.13.5. Website Selection

Documents selected for study should be identified methodically and based on clear rationale (Abbott, 2004; Elston and Fulop, 2002). A sample of general practice websites was generated by identifying a large metropolitan district in England from the government-run NHS Choices website (accessed March 2015). The district was chosen because it consisted of a diverse range of practices and populations. General practices in the district were overseen by three Clinical Commissioning Groups [CCGs] and all practices in the CCGs were included (n=85) in order to provide a broad and diverse sample. Practice websites were identified from information provided on the CCG websites, most of which also provided a link to practice websites. When no link was available the NHS Choices

website was searched and the Google search engine used. When searching for practices for which no link was available, it was sometimes necessary to use different terms as some websites were found to relate to a specific general practitioner's name, or practices were known by a different name to that registered on the CCG and NHS Choices websites. Additionally, some practices were known by more than one name, while other practices shared a name or building, making identification difficult. Where no website could be found, basic information was obtained from the NHS Choices website, but these practices were excluded from the study.

4.13.6. Methods of Data Collection

Systematic data collection is often achieved through development of an analytical tool, such as a pro-forma consisting of a series of questions exploring research aims and underpinned by a conceptual model (Elston and Fulop, 2002). In this study, a data extraction pro-forma (Appendix 8) was developed iteratively with reference to the literature, by browsing general practice websites and by considering the information necessary to answer the research aim. It was informed by a priori concepts from Social Identity Theory and Positioning Theory, which in turn inform professional identity literature. The pro-forma was to systematise collection of descriptive data such as practice size, number of clinicians, qualifications held etc. as well as to facilitate exploration of subjective, social and cultural practices underpinning the construction of the website document. To do this 'counting questions' (e.g. how many GPs, ANPs, practice nurses?), qualitative questions (for example about role descriptions, levels of practice) and questions exploring possible underlying assumptions implicit in the website (for example how clinicians are positioned within healthcare hierarchies on general practice websites) were developed.

The initial pro-forma was applied across 10 practice websites as an external pilot exercise. Amendments were made where it became apparent a specific question was not useful, or where further exploration was necessary. The amended pro-forma was then tested against several more practice websites until no new amendments were considered necessary. It was then applied to the study websites.

Initial data collection took place during May and June 2015. Each website was systematically searched manually by one researcher, starting with the website home page

and including different areas of each website from which pro-forma data could be obtained. This included staff information pages, appointment pages and clinic and services pages. Additional information available on websites in pdf form was examined and each website was searched to identify whether the practice's information leaflet, or other appropriate documents, were available via the webpage. Where present, these were downloaded and a note made if information differed. Qualitative data (such as role descriptions) were recorded verbatim.

Despite thorough piloting, whilst the pro-forma allowed collection of useful information such as how many practices employed ANPs, it was less valuable in collating qualitative data for two reasons, which only emerged as data collection progressed. It became apparent that some website data had been updated within the timeframe of data collection. Consequently when referring back to websites to collect more data, or to verify details, some of the information had changed. This meant that a more permanent record was required. Secondly, the pro-forma decontextualised data, which made it difficult to analyse qualitatively. For example describing on the pro-forma where data were positioned on websites was problematic and time consuming. It was therefore necessary to reconsider how best to collect contextualised data within a dynamic context. The decision was taken to take screenshots across all websites of: homepages; appointments pages; clinics and services pages and staff information pages, as these pages frequently contained information about different professional groups. Each individual website was also searched for other pages, links and pdfs to information relating to the study. These were also collected via screenshots. This made data more manageable, easier to access and kept it within its original context. Codes were then directly applied to the screenshot documents. Collection of these data took place in September 2015. Pro-forma data were recorded on a word document, kept on a computerised data management folder and collated on an Excel spreadsheet. Screenshots were again kept in a data management folder and thematically analysed as described in the following sections.

4.13.7. Approaches to Data Analysis

Documentary data can be analysed on two levels. One approach is to extract descriptive information about what is being communicated through analysis of content (Shaw et al., 2004). This is useful in providing data about what has been included and omitted from documents and provides answers to quantitative questions. This sort of analysis has been

criticised as potentially having limited utility in small scale studies (Shaw et al., 2004) and analysis may be flawed if it surmises that data is complete, representative and that there are no editing errors or losses, no omissions or misrepresentations of data and no inherent bias (Bowling, 2009). This can be addressed through accurate and transparent processes and this level of analysis is useful in providing a snapshot or overview of a potential issue which may require further exploration.

Yet such analysis is limited in that it does not consider that documents 'express and reproduce norms, patterns of thought and identities or subjectivities' (Freeman and Maybin, 2011 p158). This may influence not only what is being communicated, but how it may be interpreted by those receiving that information. This is why it is necessary to analyse the explicit data presented, as well as offering insight about what data are presented and why. Consequently, analysis should consider

- decision making processes which contribute to document production
- values, assumptions and ideologies which underpin authorship
- why, and to what effect, documents are socially and culturally constructed (Shaw et al, 2004; Bowling, 2009; Evans, 2014; Freeman and Maybin, 2011).

Currently most healthcare documentary analysis focuses on a superficial level of analysis (Freeman and Maybin, 2011). This is reflected in the few studies exploring healthcare providers' websites (Boyington et al., 2006; Chen and Liu, 2010; Howitt et al., 2002; Kasoff, 2006). These studies quantify the ease of which a webpage can be found and tell us something about the level of specific content, but are less successful in exploring underlying social ideologies informing the content. Even when research focuses on assumptions and ideologies underpinning document construction, such data may be difficult to find, extract and analyse (Freeman and Maybin, 2011). As demonstrated in this study, more novel forms of data collection and analysis may be required. Freeman and Maybin (2011) argue it is necessary to look beyond content analysis in order to develop a deeper level of understanding. Shaw et al., (2004) suggest research should question the political and ideological purpose of the document. This can be done by considering implicit themes, such as power relations or evidence of hierarchy. For example

- Is the document easy to understand, or does it require a level of knowledge?
- Is access to information restricted or difficult?
- Does the information provided empower or inhibit reader decision-making?

By considering such questions, the relationship between the document author and reader can be better understood. While by further analysing and contextualising themes emerging from the data, greater insight may be drawn.

In this study a structured approach to dealing with the data was adopted. It used both descriptive data and qualitative thematic analysis across the website documents in order to identify any commonalities and discrepancies (Freeman and Maybin, 2011). Data were then qualitatively synthesised in order to consider the overall story emerging from the data (Evans, 2015). While grounded in the data, the study drew on some a priori concepts identified in two theories within the professional identity literature, Social Identity Theory and Positioning Theory, in order to allow a deeper understanding of website representations.

4.13.8. Practicalities of Data Analysis

Descriptive quantitative data were collated and presented in Chapter 5. No statistical tests were applied due to the small and non-random nature of the sample. Instead it was used to inform qualitative analysis. Qualitative data were analysed thematically, adapted from the five stage framework analysis described by Pope et al., (2006) detailed in Section 4.11. Due to the different nature of the data, specifics of analysis relevant to the website study are detailed below:

STAGE 1. FAMILIARISATION

Familiarisation with, and immersion in, the screenshot data was achieved through reading and re-reading the data within the context of its original website format.

STAGE 2. DEVELOPMENT OF THEMATIC FRAMEWORK

Ideas, themes and key issues identified during the process of familiarisation were developed into a thematic framework. This drew on study objectives and theoretical insights, as well as through emergent issues identified in the website data such as

visibility and qualifications. At regular intervals throughout the process of analysis, discussion of a priori and emerging codes took place within the supervisory team.

STAGE 3. INDEXING (CODING) THE DATA

Website screenshot data were systematically indexed by applying codes derived through the thematic framework and emergent themes, which were coded as they arose. When new themes emerged these were reapplied to the entire dataset. In this study short textual descriptors, rather than numerical codes were used.

STAGE 4. CHARTING

Charting involved reordering of data under the appropriate code, or thematic heading. A table was created for each code to which summaries of data and/or verbatim text from individual cases (websites) were attached (e.g. Appendix 9). This allowed further comparison and contrast within and across cases and themes. The constant comparison method overtly seeks variations, differences and disconfirming cases across the dataset. This highlights when data does not correspond with emerging analysis. Tables were used to facilitate the grouping together of codes within overarching themes, which informed the fifth stage of analysis.

STAGE 5. MAPPING AND INTERPRETATION

Overarching themes were converted to a diagrammatic representation (e.g. Appendix 10) in order to find associations between identified themes and to map the nature and range of phenomena identified.

4.13.9. Quality

Quality markers for qualitative research are described in Section 4.5. They include triangulation, transparency, seeking disconfirming cases and reflexivity. In the website study triangulation was achieved through qualitative and quantitative descriptive data, transparency was demonstrated in making clear the processes of the study, disconfirming cases were apparent on some websites, while my positionality as a researcher and ANP are described in Section 4.5.2. Reflexivity involved similar considerations to the ethnographic study in relation to my previous role as an ANP. Consequently thorough and systematic treatment of the data was designed to counter any underlying preconceptions.

4.14. Chapter Summary

This chapter has described the methodological approach and methods utilised in the preliminary website study and the subsequent ethnographic study, in order to explore the influence of professional identity on the role of the ANP in primary care and to understand how professional groups work to develop such roles in practice. In the following chapters, study findings will be presented and contextualised within the identified theoretical framework and the wider literature.

5. Findings of Website Study

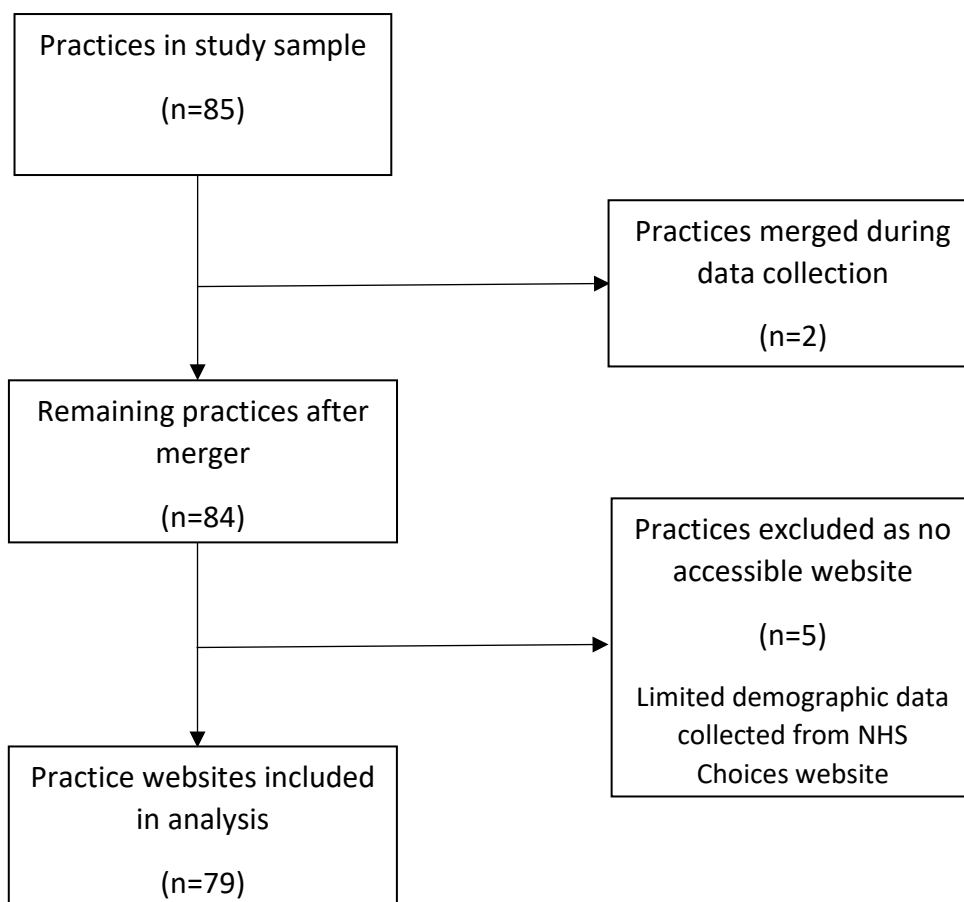
5.1. Introduction

In previous chapters, the background and context of advanced nursing was presented. The literature review demonstrated a gap in current knowledge, then professional identity theories informing a conceptual framework for the study were identified. The rationale for methodology was set out and methods explained. Two studies were carried out. Firstly, a qualitative cross-sectional study exploring how ANPs were represented on general practice websites was conducted, in order to explore the outward facing public image (macro identity) of ANPs. This also identified a priori concepts to inform the subsequent ethnographic study which considered the relationship between professional identity and ANP practice in an environment where such practice was established within contemporary primary care cultures. Analysis of both studies was based on a framework analysis technique described by Pope et al., (2006). This drew on professional identity as a framework within which to explore a priori concepts and also allowed for emergence of new themes/concepts. The remainder of this chapter presents and discusses the website study findings, with subsequent chapters focusing on the ethnographic study.

5.2. Website Study Findings

Findings are presented in three parts. The first describes the websites in broad terms, looks at what practices state they aim to achieve and then addresses authorship and quality of information. This is followed by the profiling of general practices and the professional workforce as presented on websites. Then themes identified from the data are explored, drawing on Positioning Theory and Social Identity Theory to provide insight into how and why different professional groups are represented on practice websites. Pseudonyms are used where appropriate and slight changes made to some quotations to minimise identification via internet searching. First, identification of practice websites included in the study sample is described in Table 9.

Table 9: Study Sample



5.3. Description of Websites

5.3.1. Overview

Most websites consisted of a homepage and pages relating to information about clinicians, booking appointments and the range of clinics and services available (n=77). Several websites contained information about practice policies, mission statements and further information such as practice history, self-help information and newsletters. A minority (n=14) included a link to the practice's patient information leaflet.

Most practices did not overtly articulate why the website had been developed or the intended aims. Of those which did, the majority stated the intention was to provide patients with easily accessible information about the practice, the workforce and general health information, as well as delivering a patient-centred approach (n=33, 41.8%). The British Medical Association (BMA, 2011 p3) describe patient-centredness as responding

to individuals' preferences and patient engagement and participation in decisions about their care. At the time of data collection, practices were also contractually obliged to promote specific online services such as appointment bookings, repeat prescription ordering and access to summary patient records (BMA, 2015b).

Website authorship was unclear. It was attributed on only one website and in this case the author was a GP **[Practice 45]**. As data collection progressed it became apparent there were similarities across websites both in relation to language used and the way websites were structured. The majority followed a similar structure and common phrases became recognisable, evidence they were following (albeit modified) versions of standardised pre-set templates available from website development companies.

Despite lack of explicit authorship accreditation, websites were predominantly presented from the viewpoint of GPs. This was exemplified by the use of 'we' in positioning GPs as the authors of websites. For example, Practice 73 stated 'We are a small practice of family doctors'. That authorship was implicitly attributed to GPs was also demonstrated by the use of 'our' to describe other members of the workforce. So for Practice 58, 'With the support of our committed practice healthcare team, we will continue to provide a comprehensive primary care service for our patients'. Consequently, although others may have been responsible for website production, GPs were positioned in this role. It was within the context of the positioning of GPs as website authors that websites were interpreted.

Quality of information was highly variable between and within websites, both in relation to information provided and presentation of that information. This may provide insight into the level of importance practices placed on their websites and the public image of their workforce. There was a general lack of attention to the outward-facing presentation of practices across many websites, with broken links, missing information and numerous spelling and grammatical errors. On two websites, text had not been changed from the original example [dummy] text **[Practices 18, 55]**, while on others information directed towards employees was publicly accessible. For example, appraisal procedures, incremental pay award structures **[Practice 45]**, and information for medical students **[Practice 65]** were easily accessible. Several websites published out-of-date information

and made reference to Primary Care Trusts which were obsolete two years before data collection occurred.

5.3.2. Practice and Professional Group Profiles

General practices in the study ranged from single-handed practices to multi-practice partnerships with population sizes ranging from 1,675 to 25,593 patients. Practices were situated in rural, suburban and inner city areas. Population deprivation scores covered the entire range from 1 (most deprived) to 10 (least deprived) on the National General Practice Profile Deprivation Scale (Public Health England, 2014). 42.9% of practices in the study sample were in the most deprived areas and 76.2% of practices fell in the bottom 4 deciles. Professional group profiles are detailed in Table 10.

Table 10: Profile by Professional Group			
	General Practitioners	Advanced Nurse Practitioners	Practice Nurses
Practices with staff group N (%)	79 (100)	34 (40.5)	75 (94.9)
Number of clinicians stated across websites	450	52	193
% of total qualified clinician workforce (n=695) *	64.7%	7.5%	27.7%
Number of practice partners stated across websites (% of profession)	147 (32.7)	3 (5.8)	1 (0.5)

*1 practice employed 2 physician associates and 1 employed a pharmacist practitioner. These were excluded from analysis as they were not the focus of this study

ANPs were identified as being employed across 40.5% of general practices. However, they made up only a small proportion (7.5%) of the total qualified clinician workforce of GPs, practice nurses and ANPs. ANPs were mostly women (84%) and were most likely to work as a sole ANP.

The introduction of a new General Medical Services Contract in 2004 (GMS, 2004) permitted the development of non-medical partnerships within general practice. Such partnerships could either be solely owned by non-physicians who employed general medical practitioners to deliver some services, or could include one or more non-physician members within a traditional medical partnership. Other commercial and voluntary providers were also permitted to provide primary care services (APMS, DH, 2004). It was anticipated such initiatives would develop new models of working and advance professional roles (The King's Fund, 2011). In this study ownership of general practices appeared to be dominated by general medical practitioners within traditional medical partnerships, with only five practices (6.3%) identified on websites as being owned by commercial or voluntary providers. No practices were found to be led or primarily owned by ANPs or practice nurses. Three practices each had one ANP partner [**Practices 76, 78, 82**], two of which were described as 'associate' or 'clinical' rather than full partners, while one practice nurse was a partner at a single practice [**Practice 30**]. Both ANP associate/clinical partners worked at average sized practices and while one practice employed two further ANPs, the other associate partner was a sole ANP. The remaining practice with an ANP partner was the largest practice in the sample and employed a further 7 ANPs and 16 GPs. One of the practices with an ANP partner presented comprehensive information about ANP practice on their website [**Practice 78**].

5.3.3. Summary

This section provided an overview of the sample of general practice websites, set out practice and professional profiles and discussed website quality. Websites were predominantly presented from the position of GPs. Relatively few ANPs worked in general practice. Both ANPs and practice nurses were unlikely to be partners in general practices. Website quality was found to be variable, potentially reflecting a lack of attention to the outward-facing presentation of practices and the public image of practitioners. While this may be attributable to alternative explanations such as limited information technology or public relations skills, it remains that patients and the public were presented with

inconsistent, unclear and sometimes inaccurate information across many websites. The following sections present themes identified in the study in order to explore the representation and positioning of ANP practice in detail.

5.4. Identification of Themes

Three overarching themes relating to representation, public image and positioning of clinicians and professional groups were identified from the data

1. Visibility, Prominence and Consistency
2. Levels of Professionalism
3. Quality

Each theme was considered in relation to

- how doctors and nurses were represented
- how ANPs specifically were presented
- how consultation traffic was directed
- assumptions made about patient knowledge

Website quality has previously been discussed in Section 5.3.1 and remains a continuous theme throughout. The other two themes are now considered.

5.4.1. Visibility, Prominence and Consistency

There were marked differences in the visibility of different professional groups across websites. Both ANPs and practice nurses lacked visibility when presented to website audiences. This was both absolute and in relation to GPs, who had greater prominence and appeared across websites more clearly and consistently. This has implications for the promotion of ANP roles, the public image of nursing and signposting patients to appropriate clinicians.

For ANP descriptors specifically there was a lack of clarity and consistency. The titles 'advanced nurse practitioner' and 'nurse practitioner' were often used interchangeably, sometimes being further confused with 'nurse prescriber' [e.g. **Practice 64**]. ANP practice was often couched in imprecise terms, with Practice 29 describing the ANP as offering 'a full range of general practice care', while Practice 37 stated its ANPs 'have undergone and (sic) extensive training to provided (sic) qualified consultation care for our patients',

demonstrating both lack of clarity and quality of information. Similarly, nursing was often represented in vague terms such as ‘routine nursing procedures’ [Practice 49], or ‘nursing needs’ [Practice 25, 70]. Some websites also conflated specialist and advanced nursing, which are distinct and such inaccuracies can be seen to contribute to confusion and reduce visibility around nursing roles and ANP practice.

Variance in visibility between professional groups was demonstrated across website homepages, appointment pages, ‘Clinics and Services’ pages and staff information pages, as well as other website sections. It related to both the omission/lack of information and the positioning and prominence of ANPs in relation to different professional groups.

Homepages were usually the first pages presented to readers when accessing websites via a search engine. As such, they may be considered the most prominent webpage in terms of website traffic. These pages typically contained practice overviews, signposting and health promotion information. A large proportion of homepages referred specifically to GPs, while fewer made direct reference to nurses and fewer still referred specifically to ANPs. Table 11 demonstrates the visibility of different professional groups on website homepages.

Table 11: Professional Group Visibility on Website Homepages			
	General Practitioners	Advanced Nurse Practitioners	Practice Nurses
Number of websites with professional group stated on homepage	52 out of 79* (65.8%)	3 out of 34* (8.8%)	15 out of 75* (20%)

*Number of practices employing professional group

For the 20% of homepages referring specifically to nurses, all positioned nurses as hierarchically subordinate to doctors, as did the three homepages with ANPs. Nurses also remained less visible because there was less information about them and they were unnamed. This is exemplified in Practice 69’s homepage:

Drs Brown, Smith, Green and Jones operate their partnership at 2 separate sites. Our team includes Drs Johnson, Campbell and Bell, a full Nursing and Healthcare team with dedicated reception and administrative support teams.

GPs were also prominent in other ways, with some websites publishing personalised messages from GPs on their homepages, while others published timetables for GPs, but not for nurses or ANPs.

Of the three practices which included information about ANPs on their homepages, one briefly presented ANPs in a triage role [**Practice 48**], while the remaining two referenced ANPs as part of a wider clinical team [**Practices 8, 78**]. One of these websites also provided a link to further information about the ANP's role, professional background and qualifications [**Practice 78**]. This was in contrast to the lack of ANP visibility on other website homepages.

A similar pattern was found on appointment pages, clinics and services pages and staff information pages, across which ANPs, practice nurses and GPs were positioned hierarchically. 79.4% (n=27/34) of websites made no reference to ANPs on clinics and services pages, despite indications ANPs may be involved in such services. This compares with 30.4% (n=24/79) for GPs. Both GPs and practice nurses featured more often than ANPs, but their positioning on clinic and services pages differed between both groups. When GPs delivered services, this was usually overtly stated. However, while most services listed would typically be undertaken by practice nurses, this was not explicit on a number of websites (n=27, 36%). When it was stated, nurses were often not named, but referred to interchangeably (n=20, 26.7%) and therefore lacked prominence and visibility. This is typified by Practice 46 which named individual GPs for doctor-led clinics, but stated the 'nursing team' ran other clinics. Again this limits patients' knowledge of complex and developing nursing roles and inhibits patients' ability to assess practitioners' capabilities.

Lack of ANP visibility on clinics and services pages may have been because ANPs were predominantly functioning within same day/urgent appointment services. However, there

was also limited information about ANPs in relation to these sorts of appointments across the majority of websites. Indeed, ANP visibility was particularly lacking on appointment webpages. While 91.2% (n=72/79) practices provided information about how to book GP appointments, 55.9% of webpages omitted ANP information completely (n=19/34) while a further 35.3% presented significantly less information for ANPs than for GPs (n=12/34). Similarly, 20% of appointments webpages made no reference to practice nurses. Of those that did, 59% referred to practice nurses less often than GPs. This was demonstrated by Practice 2 which referred to GPs fourteen times, nurses twice and ANPs once on its appointments page. Practice 41 signposted to different members of the primary healthcare team, but failed to mention its two ANPs and provided no information about their roles. This limited visibility impacts on patient awareness and understanding of ANP practice, thus potentially limiting the ANPs' scope.

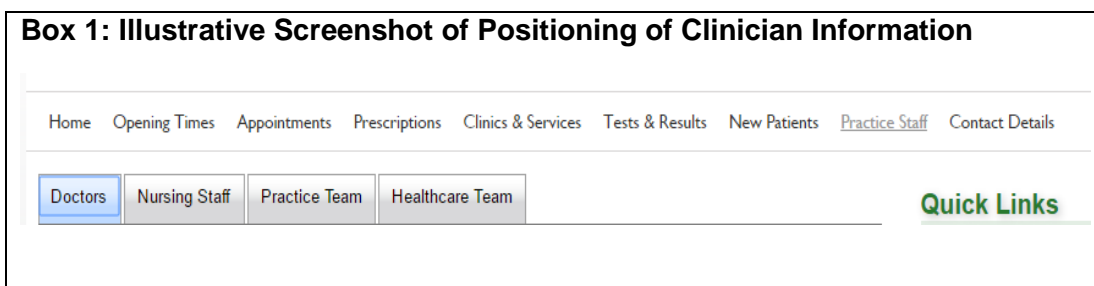
When ANPs were visible on appointments pages, there was often not enough information to allow patients to identify why and how to consult with an ANP. Three disconfirming cases (8.8%) were identified where adequate information was provided. These served to highlight the lack of visibility and appropriate representation of ANPs across other websites. Practice 8 provided a useful flowchart to enable patients to decide who to consult with, while Practice 44 positioned GPs and ANPs equally, while making a clear attempt to appropriately direct patients. Practice 81 adapted a section of pre-populated text guiding patients towards ANP appointments. A minority of websites (n=5/79, 6.3%) also directed patients towards practice nurses as an alternative to GPs using the same piece of text

In a number of cases it might be worth considering an appointment with a practice nurse rather than a doctor. Practice nurses are qualified to deal with many conditions and you may be seen more quickly [e.g. Practice 25]

The wording is of note, because its imprecision limits its explanatory capacity. It also fails to promote the value of consulting with a nurse or ANP, but rather focuses on patient throughput. Three practices using this text in relation to practice nurses also employed ANPs, but had no similar signposting of ANP practice. This indicates a lack of consistency and strategy in directing patient flow and promoting nursing/ANP roles.

Furthermore, six practices with ANPs (17.6%) referred to generic 'clinicians' on appointment pages, particularly in relation to rapid access and urgent appointments. Reasons for this were unclear. It could be interpreted as the equal positioning of professional groups and as evidence of blurred professional roles. Alternatively, referring to professional groups generically may inhibit patients' knowledge of service providers. This may be linked to perceptions about patient acceptance of ANP practice. This is indicated by Practice 74, which referred to GPs frequently, but limited the visibility of ANPs by mainly positioning them as generic clinicians (GP=12, clinician=12, ANP=3). By concealing ANP visibility the traditional public image of nursing remains unchallenged and limits patient decision-making.

Staff information pages were perhaps the clearest example of the positioning and prominence of ANPs and nurses on practice websites. In most cases clinician information was accessible through a tab on the homepage. This either linked to a single page or, more commonly, connected to several tabs with a different professional group represented on each tab (Box 1).



In both systems, staff were listed with GPs foremost. For the single page system, GPs were consistently positioned at the top of the page, while for the segregated tab system, GPs and medical registrars were represented on the first tab entitled 'Doctors' which was the default page. Information about nurses was accessed by clicking a second tab entitled 'Nursing Staff'. As a consequence, information about nurses was positioned secondary to information about doctors. As this appeared to be a pre-set template, this indicated that such ordering and segregation of professional groups was an implicit and societally accepted norm.

In relation to ANPs, one practice used the single page system and listed ANPs below GPs and above practice nurses [**Practice 44**]. ANPs at the remaining practices were

represented on the second 'Nursing Staff' tab on all but two websites (n=31/34, 91.2%). There was often a pre-populated 'Nurse Practitioner' heading at the top of this tab, indicating it was expected that ANPs would be positioned in this section. Two disconfirming websites presented advanced practitioners on the 'Doctors' tab, albeit at the bottom [**Practices 39, 80**]. It appeared that, because ANP roles did not easily fit these predefined profession-based parameters, it was problematic for practices to situate ANPs on practice websites and describe their role effectively. This may result in lack of patient understanding and awareness of ANP roles and levels of practice.

While 55.9% (n=19/34) of staff information pages described ANP roles, less than half (n=9/34, 26.5%) provided information to enable informed decision-making and contained adequate explanations of ANP practice, as per UK recognised advanced practice descriptors (SGHD, 2008; NMC, 2005/6; RCN, 2012). This can be seen to limit patient and public understanding and is exemplified by Practice 29 which stated, '[ANP] has been with the practice for the last few years and is well liked by all our patients, she offers a full range of general practice care'. By contrast Practice 64 provided a clearer description of ANP Practice, demonstrating inconsistency between websites.

*Advanced Nurse Practitioners are registered nurses who have done years of training to a Masters level to increase their skills and knowledge. They are able to do many roles which have previously been in the domain of the GP, e.g. diagnose, examine, prescribe, refer, request blood tests, X rays. [**Practice 64**]*

While such representations remained in the minority, this demonstrated information could be provided in a way that may be helpful to patients and challenge traditional public images of nursing.

Practice nurses were least likely of the three professional groups to have complete, consistent information presented on staff information pages. They were the profession least likely to be named and most likely to be presented as a group. On many webpages, information was presented on a sliding scale. This was demonstrated by Practice 49 which presented individual GP information comprehensively, with subheadings for each

GP's full qualifications. Individual ANP information was less visible as it contained qualifications in the body of text, while practice nurses were presented as a group and their qualifications not stated. These qualitative differences can be seen to subtly maintain traditional professional identities, roles and hierarchies. This has implications for the profession of nursing more broadly, as lack of visibility means patients and the wider public may not appreciate the level of practice provided by nurses and consequently base their perceptions of nursing on traditional stereotypes (Sullivan, 2000).

As well as the specific webpages highlighted, disparity in visibility was identified across websites in other ways. For example, some websites provided historical overviews of the practice, which predominantly focused on GPs while overlooking the contribution of others. In this way GPs were more visible and positioned as central to the practice. Similarly, there was a focus on the importance of doctor-patient relationships, with most practices offering patients a choice of GP. Practice 66 stated it was 'proud of its ethos of patient friendly care, where the patients get to know their doctor and the doctor gets to know the patient'. However, corresponding statements were not presented for ANPs and rarely for practice nurses. GP information also predominated through reference to single-handed GPs, GP availability and consulting times and focusing on GP access. This is important because lack of role visibility of non-physicians may inhibit patients engaging with other care providers.

5.4.2. Summary

Nursing in general and ANPs specifically lacked visibility, prominence and consistency on practice websites in this study, both in absolute terms and relative to the visibility of GPs. This was demonstrated through overt positioning and by more subtle inference of difference. Both were significant because lack of information about nursing and ANPs may prevent promotion of these roles to patients. Furthermore, the centrality and prominence of GPs may perpetuate long established and accepted understanding of nursing and medical practice which may, in turn, prevent patients from identifying and accepting the most appropriate practitioner to meet their needs. As a consequence, this may compromise the established need to direct patients to a broader range of practitioners. In this way public image and macro level professional identity directly impacts on patient care. The second overarching theme identified as impacting on the public image and macro identity of nursing and ANP practice is now considered.

5.4.3. Levels of Professionalism

A further major theme identified in the data was the finding that professional groups were assigned differing levels of professionalism on practice websites. This means there was a differential positioning of professional groups in terms of

- I. Status, Hierarchy and Ownership
- II. Rights and Responsibilities
- III. Competence, Expertise and Qualifications.

Each sub-theme is explored in turn.

I) Status, Hierarchy and Ownership

As identified previously, traditional hierarchical ordering pervaded practice websites. However, these hierarchies had expanded and grown in complexity to incorporate newer professional groups and changing professional practice and roles. GPs were almost invariably positioned foremost on lists and highest on individual webpages, with ANPs located between GPs and practice nurses. As well as this inter-professional hierarchy, intra-professional categorisation was also apparent. This is exemplified in Figure 1.

Figure 1: Extended Practice Hierarchy – Qualified Clinical workforce
GP Partners
GPs with Special Interest (GPwSI) [provide services for other practices]
GPs with specialist skills [e.g. diabetes management]
Salaried GPs
GP registrars
ANPs [including ANP partners]
Specialist Practice Nurses
Practice Nurse Managers
Senior Practice Nurses
Practice Nurses

Linked to this expanded professional hierarchy, which positioned ANPs as mid-level practitioners, was a trend towards elevating GPs to the level of expert. For example, whilst many practices highlighted nursing's role in providing services, GPs were more likely to be positioned as experts in relation to such services. 'Doctors, nurses and healthcare assistants run the diabetic clinic [while] Dr Smith and Dr Brown run specialist clinics for more complex insulin dependent diabetics' **[Practice 61]**. Correspondingly, nurses were presented as doctors' assistants, 'We run daily surgeries where the duty doctor is assisted by the triage nurse' **[Practice 17]**. Furthermore, doctors were also positioned as experts in established nursing spheres of practice such as childhood immunisations, while nurses were presented as task performers and patients as passive recipients. Several websites contained versions of

All children should be immunised if possible. The practice nurse is available for this purpose. If you have worries about immunisation then please discuss them with the doctor **[Practices 53]**

Accordingly, while nurses were positioned as being able to perform delegated procedures, tacit higher level knowledge and decision-making was equated with medicine. Consequently, doctors were presented as retaining professional jurisdiction over delegated nursing roles. This appeared to preserve the traditional triad of doctor/nurse/patient roles, where doctors are decision-makers, nurses follow instructions and patients are positioned as dependent (Carpenter, 1993). For their part ANPs were rarely overtly positioned within this framework and as consequence were seldom referred to. When reference was made to ANPs, it was in relation to delegation by GPs. Practice 58 asserts 'Doctor will decide whether it is more appropriate to send a nurse practitioner'. This may be a consequence of advanced practice not fitting with traditional perceptions of nursing identity. Positioning GPs as delegators to ANPs can be seen to stabilise challenges to established healthcare hierarchies by maintaining superordinate positioning of GPs. Furthermore, changing medicine's relationship with nursing through the development of advanced practice may have the potential consequence of affecting established relationships between medicine and patients. Therefore maintaining traditional doctor-nurse roles, identities and hierarchies ensures established relationships with

patients are maintained. As a consequence the position of GPs as experts continued to pervade.

However, in some cases ANPs were presented more equitably in relation to GPs (n=13/34, 38.2%). ANPs were sometimes described as working alongside or in conjunction with doctors; as an alternative point of contact to GPs; as providing a complimentary service to GPs; as being able to treat 'the same medical conditions as doctors' [Practice 48] or as supporting GPs. This way of representing ANPs is more analogous with RCN (2012), DH (2010) SGHD (2008) and NMC, 2005/6) descriptions of ANP practice. Consequently, by presenting information in this way across more websites, patient understanding of the role may be improved. Yet this presentation of ANPs was neither comprehensive nor consistent within and across websites. Indeed several websites focused on caveats to ANP practice or made it clear patients did not have to consult with an ANP. This is evidenced by Practice 64, 'If you do not want to see a Nurse Prescriber (sic) please make this clear to the receptionist' and Practice 37, which provided contradictory information within one paragraph

Our Nurse/Advanced Practitioners provide all services to patients in line with usual GP consultations...They are however unable to see children under 6 months of age or pregnant ladies and are unable to provide sick notes.

In addition, a hierarchy of decision-making was also identified in terms of referral to services. Despite referral and ordering investigations being core functions of ANP practice (NMC, 2005/6; RCN, 2012), a minority of websites stated ANPs could refer (n=9, 26.5%). Other websites either omitted this information, indicated these functions were solely the domain of GPs, or were ambiguous or contradictory. On some websites ANPs were only permitted to refer to specific services and order particular tests. For example Practice 49's ANP role description did not state whether the ANP could refer or order tests, while another webpage stated only GPs could refer for ECGs, but physiotherapy referrals were 'made through the GP or Nurse Practitioner'. Again this demonstrated both status differentials and lack of clarity and consistency, which may consequently limit patient understanding and access to services. For their part practice nurses were usually omitted from referral altogether, or permitted to refer within very narrow parameters. Through

promoting traditional professional identities and role demarcation, alternative models of practice were limited rather than supported.

Traditional role demarcation was also exemplified on a webpage aimed at medical students. Practice 65 stated observation of nurse consultations should not be 'considered a second rate educational session compared to sitting in with a doctor' but rather, shadowing practice nurses provided medical students with experience of 'BPs, measuring pulses, doing ECGs, peak flows, taking bloods etc.'. This both assumes medical students expect observing nursing to be less valuable than working with GPs, while simultaneously reinforcing the position of nurses as low-level task performers. As this webpage was accessible to the public, it also reinforced these perceptions to the wider community. Such positioning can be seen to exemplify the hidden curriculum (Hafferty and Franks, 1994), within which professionals are socialised and enculturated by other group members to subconsciously maintain traditional professional identities and structures (Chulach and Gagnon, 2016; Wackerhausen, 2009).

Some websites failed to present a comparably professional image of nursing, thus maintaining assumptions about nursing's lack of professional status in relation to medicine. For example, websites referred to ANPs/nurses informally by first name despite referring to GPs formally, while for some practices ANPs and nurses were represented by a cartoon [**Practice 36, 56**]. Another practice published nursing uniforms on its website [**Practice 81**], which has been utilised historically to create a specific public image of nursing (Hallam, 2000). Emotional descriptions of nurses/ANPs as 'loved' [**Practice 45**] or 'well liked' [**Practice 29**] by patients, rather than focusing on professional expertise, also challenged the professional status of nursing and maintained traditional societal expectations of nursing as inherently vocational and character driven.

This representation of different professional groups is significant. Not only does it potentially hinder patients' understanding of the complexity of care delivered by ANPs, nurses and doctors in modern general practice, it also positions practitioners in a way that may inhibit the acceptance of different healthcare providers. This is because positioning GPs as expert at the top of the practice hierarchy may indicate that only those patients who were most seriously ill, or had the most complex care needs should consult with a GP in their position as expert, 'we can free up GP appointments for more urgent and

appropriate cases' **[Practice 36]**. This does not necessarily equate with patient-centredness, patient choice or patient safety. Patients may prefer to consult with a GP because, in doing so, it may be that their illness is legitimised in a way that a practitioner presented as dealing with low level problems does not (Niezen and Mathijssen, 2014). It has previously been recognised that patients have reservations about consulting with ANP/nurses rather than GPs, either because they lack trust in nurses in some situations or because consulting a doctor infers gravitas (Rashid, 2010; Redsell et al., 2007). The contention here is that because ANPs and other nurses continue to be positioned as hierarchically subordinate to medicine on practice websites, through extended hierarchies and unclear information, lower levels of expertise and competency may be assumed. This presentation of ANPs and nurses runs counter to attempts by practices, underpinned by healthcare policy (HEE, 2015a; NHS England, 2014; NHS England, 2016), to actively direct consultation flow more appropriately.

II) Rights and Responsibilities

GPs were positioned as having rights and responsibilities over both nursing and patients, which were ascribed in a number of ways. GPs were positioned centrally with both patients and nurses allocated peripheral roles. Websites referred to 'your doctor and their staff' **[Practice 78]** and 'your GP' and 'our practice nursing team' **[e.g. Practice 72]**. Nurses and ANPs were frequently referred to as belonging to GPs, for example, our practice nurses/our trained asthma nurse/our nursing team/our highly qualified nurse practitioner. Marginalisation of the patient role was demonstrated in the way practices attempted to manage patients. Websites often contained instructions to patients such as 'Please don't hop around from one doctor to the next' **[Practice 45]**; 'try not to bring a list of problems' **[Practice 47]** and 'You need to ring **as soon as possible**' [original emphasis] **[Practice 59]**. They also emphasised the dominant position of GPs in relation to patients: 'it is at the doctors' discretion and on the doctors' instruction that these appointments are made' **[Practice 68]**; 'It is the Doctor's right to see a patient at a place of the Doctors choosing' **[Practice 56]** and 'under our NHS contract, home visits are not an automatic right, and the doctor retains ultimate discretion over their necessity' **[Practice 71]**. Some websites could even be seen to rebuke patients. Examples included Practice 59, 'If you DNA on 3 occasions we can decide to no longer treat you' and Practice 45, 'If you need an *emergency* or *urgent* appointment and WE manage to squeeze you in then it is only fair that you accept...' [original emphasis and capitals].

Positioning GPs in this way can again be seen to situate patients at the bottom of the healthcare hierarchy (Charles-Jones et al., 2003) and does not appear to reflect the patient-centred aims to which some practices aspired. It was of note that no websites implied nurses or ANPs had this relationship with patients. Thus, the status of medicine in relation to both patients and other professionals was maintained.

III) Competence and Expertise

Competence of GPs appeared to be assumed across the majority of practice websites through their positioning, as we have seen, as expert decision-makers. By contrast, it was apparent a significant effort had been made to reassure patients of nursing and ANP competence. In this way GPs were positioned as having jurisdiction over nursing. Some practices positioned GPs as supervisors and educators of nurses and ANPs: 'We have an ongoing training programme for the Practice Nurses' **[Practice 63]**; 'I am proud to have trained 4 nurses' **[Practice 5]**. This supervision of nurses was also highlighted in long term condition management flowcharts, which were authored by doctors for nurses to follow **[Practice 45]** and assurances such as 'our highly trained nursing staff work to locally agreed protocols' **[Practice 51]** and 'All our sisters are fully trained' **[Practice 3]**.

Across websites GPs routinely vouched for ANP and nursing competence. For ANPs this was demonstrated by descriptions of ANPs as 'highly qualified' **[Practice 25, 49, 80]**, 'highly skilled' **[Practice 81]**, 'fully qualified' **[Practice 51]** and 'trained to an advanced level' **[Practices 45, 82]**. This appeared to be determined by GPs. Practice nurses were vouched for similarly: 'our highly trained and qualified diabetic nurse' **[Practice 49]**. Indeed, some practices considered themselves lucky to have competent nurses, the implication being some nurses were not, 'We are very fortunate to have a highly skilled team of nurses' **[Practice 5]**. Conversely, GP competence was not described in a comparable way. Indeed, it was rarely referred to indicating this was implicitly accepted. While GP support of nursing roles may reassure patients it is appropriate to consult with an ANP or a practice nurse, it fails to challenge the disparity in professional status underpinning such positioning and perpetuates traditional perceptions of nursing.

Linked to competence is the differential presentation of professional qualifications on practice websites (Table 12). Websites were twice as likely to provide full GP

qualifications as they were for ANPs, while practice nurses were the group most likely to have no qualifications acknowledged.

Table 12: Professional Group Qualifications by Practice					
	Full qualifications stated	Partial qualifications /qualifications for some clinicians stated	Where clinician qualified	When clinician qualified	No information about qualifications
GP	66 /79* (83.5%)	5 (6.3%)	47 (59.5%)	53 (67.1%)	8 (10.1%)
ANP [RN+ MSc/PGDip]	14 /34* (41.2%)	5 (14.7%)	5 (14.7%)	7 (20.1%)	15 (44.2%)
PN	20/75* (26.7%)	8 (11%)	2 (2.7%)	4 (5.3%)	47 (63%)

*Number of practices employing professional group

Only 48% of ANPs had a documented master's level qualification which the RCN (2012), SGHD (2008) and the DH (2010) indicate as an appropriate, although not mandatory, level of qualification for advanced practitioners in the UK. However, only 32.7% of ANPs were stated as having a specific masters level advanced practice qualification.

Presentation of qualifications also varied qualitatively. Websites were more likely to provide additional information about GPs than other groups, for example where and when they qualified. Qualifications were also likely to be presented more clearly for GPs, for example in subheadings and in a consistent order. Because of this they were easily comparable. This is in contrast to ANP qualifications which were presented irregularly and therefore more difficult to understand. An example was Practice 76. This practice employed 8 ANPs, and while qualifications were stated, they were not consistent and

were presented in differing order, thus limiting the extent to which these qualifications could be clearly understood and compared. The same practice published comprehensive, consistent GP qualifications, but no practice nurse qualifications. Indeed, the presentation of baseline medical qualifications as assurance of competence, while simultaneously implying ANPs and practice nurses were not fully qualified or experienced may suggest nursing qualifications are considered less relevant and/or worthwhile. Notwithstanding the motivations, it remains that emphasis was placed on medical qualifications relative to ANP/nursing qualifications and this has an impact on how professional groups are represented on practice websites, and how they are viewed by patients and the wider public.

Furthermore, many websites used receptionist triage as a way of directing patient flow and this had particular implications for the representation of ANPs and practice nurses. Receptionist triage involved instructing patients to tell receptionists why they wanted an appointment, then receptionists directed patients to the clinician considered most appropriate. This method of triaging patients was considered particularly important when directing patients to nurses, because it was implied nurses may not have a full range of qualifications and expertise. Examples include Practice 57 which stated, 'To ensure you see a suitably qualified nurse you will be asked the reason for your appointment', while Practice 37 specified 'When requesting an appointment with our Nurse/Advanced Practitioners, patients will be asked the reason for the consultation to ensure our clinicians can deal with your problem'. This limits patient decision-making and choice which may be alleviated by publishing comprehensive and understandable information about all professional groups on practice websites. It also presents nurses as less competent, less professional and not fully qualified.

5.4.4. Summary

The presentation and positioning of ANPs and practice nurses in relation to general practitioners on the websites in this study can be seen to maintain and, in some ways, extend entrenched professional identities, hierarchies and societal expectations of nursing and medicine. This traditional outward-facing public image of professional roles can be seen as counterproductive to the current agenda of developing innovative ways of addressing some of the issues faced in primary care. While a minority of practices have attempted to position ANPs more equitably, lack of clarity and consistency limits the

effectiveness of such positions. For nursing more generally, the traditional representation of nurses as doctor's assistants pervades. Moreover, the passive positioning of patients limits patient-centredness and patient decision-making capacity, thus marginalising patients' ability to actively engage in healthcare. Changing nursing's relationship with medicine can be seen to challenge medicine's relationship with patients, and its position within the healthcare hierarchy. Consequently lack of clarity, consistency, accuracy and omission of information about ANPs and nursing more broadly, coupled with the ascription of differing levels of professionalism and hierarchical positioning, can be seen to maintain medicine's dominant professional identity and positioning within healthcare hierarchies. This not only inhibits developing and advanced nursing roles but also serves to maintain patients' positioning at the bottom of the healthcare hierarchy and in this way status quo is maintained.

5.5. Discussion

This study explored how the public image of ANPs was represented on practice websites. Websites lacked quality and consistency in relation to presentation of professional roles, potentially indicating that a low level of importance may have been placed on how the public image of practitioners was represented on practice websites by authors. Qualitative analysis of website data indicated patterns and themes which could be seen to shape the public image and outward-facing macro identity of professional groups, as reinforced by traditional and established notions of the professional identities of medicine and nursing. Whether these representations were planned or subconscious is unclear. Indeed, Chulach and Gagnon (2016) argue such concepts are so widely accepted they are often considered the norm and are therefore invisible. However, as Evans (2014) asserts, documents both project and hide assumptions and ideologies which underpin the institutions they represent. Therefore qualitative analysis can expose such assumptions and raise them to a conscious level. Social Identity Theory and Positioning Theory were utilised to gain understanding of concepts underpinning website representations and are recapped in Boxes 2 and 3. This will then be discussed with reference to the literature, but first the issue of critical mass is addressed.

Box 2: Social Identity Theory

Social Identity Theory is predicated on the principle that group membership is valuable and self-esteem is created through group status (Hogg, 2006). Groups develop cohesion by positively differentiating themselves from other groups and competing for prestige. This results in positive attitudes towards in-group members and negative attitudes and biases towards out-groups (Burford, 2012). Consequently, out-group members become standardised and in-group variability is promoted. This is linked to stereotyping and the meta-contrast principle, which minimises in-group differences, while out-group differences are maximised.

Box 3: Positioning Theory

Positioning Theory premises that identity is created through the narratives people tell themselves and others within local and broader social, cultural, historical and political master-narratives (Davies and Harré, 1990). Narratives are used to claim, assign and challenge rights and duties (Georgakopoulou, 2013; Harré et al., 2009). In Positioning Theory, narrators are positioned in relation to other characters in the narrative, to the audience and to past events and pre-existing master-narratives which all serve to create identity (Bamberg, 1997). In this study, websites are considered as narratives.

In this study, ANPs made up a small proportion of the qualified clinical workforce and only one website stated the practice was currently training an ANP. Therefore, whether there is a critical mass of ANPs available to enable shifts in workforce strategy, as identified in policies such as The Five Year Forward View and the General Practice Forward View (NHS England, 2014; NHS England, 2016) is questionable. Freund et al., (2015) identified that the number of ANPs working in primary care in England is low, while NHS Digital (2016) estimated there were around 2,300 FTE ANPs working in general practice in 2016 compared to nearly 35,000 FTE GPs (NHS Digital, 2016). This can be seen to challenge the utility of ANPs as alternative providers. The success of such workforce policies rest, in part, on whether there are adequate numbers of nurses and other professionals prepared to train as advanced practitioners. It is also dependent on whether enough GPs and practices are prepared to support ANPs, not only in training but in establishing and

gaining acceptance of the role. It also relies on how well the role is understood and represented to others.

This website study suggested there was limited information available on practice websites in relation to ANP practice and nursing more broadly. That nursing lacked visibility on healthcare provided websites was supported by previous studies exploring nursing representation on secondary care websites. Boyington et al., (2006), Chen and Liu (2010) Kasoff (2006) all found nursing content was inadequate and difficult to locate. In this study, ANPs and practice nurses were less visible than GPs, who were positioned more prominently across the majority of webpages and throughout most websites. This was in terms of depth and clarity of information, hierarchical positioning, status differentials and nuanced inferences related to competence, qualifications, expertise and rights and responsibilities. This equated to the assignment of differing levels of professionalism dependent on professional group. In an earlier study of English general practice websites, which did not refer specifically to ANPs, Howitt et al., (2002) found a similar disparity in presentation of professional qualifications between medicine and nursing, indicating little change. However this study did not focus on professional roles and did not explore this in more detail.

Representation of ANP practice was limited across websites. Little useful information was consistently provided, potentially making it difficult for patients to make decisions about whether they wanted, or whether it was appropriate, to consult with an ANP. GPs were predominantly positioned hegemonically relative to nurses, who were presented in traditional, sometimes stereotypical, roles. Why professional groups continue to be positioned in this way requires exploration in relation to professional identity frameworks.

In terms of Positioning Theory, websites structurally segregated ANPs from GPs, which minimised ANPs' contribution and visibility. They were designed in a way which divided professional groups using hierarchical ordering based on widely accepted notions of medical and nursing roles. When ANPs were visible on websites, they were predominantly positioned through pre-existing established master-narratives of nurses as less qualified, requiring supervision and lacking in competence and expertise relative to GPs. Representations of practice nursing dominated and, because ANP roles lacked visibility, this could be seen to inform the public image of both ANPs and nursing more broadly

across websites. Practice nurses were predominantly characterised as doctors' assistants and because ANPs were principally positioned within nursing, they were consequently characterised similarly. That websites often appeared to be based on pre-designed templates and pre-populated texts suggested this positioning of ANPs within nursing reflected wider societal views of traditional nursing identities. Therefore websites can be seen as reflecting the views of author, audience and society more broadly. Chulach and Gagnon (2016) suggest that structurally and societally established understanding of healthcare hierarchies are so entrenched that they have become implicitly accepted. As a consequence, despite evolving nursing roles, perceptions of nursing remain largely static. In a study of traditional media images of nursing, Hallam (2000) found that established stereotypes of nursing continued to pervade the public image of nursing despite new role development, while Dingwall and Allen (2001) suggest that the practicalities of nursing have never reflected its public image. Consequently, public representations of nursing fail to reflect current nursing practice, as demonstrated by the practice websites studied.

While there were some notable exceptions [**Practices 8, 78**], ANPs lacked representation on practice websites in two ways. Firstly ANPs were omitted from information which referred to other professional groups, with homepages, appointment and clinic and services webpages most noticeable examples. Secondly ANP roles and level of practice did not fit within webpage structures. For example, professional group segregation on staff information pages meant ANPs were predominantly positioned with other nurses. However, while ANPs are registered nurses, their roles and level of practice can be seen as more analogous with that of GPs. Consequently ANP practice did not adequately reflect either category. While two websites appeared to privilege ANP role over professional identity by positioning ANPs with GPs on staff information pages, it remained that for the majority of practices the identity of ANPs as nurses overrode their role and level of practice. Either representation is problematic. It may, therefore, have been more useful to present information in relation to clinical roles and level of practice rather than professional group. However, in this study, it appeared website authors found traditional perceptions and public images of medical and nursing identity most salient.

Social Identity Theory provides an explanatory framework within which this positioning can be understood. Based on the concept that professional groups benefit from maintaining prestige through promoting their own group and negating the value of other groups, GPs

could be seen to positively differentiate between themselves and ANPs/practice nurses on general practice websites. This was through overt hierarchical positioning throughout and across the majority of practice websites and by positioning themselves as more knowledgeable, competent and expert, thus demonstrating negative attitudes towards out-groups (Burford, 2012; Fiol et al., 2009). Websites also demonstrated out-group homogeneity and the promotion in-group variability, which again is a mechanism through which to maintain difference between groups and enhance prestige. This was achieved through naming individual doctors while describing nurses as the nurse/the nurse practitioner/the nursing team. Furthermore, in-group differences were minimised through positioning GPs as competent as a profession, while differences between nurses were maximised, for example by utilising receptionist triage of nursing/ANP appointments and describing their skills as more variable and less comprehensive than GPs'. Fiol et al., (2009) suggest distinctiveness between groups is an important part of social identity, which is predicated as much on not being part of another group as it is to belonging to a group. Therefore, preserving professional group distinction on general practice websites can be seen to serve to limit threats to professional identity.

In this study patients had a dual role as both characters within narratives and as the audience. The predominant outdated characterisation of ANPs and nurses within website narratives has the potential to impact on how the public views the roles and level of practice offered by nursing. As a consequence, a public image of nursing which does not reflect current practice can limit nursing roles (Hallam, 2000; Sullivan et al., 2000; Hoeve et al., 2013). It may be difficult for patients to access ANPs due to simple lack of awareness about the role. Patients may also be inhibited from consulting with ANPs because they are considered to sit lower in the professional hierarchy and may be viewed as less competent or less able to deal with complexity of care (Rashid, 2010). Linked to this is the positioning of ANPs as mid-level practitioners within an expanded hierarchy, which positioned GPs at the top in expert, clinical decision-making roles. The development of expert GPs, relative to an ever expanding healthcare professional hierarchy, can be seen as a means by which GPs maintain professional dominance (Charles-Jones et al., 2003). This is reflected in a study which found that when GPs took on previously specialised medical roles, medical specialists used the concept of themselves as experts to maintain their position at the top of the hierarchy. As a consequence, there was little change within power dynamics and this was seen as a

deliberate device in order for dominant professions to retain control (Martin et al., 2009). In this study, GPs can be seen to retain control in the face of professional identity threats (McNeil et al., 2013) from other professional groups. This is also supported by recent workforce strategies, which continue to place medicine at the top of professional healthcare hierarchies (Imison et al., 2016).

The positioning of nursing was also found to be implicated in the ongoing positioning of patients in relation to medicine. Despite assertions, backed by policy and professional aims, that care should be patient-centred, websites appeared to counter this. For example, keeping knowledge of skills and abilities of ANPs and practice nurses within practice structures can be seen to limit patients' decision-making capacity and maintain traditional positioning. Carpenter (1993) describes historically established positioning within healthcare, where healthcare relationships are seen as familial in that medicine adopts a paternalistic approach to decision-making and is positioned in the role of expert, nursing is positioned in a caring maternal role, while patients are positioned as child-like, with little decision-making capacity. More recently attempts have been made to shift to more equal positioning of professionals and patients (BMA, 2011). However, evidence in relation to this is mixed (Jefferson, 2013) and traditional positioning between professionals and patients persists. In a study of primary care consultations, both GPs and nurses were found to fail to work in partnership with patients, thus retaining professional control (Chew-Graham et al., 2013). Similarly, in this study it was demonstrated that websites provided didactic instructions to patients and limited their decision-making through reserving privileged information within practice structures, for example by employing receptionist triage of appointments instead of publishing adequate information for patients to make appropriate decisions. It also appeared that the maintenance of medicine's position in relation to patients required the continued subordinate positioning of nursing. This was because this position required the privileging of medicine over other groups. Consequently both patient populations and nursing were considered out-groups and were presented as homogenous, lower status groups. Why this continued positioning and perpetuation of traditional public images of patients, medicine and nursing persists is unclear, however again Social Identity Theory may increase our understanding. It has been suggested that social group identity becomes more salient when groups feel under threat (Currie et al., 2010; McNeil et al., 2013) This is because an important part of group identity is derived from being different to other groups (Fiol et al., 2009). However as distinctions between

professional groups lessen, roles become shared and levels of practice become more equal, group differentiation minimises leading to identity threat. Therefore the continued positioning of others as different mediates against such threat.

This is linked to the apparent ambivalence on practice websites towards promoting and explaining professional roles in a way which directs consultation traffic away from GPs. Such aspirations were set out on a number of websites and reflects current healthcare policy of developing the wider clinical workforce (HEE, 2015a; NHS England, 2014; NHS England, 2016). Why such practice and policy aims did not appear to be supported on many practice websites requires exploration. In a study of primary care ANPs and physicians in USA, Fletcher et al., (2007) found physicians experienced tension between the pragmatic necessity of providing a service and an underlying need to protect professional territory. Website representations of ANP practice may be seen to demonstrate similar dissonance and may inform understanding of underlying attitudes and behaviours in relation to ANP roles.

This study explored the representation and positioning of professional groups on general practice websites, with particular attention to ANP roles and practice. This had not been explored previously. By utilising qualitative analysis and through underpinning the study within a framework of professional identity, a more nuanced understanding of such representations was gained. This study was limited by its small and non-randomised study sample and through the limitations of documentary analysis in being able to fully understand underlying ideologies and motivations which underpin such documents. Accuracy of representation was also unable to be verified, for example whether staff levels, role descriptions and qualifications were correct. However, it was professional representation that was the focus of this study. The study was also limited by lack of patient input into how website information was understood and interpreted, from which future research would benefit. As would exploration of other forms of media such as Facebook and Twitter which were beginning to be used by a minority of practices.

This study achieved its aim of gaining a snapshot of the representation of the outward-facing public image and macro level professional identity of ANPs, relative to other professional groups. It highlighted that little attention appeared to be focused on websites in general, and professional group representation specifically. The study developed

understanding of the extent to which patients could be involved in decision-making about healthcare providers and how this may influence acceptance and utilisation of ANP practice. Moreover, a potential lack of critical mass of ANPs in general practice was identified and it was recognised that ANPs, and nursing more broadly, lacked visibility both absolutely and in relation to GPs. It also identified that professional groups were ascribed differing levels of professionalism in order to maintain traditionally demarcated professional roles and status. Themes of Visibility, Prominence and Consistency and Levels of Professionalism were identified as means by which professional identities, roles, jurisdictions and professional hierarchies were maintained. It was also recognised that in order for medicine to retain its position in relation to patients, maintenance of its position relative to nursing was necessary. Furthermore, mismatch between policy drivers and the realities of delivering healthcare appeared to create tensions between maintaining professional identity and meeting service needs, which may impact on the success of different ways of working. The themes of Visibility, Prominence and Consistency and Levels of Professionalism were carried forward to inform the thematic framework of analysis of the subsequent ethnographic study, along with concepts developed from Social Identity Theory and Positioning Theory, grounded in Bamberg's (1997) three levels of analysis. The following Chapters present findings from the subsequent ethnographic study.

6. Ethnographic Study Findings: Practice Overview and Establishing Trust

6.1. Introduction

Chapter 5 explored website study findings and identified themes informing the ethnographic study. This Chapter and Chapter 7 reports on the findings of the ethnographic study. It begins with an overview of the two study sites in order to provide a 'grand tour' of sites as identified by Whitehead (2005, p15), to set the scene before refining identified themes. Themes are then explored in detail, leading to a discussion in Chapter 8 which brings together the study findings in relation to the current literature and from which I draw conclusions.

6.2. Overview of Study Sites

The study sites consisted of two general practice groups in England, Oakcroft Alliance and Moorfield Practice (pseudonyms). Sites were selected for maximum variation in relation to number and experience of ANPs, practice exposure to ANPs and differed in a variety of ways including size, structure and organisation. Descriptive data for both sites are set out in Table 13. Oakcroft was a group of practices led by one overarching practice, while Moorfield was a single practice of typical size. Outlines of both sites are set out, and initial similarities and differences discussed. Data collection was carried out between September 2015 and March 2016.

Site	Total Patient Population	Population Deprivation Decile*	Number of ANPs	Number of GPs	Number of Practice (Registered) Nurses	Number of Health Care Assistants
Oakcroft Alliance	39,938	3-7	6	30	15	6
Moorfield	12,458	3	1 + 1 trainee	9	3	3

* Public Health Profile Population Deprivation Decile: 1=highest deprivation, 10=lowest deprivation

6.2.1. Site 1: Oakcroft Alliance

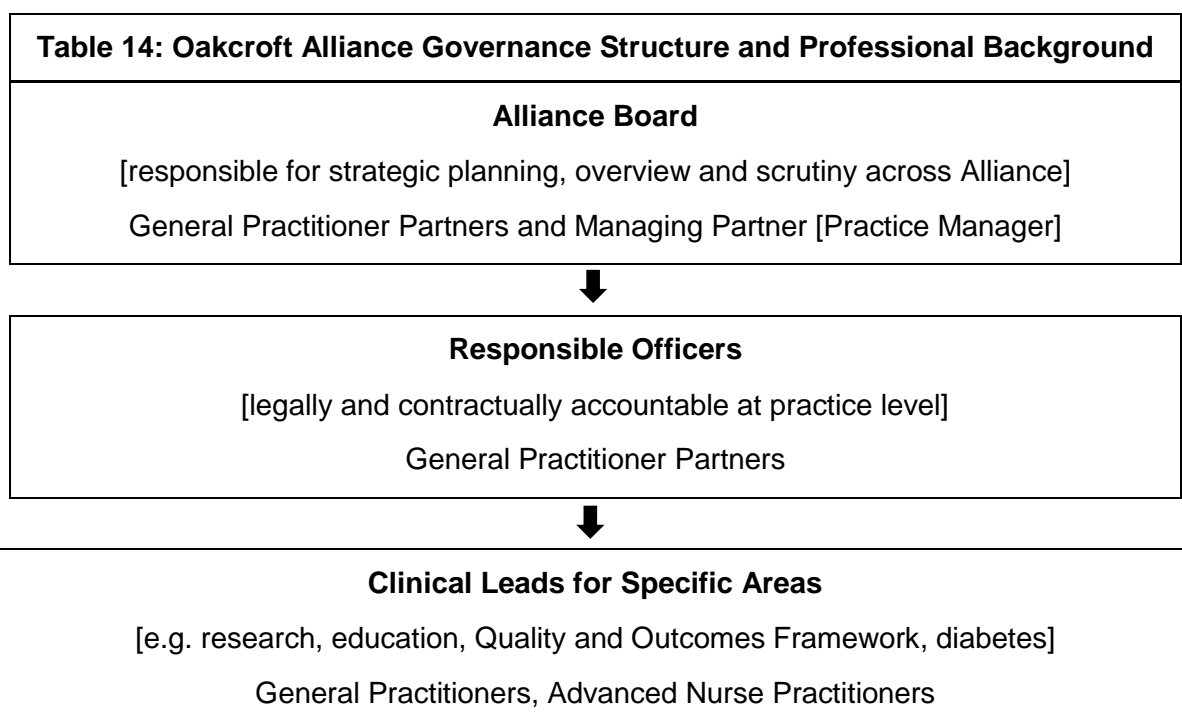
At the time of data collection, Oakcroft was an alliance of six general practices under the leadership of one principle practice of the same name. One practice was under temporary management by the alliance and was excluded from the study. The principle behind this model was to create an economy of scale to streamline non-clinical functions such as administration, management, human resources and to standardise clinical pathways, while maintaining a distinctive individual identity for each practice. The plan was to incorporate additional practices in the future. It was expected patients would be able to recognise distinctions between practices within the alliance, but have an expectation of a specific standard of care.

we've got continuity of care and keeping that NHS feel to those sites...but at the same time getting the benefits of a bigger corporate structure...Each practice is known as its practice but then it's secondary that they're part of a bigger group of practices. [Manager 3 Interview, line 32]

Practice populations ranged from high to lower deprivation and were predominantly of white British origin. The lead practice was situated in the centre of a small town, close to another practice in the alliance. Other alliance practices were located on the outskirts of a large nearby city. The bulk of data collection occurred at the lead practice because all the ANPs worked there in some capacity. Observations and interviews also took place at three other alliance practices and at a local business centre where a full alliance meeting was held.

The lead practice building was modern and purpose built, as were the others in the alliance. It had an attached pharmacy and a small car park, with parking reserved for doctors near the entrance. Others, such as the community matron, were issued on-street parking permits. The practice housed district nurses and health visitors. It delivered a number of specialist services to other practices in the area, led by GPs with special interests (GPwSIs). This included a tertiary cardiology service within which two specialist ANPs worked. Specialist hospital outreach services were also hosted at Oakcroft.

The alliance was headed by a partnership board of thirteen, made up of twelve GPs and one non-clinical managing partner. The board had a clear leadership and governance hierarchy (Table 14). Board members were responsible for developing strategy and held overarching accountability across the alliance. The next tier in the governance structure were 'responsible partners' who were accountable for performance at individual practice level. All responsible partners were GPs. Below this were clinical leads with responsibilities either within or across individual practices, although the responsible partners retained overall accountability for each practice. No nurses were partners or board members, however some ANPs held clinical leadership roles in long term condition management. Previously one ANP had been termed a 'clinical partner' although this had ceased when the new board structure was implemented. Each practice had a non-clinical patient services manager responsible for day-to-day running of the practice.



The lead Oakcroft Practice was a teaching and training practice offering placements for medical students, foundation year doctors and general practitioner registrars. Pre-registration nursing students were placed with the district nursing team. One ANP was involved in supervision of medical students and foundation year doctors. She retired part way through data collection and her supervisory role was taken over by a salaried GP.

Oakcroft Alliance was keen to present itself as pioneering and at the forefront of service delivery and innovation under the direction of the lead practice partners.

that all stems from Oakcroft Medical Practice and the innovation and the leading edge that Oakcroft has been. You know, over the years it's been first wave fund holding practice, first PMS practices. It's had clinicians in it that have worked for, been clinical leaders for the NHS, they've been chief execs of PCTs. It's the culture of this practice to be working in the system to know what's coming, so being prepared and saying, 'Oh we'll try this' [Manager 3 Interview, line 321]

To this end a number of distinctive roles had developed over time. One ANP had first trained and then worked at the lead practice for over twenty years. She was one of the first nurses in the region to train in the role, which was initially funded by an external NHS funding source. The practice had provided placements for trainee ANPs and nurses undertaking prescribing courses, although it had not employed further ANPs until more recently, in response to GP recruitment shortfalls. The alliance, however, had chosen to move towards utilising these ANPs in a different way from the established ANP role as a primary diagnostician, but rather used ANPs in a predominantly specialist role

So we've been looking at developing different sort of hybrid roles really, so nurse practitioner role we've had for a long time. The practice has always valued that role. We had [ANP] who was one of the [first] nurse practitioners in [city] many years ago, so always been innovative in that thinking and accepting, you know, the nursing in that role. We've then since moved on to specialist nurses...So they're not sat in the building seeing general patients like our traditional roles of a nurse practitioner did. [Manager 3 Interview, line 72]

The lead Oakcroft practice had recently become involved in training a physician associate and supported the development of innovative healthcare assistant roles, 'I've just become assistant practitioner in cardiology...so I had to go to university to get the Foundation Degree' **[Health Care Assistant 1 Interview, line 3]**. Innovative roles, including ANPs, were seen as a way of making general practice viable within the context of the current challenging climate and decreasing medical workforce.

inevitably there are going to be more nurse practitioners. Why? Because the doctors are going to leave en-masse, so therefore the only way GP practices can survive is to train its practice nurses...there's loads of pharmacists unemployed so we've got that body that we can pull on.
[GP3 Interview, line 601]

Oakcroft appeared to have a stable workforce that was proud to be part of an alliance with an innovative reputation and, for its part, the alliance board expressed recognition of the value of a happy and well supported workforce. However, the pace of change had been difficult for some and there appeared to be top-down implementation of some working practices.

It would probably be more accurate to say we are informed of decisions rather than consulted or have any input...It's changed a lot. You can speak your mind and they are good at listening, but sometimes you just have to accept the changes, but it is not all good. Some people have left because they don't like it. **[Practice Nurse 1 Interview (not audio-recorded), line 51]**

In terms of organisational practicalities for Oakcroft patients, GP and nurse appointments were mainly pre-bookable via telephone, online or in person. GPs were responsible for on-call and emergency surgeries. One ANP worked on a part-time basis in the core role of providing routine generalist appointments where patients presented with undifferentiated diagnosis. She also provided follow-up and review appointments as well as crossover/overspill work from the practice nursing team (e.g. asthma reviews). She retired

during the course of the study and her role was not replaced in a similar capacity. Two further ANPs had hybrid roles, dividing their full-time roles between routine generalist appointments and nurse specialist roles. Two others worked full-time in a specialist nurse capacity only. The remaining ANP was termed a community matron and worked on a part-time basis with a pre-defined caseload of frail elderly patients. No ANPs undertook on-call responsibilities and, with the exception of the community matron, did not carry out home visits.

There was lack of clarity among members of the wider practice team about whether patients were informed they would be treated by an advanced nurse or general practitioner when they booked appointments. Both interviews and observational field notes demonstrated this.

I asked what happens when booking an appointment with the ANP. [The receptionist] said, 'well, patients request her by name as they know her. But if the doctors are full and we say "you can have an appointment with the ANP", some patients say "I don't want to see a nurse, I want to see a doctor" so we tend not to tell them she's a nurse anymore'.

[Observational Field Notes Oakcroft, line 792]

When patients attended the lead Oakcroft practice, they were called to their appointment via an electronic screen displaying their name. Consultation rooms had a clinician's full name on the door. GPs had the prefix 'Dr' and practice nurses and one of the ANPs were prefixed with 'Sister'. Only one ANP had a dedicated consultation room, while the others mainly worked out of one consultation room, which had the name of a GP on the door. Non-clinical rooms were based on the first floor and a large open plan office housed the administration team, with the community matron's desk in the corner. There was also a large meeting room and a small staff room. The staff room was very busy and appeared to be where most informal and semi-formal conversations and 'corridor talk' went on. Doctors and ANPs did not wear uniform, but dressed smartly. Practice and district nurses wore a recognisable nurse's uniform of dark blue tunic and trousers, while health care assistants wore the same uniform in purple. Practice nursing and administration/reception team members wore name badges, but doctors and ANPs did not.

Oakcroft held a weekly working lunchtime multidisciplinary team meeting which all available GPs, registrars and foundation year doctors attended, as did the two ANPs based at the lead practice and the trainee physician associate. Other ANPs occasionally attended in their role as Long Term Condition Lead. The practice nurse manager represented the nursing team, while a representative from the district nursing and health visiting teams attended parts of some meetings to discuss issues relating to their caseloads. Meetings were predominantly clinical and chaired by a senior GP partner, with another GP partner documenting on the computer. Clinicians added names of patients to a computerised list prior to the meeting, who were then discussed. Full alliance team meetings were held off-site on a monthly basis to which both clinical and non-clinical team members were expected to attend. The practice nursing team also held separate regular meetings and I was told ANPs held occasional meetings, but none occurred during data collection.

Each practice in the alliance had a separate website providing information to patients about the practice, services and staff. Websites were based on a template, but populated in different ways. ANP representation across websites is summarised in Table 15. In line with website study findings, there was inconsistency in ANP representation across the alliance, both within and between websites and in comparison with GP information. ANPs lacked representation on appointments webpages and clinics and services webpages. Specialist ANP roles were not represented, except for Practice 3. In some cases information was outdated and inaccurate. In contrast to most websites in the website study, one practice included the name and qualifications of one ANP at the bottom of the 'Doctors' tab.

Table 15: Website Representation of ANPs at Oakcroft Alliance						
Practice	Appointments Webpage	Clinic and Services Webpage	Clinical Staff Information Webpage	Qualifications Stated	Additional Information Explaining ANP Role	Comments
1	x	✓	ANP Information on Nursing staff Tab	Partial	Partial	Refers to 2 ANPs only despite all 6 working at Practice
2	x	x	ANP Information on GP tab	✓	x	
3	x	x	ANP Information on Nursing Staff Tab	✓	✓	
4	x	x	ANP Information on Nursing staff Tab	x	x	
5	x	x	No Information	x	x	Specialist, but no generalist ANPs

6.2.2. Site 2: Moorfield Practice

Moorfield Practice was situated in a large multicultural city and was a single practice based across two sites. Both main and branch surgeries were close to the city centre in busy residential and commercial areas. Patients could chose to attend either surgery, and staff worked across both sites. The surgeries were modern, purpose-built premises with the main surgery having an attached commercial pharmacy. The main site was surrounded by a large car park, mainly reserved for staff. While the practice was called Moorfield, a large sign in the grounds stated 'Doctor [Surname] and Partners' with 'Moorfield' underneath. The bulk of data collection occurred at the main practice as this was where the majority of staff spent most of their time, where the management team were based and where meetings were held. Two interviews were conducted at the branch surgery.

The practice was of average size, with a high proportion of the population of south Asian origin. It was owned by a partnership of four GPs, with a further salaried GP and an ANP termed 'associate partners'. Managerial and strategic oversight was provided by a practice manager who, while not a partner in the business, appeared to exert significant influence.

So I have full responsibility for all clinical, non-clinical...I do everything from financial planning and budgets and forecasting to strategic development of the business. Business plans to the day-to-day management and general, you know, kick up the arse when required [laugh], you can quote that! [Manager 2 Interview, line 5]

The stability of the practice, in common with other general practices, was perceived to be challenged by the current climate within the NHS. This had implications for how the practice might develop in future.

surviving at the moment in terms of current political context, because general practice is struggling, we're struggling in terms of GP retention and GP recruitment...we're sort of held ransom by our budget

to some extent...we are tied by our budget which obviously we need to work to in order to be stable as a business **[ANP2 Interview, line 332]**

Moorfield was a training practice for general practitioner registrars and provided support for the practice's case manager who was training as an ANP. The established ANP was involved in supervising both. The practice also provided pre/post-registration nursing placements. Physiotherapy services, health visitor and district nursing teams were also attached to the practice. Administration and reception teams were led by their own manager as was the practice nursing team.

From a patient's perspective, most appointments for GP and nurse consultations were pre-bookable by telephone, in person or online. The ANP was included in the GP rota and undertook acute home visits and on-call responsibilities as part of her remit. The trainee ANP held a pre-defined caseload of elderly frail patients. She had recently started an advanced practice course so was shadowing GPs and the qualified ANP at the time of the study.

Telephone appointments were available with GPs and the ANP. A minor illness walk-in clinic ran each weekday morning, staffed by either two GPs or a GP and the ANP. Like Oakcroft, the practice policy about whether patients were told their appointment was with a general or advanced nurse practitioner was unclear. While the practice manager stated patients were not told, 'No they won't differentiate' **[Manager 2 Interview, line 133]**, the reception team reported patients were always informed. From observation and reports from others it became apparent this was inconsistent.

[the receptionist] was answering the phone...She did not inform patient that [ANP] was an ANP. A little while later I asked whether she always informed patients. She said 'yes, we always do' and another member of the reception team confirmed this. **[Observational Field Notes Moorfield, line 370]**

Consultation rooms for GPs and the ANP led directly off the main waiting area while practice nurse rooms were situated down a separate corridor. The clinician's full name was on the door of the consultation room. GPs' names were prefixed with 'Dr' and the ANP had no prefix or title. The ANP worked in a shared room. GPs and ANPs did not wear uniform or name badges. Reception and administration team members wore a uniform in corporate colours and a name badge as did practice nurses, whose uniform was not a traditional style, but resembled a uniform more associated with beauty therapists.

The reception office appeared to be the hub of the practice where members of the team met and chatted both informally and more formally. The practice held weekly lunchtime meetings which were described as multidisciplinary and consisted of the practice manager, all salaried and partner GPs, the ANP and case manager, the human resources manager (who took minutes) and the practice nurse manager and reception manager who represented their teams. When the practice nurse manager was away, no replacement from the nursing team attended. The practice meeting was led by the practice manager and followed a regular format. General issues were discussed during the first part of the meeting. The practice nurse and reception managers then left and further clinical matters were discussed. These were led by GPs or ANPs who had responsibility for specific clinical areas, although the practice manager continued as chair. District nurses and health visitors regularly attended parts of the meetings to discuss specific issues relating to their caseloads. Full team meetings were held once every three months and included all members of the practice team. The ANPs and practice nursing team appeared quite distinct from each other. ANPs did not attend nurse team meetings and there was little cross over between roles, 'I think the roles have been pretty different from day one really' **[Practice Nurse 5 Interview, line 186]**. However the practice nurse manager, ANPs and district nurse team leader did meet to plan the introduction of domiciliary long term condition management provision, which was led by the ANP.

Moorfield Practice had previous experience of training and employing several ANPs. The reasons ANPs left the practice were unclear. Some related it to personal reasons, while others suggested the management system actively managed out those who were not aligned with the practice ethos.

We did recruit another nurse practitioner and she didn't stay very long, she wasn't very good. We had to performance manage her out of the business quite quickly. Her skills were not what we would have hoped and she wasn't an experienced nurse practitioner, so again we were a bit wary. [Manager 2 Interview, line 38]

Past experience made Moorfield cautious about employing further ANPs and there was a break in ANP employment for several years until the current one joined approximately three years before this study began. This was in response to difficulty in recruiting GPs. The trainee ANP was then employed as a case manager. She was already known to the practice as a community nurse and was identified as being capable of developing into the role. In order to support this, the practice negotiated funding with local commissioners, without which Moorfield would have had difficulty supporting ANP training or any future role.

We would not have been able to bring [ANP] into the business if I didn't have funding to support it and that was the crux really...If we hadn't have had that I don't know if we would have had [ANP] here [Manager 2 Interview, line 47]

Like Oakcroft, Moorfield had a website which provided information to patients and the wider public. Consistent with the website study, information on ANPs across the website was minimal and limited compared to GPs. Information about the qualified ANP was provided under the 'nursing staff' tab. Partial qualifications were stated with a very brief description of the role. In variance to the website study, the ANP was referred to on the 'Seeing a GP' appointments page. However, there was an absence of information about the trainee ANP/case manager.

6.2.3. Cross-Site Comparisons

Study sites were selected to offer a broad range of experience in relation to practice populations, organisational structure, size of workforce and particularly make-up of the ANP workforce. Due to the overarching structure governing general practices, there were inevitably some similarities between sites as well as a number of differences, thus allowing both comparison and contrast. Table 16 details patient feedback as published on

the NHS Choices website at the beginning of data collection (September 2015). Oakcroft rated more highly for overall service and had a greater proportion of patients who would recommend the practice to others. The percentage of patients satisfied with GP and nurse consultations was similar both across sites and across professions, although it was unclear whether ANP consultations were considered as GP or nurse consultations.

	NHS Choices user ratings (out of 5 stars)	% Patients who would recommend practice	% Patients satisfied with GP consultations	% Patients satisfied with nurse consultations
Oakcroft	5	96 (among best performing practices nationally)	90 (average)	85 (average)
Moorfield	3.5	72 (mid-range nationally)	92 (better than average)	90 (average)

In common with the national and international picture, both sites were facing financial constraints, changes to workforce capacity and clinical staff shortages, as well as increasingly elderly populations with complex co-morbidities. Oakcroft Alliance presented itself as an innovative practice of longstanding, at the forefront of service development at local and national levels and well suited to meeting and leading strategic development of general practice. Moorfield positioned itself as working hard under a newer management initiative to develop and maintain quality of patient care and achieve financial stability within the current challenges to primary care and the NHS more broadly.

Oakcroft had worked with one ANP for many years, until recently recruiting others. Moorfield, despite working with ANPs in the past for short periods of time, had only established the current role relatively recently. However both practices had turned to ANPs in response to GP shortages, although each site utilised ANPs in different ways.

Both employed ANPs with a range of experience from established ANPs to those less experienced in the role. Some ANPs had worked as a lone ANP within a practice, while some had experience of working in a team.

The commonalities and differences between the two sites allowed breadth and depth of understanding about the continuing establishment and utilisation of ANPs in these contexts, embedded within primary care teams and within the current dynamic and challenging healthcare environment. The information presented in this overview sets the scene for the findings elicited during collection and analysis of data. First, participant characteristics are described.

6.3. Participant Characteristics

A wide range of participants were recruited to the study across both sites. Some participated either in observation and interview, others in both. In total 30 participants were interviewed including all nine ANPs. Eight out of nine ANP participants were female and all but one had a specific ANP qualification or were working towards one. An ANP at another practice [ANP9] was recruited through snowball sampling via Oakcroft ANPs and is included with Oakcroft ANP characteristics in Table 17. Table 18 describes Moorfield's ANPs.

Participant Identifier	Qualification	Role	Interview	Observation
ANP1	MSc Nursing BSc Nurse Practitioner 1990s	Generalist	✓	✓
ANP3	PGDip (ANP) 2006	Community Matron	✓	✓
ANP5	PGDip (ANP) 2014	Hybrid Generalist/ Specialist	✓	✓
ANP6	MSc (ANP) 2000	Hybrid Generalist/ Specialist	✓	✓
ANP7	MSc (ANP) 2006	Specialist	✓	✓
ANP8	MSc Nursing (No specific ANP qualification)	Specialist	✓	✓
ANP9	MSc (ANP) 2012	Generalist	✓	x

Participant Identifier	ANP Qualification	Role	Interview	Observation
ANP2	MSc (ANP) 2008	Generalist	✓	✓
ANP4	Studying towards PGDip (ANP)	Case Manager	✓	✓ (consultations not observed)

All members of the primary healthcare team present during data collection took part in the study to a greater or lesser extent, including members of administration and reception teams and wider practice team members. Significant contributions of primary healthcare team members are detailed on Table 19. GPs were disproportionately represented as they all attended meetings whereas other professional groups had one, or sometimes no, representative at meetings. Types of manager and seniority of GPs/practice nurses are not detailed to aid anonymisation.

Table 19: Primary Healthcare Team Characteristics			
Participant Identifier	Site	Interview	Observation
Student Nurse 1	Moorfield	✓	×
Health Care Assistant 1	Oakcroft	✓	×
Practice Nurse 1	Oakcroft	✓*	✓
Practice Nurse 2	Moorfield	✓	×
Practice Nurse 3	Moorfield	✓	×
Practice Nurse 4	Oakcroft	✓	×
Practice Nurse 5	Moorfield	✓	✓
Manager 1	Oakcroft	✓	×
Manager 2	Moorfield	✓	✓
Manager 3	Oakcroft	✓	✓
Manager 4	Oakcroft	✓	×
Manager 5	Oakcroft	×	✓
Receptionist 1	Moorfield	✓	✓
Receptionist 2	Moorfield	✓	✓
Receptionist 3	Oakcroft	✓	×
Receptionist 4	Moorfield	✓	✓

Physician Associate 1	Oakcroft	✓	✓
Medical Student 1	Oakcroft	✓	✓
GP Registrar 1	Moorfield	✓	✓
GP1	Moorfield	✓	✓
GP2	Oakcroft	✓	✓
GP3	Oakcroft	✓	✓
GP4	Oakcroft	x	✓
GP5	Oakcroft	x	✓
GP6	Oakcroft	x	✓
GP7	Oakcroft	x	✓
GP8	Moorfield	x	✓
GP9	Moorfield	x	✓
GP10	Moorfield	x	✓
GP11	Moorfield	x	✓
GP12	Moorfield	x	✓
District Nurse 1	Moorfield	x	✓
District Nurse 2	Oakcroft	x	✓
District Nurse 3	Oakcroft	x	✓
Health Visitor 1	Moorfield	x	✓
Health Visitor 2	Moorfield	x	✓
Health Visitor 3	Oakcroft	x	✓

*not audio recorded

6.4. Presentation of Findings

Several ways of presenting findings were considered. One was to separate macro, meso and micro levels of identity. However, it became clear these levels were enmeshed to the extent that such presentation lacked structural clarity and lost context. It was also necessary to present findings across sites. This was both to aid anonymisation and because, while both sites were initially analysed separately, cross-site analysis was then undertaken to compare and contrast findings and draw deeper insight. Therefore, study findings are presented thematically for structural clarity, with shared themes and differences across sites highlighted.

Themes identified were:

- Levels of Identity, Layers of Trust
- Hierarchy, Power and Professional Identity
- Identity in Practice -Negotiating Professional Relationships.

The remainder of this chapter explores the association between trust and identity, while the following chapter focuses on the relationship between professional identity, power and hierarchy and well as how identity underpins professional relationships. Findings and analytical discussion with reference to the literature are presented concurrently where appropriate in relation specific themes. These are then drawn together and related to the literature more broadly in Chapter 8. This is because ethnographic practices are essentially non-linear. That is, exploring findings, analysing, drawing from other literature and writing are concurrent analytical processes (Hammersley and Atkinson, 2007; Van Maanen, 2011), which build detailed understanding of the culture explored.

6.5. Levels of Identity, Layers of Trust

Trust was a significant theme emerging from the study data. Trust between members of the primary healthcare team appeared to be multi-layered and grounded in professional identity at individual, relational and group/social/institutional levels. First trust of ANPs, then ANPs' trust of others is explored.

6.5.1. Trust in ANP Practice

From management and GP perspectives, both study sites felt it was important to employ ANPs they trusted. This was based on past negative experiences of working with ANPs and a perception of variability among ANPs which was not present when employing GPs.

the GP would expect to be up and ready and running to see anything, make decisions about anything and manage everything that is thrown at them straightaway. With a nurse practitioner I wouldn't necessarily expect them or want them to be doing that. I want them to very much work within their own competencies which are going to be very variable [GP1 Interview, line 61]

All GPs and senior managers interviewed expressed concern there was wide variation, not only in the roles ANPs were prepared to undertake, but also quality in terms of standards and level of practice.

I still think there is more variation in the skills of a nurse practitioner and experience than there are amongst doctors... I'm more confident that the doctor I get through a locum is going to be nearer to our doctor's experience than if I try to get a locum nurse practitioner, because there's such variation of what is meant by a nurse practitioner... So when you get hold of a good nurse practitioner, they're good but our experience is there aren't a lot of them about. They're few and far between. [Manager 3 Interview, line 176]

Such perceived variation limited practices' willingness to employ ANPs because, while practices were satisfied with the quality of ANPs in their employment, concern remained that these practitioners were the exception rather than the norm and that 'there is quite a wide variance in ability and that's difficult to employ' [Manager 2 Interview, line 322]. It was not that practices could not recognise the value of effective ANPs, but rather they had found - or assumed - practitioners of the required calibre were not readily available, 'we

keep saying “where on earth are we going to get another [ANP] from? There just isn’t one”.’ [Manager 3 Interview, line 651]. Consequently, practices considered themselves ‘lucky’ [GP2 Interview, line 374] to have high quality ANPs working at their practice, but were not sure this could be replicated.

our nurse practitioner functions pretty much as a salaried GP, so yes she could make an individual difference. As a group, I don’t know if that’s the case [GP1 Interview, line 131]

This was something that was capitalised on by some ANPs in the study and it was ANPs themselves who most clearly articulated perceived variability in the quality and standardisation of other ANPs. Drawing on lack of ANP regulation in England, ANPs positioned themselves as different to other ANPs who may be less effective, less trustworthy or less competent. This was explicit in interview and also implicit in the way they presented themselves to others within the primary care team and to myself as an audience for their narratives. They utilised shared concerns within the practices to their advantage by positioning themselves as different to other ANPs, thereby shoring up their position in the practice.

I know some nurse practitioners won’t see babies under 6 months, they won’t see pregnant women, they want 15 minute appointments and they won’t do on-calls and they won’t do visits. Probably in their mind they’re working in their competency. I imagine colleagues will see that as being fairly fussy about their role and not as broad minded as a GP who will just take anything on. I just take on what feels comfortable and what I feel competent to be able to deliver as I’ve gone along with my role really and I think that maybe some of the reason why people say I’m not like an ordinary nurse is I probably do more when you compare me to those other nurse practitioners who aren’t as comfortable [ANP2 Interview, line 515]

It was not only during formal conversations that ANPs expressed these views. It became clear that for some ANPs this was a narrative that threaded through informal conversations, while others used narrative stories to position themselves favourably in comparison to *normal* ANPs.

Walked to meeting room with ANP, she asked me what other ANPs at other practices in my study were like. I started to say ANPs I had encountered worked to a high standard, but she interrupted when I said 'they are-' and she said 'very variable'. When I said, 'no, I've found them to be very good' she said 'oh' pulled a face and sounded surprised. [Observational Field Notes Oakcroft, line 286]

Individual ANPs not only positioned themselves as different to other ANPs, they also positioned ANPs as unlike other nurses. ANPs utilised traditional perceptions of nursing identity to position themselves as more capable, competent and risk tolerant than other nurses.

suddenly it's your responsibility to come up with the problem, the solution, the diagnosis, the treatment, sign the prescription, it's really scary stuff and its definitely not for everybody and it, you know, it's not that you're better than them it's just that, you know, you're wired differently and you're willing to take that risk and I think if you want to be a nurse practitioner you have to accept that grey area of not always knowing what to do and being outside your comfort zone [ANP1 Interview, line 321]

As a consequence, there was scepticism as to whether there was a critical mass of potential ANPs with the ability, desire and motivation to take on the role, again strengthening the position of ANPs currently in practice.

I think there's a mismatch between sort of policy makers' ideas and what nurses actually see as a position that they want to find themselves in. I spoke to the district nurse and the practice nurse, how they feel about upping up their skills...and they just don't want to know. So I'm not sure that that level of autonomy is what a lot of nurses want. I think they are quite comfortable with working within protocols and guidelines...So I don't think they are the answer. I think nursing is in crisis anyway in terms of recruitment and retaining staff and trying to attract nurses to do a nurse practitioner role which a lot of nurses see as having an awful lot of responsibility and it's not going to appeal [ANP2 Interview, line 256]

The simultaneous positioning by ANPs as different to the majority of nurses and dissimilar to ANPs as a professional group, can be seen as a mechanism by which ANPs further protect their position within practices. Indeed there was some indication that ANPs did not actively support other nurses to develop by implying most nurses were unsuited to advanced roles and suggesting there was no practice requirement for further ANP roles.

There wouldn't be another role for another nurse practitioner to be fair. There are 3 practice nurses, one of them has done her nurse prescribing...In my experience she doesn't prescribe hardly ever, so she doesn't appear to have a confidence around it...the other practice nurse who is keen to do her independent prescribing and has articulated aloud that she's going to do it, but again that's more of a personal desire than any sort of PDP [professional development plan] or anything which is identified that would be useful for her to do. [ANP2 Interview, line 341]

In this way ANPs were positioned as individual, relative to both nurses and other ANPs. This perceived individualism requires exploration. Some ANPs recognised that nursing as a profession was culturally not always supportive of other nurses, both at individual and professional levels. One ANP suggests, 'sometimes nurses are a bit harder on each other, when sometimes maybe they don't need to be' [ANP6 Interview, line 214], while another is more blunt, 'a lot of that is just females and being together and being catty which is what a life time in nursing I'm fully aware what women are like together' [ANP2 Interview, line 328]. For one GP this was part of the identity of nursing, 'some of that is nursing. I've worked with nurses a long time, no disrespect' [GP3 Interview, line 668].

That ANPs positioned themselves in an individualistic way can be seen as a consequence of a lack of a cohesive professional identity, where this is perceived as a social (group) level of identity. Drawing on Social Identity Theory, the very variation and lack of clarity within advanced practice means there are few shared norms and beliefs to mediate the shaping of a shared ANP professional identity. As a consequence, ANPs as a group can be seen as unsuccessful in forging a strong internalised group identity while failing to develop a powerful public image of advanced nursing, thus minimising their strength as a professional group. So while an ANP's personal credibility and value were promoted by individual ANPs positioning themselves as different, special or unique, ANPs as a professional group were less successful in strengthening advanced practice as a profession.

ANPs in this study were generally supportive of the other ANPs they worked with or knew, it is rather *unknown* others, or previous colleagues, who were positioned as being of variable quality. This is reflective of Social Identity Theory which describes the often negative stereotyping of out-group members in order to increase in-group prestige (Burford, 2012) and can also be seen in the positioning of ANPs as different to other nurses, who were stereotyped as risk averse and lacking confidence. In these ways unknown ANPs and non-ANP nurses were presented as homogenous others in order to increase the capital of the current ANP workforce.

people I've met, you know, in various different roles...it's a vast variety of what nurse practitioners are doing and, I guess, if a practice or anywhere else is advertising for a

nurse practitioner post, what they would do, be expected to do, could be very wide [ANP5 Interview line 48]

As a consequence of focusing on the individualism of ANPs, there was a lack of trust in ANPs as a professional group. Literature pertaining to the introduction of new ANP roles surmises concerns about ANP practice will resolve with time and exposure to ANPs (Andregård and Jangland, 2015; Sangster-Gormley et al., 2013; Nardi and Diallo, 2013). In this study, apprehension about the standard of ANPs persisted despite exposure to ANPs working within practice teams over a number of years. This was because these ANPs were positioned as different to the majority of ANPs, for whom a large degree of suspicion persisted. For this reason, practices in this study preferred to employ ANPs they had experience of. Indeed, eight out of the nine ANPs in this study were known by, or recommended to, the practices they worked for, the only exception being the ANP who was originally seconded to the practice over 20 years ago.

We knew [ANP] through personal contacts...so just asked to meet with her and see what I thought and whether she'd fit into the team and did just that. We had no job description. We had no advert for an advanced nurse practitioner. It was very much about employing the individual [Manager 2 Interview, line 21]

That ANPs were known to the practice prior to employment was not merely a matter of coincidence or ease, but rather an active decision which differed from the way practices recruited GPs, 'I don't think I would ever put out an advert for an ANP and accept any applicant' [GP3 Interview, line 224]. Trust was limited to ANPs of whom practices had experience.

I think it is entirely because it's about trust and so it's about, I think, if they knew of another nurse practitioner who one of the partners or members of the team had experience of and who they trusted and I think my gut instinct is they would more than happily employ more nurse practitioners. I think they're probably not so willing to

employ nurse practitioners who they have no experience of previously and so they don't know what standard they work to so I think that they prefer to employ people who they know **[ANP5 Interview, line 103]**

Manager 1 acknowledged that while the practice preferred to recruit ANPs through prior knowledge or recommendation, this had the potential to be problematic. This was supported by an ANP who reflected that while practice decision-makers may support ANPs with whom they have a good relationship, this did not always transfer to effective ANP practice.

there was a lot of familiarity with [them] personally, but actually objectively I wouldn't have put either on the [ANP] course because they were very comfortable as a practice nurse and they knew how to do chronic disease management very well and that's what they were comfortable at, is following national guidelines and following protocols and flow charts, but actually put them in a position where you're effectively working on your own and thinking independently didn't suit either of them. **[ANP2 Interview, line 292]**

The practice of employing ANPs who were known or recommended to the practice could be seen to significantly limit the scope for employing ANPs. This was particularly because practices were becoming less keen to support ANP training due to funding issues. Consequently, the number of ANPs practices were exposed to was further reduced. Despite both sites being exposed to ANPs for a number of years, their experience remained limited.

I suppose they haven't got that much experience of nurse practitioners training through the practice...there were nurse practitioners who were training who were looking for sites to train and I know that Oakcroft wasn't able to offer those nurse practitioners training **[ANP5 Interview, 115]**

During the course of the study it became apparent that personal characteristics and the relationships between practitioners and managers/employers were as important as the role characteristics of ANPs, and often took precedent. Indeed all parties recognised the need to fit with the practice ethos in order to make the role work.

for me it's always about employing the right individual with the right attitude and then, you know, clearly the clinical skills to back that up, but much more about fit for the business and their ethos and their, I suppose, overall personality sits with that of the vision of the management team. [Manager 2 Interview, line 31]

That personal characteristics and relationships between practitioners took precedence over more formal aspects of ANP employment was demonstrated by knowledge about role requirements and qualifications of ANPs. When GPs and managers were asked *what qualifications and training do you look for when employing an ANP?* responses were similar, with both managers and GPs having unclear expectations.

That they've done the basic nurse- well I can't tell you, I'd have to look back at what that actual qualification is [Manager 3 Interview, line 269]

Only one manager was aware of the qualifications, skills and experience required of an ANP as set out in the Department of Health's 'Advanced Level Nursing: A Position Statement' document (DH, 2010a) and had a copy of a recent job description to support this. Although she stated she had revised for our interview as she had anticipated I would ask this. General lack of knowledge around ANP qualifications reflected the lack of emphasis and value placed on such qualifications. Despite concerns about the variability and inconsistency of ANP practice, GPs felt ANP qualifications were less important than other qualities: 'I think it's more than qualifications. I think it's more about attitude and experience isn't it and that's the key for us really' **[GP1 Interview, line 108]**; 'Do I particularly care what the ANPs who are in my organisation whether they've got a qualification certificate or gold stars?...Just because you've got a certificate doesn't mean you're good' **[GP3 Interview line 227]**. However, practices appeared to be more confident

in trusting GP qualifications. This reflects website study findings which presented GP qualifications more consistently, accurately and prominently than ANP qualifications, indicating greater emphasis was given to medical qualifications.

I have a certificate that says I am a GP. I go through on-going state-run appraisal and revalidation, you know, I am a GP because the GMC says I'm a GP. What is a nurse practitioner and that worries me a little bit [GP3 Interview, line 208]

While it is recognised that specific ANP education and qualifications are not mandatory and there is no overarching ANP regulation in England (Freund et al., 2015), it remains that there are many accepted Master's level ANP courses and a recommended level of practice on which employers of ANPs can draw (AAPE, 2016; DH, 2010a). Therefore, why practice decision-makers emphasised individual personal characteristics of ANPs over qualifications and experience requires unpicking. Sluss and Ashworth (2007) have drawn on Social Identity Theory and Role Theory to develop the concept of Relational Identity. Through this they theorise that workplace identity is developed through relationships which mediate between an individual level of identity (person-based characteristics) and a social or group level of identity, based on the roles people play in an organisation. For successful workplace functioning to occur, it is suggested both role and personal aspects of identity need to be positively perceived. When, for example personal characteristics are viewed positively, but the role is viewed more negatively 'ambivalent relational identification' (p24) may occur, resulting in 'mixed feelings' (p24). However, this can be somewhat overcome if relationships develop which privilege personal characteristics and minimise role characteristics. In this way relational identity can moderate the effects of negative role perceptions if good working relationships, based on personal characteristics, are formed. It would appear in this study that, to an extent, personal characteristics of individual ANPs allayed the concerns of decision-makers about ANP roles and practice. However, this effect was limited because it did not extend to ANPs as a profession, but rather remained at the level of personalised relationships.

While positive professional relationships and personal characteristics were considered to counter concerns about ANP standards of practice and qualifications within the study sites,

this was not always reflected in other environments. For one ANP, positive personal characteristics and prior good professional relationships were unable to overcome several practices' concerns about ANP practice.

when I qualified as a nurse practitioner I was looking at how to go about using those skills I've learnt as a nurse practitioner. I approached some of the practices who I knew well through my previous role and I had a good relationship with, to see whether they would be interested in having a nurse practitioner and some of the practices were really, really anti-nurse practitioner and were like 'no we would never ever have a nurse practitioner and no we don't think anything of them and we don't think they have a role at all'. [ANP5 Interview, line 90]

Even Oakcroft and Moorfield, who were clearly more accepting of ANP practice, had to think very carefully about whether to employ ANPs. In some ways ANPs were presented as a last resort in plugging GP shortages rather than being a positive choice towards advanced nursing practice, 'Yeah it's come out of necessity of not being able to get enough doctors' [Manager 3 Interview 103]

So we sort of went off the idea, that was about 15 years ago and then we were going through a time where we were finding recruitment particularly difficult and started to reconsider again whether a nurse practitioner would be a useful person to have around [GP1 Interview, line 12]

Indeed, it was clear that ANP employment was a pragmatic necessity, while GPs remained the clinician of choice.

I think there is still that view that the doctors are the most efficient thing in the system still and maybe we haven't come as far as I thought in our thinking, that we're still doctor sort of driven and I think it is only the fact that the

money drives...we need to be looking at other ways of working and that's what drives us looking at other types of clinicians. [Manager 3 Interview, line 383]

One reason may be that the apparent variability in quality of ANPs meant GPs felt their role was made more difficult by the perceived need to support ANPs more thoroughly. For their part, ANPs recognised practices required a high level of competence in exchange for support.

I suppose looking at the reasons we didn't want to [have an ANP] when we had our break from employing them. The feeling that actually they may not be able to work efficiently and effectively as a salaried GP might be able to, they may need more supervision and take more time away from partners because of that and they may need limits placing on what they can and cannot do [GP1 Interview, line 187]

Related to this, from a supervision and clinical governance perspective, GPs felt that as owners of practices it was their responsibility to benchmark and supervise standards of advanced practice. GPs' position as business owners meant they had an additional overarching responsibility and vicarious liability for ANPs they employed, 'as my practices are contracted to supply a service, it's actually very much up to me to make sure that the people doing that [are] competent and the service is safe'. [GP3 Interview, line 230]

It was not only GPs, but managers, other nurses and non-clinical members of the primary healthcare team who considered it was the responsibility of GPs to ensure ANP competence. For members of reception and administration teams, as well as nurses, trust in ANPs appeared to be assumed. This was because doctors as business owners were considered responsible for assessing ANP competence and this was accepted as legitimising the ANP role. In this way doctors were trusted to ensure and vouch for ANP competence.

the amount of knowledge and skills that our ANP must have...It must be on an equal basis otherwise they wouldn't be happy with her doing that role and they clearly seem to be. [Practice Nurse 5 Interview, line 472]

Indeed, reflecting the literature review, competence and safety of ANP practice were recurring narratives throughout the study, with both ANPs and colleagues arguing there needs to be clear public protection associated with ANP practice.

Some are going to feel more competent than others but feeling more competent than others doesn't necessarily mean you are more competent than others so you very carefully need to define what way exactly [GP1 Interview, line 64]

GPs saw it as their responsibility to define ANP roles and trust in ANP practice was set within a clearly demarcated framework. This appeared to be underpinned by the distinction between what were presented as lower level skills and tacit, high level knowledge, which were seen as clear differentials between ANPs and GP practice. In this way 'advanced' ANP practice was analogous with a rudimentary level of medical skill.

it's not the basic bit because to be fair, to be honest I reckon I could teach a sixth former in 6 weeks to do some of what we do, yeah, you know, like the minor injuries, common colds, bits and pieces but it's the other bits, you know, the clinical reasoning. [GP2 Interview, line 886]

While both sites appeared comfortable with ANPs working at this level, there was mistrust in ANPs' abilities in skills which were considered to require critical thinking and higher level reasoning. This was particularly apparent in relation to ANPs' diagnostic skills and level of decision-making, with one GP expressing particular unease. This appeared to be informed by traditional understanding of medical and nursing identity, from which it seemed difficult to break.

So GPs diagnose, GPs risk assess and make decisions. That comes from our medical training and nurses come through a slightly different path and I do worry about them when we're both sat as generalist equals...we are trying to train people who have not had that very wide pragmatic approach to medicine **[GP3 Interview, line 83]**

For their part, some ANPs regularly sought support from GP colleagues and observation indicated they were not always confident in decision-making, although I was unable to directly compare GP behaviour. Likewise, some ANPs suggested they would seek advice at an earlier stage than GP colleagues and were not prepared to engage in work they considered risky. 'I won't do any risky scripts, any pregabalin, any tramadol, any diazepam...I don't do those. I take it to a GP' **[ANP9 Interview, line 529]**. This was something other team members such as GP Registrars and medical students, as well as practice management, had also identified.

for that set of patients that we saw together, if a GP saw those patients the GP would be slightly less worried. So she's almost, the nurse practitioner's almost overly safe, it was just something we all noticed actually **[Medical Student Interview, line 36]**

That ANPs were considered more cautious and risk averse than GPs was seen as a consequence of their socialisation and identity as nurses, which appeared to others to be entrenched to such an extent that this identity became fixed. While ANPs positioned themselves counter to the cautious risk averse nature of nursing identity, others perceived ANPs had difficulty moving away from this. This was considered to inhibit practice and had implications for those organising and running practices.

the other thing with the nurse practitioners, most of them won't do a home visit, so the home visits are left to the doctors and this is back to them working in a more rigid risk adverse thing. So that's a big bug bear to all the doctors and the practice that we can only water down our doctors so far because there are

still so many visits every day to be done and the nurse practitioners won't do it and then in terms of the on-call. So we've got one nurse practitioner who is part of the on-call rota and works like a doctor. The others just scare away from it and won't do it, so that's another inefficiency in the system
[Manager 3 Interview, line 417]

This caution was not considered to resolve as ANPs gained experience or the role became established, 'I've never seen that change with experience' **[GP3 Interview, line 111]**. This is of note as it indicates that, in this study, experience of working with ANPs may have contributed to and confirmed, rather than challenged, deep-rooted perceptions of ANP practice. This was significant as at Oakcroft Alliance, ultimately the decision had been taken to move away from the ANP role as primarily a diagnostician, rather increasingly utilising ANPs as specialists in a specific disease area. While this may alleviate some elements of GP workload, it intrinsically changes one of the central tenets of advanced practice; that of managing undifferentiated diagnosis. In this way traditional professional identities of medicine and nursing were maintained. Even at Moorfield, where the ANP role was more closely aligned with a traditional generalist diagnostic GP role and the ANP was observed to reliably function at a similar level as a knowledgeable GP, the difference between ANP and GP practice was clearly demarcated by GPs. Accordingly, ANPs were trusted to provide care which was considered good enough while GPs were positioned as adding value.

what that comes down to though is your background...It's very easy to look up and find the answers to questions and problems, but what you actually do is be in a position where your mind is full of stuff so that when somebody walks through the door, it triggers that memory of that problem or that way of managing. It kicks something off, so you need your background information reading skills to be able to do that and that's where one of the differences lies isn't it? What you're taught at medical school is different from what you're taught during nurse training and what you learn as a nurse practitioner is not the same basis as the medical school **[GP1 Interview, line 300]**

This again reflects the website study whereby expert GP roles were created in order to maintain GPs' position at the top of the professional hierarchy. Although in this study there was some frustration that members of the wider healthcare team did not recognise differences between roles, 'they don't recognise the things that we do and ANP doesn't do or can't do, do you get me?' **[GP1 Interview, line 398]**. However, ANPs themselves recognised GPs had lower expectations of ANPs' level of practice than they did their GP colleagues, 'the GPs they sometimes say "well you do that, I might do something different and something more complicated but don't worry about that you just do this".' **[ANP5 Interview, line 261]**. This perceived difference between ANP and GP practice led to the view that ANPs may have a negative impact on practices by increasing GP workload, creating greater disruption for patients and having cost implications for practices.

it's the percentage thing, that patients are going to go there but then that nurse is going to pass too many of them back off to needing doctor support...We've just spent money on a contract that we're just now going to duplicate because there's too many of those patients now going to see a doctor as well **[Manager 3 Interview, line 210]**

However, this perceived low threshold for referral and limited decision-making had not been quantified and despite a generalist ANP working Oakcroft for over 20 years, no formal assessment of the veracity of these perceptions had been made. Notwithstanding this, decisions about ANP roles were taken on the basis that ANPs were less able than GPs. In this way trust in ANPs was only present within parameters defined by GPs themselves.

do nurse practitioners bring back patients more often for review because of that risk adverse thing again? But we don't know because we've not got, you know - some people think that's the case - but we don't have the hard data to know if that really is the case **[Manager 3 Interview, line 445]**

Furthermore, while ANP practice was seen to require scrutiny and oversight, GPs were positioned as the gold standard against which ANPs should be judged. This was because medical training and experience was considered superior to the knowledge and experience of ANPs.

although you can learn the knowledge and the courses are very explicit in their outcomes and things like that, there is a lot to be said for experience as well. So for instance, in my 11 years of medical training...I probably saw 20,000 probably in my training before I was let loose independently. Because what worries me if you have people who've not had all that experience [GP2 Interview, line 251]

While this appears to minimise the prior experience of ANPs, it also indicates ANPs continue to be positioned within a traditional identity of nursing, which presumes secondary positioning to medicine. Indeed, one GP suggested ANP practice may become more aligned with the level of medicine, but only because medical training and experience were becoming more deficient.

In my experience working with nurse practitioners they don't quite do that to the same level that GPs do that. Now I think that might change as the GPs coming into the system, in my personal opinion, are dramatically less experienced than the GPs who came through from my generation...I think that we are seeing less experience in clinicians and that might match a route taken through nursing to get to the same place, although some nurses have had incredible careers as well. [GP3 Interview, line 64]

Indeed for those nurses who were considered to be intellectually able, a career in medicine rather than advanced nursing was considered the most appropriate option by both doctors and nurses, '[It's] as if you're too bright to be a nurse. When I worked in the hospital people used to say to me regularly, "you're wasted in nursing, you should go off and do medicine".' [ANP2 Interview, line 503]. This again reflects the traditional

positioning and professional identities of medicine and nursing, while the contribution of ANPs is overlooked. Accordingly, nurses are unlikely to be fully trusted and accepted unless they undertake medical training.

[During the MDT meeting] an informal chat turned to a current nursing student at the practice. The ANP said, 'She's really smart, she wants to be a doctor not a nurse. She's really good'. [GP] agreed 'yes she sat in with me and she corrected me on something - not something medical - but I thought she was very good, bright. [Observational Field Notes, line 399]

6.5.2. Summary

It was clearly important practices trusted ANPs they employed. However, ANP practice was circumscribed by GPs and managers, so that ANPs were trusted within defined limits. Although individual ANPs were valued, as a professional group ANPs lacked the trust of decision-makers. Their skills were seen as variable, they were positioned as risk averse and their knowledge was not seen as comparable with that of doctors. This was perceived to be, in part, as a result of socialisation and professional identity as nurses and was not considered to change as ANPs became established in practice. Perceived variability in ANP practice meant employers saw ANPs as individuals and employed those ANPs of whom they had personal knowledge or who were recommended, which could be seen to limit employment options. For their part, ANPs appeared to utilise this individualism to bolster their own position within practices through the negative positioning of other ANPs and nurses. Furthermore, professional identity could also be seen to impact on the trust ANPs had in others.

6.5.3. ANP Trust in Others

Trust was not only an important consideration for employers of ANPs, it was also necessary for ANPs to trust that practices would support them appropriately. This was something most ANPs in this study felt may not be the case, due to past experiences and socialisation as nurses within healthcare hierarchies. While ANPs reported being well supported in their current workplaces, they referred to negative past experiences which influenced their confidence in securing support in adverse or challenging circumstances. These narratives ranged from bullying, taking a previous practice to tribunal, being

ignored and being unsupported when something went wrong. ANPs attributed this lack of support to their position and identity as nurses.

I've had situations where you think you're going to be supported and you're not by the medics if something untoward occurs...basically something went wrong with a patient but it wasn't anything directly that I'd done but the family questioned my consultation with that patient. Why I hadn't picked up [diagnosis] and I'd seen them?...but [the doctor] wouldn't come in and see the patient, she was too busy and her quote was, 'it's a nurse led clinic, you don't need me, otherwise it's a [doctor] led clinic'. [ANP8 Interview, line 211]

Such narratives of past events led to the perception that ANPs were likely to be unsupported by employers, even if they currently felt supported. 'I do feel supported, but again if it became a crisis I don't know really'. [ANP8 Interview, 318]. One ANP had been well supported by her practice when a significant event had occurred, but still ANPs felt vulnerable.

I had a really difficult, difficult case all last year. I ended up having to go to coroner's court...one of the doctors took a day off and came with me, you know. They were all lovely, bought me a bunch of flowers, you know, and I couldn't have felt more supported. I couldn't have felt more than one of them. It made me feel very, very vulnerable because as a nurse you never have to go through anything like that...It was the worst experience. I could have walked away...everybody looked through everything that I did and just said, 'Look you did more than we would have done'. [ANP9 Interview, line 568]

However, it became apparent as formal interviews and informal chats when shadowing ANPs progressed, that ANPs might not always feel as supported by their current practice as they initially suggested.

I was very much given no option, right from the start they said 10 minute appointments. They allowed me two weeks of having a block every, sort of, three patients I had a bit of time to catch up, but even then they kind of said 'you have it for a few weeks, but as soon as you're comfortable that's got to go', so I do think I've no option in that area so I've accepted that as part of it [ANP 5 Interview, line 236]

This vulnerability led to a perception amongst ANPs, and nurses more generally, that they had to prove themselves to be at least as competent as a doctor.

We have to go through all this training again, we do everything spot on and perfect and this, that and the other. Whereas the GPs, it's ok for them to have forgotten the score...I do find that nurses feel that they they've always got to be ultra-safe and ultra-document, even along with all the other training that they've had before. I think we tend to be more cautious, that's the right word, more cautious. [ANP6 Interview, line 211]

Added to this, ANPs also felt vulnerable because they did not trust that they would receive support and protection from nursing's professional bodies, with some ANPs rather seeking protection from medical organisations.

It frightens the life out of me that I don't have a governing body that will stand up and understand what I do...the MDU [Medical Defence Union] were better than anything that the NMC's ever done for me and RCN. [ANP9 Interview, line 185]

Furthermore, ANPs felt exposed because they were nurses. That it was their shared identity as nurses that left them feeling vulnerable was supported by the breath of ANPs who felt this way. One ANP was educated as a registered nurse and an ANP in the USA, but shared the feeling of vulnerability with English nurses.

I think there is a feeling of vulnerability. Maybe we're all like that, I don't know but I think it comes down harder on nurses if there is an error made and it's a nurse that's made that decision. I don't know whether there is evidence for that but that's what it feels like, that it would be massive. [ANP 8 Interview, line 287]

Some GPs recognised that the socialisation and conflicted identity of nurses increased their vulnerability to blame, although conversely, others felt their position as GPs was more risky due to their identity as doctors, 'you're more likely to get sued as a doctor...and the reason for that is they expect you to get it right all the time' **[GP2 Interview, line 574]**. This was because it was perceived patients expected a clinically higher standard from doctors, while nurses continued to be considered as carers. In this way outward-facing professional identity at a societal (macro) level, i.e. the dominant public images of nursing and medicine, framed professional vulnerability to blame.

nurses have always had this view and it's beat into you right from the start...You're supposed to be clinicians making decisions in your own right, you should be the handmaid of the consultant and the servant to the patient – bollocks! But because of that perception a lack of care was blamed very, very much on the nursing rather than the institution which allowed it to occur...because the nurse wasn't a compassionate nurse they were hammered. How many doctors got heavily criticised out of Mid Staffs? Virtually none. [GP3 Interview, line 690]

ANPs considered their vulnerability was attributable, in part, to the lack of public understanding of the ANP role. Nurses were not expected to perform in roles more

aligned with medicine and there was a dissonance between public image, which privileged traditional nursing identity, and realities of ANP practice.

I think the only reason I ended up in coroner's court was because I was an ANP. I did wonder whether or not this family wondered whether they might be able to, I might be easier prey **[ANP9 Interview, line 594]**

Furthermore, this lack of trust appeared to influence consideration of advanced practice by other nurses, with the majority indicating they did not want to work at an advanced level.

I don't think I want the responsibility that comes with an ANP...oh no it frightens me...it's kind of overwhelming.
[Practice Nurse 2 Interview, line190]

There was also a perception among others that ANPs had the potential to be exploited.

sometimes I get the feeling that, I don't know it's weird like for home visits and things like that. They might get put on. 'Oh we possibly haven't got time, oh just give it to her'.
[Health Care Assistant 1 Interview, line 132]

Consequently, both Moorfield and Oakcroft had experienced little success in recruiting ANPs from their practice nursing teams. Because, as described earlier, practices in this study preferred to recruit ANPs they know and trust, such disinterest limited the options of practices wishing to develop and utilise ANPs. 'We've given them all the option and none of them are interested at all [laugh]. Not in a million years I was told' **[Manager 2 Interview, line 343]**. Additionally, newer nurses considered medicine a more viable career option than advanced practice, because medicine was seen to have a clear career structure and they were largely unaware of advanced practice. 'I think it should be advertised more and especially to student nurses'. **[Student Nurse 1 Interview, line 377]**

[Student Nurse] told me she feels it would be more beneficial to go to medical school as she will get paid more as a doctor than an ANP and there is a better career pathway.

[Observational Field Notes Moorfield, line 508]

In this study, past experiences and deeply held assumptions, grounded in nursing identity, can be seen to impact on the level of trust ANPs have in their colleagues, employers and professional associations. Such perceptions leave them vulnerable and thus impact on ANP practice. The professional identity of nursing, at macro/social/institutional level, interactional level and at the internalised micro level, all impact on ANP roles and levels of practice. Consequently, trust is a complex, multi-layered construct which has implications beyond ANPs to other areas of practice within rapidly changing healthcare workforces. In this study, the importance of trust was also apparent in the developing roles of physician associate and advanced practitioners other than nurses. This was both in relation to how ANPs and wider members of the primary healthcare team viewed such roles.

6.5.4. Trust in Wider Advanced Practice

The physician associate role is established in the USA and has recently been introduced in the UK to address medical workforce shortfalls (Drennan et al., 2014b). In this study, Oakcroft Alliance was involved in training a physician associate, while Moorfield had considered, but decided against it. ANPs in particular expressed considerable mistrust of physician associates, positioning ANPs as superior by utilising arguments originally used against ANPs. This suggests an element of role protectionism and strengthening of one's own identity through disidentification with others (Fiol et al., 2009). In this way ANPs' position was privileged over others.

*we're a sort of maxi-nurse with the many medical skills.
They are like mini-doctors, they're just a doctor minus,
they've just not got the same experience or training*

[ANP1 Interview, line 40]

Only one ANP took the counter-view. Again this was framed within the understanding that it was the person, not the role, which was key to success.

Yeah, it sounds a great idea. I think at the end of the day any role, and I'm very clear about it, I'm very clear that any role is largely down to the person...In a way I don't think it matters what you call people as long as people have the training, are competent in what they do, they know what boundaries they work within. **[ANP5 Interview, line 292]**

It is of note that the medical student interviewed in this study held similar views to the majority of ANPs, which were stated as shared by others in the profession. Lack of trust in physician associates potentially has implications for future working practices and relationships. It also exemplifies Monrouxe's (2010) assertion that medical students begin to internalise their profession's dominant purview at an early stage. This medical student clearly identified with, and aligned herself to, junior doctors in her narrative.

it makes me feel quite uneasy actually...I was talking to quite a few junior doctors there and, no just hearing about it and just, I don't know the details, but the length of time they have to train is a lot shorter than say a medical student and so it was more my view, and the other junior doctors' views, that it would be sort very, very difficult to get all of that background knowledge in that amount of time and actually that, well, the junior doctors are saying they were not looking forward to when they would have to work together because they were imagining that they would be a lot of, they would be quite a lot of friction
[Medical Student Interview, line 131]

This view was something the physician associate student had already encountered and, reflecting the ANP literature in Chapter 1, there was an assumption that exposure and time would form a solution. However, in view of the experiences of ANPs, the extent to which this was realistic remains to be seen.

in university some of the medical students don't really understand our role and they feel like we're maybe taking their jobs which is not quite true. In fact I just think once they're actually out there working with the physician associate and they actually see that we complement them rather than taking their job or anything, I think they will be more accepting because I think they don't have the knowledge about physician associates **[Physician Associate Interview, line 139]**.

It was of note that scepticism was also expressed about advanced practitioners from healthcare professional backgrounds other than nursing.

it makes you question how advanced practice will fit their roles and patient perception of a physio being able to assess you, generally assess a patient and prescribe on the back of what they see. I find that quite intriguing **[ANP4 Interview, line 50]**

some of the physiotherapists, you know, have actually trained to become prescribers and they admit that they've no idea because they've now got full access to the BNF and they've no idea about most of it. **[GP2 Interview, line 439]**

It appeared that fixed perceptions of own and others professions were not confined to nursing, but influenced trust in other professional groups, as well as potential 'new' professions. This suggests issues of identity and trust may extend to advancing roles more broadly.

6.5.5. Summary

In this study, trust was considered central to the success of ANP roles and consisted of several interwoven layers. Practice leaders emphasised the importance of being able to trust ANPs to be competent and safe, while ANPs considered it important that they were both trusted by their employers and were able to trust their employers to support them.

However, previous negative experiences, expectations and preconceptions underpinned by concepts of professional identity at different levels inhibited trust of both parties. Practices considered ANPs who were trustworthy to be special or different to ANPs as a professional group and, as a consequence, trust in ANPs did not extend to unknown others, something which ANPs themselves capitalised on. However, trust in even established ANPs appeared to be within clearly demarcated parameters, set by GPs and managers. For their part ANPs suspected practices had the potential to be unsupportive, even in the light of counter-evidence, and this left them feeling vulnerable. This was amplified because ANPs did not trust their professional associations to adequately support them and did not feel the pervading public image of nursing represented their roles. In addition, there was an expectation from members of the wider primary healthcare team that GPs as practice leaders were responsible for monitoring and legitimising ANP practice, while some mistrust of similar emerging roles was also evident, particularly among ANPs and medical students.

In relation to Social Identity Theory, professional groups maximise differences between themselves and others by emphasising in-group cohesion and maximising out-group differences. This can be seen in the presentation of doctors as a homogenous group in terms of standards, while ANPs are considered to be of variable quality. In this way the medical profession can be seen as more successful in developing a cohesive group identity thus strengthening their professional position, while ANPs continue to be appraised at the level of individual characteristics and their relationships with other team members. While this may be a successful strategy for individuals, the differences attributed to ANPs by both ANPs and others professional groups, can be seen to have a negative effect on ANPs as a profession more broadly and has the potential to limit more widespread utilisation of ANPs.

Positioning Theory suggests individuals create identities by narrating stories about themselves in relation to others. These narratives are underpinned by past events and pre-existing master narratives and are constructed to present to an audience. In this study ANPs appeared to draw on master-narratives and past events which positioned ANPs as vulnerable, despite overtly stating they felt supported by the practices they worked for. In this way the strength of previously developed beliefs was greater than positive or neutral current experiences. However, there was an underlying counter

suggestion that ANPs were not always as well supported in practice as they presented themselves to be. For their part practices characterised ANPs as being inconsistent in terms of standards, with the ANPs they employed positioned as different from their professional group. This led to the ANPs themselves gaining a position of relative power as individuals. Again this focus on individual characteristics meant that as a professional group ANPs were seen as less successful, with practices questioning the standard of ANPs as a profession, again limiting ANP practice both in terms of scope and critical mass. Furthermore, the positioning of GPs and managers, by themselves and others, as adjudicators of ANP practice led to the ascription of ANP practice parameters by medicine and management. Consequently, ANPs continued to be situated relative to traditional perceptions of nursing identity and established healthcare hierarchies.

In this study, trust within primary healthcare teams was inextricably linked to professional identity and this influenced how ANP roles were enacted in practice. Perceived inconsistency and vulnerability of ANPs impacted on the way ANPs practiced and the roles they delivered. ANPs continued to be situated within traditional nursing identity and within established healthcare hierarchies. This positioning of ANPs is discussed in Chapter 8. First, Chapter 7 presents further study findings.

7. Ethnographic Study Findings: Professional Identity in Practice

7.1. Introduction

As demonstrated in Chapter 6, professional identity played a significant role in shaping ANP roles and practice in relation to trust as a multi-layered concept. It also provided an explanatory framework through which such practices can be explained. This chapter explores two further themes identified as impacting on ANP practice and explores professional identity in practice: Professional Identity, Hierarchy and Power and Identity in Practice – Negotiating Professional Relationships.

7.2. Professional Identity, Hierarchy and Power

A theme emerging from the data which influenced the role and position of ANPs was the relationships between professional identity, hierarchy and power. While the hierarchical nature of healthcare organisations is not a novel finding, it was found to have a significant impact on the position of nursing in general, and ANPs specifically in this study. It was also of value to explore where ANPs were positioned by themselves and others within such hierarchies and how power differentials affected ANP roles. This section explores the structure of general practice and ANPs' position within it. It then goes on to explore the relationship between ANP practice and decision-making power and then considers the role of professional identity in influencing and maintaining hierarchy and power.

Study sites presented themselves as non-hierarchical: 'we're not hierarchical. We're really all very flat' [**Manager 1 Interview, line 301**]; 'I don't see a pyramidal structure. I don't see the GP at the top. I don't see me being better than the receptionist' [**GP3 Interview, line 677**]. However, it was apparent practices had a distinct hierarchy with GPs positioned at the top and nurses in a secondary role. This hierarchy was demonstrated in the organisational structure of each site and could be seen more subtly in the way practices functioned. Firstly the organisational structure of the practice, and ANPs' and nursing's position within it, is considered, then hierarchical functioning within practices is explored.

7.2.1. Organisational Structure of Practice Sites

As described previously, the Moorfield Practice partnership consisted entirely of GPs, while the Oakcroft Alliance partnership was made up almost exclusively of GPs with the exception of the practice manager, who was a full equity partner. Neither practice at the time of data collection, nor ever prior to this, had ANPs or nurses that were full equity

partners. 'Board level is for the owners, so you know, it's not that they [nurses] are not represented but you have to be an owner of the practice.' **[Manager 2 Interview, line 215]**; 'we're a GP partnership you see and because we're a GP partnership, we have no nurse partners' **[GP3 Interview, line 483]**. One senior GP thought partnership was only open to GPs within their current partnership agreement, despite the practice manager being a full equity partner and the GMS Contract (2004) opening up partnership to non-medical colleagues. 'Because you're not a GP and we have a partnership model you can't be on the board.' **[GP3 Interview, line 508]**. However, Moorfield and Oakcroft differed in the level of strategic influence held by ANPs.

At Moorfield, while nurses were not positioned at the highest partnership level, the established ANP was an associate partner. Both she and a salaried GP had successfully been accepted on a practice programme to gain experience of practice partnership, although the practice did not commit to a future partnership role.

For avoidance of doubt, this offer and your appointment as an Associate Partner will not admit you to the Partnership. Instead it will give you an opportunity to learn what is involved in being an Equity Partner of the Partnership and give the Partnership an opportunity to evaluate your suitability for admission as an Equity Partner in the future **[Letter of Appointment of Associate Partner, page 1]**

This was seen as a way of retaining effective practitioners in the face of GP shortages. However, it was unclear where the programme would lead and there was no set time or framework within which full partnership would be achieved, 'whether this partnership opportunity is available I have no idea because nobody has revealed their hand' **[ANP2 Interview, line 396]**. Indeed associate roles were seen as a way of motivating some practitioners without the need to offer full partnership.

partnership still might not be right for people, but is it that we can keep people engaged by having an associate partnership for ever and a day? You know, so if they know that they're getting financially rewarded, which they do if they deliver a piece of work, that might be enough.

[Manager 2 Interview, line 268]

The ANP's position came about largely from the support of the practice manager. That backing from powerful decision-makers and influencers within the practice was important was acknowledged by ANPs.

I went for the associate partnership partly because I was leaned on quite heavily by my employer to go for it. So [Practice Manager] was very keen that I went for it, I think because she wanted to sort of recognise sort of my contribution to the practice to be fair and wanted to retain me. [ANP2 Interview, line 420]

Management and GPs stated associate partnership meant the ANP made an equal contribution to decision-making. However, the ANP felt ultimate decision-making remained with the full equity partnership.

I still feel that the weight of the decision-making is given to the partners, the proper partners who have an interest in their business... You almost feel you don't have the same authority as them because you are not partner and there is a distinction [ANP2 Interview, line 450]

The ANP was seen as bringing a different viewpoint to GPs because she was a nurse. This was framed within a characteristic master-narrative of nursing identity – that of being an emotional nurse. It was this which was seen to distinguish ANPs from GPs, who were positioned as rational decision-makers.

[ANP's] biggest challenge is I think as well, because she is a nurse, is all patient focus, all clinical, quite emotional and a lot of her things she'd like to do gets a challenge from me that says, 'okay well how are you going to cost that? How are you going to fund it?' **[Manager 2 Interview, line 254]**

For her part, the ANP presented an anti-business narrative, 'I know where my skills lie and it's not understanding how a business works.'**[ANP2 Interview, line 456]**. Rather she considered her motivation was to achieve a high level position in behalf of nursing, 'I was motivated to go for it just to get a nurse on the board to be fair.'**[ANP2 Interview, line 425]** Thus, it appeared there was a dissonance between the reality of business partnership and the status of being a partner. This appeared somewhat contradictory because business decisions impact on clinical practice and in order for nurses to engage in strategic decision-making, it is necessary to be involved in business aspects of partnership. Furthermore, while the ANP considered she had achieved this position on behalf of nursing, other nurses did not recognise this as such.

HA: *Do you feel that as a nurse you're represented at board level?*

PN: *I don't know because you don't get any feedback on that.*
[Practice Nurse 2 Interview, line 193]

Indeed, there was a feeling practice nurses would never be considered for a strategic level role because of their identity as nurses. The implication was that by behaving more like a GP, the ANP was able to achieve this status within Moorfield.

I felt disappointed that she was considered for that and I wasn't, but I do remember thinking at the time, 'what does a nurse have to do to get invited to be an associate partner?'. Yeah I did think that. I mean I wouldn't begrudge her anything. I think she's absolutely fantastic but yeah there was a little bit of me that thought, 'well

yeah I wonder how many associate nurse partners there are?’ [Practice Nurse 5 Interview, line 195]

The ANP, however, perceived she had a different skill set and characteristics to other nurses which made her a suitable choice for associate partner. Reflecting an earlier narrative, the ANP positioned herself as different to other nurses. By creating a role for herself alongside GPs her outward identity as a nurse was minimised, particularly in the view of other nurses.

[Associate partnership] wasn’t offered to the practice nurses or the nursing staff and to be fair, I think that’s fair because in terms of what they are talking about, it is higher level thinking and that’s not to dumb practice nursing down, but I’m not entirely confident they would be able to even deliver. [ANP2 Interview, line 409]

To me she doesn’t represent nursing, no in all honesty, because it’s a very different role to the nursing role that I do myself and think about when I think about general practice, so I consider her more of a GP than a nurse [Practice Nurse 5 Interview, line 501]

At Oakcroft, the situation was more complex. There was no representation of nursing at a higher strategic level. While GPs and managers interviewed said it was being considered, it was not a priority. Even if eventually fruitful, the alliance were considering a lead nurse position, not board positions for ANPs or nurses per se.

So we’ve got them at clinical lead level but there’s not actually somebody sat on the board yet because we’ve not worked through what that lead nurse is and what we can afford them to be. [Manager 3 Interview, line 263]

The alliance had a complex system of associate and shadow partners with the potential to become full equity partners. However, no ANPs or other nurses were on this

programme. The alliance structure was set out in a document which made reference only to general medical practitioners as associate or shadow partners, although the practice manager, who herself was a full equity partner, suggested that this was an oversight and strategic level roles were open to both GPs and ANPs. Because the explanation of the structure was complex, the following quotation has been reorganised in order to form a more coherent illustration.

we have people that are full equity partners and they sit on the partnership board and they are formal partners...then we also have some salaried roles where they are what we call associate partners and they're still salaried but they take on delegated duties from the other partners to manage a particular site as if they were a partner...Whereas the true formal partners are looking after a site but they're also looking after the entire thing and so the salaried associate partners are taking a lot of partner responsibilities for a particular site and focusing there...the shadow partners are actually going to buy in...So they've been shadowing on the board. If you're an associate partner for that site, you wouldn't attend the board meetings because the board meetings are around more everything...one of the nurse practitioners she's shown interest in the past of maybe wanting to be a full partner and, you know, we wouldn't have anything against that...if we get the right person then it doesn't matter, you know, what profession they are. [Manager 3 Interview, line 518]

However, it remained there were no ANP full equity partners, associate partners or shadow partners despite the practice employing ANPs for over 20 years. It was of note that an ANP had previously been termed a clinical partner but, from the viewpoint of others, this was seen as little more than a title and the arrangement had ceased. It was clear from how different parties talked about this, that the ANP in question had little control over what had happened to her.

Unfortunately for [ANP] that was a complete fudge to her situation...she was given the sort of title of being a partner but was never formally a partner. She was always an employee...so we just cleaned up what the real position was later on than what it had been at the front. I think [ANP] should have been given a proper option to be a partner at that time but wasn't. It was a fudge I think to personally appease her at that time and then she worked a long time believing she was a partner and being sold to everybody else as if she was a partner, but she actually wasn't ever formally a partner. [Manager 3 Interview, line 479]

It was kind of, it was a fudged partnership, it wasn't a very well, legal. I didn't buy in. It was for a number of years. I was, sort of, my name was on the letterhead...I was kind of dubbed 'clinical partner' and I did negotiate a very good pay scale for myself so it was kind of, I felt, the best of both worlds. I was getting a kind of senior management role in the practice, I was paid well for what I did, I was recognised for what I did, I was on a par with the GP partners, but I didn't have to kind of buy in. In the end it's quite complicated, I still don't know how I feel, to be honest, about how the end of that arrangement was actioned. I think that I was let down a little bit, it kind of it just suddenly dissolved [ANP1 Interview, line 118]

However, the alliance was planning to make significant changes to its partnership structure and was considering forming a 'John Lewis' style partnership where employees were shareholders. This would be a radically different model for general practice, although it would still require strategic clinical leadership and board level direction. While it was implied that all levels of strategic leadership would be available to nurses as well as GPs, it remains to be seen whether such hierarchical breakdown will occur.

It may be as a consequence of the lack of nurse representation at a strategic level, that the alliance had no strategic plan relating to ANPs. The alliance was undergoing a series of reforms, but it appeared that the role of nursing, and ANPs specifically, was not at the forefront of this.

HA: *Can you tell me a bit about the practices' strategy in relation to nurse practitioners?*

GP: *That's a difficult one because there's no actual strategy or official strategy with regards to nurse practitioners* **[GP2 Interview, line 371]**

It was of note that, for their part, some ANPs had given little consideration to the role of ANPs at a strategic level, while others had tried to challenge the lack of nurse representation, 'No, when they presented this I stood up and said, you know, 'where's our nursing representation?' **[ANP3 Interview, line 226]**

HA: *Is there any nurse representation at board level in the alliance?*

ANP: *Oh good question...No I don't think there is...There's been no mention of nurse representation at the moment really*

HA: *And are there any opportunities for nurses to become partners?*

ANP: *Well I assume so. I've never really asked* **[ANP7 Interview, line 498]**

While some ANPs had not considered the value of nurses having strategic level influence on decision-making, some ANPs felt that decisions were made about, rather than by, nurses. This was important for two reasons. Firstly it highlighted the perpetuation of longstanding concepts of professionalism in terms of medicine maintaining jurisdictional control over nursing. Secondly, because medicine and management influenced the future direction of nursing, the shape of patient care was consequently impacted. Furthermore, ANPs saw the high level involvement of ANPs within practices as recognition and acceptance of the contribution ANPs make, something that it was acknowledged that the alliance had yet to achieve.

when you see a nurse practitioner as a partner and making decisions, I think that is very forward thinking of the practice, to really put a stamp on how they value a nurse practitioner, and therefore nurses, and all that goes with it. So yeah, I think there's also that status thing, of saying 'actually we value our nurse practitioner so much we made them a partner and we think they were so beneficial' and I think that sends a statement out to everybody that's around. (Pause) We're not there yet here. [ANP6 Interview, line 504]

Although there were differences between Moorfield and Oakcroft, it was evident that in relation to formal hierarchical structure, medical practitioners remained in an overall position of power, with strong input from managers. For ANPs their status as nurses within the practice hierarchy affected their contribution to strategic decision-making and their influence within the practice, which in turn impacted on the role and positioning of ANPs and nursing more broadly. In some ways nurses seemed to passively accept their position within their practice's professional hierarchy which created and maintained a power differential between professions, although there were some exceptions to this. However, it was not only in the formal organisational structure of practices in which professional hierarchies were apparent. Professional hierarchy was also observed and narrated more informally in the ways both Moorfield and Oakcroft functioned as organisations. That is, the way hierarchy was displayed and presented in everyday events.

7.2.2. Organisational Functioning

Hierarchy was implied and reinforced within day-to-day functioning of both study sites. This was demonstrated through observed behaviour and narratives, which were subtly framed in hierarchical ways, 'you're working down the chain aren't you' **[GP1 Interview, line 283]**. The way GPs talked about and presented themselves served to remind others of their position within the practice. They positioned themselves and other GPs as senior to, and supervisors of, nurses.

Informal chat before meeting started. Senior partner was telling a story and said 'not that seniority matters here, but I am the senior partner' **[Observational Field Notes Oakcroft, line 67]**

Hierarchy was apparent within the structure of multi-disciplinary clinical team meetings and was played out by both doctors and nurses in their interactions with each other. GPs often took a central role in meetings with nurses positioned subordinately. The behaviour of some nurses could also be seen to contribute to their subordinate positioning, 'Practice nurse offers to give up seat for GP – he declines'. **[Observational Field Notes Moorfield, line 682]**

the senior partner took charge of the meeting and logged on to the computer. No one considered starting the meeting without a GP being present...Apparently any clinician can add a patient to a list on the computer system and then the team will discuss the patient. In reality the majority of patients were added by GPs. The district nurse brings her list of patients on a piece of paper [rather than putting them on the computer which the GP then does]. GPs ran the meeting, controlling the computer and documenting notes. GPs also raised patients they wanted to discuss and clinical issues. While other clinicians were involved in the part of the meeting relating to them, only GPs were involved throughout the meeting. Both the district nurse and health visitor left after their part of the meeting. **[Observational Field Notes Oakcroft, line 159]**

[At the multi-disciplinary meeting they discuss Any Other Business]. GP registrar asks his queries. Practice nurse then puts her hand up (no one else does this) and says 'I've got something'. GP partner starts talking at the same time. Practice nurse defers to him, but he lets her go first. **[Observational Field Notes, Moorfield, line 726]**

However, the positioning of ANPs at multi-disciplinary clinical team meetings varied between Moorfield and Oakcroft. At Moorfield, the ANP positioned herself more centrally, while at Oakcroft, like the practice nurses, ANPs played a more peripheral role. In the meetings at Moorfield, the ANP appeared to overtly adopt a principal role. She took an active part in most aspects of meetings, and volunteered to take responsibility for leadership roles or projects whenever they arose. She positioned herself both physically, and through her behaviour, as close to GPs and distanced herself from other nurses. Moorfield's trainee ANP mirrored the established ANP's behaviour.

It is noticeable that ANP reports on something at each meeting I've attended and [trainee] ANP routinely reports on 'her patients' **[Observational Field Notes Moorfield, line 608]**

For the ANPs at Oakcroft, their participation in meetings was more peripheral. This could be seen to leave them marginalised, sometimes to the point of invisibility or being ignored, 'GP4 arrived [at MDT meeting] and said, "Is no one here?" presumably meaning "are there no GPs here?" as other healthcare professionals were there'. **[Observational Field Notes Oakcroft, line 155]**

[At MDT meeting] ANP started to talk about one of 'her' patients. GP said 'we need to get on because we've got a lot to get through' so this was not discussed further. ANP told me last week she considered the MDT meeting to be her clinical supervision as she doesn't have any formal supervision and this concerned her because she was the only one seeing her patients and didn't want to miss anything. At the meeting 'her patients' and the unplanned admissions she had put on the list to discuss were not really discussed, she just said 'put them on (the computer) as "discussed at MDT meeting".' **[Observational Field Notes Oakcroft, line 1017]**

The reasons why ANPs at each site may have been positioned differently requires exploration. At Moorfield the ANP's role was much more closely aligned with that of a traditional GP and the ANP expended a great deal of time and energy in performing at the level of a GP, talking like a GP and taking on traditional GP roles. She also positioned herself as distinct from the other nurses at the practice. This role may be seen by doctors as more valuable than an ANP role more aligned with nursing. More pragmatically, they may also appreciate that the ANP volunteered to take on such a heavy workload, thus reducing theirs. Furthermore, this ANP was supported and included by the practice manager, who led the meetings, while at Oakcroft the meeting was led by GPs. At Oakcroft ANP roles were more diverse and closer to an extended/specialist nursing role rather than a GP substitute role. Such roles can be seen to fit within a traditional professional identity of nursing, leading to the perpetuation of the longstanding subordinate position of nursing within practice and professional hierarchies. It appears that unless ANPs recognisably behave like GPs to powerful decision-makers, their status remains fixed.

In relation to Positioning Theory, ANPs could be seen to be influenced by a traditional 'passive nurse' master-narrative, which colludes to maintain traditional professional identities and established hierarchies. ANPs may not recognise this as such, but rather see themselves as experienced nurses pragmatically managing their workplace. In terms of Social Identity Theory, GPs may be more accepting of roles which are recognisably similar to their in-group values and beliefs. Moreover, ANPs may struggle to disassociate from longstanding and sometimes subconscious underlying beliefs about what it is to be a nurse. This is relevant not only because it impacts on how ANPs behave within inter-professional interactions, but because these ANPs can be seen as role models for less experienced nurses who are socialised to create their own professional identity through such role modelling. It was clear that for some ANPs traditional notions of the position and identity of nursing persisted, 'I'm from the old school of nurses where – I mean when I started nursing we were handmaidens for doctors. We did do things for doctors and we did like to be helpful' [ANP9 Interview, line 299]; 'what I do is still nursing. I don't have to be wearing a frilled apron' [ANP1 Interview, line 263].

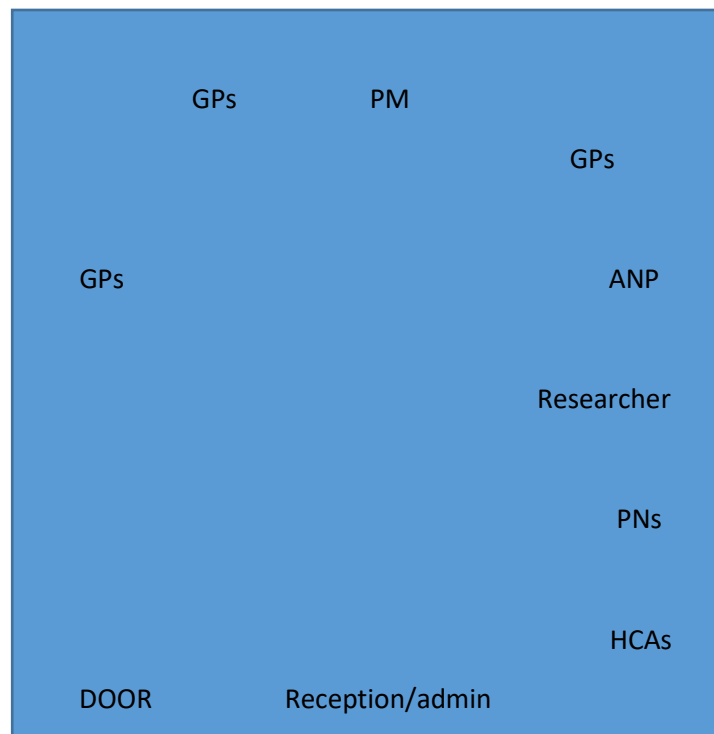
These ANPs drew on traditional nursing narratives to maintain a nursing identity in the face of more medicalised role development. However, this identity may make ANPs less

visible and leave them in a more marginalised position within the practice. How ANPs contribute to clinical team meetings is important because the focus of these meetings related to patient care and clinical decision-making, as well as planning of services. If ANPs' input into such decision-making is minimised this ultimately impacts on the shape of patient care. Furthermore, if ANPs are required to behave in a similar way to GPs, this limits the scope and usefulness of multi-disciplinary team meetings.

Professional hierarchy not only played out at multi-disciplinary clinical team meetings, but was also evident at larger team meetings which were held regularly at each practice for both clinical and non-clinical colleagues. At both Moorfield and Oakcroft, professional silos were evident, which sometimes led to tensions for ANPs whose role did not fit neatly into such differentiations.

[At full team meeting] Groups sat in professional silos in a large circle i.e. GPs together, reception/admin staff in another group and practice nurses together. Practice manager sat next to GPs. I was sat between ANP [who sat next to the GP's] and practice nurse [Observational Field Notes Moorfield, line 57]

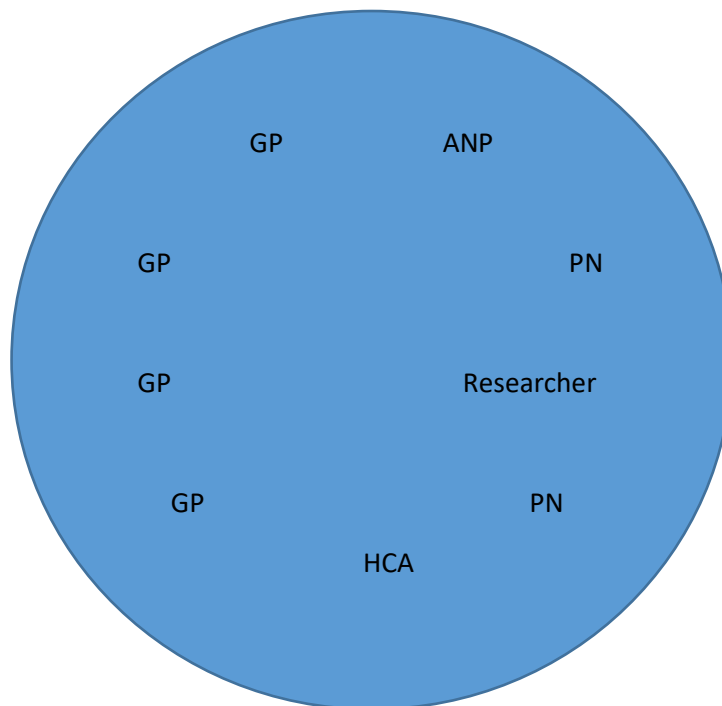
Figure 2: Room Seating Plan - Moorfield Full Team Meeting



As Oakcroft was a much larger organisation, the structure was more complex. The six practices within the Oakcroft Alliance met once a month at a local business centre and followed the same structure of sitting within professional silos.

The meeting took place in a large room. There were large circular tables and the staff I recognised sat at tables within practice groups and different professional groups sat next to each other within these practice groups. I sat at the same table as an ANP and practice nurse I had met previously. We were joined by another practice nurse who sat at the other side of me, with the HCA next to her. Four GPs then took the remaining chairs and sat next to each other [starting next to the ANP, then filling up empty seats]. All were from the same practice within the alliance. Non-clinical colleagues from the practice sat at another table. [Observational Field Notes Oakcroft, line 816]

Figure 3: Table Seating Plan - Oakcroft Full Alliance Meeting



It was of note that ANPs at Oakcroft recognised the tension experienced during these meetings related to their tenuous place within the professional hierarchy and their own perceptions of their professional identity within nursing. There was a dissonance between the professional identity to which ANPs aligned themselves and the role they performed.

when [ANP] and I first started the [protected learning time] events were, occasionally they'd have sessions where it was nurses in one room and doctors in another and we didn't quite know which room to go in because [ANP] seemed to sit in with the doctors, [ANP] hovered and then went with the doctors but then, you know, I suppose it would depend on the subject matter. I guess we saw ourselves probably more listening in on the clinical stuff that the doctors were getting, but no one really said one way or the other and we kind of just had to make our own mind up about it...Do you stay in allegiance with the nurses or do you go sit with your clinical medical colleagues? It's a difficult one really isn't it? You're kind of caught between the two...I kind of feel, you know, as I say an allegiance to the nursing profession, but then some of the conversations perhaps you want to have about these things it's a chance to catch up with people you don't normally have a chance to sit down and have a catch up with and perhaps those are the kinds of conversations you want to be having with the partners and the medical staff, so yeah it's a difficult one. I don't know the easy answer to that.

[ANP7 Interview, line 555]

This tension ANPs felt between allegiance with the nursing profession and the perception that they were more closely aligned with GPs in terms of level of practice was manifest in the narratives of many ANPs. It was evident that where professional groups were situated within practice and professional hierarchies had an impact on the division of labour.

there's this new faecal test for inflammatory bowel disease and there was debate at the practice level about whose responsibility it actually was to do the test, because it's not very pleasant doing it, as to whether that should be the GPs within the consultation or whether that should sit with the practices nurses and they do it and put something on the system. And when it was being debated, because obviously no one massively wanted to do it, I couldn't really work out who to side with [ANP5 Interview, line 145]

However, despite this dissonance between role and identity, ANPs were reluctant to relinquish their identity as nurses. This is illustrated by a matter that had arisen at Oakcroft. The alliance had identified an issue with patients accessing ANPs. There was a perception patients preferred to consult with doctors rather than nurses, particularly if they felt their condition was more serious. In this way it appeared that patients, as well as professionals, participated in the perpetuation of healthcare hierarchies, 'if they've got something more complex they want to see somebody who they think is better'. **[GP2 Interview, line 912]**

Their first preference still now is a doctor and they feel like they've got a second class service if they've not seen the doctor...If we've got so many patients going round the system because they've seen the nurse practitioner and they're not happy and still feel like they haven't had the service that they want because actually the service they want is a doctor. [Manager 3 Interview, line 141]

To counter this the alliance were considering changing the title from advanced nurse practitioner to advanced clinical practitioner, 'getting rid of the nurse title in some respects may actually help' **[GP2 Interview, line 155]**. However, this was something ANPs expressed ambivalence about. It is of note that at this point ANPs had not been consulted on the change of title, 'we've not spoken to the nurses about it in terms of

dropping that nurse word but I think that's where we we're sort of going' **[Manager 3 Interview , line 634]**

*I'm very adamant I want nurse in my job title rather than just clinical practitioner. I would want nurse in there somewhere...Yeah it matters to me because that's my identity, you know, that's what I've been trained, that's what my training is and I think that's important to hang on to that. **[ANP8 Interview, line 387]***

That it was important for ANPs to retain their identity as nurses was met with some incredulity from GPs, who felt nurses contributed to maintaining their subordinate image. GPs considered rather than trying to change an entrenched system of professional identities and hierarchies, a more practicable solution would be to simply change the title. This was because advanced practice would never be considered equitable with medicine while ANPs remained positioned as nurses by both colleagues and the public.

*lots of people want to keep lots of titles, [it] tend[s] to be people who felt they've had a struggle...Whereas I think if you want to try and, I suppose a more equality in sort of patient views, colleagues views, you need to show that people have got similar skills, but also recognise the diversity so I actually think clinical practitioner is sort of better. **[GP2 Interview, line 172]***

How this would play out in practice remains to be seen because it appears that professional identity is ingrained at a fundamental level. To simply remove the nurse title ignores the fundamental and subconscious positioning of nursing within professional hierarchies as demonstrated in this study. This potential solution was devised by GPs and managers. ANPs had not themselves suggested a solution. Indeed it was unclear if they were even aware there was a problem, as they did not refer to patient acceptability as an issue and they had not yet been consulted about the title change at the time the study was being conducted. This again indicates the lack of strategic decision-making and influence

of ANPs. It also poses questions about patient decision-making and whether patients should be aware of the profession of the clinician they are engaging with.

For reception and administration colleagues, hierarchy in relation to ANPs was displayed in numerous informal ways. For example, at Moorfield, the ANP's position within the practice's professional hierarchy affected how reception staff interacted with her. This was something the trainee ANP identified and I witnessed during observation.

I went back down to the reception office. The reception staff were talking about an incident at the surgery when a fire exit door was left open. They were having a laugh and saying that a ghost might have been responsible. I went in half way through the conversation, but they started telling me about it and involved me in the conversation. However, when the ANP walked in they all immediately stopped talking and got on with their work.

[Observational Field Notes Moorfield, line 917]

Although some colleagues positioned ANPs at a similar level to GPs and also perceived that GPs saw ANPs in this way, others including ANPs, were not convinced this was the case. This was because ANPs' identity as nurses continued to subsume the more medical role they performed.

R: *I would class [ANP] as a doctor.*

HA: *And do you think that the GPs would class [ANP] as one of them?*

R: *Probably not, it's sort of cliquey isn't it?*

HA: *Do you think so?*

R: *Yeah you know at school when you have your little cliques, I think like [ANP's] just in her own team and then you've got like your doctors. [Receptionist 1*

Interview, line 56]

It was not always GPs, but managers who continued to position ANPs as subordinate within traditional professional hierarchies. However, GPs did little to challenge this.

I think in the ethos of the practice I'm up with the doctors but in the manager's eyes I'm still a nurse...I have this conversation quite regularly with them and the doctors understand that, but they let the practice manager just get on with it. [ANP9 Interview, line 407]

For their part, managers suggested equivalency between GPs and ANPs, something which was sometimes contradicted on reflection.

we wouldn't just go 'well that's a doctor, we'll have the doctor over the nurse practitioner'. We would genuinely look at, well it would have to be an exceptional nurse practitioner and a doctor that we weren't that impressed with to make us chose the nurse practitioner over the doctor. [Manager 3 Interview, line 463]

Moreover, some ANPs felt their contribution was not always recognised because they continued to be positioned by others within a nursing identity.

I'm a member of the board and I have associated responsibilities around - I lead for prescribing, I lead for unplanned admissions, I mentor somebody doing a Master's which the practice receives back-fill money for and I lead on various QoF areas. I've got a GP with specialist interest qualification and I'm about to do another one and I am paid significantly less than a newly qualified salaried GP and there is no getting away from that...[I'm an] experienced nurse practitioner, doing the job over 10 years and on paper everything, my CV, when they've evaluated my practice, my patients, my colleagues, it's all marvellous and then why I should receive less when I have more responsibility than a

newly qualified GP who is doing less than me does not make sense. [ANP2 Interview, line 191]

Such status differentials led to a lack of parity between GPs and ANPs. Because ANPs were positioned within a nursing identity and not as doctors, practices were able to justify such disparity. ANPs also highlighted that their identity as nurses influenced their ability to negotiate within this framework.

Oh no there's not parity. There's not parity in recognition, salary, things even like annual leave. Study time I think that's negotiable and certainly because I was employed by the practice I negotiated my terms and conditions when I moved over, but having said that I didn't really because I'd always worked for PCTs before, so it was all in a set package and so perhaps I could have negotiated more if I had the nous [ANP3 Interview, line 460]

7.2.3. Summary

It was clear that power, ownership and hierarchy within these general practices was created and maintained through a complex blend of variables which drew, in part, on long-held underlying beliefs about what it is to be a nurse or doctor. These beliefs were not only held internally by the practitioners involved, but also externally by others who have notions of medicine and nursing within which ANPs do not quite fit. Although the practices in this study may have considered themselves to be non-hierarchical, this was not reflected in the positioning of doctors and nurses within traditional professional hierarchies, as identified through observation of activities within practices and in narratives presented by participants. This impacted on ANP practice from a strategic level down to the everyday practicalities of delivering patient care and the perception and treatment of ANPs by others within practice teams. For their part ANPs appeared to struggle with their conflicted positioning and professional identity within traditional professional hierarchies. It was evident that a professional lifetime of socialisation had contributed to the positioning of ANPs within practices. For ANPs it appeared that managing, rather than overtly challenging, established professional identities and hierarchies was a tool by which ANP practice was negotiated and established.

7.3. Identity in Practice - Negotiating Professional Relationships

7.3.1. Introduction

In the previous section it was demonstrated that ANPs continued, to a large extent, to work within established professional hierarchies and a traditional professional identity of nursing. In this section, it is argued that because ANPs' professional identity and place in the hierarchy is less established than for other roles, their ability to negotiate within this environment resulted in the long term success or otherwise of the ANP role.

ANPs recognised the importance of effective working relationships within primary healthcare teams. Because the ANP role was considered to be novel within traditional professional hierarchies and identities, ANPs considered that it was their responsibility to negotiate these relationships and make them work, 'I felt that it was up to me to say what I could do and to show people' [ANP3 Interview, 423]. ANPs were aware that not only did they need to negotiate an effective working relationship with GPs, they were also required to mediate their role within an established nursing hierarchy and the wider practice team. Some ANPs had an overt awareness of the necessity to negotiate professional relationships, while for others this was something they appeared to do on a more implicit level. Either way, ANPs adopted a number of strategies in order to establish and maintain their role. The strategies identified were categorised as: utilising the doctor nurse game; professional dirty work; conciliating nursing. This section explores each in turn.

7.3.2. Utilising the Doctor-Nurse Game

ANPs acknowledged that skilled negotiations were required in order to establish and successfully maintain ANP roles within the primary healthcare team. In relation to GPs, ANPs drew on past experiences and pre-existing master-narratives of how doctors and nurses were expected to behave in order to locate their role within the established system. In particular, this was related to Stein's (1968) theory of the Doctor-Nurse Game. Experienced nurses in this study continued to draw on this theory to explain the behaviour of themselves and others.

there's a theory called the nurse-doctor game we got told [about] at my nurse training and I was outraged by it. How ridiculous, how ridiculous is it to say that these professional people play a little game together and all of

that? And I thought 'it's absolutely appalling' and, of course, then you start working as a nurse and you realise that everyone is playing that game and it's absolutely true

[ANP5 Interview, line 437]

The Doctor-Nurse Game was first described by Stein (1968) to articulate the complex negotiations and behaviours that take place within professional hierarchies which maintain the status of both doctors and nurses. This required the adoption of professionally stereotypical roles by both parties. In this theory, doctors were required to maintain the perception of their status as powerful, though benevolent, decision-makers, while nurses were expected to subtly infer contributions without challenging the overarching status of medicine. This theory has been subsequently challenged by those, including more recently Stein himself (Stein et al., 1990) who argue nursing has become increasingly professionalised and medicine more democratised, leading to a balancing of roles and an end to the Doctor-Nurse Game. However, aspects of the Doctor-Nurse Game were evident throughout the study across different nursing roles.

While ANPs were central to the study, how other nurses behaved and were regarded was of interest because this influenced how nursing as a profession was situated within healthcare teams and how nursing was viewed by wider professional and organisational networks. It also indicated the landscape within which ANPs were expected to negotiate their roles and relationships. In this study nurses demonstrated the Doctor-Nurse Game by using indirect means of achieving outcomes in a non-threatening way. This was exemplified by a nurse who asked a question at a meeting, but instead of challenging the answer, sought other means of getting the outcome she wanted. Another example was of a group of nurses who wanted a letter to be written on their behalf by a GP, because they felt it would be better regarded than a letter from a nurse. However, instead of simply requesting this, an elaborate game was played out.

[Nurse] talks about a patient's clinical issue...[Agreed] how to respond from a practice perspective, but then after meeting she goes to 'friendly' GP and asks him to look at notes/meds anyway **[Observational Field Notes Moorfield, line 738]**

[Nurses] concerned as felt not enough was being done for a patient by another agency. GP suggested that the practice could put concerns in writing. Practice manager said 'if a GP writes it might carry some weight. There will be a manager somewhere who sits up straight when they get a letter from a GP – I know it shouldn't happen like that'. The nurses agreed. One said, 'if you would be happy to write a letter -', while the other said, 'it carries more weight than us'. This is interesting because 1. The nurses hadn't tried writing themselves 2. In retrospect this was obviously the outcome they were playing for, but they did not directly ask the GPs to write the letter.

[Observational Field Notes Moorfield, line 753]

These interactions appeared to be conducted on a subconscious level and in a way that did not challenge the position of nurses, but rather maintained the respective positions of medicine and nursing both within the primary healthcare team and the wider healthcare community. What was different for some ANPs, however, was their conscious awareness of such interactions, even if they were not aware of Doctor-Nurse Game Theory itself, and their ability to utilise it to drive their position as ANPs forward. This awareness was significant because, as Stein (1968) asserted, for those professionals who do not follow the rules of the game, severe penalties are incurred. This was apparent for one ANP who had tried to promote the ANP role in a leading medical journal and had received a negative reaction from doctors and others, including hate mail.

HA: *Why do you think you got that reaction?*

ANP: *I think it was because [the journal]...made it look like nurses were taking over medicine and we could do it as well, and what I really wrote was that we were, I quoted some research that said nurses were very good at communication and that we were safe in our role and, in fact, patients really liked consulting with nurses. And that was a real red rag to a bull because I was daring to say, not only that we were good at it, but patients were*

sometimes preferring us...you know the doctor-nurse game we used to play on the wards? 'Oh, do you think doctor, it would be a good idea if we did such and such?', or 'What do you think's going on here, nurse?', 'Well I think its so-and-so', 'Oh yeah, that's a good idea', but it's all a bit subtle and you play the doctor-nurse game. I think that still goes on and what I wasn't doing when I wrote the article was playing the doctor-nurse game. I was saying 'actually, you know, we are a pretty good group of professionals who are skilled and competent and you should respect us, but we need to work together'. [ANP1 Interview, line 439]

For another ANP, when she did not play the game it resulted in a withdrawal of medical support. By positioning herself as leading a service, traditional professional order was challenged, 'this consultant wouldn't come in and see the patient, she was too busy and her quote was, "it's a nurse led clinic, you don't need me, otherwise it's a consultant led clinic" [ANP8 Interview, line 220]. Consequently, the ANP made sure there was no repetition at her current practice and was careful not to position herself in this way, 'ANP8 says (for the second time) "I think they [GPs] are ok as long as you don't know any more than they do".' [Observational Field Notes Oakcroft, line 1443]

It appeared that ANPs learned from past difficult events they had experienced as nurses attempting to expand their role. As discussed in the earlier theme of trust, they actively shaped their current experiences within the context of past negative events and master-narratives of feeling bullied or ignored. It was through reflecting on and overcoming such experiences that ANPs were able to develop the skills and resilience to adapt and proactively manage future situations, in order to achieve a more positive outcome.

I had a practice where I went to their meeting and [GPs] literally sat with their backs turned to me. It wasn't an accident, it was very clearly deliberately 'we don't want to have anything to do with you'...I managed to get the trust and some degree of communication with even that

practice, so I'm, you know, I'm well experienced, as most experienced nurses are, in kind of working out how to do that...I suspect if you were a less experienced nurse you would run into more problems, but I know how to sort of work with GPs. [ANP5 Interview, line 441]

I survived it fine, it probably made me a better person...a few years later the same medical journal wanted to do an article on nurse practitioners and they wanted to interview me and I said that was absolutely fine, but I wanted to see the finished thing before they published and we had completely different feedback from that. [ANP1 Interview, line 401]

While ANPs may be castigated when they did not play the game, they were also rewarded when they did. ANPs often deferred to GPs in meetings and regularly checked with GPs re management plans. For their part, GPs would sometimes allow nurses to talk first in meetings and would reassure ANPs they were valued as experts in their particular field. In this way GPs could be seen to subtly retain overarching control and delegate suitable work to others. 'Dr [surname] told me that if I left they'd have to close the practice down (laugh)' [ANP9 Interview, line 563]. For their part, ANPs considered doctors who supported them as 'very well trained' [ANP 6 Interview, line 167].

In fact [GP] was just saying to me last week, you know, 'my expertise is [condition] and yours is [condition]' so, you know, he would acknowledge that I am better seeing the patients than he is sometimes, although again I'm not sure that's actually true. [ANP 7 Interview, line 582]

However, GPs retained control within these professional interactions.

GP On-Call sent a task to ANP asking to see her to discuss home visits. ANP then went to the GP's consultation room downstairs...GP said 'I'm told you're

the very important person I need to speak to'. They went through the list of home visit requests. [Observational Field Notes Oakcroft, line 892]

How GPs controlled professional situations and how ANPs expertly negotiated their position within professional relationships was exemplified through observation of an ANP who was required to present a leadership aspect of their specialist role at a multi-disciplinary team meeting. At the time of the meeting I was puzzled as to why the ANP had not adopted a more central leadership position in the meeting, but on reflection realised that they had successfully delivered the required proposal in a way that was non-threatening to both GPs and practice nurses, who were required to follow it.

ANP arrived to talk about a pathway/protocol they had devised. ANP turned up at 12:55pm as the practice had asked them to present at 1pm. However a GP asked 'Can we carry on with the [MDT] meeting, then you won't feel rushed?' ANP agreed. It was 1:20pm when they finished MDT and ANP started the presentation [the meeting was scheduled to finish at 1:30pm]. GP apologised for taking so much time and ANP said it was ok because the cases they were talking about were interesting. ANP didn't do a PowerPoint, but brought a flowchart handout. GP said, 'why don't you stand at the front?' ANP didn't but squeezed in at the table between me and the practice nurse instead. ANP presented a pathway that was to be implemented by the practice nurse who chipped in at times with her comments. [Observational Field Notes Oakcroft, line 372]

Positioning Theory suggests that interaction with an audience is based on embedded identity narratives. That is, individuals present themselves to others in a way that is culturally acceptable as informed by their shared understanding of identity. As in this example, some ANPs utilised the Doctor-Nurse Game to reframe their nursing identity in a way that allowed the ANP role to be acceptable to others. One ANP drew comparisons

with societal gender divisions, suggesting that nursing is implicitly gendered female while medicine, regardless of the gender of individuals within it, continues to be gendered male. For Davies (1995) this means nurses are positioned as emotional and divided, while medicine is seen as dominant and in control. For ANPs to succeed, they needed to learn the rules and act within culturally accepted parameters.

you can liken it to a woman in a man's world, you know, as a nurse you're in a doctor's world and unless you understand how doctors communicate, then you're not going to get very far...You have to play by their rules
[ANP9 Interview, line203]

For ANPs this meant they were required to maintain a non-threatening identity while demonstrating they were suitably removed from traditional perceptions of nursing as emotional and reactionary, in order to perform their role.

nurses are very good at telling you what the problem is, so they are worriers. So if something is going wrong they will tell you what it is and their decision is very emotional...What I've seen is [ANP] can take a step back and say, 'well okay have we thought about this?', you know, 'why are you panicking about that, it's not that severe?' because she has that breadth of knowledge to say, 'well it's fine, it's not a problem, we can get sorted, we can do that, why is everybody panicking?' And I think that is the difference and I've come across very few nurses that have that ability that [ANP] does. Most tend to be emotionally led
[Manager 2 Interview, line 383]

As a consequence, ANPs emphasised a skill set which was complementary to GPs. All ANPs in the study referred to the centrality of holistic, patient-centred care, communication skills and relationship-building with patients as central to their role and identity as ANPs. 'That's your *raison d'être*, that is what we do - we relate to people, we listen to people, we communicate with people' **[ANP1 Interview, line 359]**. They also

considered these were skills in which nurses were more accomplished than doctors, with which most GPs and managers agreed. ANPs were careful to emphasise their skills as being 'better' than GPs in areas that were not considered to be core to the role and professional identity of GPs and were careful to create and maintain a role that would be least challenging to most GPs. Although one GP strongly disagreed that ANPs were superior to GPs in relation in to holistic, patient-centred care, communication and relationship skills.

It irritates the hell out of me but that's just the difference between nurses and doctors in general. Nurses have always seen themselves as holistic and patient-centred
[GP3 Interview, line 125]

Some ANPs in this study focused on maintaining their identity as nurses while others attempted to move towards a more masculine, medical way of working and had attempted to distance themselves from nursing. Either way ANPs had learned the rules of working within this hierarchical context, the success or otherwise of which can be seen to be dependent on the salience, strength and character of the nursing identity underpinning their practice. However, while most ANPs in this study alluded to the importance of negotiating their role in this way, one ANP felt strongly she was not playing the Doctor-Nurse Game.

I don't view it as a game in terms of coming to work and seeing how I can play it to my advantage. I'm not as calculating as that. I'm a bit more naïve in terms of I do my job well and try and put my hand up at all the right bits and articulate myself and demonstrate leadership and that's enough **[ANP2 Interview, line 714]**

However, this ANP volunteered to take on a disproportionate workload and was given roles within the practice that others were less keen to do, 'I've been asked to be the lead for elderly care, despite already being the lead for something else' **[Observational Field Notes Moorfield, line 565]**. This acceptance of unwanted tasks was recognised by other ANPs as integral to the Doctor-Nurse Game.

Medicine has always delegated what it didn't want to do to others - like nurses...if the doctor's delegated it that's fine, but if nurses come along and say, 'Oh, I like the look of that' and 'I can do it' and 'I am quite good at it', suddenly we're being a little bit uppity and actually taking things away from them, rather than them delegating it to us...there shouldn't be any sense of the nurse being more than the doctor, or actually better than the doctor or, you know, the doctor-nurse game [ANP1 Interview, line 447]

Indeed, most ANPs in the study recognised it was important for their successful relationship with GPs and their position within the practice that they took on less desirable roles, were seen to reduce GP workload and were of overall benefit to the practice, including financial benefit. Such roles can be termed professional dirty work.

7.3.3. Professional Dirty Work

Drawing on the work of Abbott (1988) and Hughes (1984), Allen (2001) describes the delegation of lower status tasks to others while high status work is retained by dominant professions within professional healthcare hierarchies. Traditionally this delegated work was considered to be actual 'dirty work' such as the faecal calprotectin test described in section 7.2.2 or lower status routine tasks that others are happy to lose. These delegated tasks remain under the jurisdiction of the dominant profession which defines the parameters within which work is safe and acceptable to delegate. Usually such work is then gradually absorbed into the accepted workload of others. Due to changing workforce reconfigurations and fiscal constraints, it has become increasingly necessary to renegotiate such working patterns within healthcare provision. Moreover, how these workflow issues are resolved plays an important role in how patient care is delivered and the choices available to patients.

At Moorfield and Oakcroft, the work delegated to nurses in general was positioned by GPs and managers as task/protocol driven and this was considered safe because it continued to remain under the jurisdiction and governance of GPs, 'They're just responding to a management plan or a set protocol' [Manager 3 Interview, line 677].

So if we were to say that I diagnose somebody with pernicious anaemia and I send them to see the practice nurse to get their B12 injections, that nurse is just undertaking orders from the doctor. [GP3 Interview, line 48]

For ANPs, their role was not quite so straight forward as much of their work centred on more autonomous high level clinical decision-making. Because at both Moorfield and Oakcroft, the GP workload was becoming unsustainable, there was a recognition that it was necessary for such work to be taken on by ANPs.

we're going to be working with a GP [workforce] basically which is 60% of what it should be in the next 2 years. Probably in 5 years 50% of what it should be, so seeing a GP is going to be a luxury. [GP3 Interview, line 404]

However, there appeared to be some dissonance and ambivalence between what some GPs intuitively felt comfortable in delegating to ANPs and the pragmatic necessity of managing the working day.

as you get wider roles, I think you'll start noticing there will be a bit of a difference [between GPs and ANPs] and that's where your experience will show through [GP2 Interview, line 916]

As a consequence, GPs continued to retain control over this level of work by positioning themselves as having ultimate authority over patient care and through shaping what they considered to be advanced practice.

Advanced practice for me is somebody who supports the patient down a very specific management path...If we look at the idea that I see somebody with elevated blood pressure readings and I send them off for an ambulatory blood pressure machine, that will be fitted by a nurse but the results could be interpreted and therefore diagnosed

and the on-going management plan constructed by a nurse, but in that role I would say that's advanced because they are actually taking the evidence and implementing it to the patient in their own fruition. Maybe following a protocol but deviating from the protocol as appropriate and at that point that's an advanced state.
[GP3 Interview, line 47].

That GPs retained jurisdiction over advanced practice was also evidenced by ANPs who positioned themselves as being 'allowed' to be autonomous: 'the partners were very well trained as far as what that should encompass and what [ANPs] should be allowed to do' **[ANP6 Interview, line 167]**; 'you need sort of permission to be able to work within that really' **[ANP2 Interview, line 428]**.

As long as you have a GP there to support you, I think there is no problem at all. As long as it's drilled into you that you work within your boundaries, then there's no problem at all. **[ANP9 Interview, line 349]**

Such supervised autonomy gave ANPs permission to negotiate roles traditionally considered more prestigious, albeit shaped by GPs' views of what such roles should contain. In this way GPs were able to delegate roles they were comfortable to relinquish either because it was more convenient, had a financial benefit or that they did not want to do for practical reasons - that is professional dirty work. ANPs were aware that in order to establish, strengthen and maintain their position within the practice, they were required to take on this work.

it's always the [financially incentivised] QoF that ends up not really achieving. So if we can manage the patients with [condition] for the practice then, you know, I think it will be beneficial for them and if, you know, ultimately let's face it, what we need to do is take some of the workload off the GPs because they're just aren't enough GPs to do it. So yeah if we can sort out [condition] management and do the

[condition] and drug reviews and things like that and see the new patients with symptoms, yeah I think they'll see, hopefully see the benefit **[ANP7 Interview, line 411]**

However, when ANPs declined certain aspects of professional dirty work they were positioned as problematic and as *refusing* to take on work that would be readily delegated to them because others did not want to do it.

We don't get home visits out of them, we don't get the on-call work out of them and the doctors will say that they're the bits of their day that are the worst bits of the day, that if they could get rid of they'd want to get rid of **[Manager 3 Interview, line 642]**

By not taking on some aspects of professional dirty work ANPs reduced their usefulness to practices. A minority of ANPs recognised and attempted to redress this while other ANPs sought to mediate this by finding other ways to fulfil practice needs.

I chose not to do the on-call and visits, I was pressurised into doing it a few years ago and in the end I said, 'Fine, ok, I'll do it, but you need to pay me exactly the same as a salaried GP because I'm doing exactly the same as them' and then they said 'ok' and then actually I found other things to do to bring money into the practice...So the thing I contribute is the FY2 and the medical student training and that was a way of also validating my salary, which is a very good salary, but it's not at the level of the salaried doctors. **[ANP1 Interview, line 177]**

That some GPs appeared keen to delegate home visits and on-call work to ANPs is of note. This is because such work is considered to be some of the most risky in general practice and both GPs and managers positioned ANPs as being more risk averse and less experienced than GPs. It appeared that the desire to pass on such professional dirty work outweighed concerns expressed about ANP competence. This may be related to

what Jerolmack and Khan (2014 p1) term 'attitudinal fallacy'. That is, what people say does not necessary correspond with how they behave, so that while GPs' underlying professional identity may inform their belief that they are best placed to carry out such roles, this may be overridden by pragmatic necessity to get the work done. However, this requires further exploration. At Moorfield the established and trusted ANP was already successfully carrying out these roles, as was the ANP who was not connected to either study site, while at Oakcroft currently only one ANP had been identified as having the capability and willingness to take on more risky roles. In addition, despite the Oakcroft Alliance indicating they wanted ANPs to take on such roles, the decision had been taken to move away from this to such an extent that the most recently employed ANPs did not have any on-call, acute home visit or undifferentiated diagnostic duties due to the specialist nature of their roles. It appeared again that trust in individual ANPs was central to whether GPs were happy to delegate such roles. This trust was ring-fenced within personal characteristics and not extended to the ANP profession as a whole. Furthermore, at Oakcroft it was asserted that ANPs could have financial parity with GPs if they participated in acute roles such as on-call rotas. However, as the strategic decision was taken to move ANPs away from a generalist towards a specialist model, it was unclear how ANPs could achieve this parity. This also demonstrates that unless ANPs perform in the same way as a GP, their value is considered less. It was also of note that while Oakcroft stated the same opportunities were available for both GPs and ANPs, documentation consistently referred to GPs only.

Manager: *we've established a new contract for salaried GPs but it's salaried GPs, ANPs, so they can have the same contractual conditions as a GP.*

HA: *So do they get paid the same as a salaried GPs?*

Manager: *Yeah pro-rata to what they're doing, absolutely. So if they're taking on appointments, you know, if they were to do acute appointment sessions and things like that, absolutely yeah. [Manager 1 Interview, line 306]*

For managers, allowing ANPs to develop their role within a supportive environment resulted in a more coherent and effective workforce. This involved balancing the requirements of the practice as a business with investment in personnel.

[It] really is about being a good employer and developing and investing in your people and actually giving them permission to work at what they're best at, because if somebody is doing what they love doing and they are great at then I'll reap the rewards from that. [Manager 2 Interview, line 372]

It was not only GPs and managers who benefited from ANPs taking on professional dirty work. ANPs were considered a pragmatic solution to many of the problems reception and administration teams had to negotiate. To this end, non-clinical colleagues appreciated the usefulness of ANPs in for example seeing extra patients, telephoning patients, signing prescriptions and dealing with paperwork in a timely fashion. Receptionists positioned ANPs as more approachable and amenable than some GPs in helping patients. As a consequence this helped reception staff manage their workload.

Her work ethic is unbelievable. If she's been on holiday for a week she'll be at work for like quarter past 7 so she can catch up, you know, she won't ever leave anything undone. Everything is done on the same day, you know. Bloods, because she gets pathology passed to her, her prescription tasks they're passed to her, you know, and she'll just get on with it and do it. She'll see extra patients if she needs to see extra patients. She'll come through and give reception a little bit of support if they're unsure of when she's looking at the duty doctor list where to put things, you know. Yeah her work ethic is unbelievable, really is, she's a very hard worker, massively. [Receptionist 4 Interview, line 252]

Indeed, it appeared that reception colleagues were often utilised to transmit ANPs' narratives of being taken advantage of by GPs and managers and of ANP popularity with patients, something which can be seen to demonstrate subversive tactics in negotiating positioning within the workplace.

[Talked to two receptionists, one says] 'A lot of [patients] like [ANP], we call it her fan club' {this gets repeated often and ANP also says this} I asked if any of the GPs had their own fan club. They thought about it and one said 'Yeah, Dr [Surname], Dr [Surname] and Dr [Surname] do'. One receptionist goes on to say they saw no difference between GPs and the ANP saying 'if you asked her the difference, she'd say about 20 grand' {I've heard this several times too}. [Observational Field Notes Moorfield, line 824]

However, while administration staff benefitted from their relationship with ANPs, for some ANPs their position as nurses meant that they were not afforded the same level of consideration as doctors from administration and reception team members.

When I went back down to ANP's consultation room a member of the admin team and a health care assistant were in her room [ANP had left to collect something]. The health care assistant said, 'we need to move you, we need this room'. The admin team member said, 'It's for a consultant, a consultant needs a room and we don't have one, so we need to use this one. You can have it back in an hour'. They started packing up ANP's equipment and moved it to another room. When ANP came back she looked and sounded annoyed and said to me, 'I'm just going to have to sort this out. This happened last week as well and I've told them that they can't keep doing it and they can't keep moving my stuff. Why didn't they just leave it in the room? They do this, they don't organise the rooms properly'. She went to speak with them, but when she came back we moved to another room anyway. [Observational Field Notes Oakcroft, line 1138]

The implication here was that ANPs' identity as nurses, as viewed by both themselves and others, underpinned their relationships with colleagues, while their willingness to take on professional dirty work was a means by which these relationships were negotiated. As described previously, Sluss and Ashforth (2007) theorise that

relationships between individuals can mediate established professional group identities and ways of working. In other words, by working together, stereotypes and biases towards other professional groups diminish. In this study ANPs used their relationships with others to embed ANP roles within practices. They negotiated their positions within practices through developing roles that were beneficial to the practice, either through taking on work GPs considered less prestigious, reducing GP workload or providing financial benefit to the practice. This strategy was extended to non-clinical members of the healthcare team who also benefited from ANPs' support in managing their workload. In this way ANPs successfully carved out positions within the practice which made them useful to, and valued by, others. For their part, GPs appeared to some extent to position pragmatic practice needs over underlying concerns about ANP practice. However, while such negotiated relationships could be seen to be successful in identifying a niche for ANPs, it appeared that professional identity at a group level remained fixed. That is, the position of GPs as leaders and delegators was maintained, while non-clinical colleagues drew on ANPs willingness to support them but this was sometimes not reciprocal. Because of this, ANPs experienced additional pressures within their working day. Therefore, in this study, relational identity could only be seen to be partially successful in overcoming fixed concepts of professional identity at group level.

In relation to Positioning Theory, Bamberg (1997) suggests that how individuals situate themselves in relation to others can help explain underlying identity narratives. In this study ANPs were observed as positioning themselves as a helpful nurse which GPs, managers and non-clinical colleagues capitalised on and ANPs utilised to develop a specific sphere of practice. However, when ANPs declined some aspects of professional dirty work they were positioned as problematic and risk averse. Sometimes ANPs were pressured to take on work they did not feel comfortable with, due to the perceived riskiness of the role. By declining such roles ANPs could be seen to put additional pressure on GPs and practice managers who had to continue to provide these services to patients. This led to some ANPs incorporating these aspects of general practice into their role or diversifying the role to meet practice needs in alternative ways. Meanwhile practices adjusted ANP roles over time to better fit the requirements of the practices and to support ANPs to work in a way that was comfortable for them. This enabled colleagues from different professional backgrounds to work together to provide a more

effective service for patients. However, unless ANPs matched traditional GP roles like-for-like they continued to be considered to be less effective or useful than GPs.

In this section, the utilisation of professional dirty work as a means of mediating relationships with GPs and non-clinical colleagues was explored. This strategy was also found to be used in part with other nurse colleagues. However intra-professional relationships between other nurses and ANPs at individual, relational and group level were more complex. As a consequence it was perhaps with other nurses that the ANPs' role was hardest to reconcile. This is considered in the following section.

7.3.4. Conciliating Nursing

As evidenced in previous sections, experienced ANPs recognised the importance of negotiating relationships with colleagues in mediating ANP practice. In relation to other nurses, ANPs again drew on past events and underlying master-narratives which informed their understanding that intra-professional relationships had to be carefully negotiated. This was because the ANP role did not neatly fit within traditional expectations of what it is to be a nurse. Some ANPs anticipated other nurses might be unsupportive of advanced practice because they had experienced this attitude previously.

The team that I came from weren't supportive and really quite negative and thought that I was, well in their words, 'above my station' and why did I want to be an ANP?

[ANP4 Interview, line 380]

This was reflected in a practice nurse interview.

I worry about the blurring of roles I guess, you know, with people that might have ideas above their station or think that they could do things perhaps that they don't have quite the skills and experience to be able to do. [Practice

Nurse 5 Interview, line 522]

As a consequence, one ANP was surprised when other nurses were accepting of the role.

the nurses are great, they're very responsive, you know, the rapport is really good and I wouldn't have been surprised if they'd been a bit of hostility thinking 'well who do you think you are?' but there's none of that at all.

[ANP8 Interview, line 373]

The longest established ANP in this study positioned other nurses as completely accepting of advanced practice and she saw her position as an expert resource as mediating her relationship with other nurses. Such support was appreciated by other nurses. When ANPs had experienced difficulties in their professional relationships with other nurses, they considered that it was their responsibility to overcome these.

I think that's up to the individual to build that explanation and working with people so that they do know. Like I said when I first came there were lots of suspicion from district nurses...Whereas, you know, over time it's up to me to say what I do, to show them and I think that has happened. I think that the team here value the role and know [what] it's about. I've supported them and they've supported me **[ANP3 Interview, line 365]**

It may be assumed then, that any intra-professional tensions may dissipate with time and interaction with ANPs. However, some ANPs suggested this was not always the case, as experienced when delegating work to other nurses and where nurses felt ANPs had a supervisory role over them.

HA: *So how supportive do you find the wider nursing team to the ANP role?*

ANP: *Erm. Hmm (long pause). I think some of them are fantastic and very accepting and I think I have had that, 'Oh, are they just going to come in here and tell me what to do and step on my toes?'...its only in a few circumstances when I've seen, not really quite understanding what the ANP role was and thinking*

because it says advanced nurse practitioner that meant that I was automatically their boss and automatically I was going to tell them what to do [ANP 6 Interview, line 368]

It was recognised that while some colleagues positioned themselves as accepting of ANP roles, this did not necessarily reflect underlying attitudes and beliefs. Such attitudes were more likely to be shared with others and not expressed to ANPs themselves.

people have always been very kind and very nice about what they've said about me. They've never been unpleasant. I know from sort of anecdotal gossip district nurses will say, 'Oh asking us to go and do bloods, can't she do it, she's a nurse?' and all this sort of stuff. [ANP2 Interview, line 322]

There was also a perception that while superficially supporting advanced practice, some nurses displayed underlying behaviour contrary to this long after the role had become established.

It's often interesting in terms of people's self-awareness. I can think of somebody here who would say fairly strongly that she's very, you know, she works at an advanced level, she's all for innovative nursing practice etc., etc., but actually her behaviour is contrary to that. So there's often a mismatch between what people say and their actual behaviour. [ANP2 Interview, line 313]

However, other nurses were more overtly negative towards ANPs, something which caused some ANPs to reflect that this was perhaps intrinsic to the professional identity of nursing.

I think sometimes in nursing some nurses are very supportive of those that want to develop and move on and some are not as supportive and it's something I've never understood...I don't know why they were like they were and they are still like that now when I see them out and

about. I bumped into a few of them the other day and they were very condescending I think is the word and very, 'oh how's it going being a doctor?' **[ANP4 Interview, line 386]**

Because some nurses appeared uncomfortable with ANP leadership and delegation, their narratives often positioned ANPs as nearer to doctors and separated ANPs from the wider nursing team.

[Informal chat with practice nurse] I didn't ask about ANPs but she volunteered that, 'I don't, well no one here, thinks of them as nurses, we think of them as GPs because that's what they are. The practice nurses are separate from ANPs. I wouldn't want to be one as I've got the perfect job for me.' **[Observational Field Notes Moorfield, line 306]**

Martin and Hutchinson (1999) first highlighted that ANPs experienced discounting when trying to establish their position within healthcare environments. Social psychological discounting included: undermining; ignoring; excluding; blaming; verbal abuse; stigmatisation, misidentification and being made invisible. Such discounting was found to leave ANPs marginalised. Elements of discounting could be seen in this study in terms of ANPs' relationships with other nurses, despite the long establishment of ANPs at these sites. By positioning ANPs with GPs, other nurses discounted ANPs' identity as nurses.

They've no idea what on earth she's on about. Was she a doctor? Was she not a doctor? Was she a nurse? Well if she's a nurse why is she telling me to go and do this? **[ANP4 Interview, line 527]**

Similarly, some nurses implied that taking on traditional medical roles removed the essence of nursing, or was letting down nursing as a profession. As a consequence ANP practice was discounted as being inconsistent with nursing, 'I don't see myself becoming

an ANP...I could do it and maybe I possibly could actually, but I really enjoy what I do nursing'. **[Practice Nurse 4 Interview, line 180]**

it's not a job that I've wanted to do, you know, because people have said to me, even GPs here have said to me, 'do you not fancy doing your advanced nurse practitioner course?' and I really don't because when I came into nursing, I had a clear idea of what I thought nursing was and I still have that idea in my head and that's never involved putting my name on that little green slip, so I'm not even a nurse prescriber **[Practice Nurse 5 Interview, line 113]**

Furthermore, practice nurses framed their reluctance to deviate from defined parameters and reliance on GP oversight within a patient safety narrative, which they presented as a positive attribute specific to nurses and what was expected of 'good' nurses. They positioned themselves as safe by working within pre-specified parameters and through ultimate supervision and oversight by doctors. The implication being that by developing a broader, more critical perspective, ANPs were not conforming to this expectation of being a good nurse.

the doctors know what we're doing. They're looking at what we're doing and they know that we are working within our competencies within our roles and not, you know, putting anybody at risk, not doing anything other than working at a step by step approach really. **[Practice Nurse 5 Interview, line 368]**

Discounting was particularly evident in one nurse's narrative of a conversation with a GP several years earlier about the introduction of an ANP to the practice. The nurse discounted the ANP role on a number of levels and indicated that the ANP's appointment was irrelevant to her. However, management saw nursing's reaction to the ANP very differently, as is evidenced by their contrasting narrative. The manager positioned nurses as resistant to change, suggesting this was part of an underlying nursing identity.

1. Practice Nurse Narrative

Very interestingly Dr [Surname] pulled me before [ANP] started and said, was I nervous about her coming and joining the team and I thought it was a bit of an odd question to ask really and I said, 'for what reason would I be nervous?' Well he said, 'well she's an advanced nurse practitioner' and I thought, 'Well that still doesn't answer my question. She's not coming in as my boss'. We do two completely different things and, you know, my opinion of that has never changed because her role in the practice and my role in the practice are completely different. I couldn't do her job but I don't think she could do mine either. [Practice Nurse 5 Interview, line 169]

2. Manager Counter-Narrative

When [ANP] first arrived there was a sense of nervousness and I think the practice nurses thought she would come in and maybe undermine what they were doing. They were really worried about her role...they sorted themselves out after time, but that was more my team being here a long time and practice nurses just getting used to change - Oh my god! [Manager 2 Interview, line 453]

It was of note that the practice nurse stated her opinion of advanced practice had not changed, but the manager suggested practice nurses had been reconciled to the role. This may be understood as the pragmatic necessity for nurses to appear to overtly accept ANP roles because of their subordinate positioning, while lack of formal contribution to decision-making within practices makes them unable to actively disagree. Consequently, the only way nurses can make their feelings known is through behaviours such as discounting. In this study, despite the practice nurse asserting the ANP role was unrelated to hers and had no leadership jurisdiction over practice nursing, it was apparent the ANP was involved in managing practice nurses in an area where they, rather than the ANP, specialised. In this way the practice nurse could be seen to discount

the ANP's role, as was evidenced by a meeting with ANPs, practice nurse and district nurse colleagues.

The meeting was to review the way the practice does long term condition home visits. ANP took a definite lead and was clearly in charge. Practice nurse turned up late. ANP is quite direct and gave very clear instructions about what she wanted them to do next. Practice nurse raised some issues which may make [doing these] more difficult.

[Observational Field Notes Moorfield, line 556]

The ANP role was also discounted by some nurses who positioned it as unnecessary or ignored the contribution made by ANPs. One practice nurse did not acknowledge an ANP's specialist role in the management of a long term condition, even though the ANP regularly carried out such clinics at a similar level to GPs. Despite this the practice nurse did not mention the ANP or consider her to be a source of support, rather a GP newly qualified in [condition] management was positioned as supporting practice nurses.

the one [GP] who did [condition] left and now there is no one but me. I've told them I need support and one of the [GP] partners is now doing the [condition] diploma

[Practice Nurse 1 Interview (not audio-recorded), line 75]

It was not only primary healthcare team nursing colleagues who could be seen to discount ANP roles. One ANP reported relationships with secondary care and specialist nursing colleagues could also be problematic, while another ANP was discounted because she was a specialist rather than generalist ANP.

I think there is quite a lot of bitchiness amongst nursing, a lot of superiority particularly from the specialist area. I mentioned that I'd done the Master's in [condition]. If I refer to a [specialist] nurse...I'll get quite a snotty reply and that's not fair really because actually on paper I'm

better qualified than them, but it almost feels like they want to get one up on me in terms of that they are the specialist in that area and they do it exclusively all the time...you just get this feeling like, 'who does she think she is referring me this?' **[ANP2 Interview, line 678]**

While Martin and Hutchinson (1999) identified that ANPs were discounted by others, in this study ANPs could also be seen to discount other nurses. Nurses were sometimes talked over by ANPs in meetings, positioned as lacking understanding and sometimes described on a similar level to healthcare assistants. Some expressed negative opinions about other nurses, 'Nurses embarrass and irritate me all the time'. **[ANP2 Interview, line 676)**

[In meeting] Practice nurse tried to talk, but was talked over by ANP. Practice nurse talked quietly, then faltered and stopped talking to the group **[Observational Field Notes Oakcroft, line 359]**

ANP said, 'yeah, typical nurse, just says something but doesn't think it through or know any rationale behind it'. **[Observational Field Notes Moorfield, line 469]**

Furthermore, as described earlier, some ANPs could be seen to engage in discounting other ANPs, which reflects the individualism previously highlighted. This was demonstrated in one ANP's ambivalence, rather than positive support, of her practice employing a further ANP.

They all came to me and said 'if we took on another nurse practitioner on, how would you feel?' I don't feel anything as long as they can work as part of the team it doesn't matter. It's not threatening in anyway. **[ANP9 Interview, line 377]**

While it is important to acknowledge that not all nurses participated in discounting and many were supportive of ANPs and vice versa in this study, intra-professional working

relationships remain a core issue within nursing and can contribute to the success of ANP roles. It was noted in a study relating to the establishment of secondary care ANP roles in Canada (Reay and Golden-Biddle, 2008), that nurses were more difficult to convince than doctors of the relevance and utility of ANP roles, despite ANPs engaging in strategies to demonstrate their worth to other nurses. Yet much more focus is placed on ANP relationships with doctors and others, both in the literature and within the practice teams in this study. At both sites ANPs used various techniques to forge intra-professional relationships such as explaining their role, taking on overspill work and providing a source of experienced and expert nursing knowledge, as well as seeking advice from other nurses. While this was successful to an extent, perceptions of advanced practice appeared to remain relatively fixed and the dichotomy between ANPs and other nurses appeared to hold firm. ANPs seemed ill equipped to develop novel strategies to address this, which may be considered surprising as they had become very adept at negotiating their role with other members of the primary healthcare team. It may be that ANPs preferred to focus their resources on those considered traditionally more powerful. However nursing can hold its own form of subversive power (Hart, 2004) as evidenced by the discounting of ANPs long after the ANP role has been officially established.

As discussed in Chapter 6, it has been suggested by some nurses, doctors and managers that internecine discord is somehow intrinsically embedded within the professional identity of nursing. From a Social Identity Theory perspective it is through developing and maintaining a robust group identity that professional groups are able to negotiate their roles more effectively from a position of strength (Fiol et al., 2009). However, nursing as a profession appears split. On one hand, nursing can be seen to be such a fragmented group that developing cohesive group identity is difficult. This is particularly relevant to ANP roles which can be seen to stray from core nursing identity into medical professional territory, which traditionally delegates work to nurses. In this way ANPs may be considered less as nursing colleagues and more as task delegators. By contrast, as a professional group, nursing appears to hold a fixed identity of what it is to be a nurse to such an extent that deviation is seen as illegitimate, even when the idealised identity does not relate to the pragmatic needs for modern healthcare services. While individual ANPs worked to negotiate intra-professional relationships within this context, it appeared that relational identity again was unable to fully overcome professional identity at a group or institutional level. Furthermore, from a Positioning Theory perspective, it could be understood that

ANPs spent less time and effort engaging in relationships with other nurses because they were considered less powerful and therefore less able to influence ANP practice than others, such as managers and GPs. By positioning nurses negatively, this allowed nurses to be discounted, freeing up negotiative resource to focus on powerful others. However as nursing roles develop exponentially across and between professions and across primary and secondary care, the impact of relationships within nursing on healthcare delivery is likely to increase and the need to forge strong intra-professional relationships will become ever more necessary.

7.3.5. Summary

In this section, the impact of negotiating professional relationships on ANP practice was considered. Experienced ANPs had learned to expertly negotiate their role over time and across the primary care workforce. However, the extent to which they enjoyed success was limited by relatively fixed institutionalised notions of medicine and nursing, which continued to influence how ANPs were positioned. As it was unlikely that individual ANPs could affect a change at the institutional level, they worked at a relational level to forge relationships across the primary healthcare team and within ever extending professional hierarchies. It was clear that despite long term establishment of ANPs at both sites, relationship building was on-going and the success of ANP roles was very much dependent on relationships between professionals at both an individual and group level.

7.4. Summary of Findings

In Chapters 6 and 7, the main themes identified in this study were presented and interconnections between themes explored. In the following chapter these findings are discussed in relation to the pre-existing literature and utilising a framework based on Social Identity Theory and Positioning Theory. From this conclusions and recommendations are drawn.

8. Discussion

8.1. Introduction

This study set out to address a gap in the literature by exploring the relationship between professional identity and advanced practice from the lived experiences and multiple perspectives of different members of primary healthcare teams. It explored what happens to advanced practice roles after they become embedded and established within the workplace, which is a currently under researched area. The study makes an additional contribution in an area where research is lacking - the nature of intra-professional relationships in relation to advanced nursing practice (Bonsall and Cheater, 2008; Powell and Davies, 2012). The study was situated within the context of a specific area of primary care – general practice. This is an important area of research as national and international policy drivers continue to direct an ever greater proportion of healthcare services towards primary care in general, and in England to general practice specifically (Freund et al., 2015; HEE, 2015; Kooienga and Carryer, 2015; NHS England, 2014; NHS England 2016; Martínez-González et al., 2014). At the same time, other policy drivers promote the need for roles which extend across traditional professional identities, boundaries and hierarchies (DH, 2010a; HEE, 2015a; McInnes et al., 2015; NHS England, 2016; Por, 2008; Rolfe, 2014). As a consequence, how professional groups continue to develop and work together plays a pivotal role in the success or otherwise of such policies. This study encompassed two strands. The website study explored outward-facing macro level professional identity in relation to ANP representation on general practice websites. The ethnographic study allowed depth of understanding about the values, beliefs and interactions which coalesce with group and societal level influences, to construct professional identity and explored its impact on ANP practice. It provides insights into how ANP roles were negotiated within the sites studied and how such working may be harnessed, supported and tensions addressed. From this, policy and practice recommendations are suggested.

The ethnographic study identified three overarching themes set out in Chapters 6 and 7, while Chapter 5 described and discussed the findings of the study of ANP representation on general practice websites. In this chapter, key findings of the ethnographic study are explored in relation to the current literature, and the website study where appropriate, with reference to a theoretical framework of professional identity. Methodological issues, including strengths and limitations, are discussed and contribution to knowledge relating

to both the website and ethnographic studies are highlighted. Conclusions are then drawn and recommendations set out in relation to current healthcare workforce and nursing policy and practice, along with suggestions for further research.

8.2. Key Findings

8.2.1. Levels of Identity, Layers of Trust

Trust was central to ANP practice within primary care teams and was most relevant between ANPs, GPs and managers. It was imperative for GPs and managers to trust ANPs and for ANPs to feel trusted and well supported by managers and GPs. The theme of reciprocal trust has been established previously in the literature (Schadewaldt et al., 2013) in that GPs and managers need to have confidence in ANP competence and ANPs feel trust should be demonstrated by, for example, referring patients to ANPs or valuing their input. In studies of the introduction of new advanced nursing roles it has been suggested trust is built over time in a linear fashion (Andregård and Jangland, 2015; Kilpatrick et al., 2012). However, reciprocal trust is not always achieved (Bailey et al., 2006; Poghosyan et al., 2013a). By situating the concept of trust within a framework of micro, meso and macro levels of professional identity, it can be seen that trust is built in complex layers, underpinned and influenced by past experiences and preconceptions of professional healthcare identities and hierarchies. Consequently, this study extends and deepens knowledge of reciprocal trust in a number of ways, allowing deeper understanding of the way trust impacts on ANP roles in practice.

Firstly, it was identified that ANPs felt a level of vulnerability and mistrust of their current employers, despite overtly stating they felt trusted and well supported, and some (although not universal) evidence to suggest they were currently supported. Even when ANPs trusted GPs and managers to support them on a day-to-day basis, this was mediated by a suspicion this might change arbitrarily if they made a mistake or fell out of favour. In which case trust and support would be swiftly withdrawn. This suggests that for ANPs trust was precarious and unstable even in the context of established ANP practice. Oliver and Montgomery (2001) suggest trust is, in part, developed through the generalisation of past experiences to a particular current context, while for Positioning Theorists, identity is created through the internalisation and narration of past events and pre-existing master-narratives (Garcia and Hardy, 2007). In this study ANPs referred back to their socialisation as nurses, negative narratives of others and previous undesirable

experiences in relation to traditional relationships between medicine and nursing. This appeared to subsume current experiences and reflects what Frank (2010) describes as black boxing, where narratives are shared and retold to such an extent that they become unequivocally and culturally accepted. Previous studies of trust in relation to ANPs focused on GPs' trust of ANPs and ANPs feeling trusted by GPs (Schadewaldt et al., 2013). This study identifies another layer of trust related to professional support in times of adversity and at this level ANPs felt less secure. This has implications for practice, particularly because ANPs also expressed vulnerability due to the lack of professional regulation, standardisation and perceived lack of support from nursing's professional bodies. It is questionable as to the extent to which nurses might be willing to take on advanced roles in the light of such vulnerability. This impacts on future practice and policy strategies aimed at mobilising nursing, and other workforces, to take on advanced and expanded roles. Indeed, practice nurses in this study articulated an unwillingness to take on advanced practice roles for just such reasons and because advanced practice was not seen as reconcilable with mainstream nursing identity. Furthermore, student and newly qualified nurses knew little about ANP practice and considered medicine, rather than advanced nursing, a more viable career option. Consequently, recent policy dichotomising nursing into unregistered assistants and graduate nurses with advanced skills (CoDH, 2016; HEE, 2015c; Willis Commission, 2012) may be challenged.

Secondly, it was identified that it was not simply a matter that ANPs were required to demonstrate competence in order to gain trust, but individual characteristics and relationships appeared to be of greater importance to GPs and managers. In this way person-based characteristics were privileged above role-based characteristics (Sluss and Ashforth, 2007). However, this was only effective to a certain extent because trust of the person did not extend to trust of the professional group. GPs and managers did not trust ANPs in general, but 'their' ANP specifically. This restricted practices' willingness to work with ANPs in that they preferred to employ ANPs of whom they had previous knowledge, or who were recommended to them by trusted others. For their part ANPs had a level of trust in specific GPs who they felt to be supportive, but perceived the culture of medicine in general to be unsupportive of nursing. Therefore the influence of identity at a macro, or professional group, level subsumed lower order identities such as role/relational identities (Currie et al., 2010).

In a study of doctor-nurse relationships in primary care in New Zealand, nurses gained trust through demonstration of competence as measured against understanding of professional roles and identity (Pullon, 2008). This is counter to the findings of this study which, while recognising competence as essential, demonstrated that trust was formed through personal characteristics and inter-professional relationships rather than in a direct linear association with competence. Pullon's (2008) study was concerned with doctors and nurses working in mainstream professional roles within well demarcated role boundaries and professional identities. Therefore this direct association may have been clearer than for advanced practice roles, where ANPs have unclear and less recognised roles and professional identity traits, and lack a strong cohesive ANP-specific professional identity. It may, therefore, be more difficult for others to measure ANP competence in this more straightforward manner, leading to person-based assessments of trust predominating role-based identity.

It was also demonstrated that even established ANPs were only trusted within frameworks demarcated by powerful decision-makers. This was particularly apparent in relation to work positioned as higher level, such as diagnosis. McMurray (2011) similarly found physicians were reluctant to relinquish diagnostic roles to others. Positioning Theory can explain this as the positioning of medicine in a way which continues to allow doctors to ascribe roles and responsibilities to ANPs, thus retaining ultimate control. In a recent paper summarising views of future pre-registration nurse education, the Council of Deans of Health outlined the expectation that in future 'the registered nurse will be able to diagnose and assess patients' needs' (CoDH, 2016 p12), which includes clinical examination and assessment as well as consideration of whether all registered nurses should have prescribing skills. As much of this can be seen as core to medical identity, it is relevant to consider the experiences of ANPs and the potential for the influence of the hidden curriculum and socialisation of the wider healthcare team when planning such changes.

Finally, in this study ANPs utilised decision-makers' lack of trust in ANPs as a professional group to shore up their own individual status and roles within practices. In this way they distanced themselves from their professional group, who were essentially mistrusted, while carving out a niche for themselves within the practices in which they worked. Maxwell et al., (2013) found that in the introduction of new nursing roles in secondary

care, nurses were more successful in niche roles based on their personal skills, characteristics and their relationship with powerful others, who identified them as being special or different to other nurses. While a study exploring new role implementation of modern matrons found individual matrons positioned themselves as different from other matrons (Matykiewicz, 2011). However, this was in relation to diversity of role specification, rather than standards of practice, individual abilities or characteristics. By contrast in this study, it was ANPs themselves who promoted and positioned themselves as different to other ANPs in terms of quality and standards and this influenced their standing within practices. Individual ANPs negotiated their place in the primary healthcare team by utilising traditional understanding of the professional identity of nursing to position themselves as different to other nurses and ANPs, thus using widespread acceptance of professional identity at a macro level to privilege and protect their position relative to other nurses and ANPs. This continued, and even strengthened, long after the role became established. This is significant as this has not, to my knowledge, been identified previously and has the potential to impact on the utilisation of ANPs, both in terms of scope of practice and critical mass and therefore requires further study. It may be that ANPs find making the distinction between themselves as individuals and ANPs as a group easier than would more established professions, because their professional identity at a group level lacks clarity, is not well established and as a consequence is weak. In this way the very lack of consistency which characterises ANP education and practice both nationally and internationally (Bryant- Lukosius et al., 2004a; Carryer et al., 2007; Lowe et al., 2013), can be seen to work to enhance individual ANP's status and stabilise their position within practices. This may be one reason why lack of clarity and consistency has never been fully addressed and overcome, despite interventions designed to counter this (Bryant-Lukosius and Dicenso, 2004b).

8.2.2. Hierarchy, Power and Leadership

Hierarchy and power differentials are well recognised within healthcare organisations and have been established as an influence on ANP practice, in that medical hegemony is seen to shape its scope (Schadewaldt et al., 2013). In this study, such hierarchies and power differentials continued to exert influence on ANP practice despite long establishment of, and exposure to, ANPs. Furthermore, hierarchy and power evident at these study sites went beyond the nurse-doctor interface to encompass other members of the primary healthcare team. Gaining insight at a micro level helps uncover the processes

which contribute to enduring healthcare hierarchies and raises such processes to a conscious level (Currie et al., 2010; Wackerhausen, 2009). This study provides insight into how members of the primary healthcare team contribute to the creation and maintenance of hierarchical working, the mechanisms of which influence ANP practice and are grounded in concepts of professional identity. Consistent with the majority of general practices in England, both study sites were owned by medical practitioners (McMurray, 2011; Peckham, 2003). Consequently the dual role of GPs as practice owners and clinical leaders impacted on hierarchies and power relations, therefore discussion is situated within this context.

Leadership is a central domain of ANP practice (Carryer et al., 2007). In a study of new ANPs' transition to advanced practice in an acute setting, Woods (2000) suggested that by forging a new professional identity outwith traditional nursing, ANPs ought to be able to more readily access formalised power and thus influence the shape of advanced practice. In this study, however, ANPs did not yet have access to the highest levels of power and decision-making, and their professional identity, as perceived by others, remained closely linked with mainstream perceptions of nursing. This had implications for service development and patient care, as ultimately decisions about both continued to be taken predominantly from medical and management perspectives. There appeared to be an echo chamber effect where views of both medicine and managers closely mirrored each other and were entrenched in traditional notions of identity, although the origin and direction of these perceptions differed between sites. At Moorfield the practice manager's views appeared to impact on GPs, while at Oakcroft, managers' understanding of ANP identity appeared to be heavily influenced by GPs' perceptions. Either way, the identity of ANPs continued to be situated within a traditional nursing identity, which was formulated at a professional group level. This was reinforced through the sharing of these perceptions by both management and medicine which, therefore, became doubly black-boxed (Frank, 2010). That both professional and managerial groups shared views of nursing identity can be seen to raise this to a common societal level of understanding. In this way the traditional identity of nursing was so fixed, it became implicit and accepted to the extent that it largely subsumed professional relationships and individual characteristics of ANPs (Currie et al., 2010; Wackerhausen, 2009).

While one ANP at Moorfield was an associate partner, no ANPs in the study were working at the highest level of strategic leadership. It seems unlikely that none of the experienced ANPs in the study were capable of performing at such a level, or conversely that all GP partners had the commensurate capabilities to carry out strategic leadership roles effectively. For GPs, however, partnership was almost a rite of passage, while for ANPs focus was firmly placed on identifying a specific practitioner who held the requisite characteristics to perform at this level. Both study sites had moved towards being more inclusive of ANPs in strategic decision-making and leadership, but this was predicated on identifying an ANP who was considered suitably different from decision-makers' traditional views of nursing to be able to contribute to a strategic role. In this way, positive experiences of ANPs were contained at an individual level, while negative experiences were generalised to ANPs as a group. However, the converse was found for doctors, who were viewed positively as a baseline.

That negative experiences were attributed at a group level reflects a central tenet of Social Identity Theory, by which status is derived from negation of other groups, thus strengthening in-group cohesion (Fiol et al., 2009). The minimal group level ANP professional identity identified in this study may, therefore, be an antecedent of the restricted involvement of ANPs in strategic decision-making. This is because the vacuum created by lack of effective ANP identity was filled by others who then framed ANP practice based on their shared perceptions and political interests. While Woods (2000) saw the forging of a new identity by ANPs as a gateway to professional status, in this study ANPs appeared to be unable to fully shake off deep-seated interpretations of nursing, which were seen as counter to attributes required for high level leadership. It was not that practice decision-makers did not draw from real life experiences of working with ANPs, rather that they interpreted this experience through the lens of traditional nursing identity. This consequently impacted on the strategic influence of ANPs within the organisations studied. Similarly, while not related to leadership per se, a study of the introduction of novel nursing roles in a secondary care setting found nurses were unable to overcome group level characterisations of nursing identity and as a consequence were unable to fully implement their role (Currie et al., 2010).

In this study, managers and GPs continued to hold power in relation to fledgling ANP strategic decision-making roles and ANPs relied on their patronage. This had a significant

impact on ANP roles. For example, the appointment of an ANP as associate partner was attributed to the support of Moorfield's practice manager, while the employment of specialist rather than generalist ANPs at Oakcroft was shaped by GPs' views of advanced practice. It has been noted in the literature that patronage from powerful others (Maxwell et al., 2013), in particular managers, is central to mediating nurse leadership (Martin and Waring, 2013; Elliott et al., 2016). A strategy of engagement with managers may, therefore, be a suitable way forward for the strategic level development of ANPs.

That ANPs did not appear to be attaining strategic decision-making and leadership positions was reflected in the general practice website study carried out as part of this thesis. This identified that only three ANPs from 79 practices were described as partners. In England ownership of general practice is open to non-medical clinicians, which can be seen to support ANP leadership and autonomous practice (GMS, 2004). However, the number of ANPs, and nurses more broadly, in such positions remains limited (McMurray, 2011). Because structural impediments are fewer than in other countries where a similar pattern is noted, for example Australia, New Zealand and North America (Schadewaldt et al., 2016; Finlayson and Raymont, 2012; Weiland, 2008), it may be reasonable to attribute this, at least in part, to ANPs' positioning within traditional professional hierarchies and their identity as nurses.

In this study, nurses were positioned as emotional and risk averse, which ANPs were only seen to overcome to a certain extent. Indeed, all representative team members in this study framed ANPs as emotionally driven and this reflected a wider understanding of the sensitive nature of nursing more generally. While ANPs, other nurses and non-clinical colleagues saw the emotionality of ANPs as a positive trait analogous with a traditional nursing identity, GPs and managers saw this rather more negatively. This reflects the assertions of Carryer, et al., (2007) that ANP and medical practitioners are set apart, not by the roles they enact, but through divergent underlying philosophies. For decision-makers, the hidden narrative here appears to be one of anti-intellectualism and rationality, with ANPs and nurses more generally, seen as emotionally reactive to situations, less tolerant of risk than GPs and lacking the ability to see the bigger picture and to make decisions in a rational way. For Davies (1995) this is linked to the gendered professional identity of nursing in which societal notions of femininity impact on how society views the

status of nursing. Characterising nursing in this way leads to exclusion from strategic decision-making, because leadership - and the profession of medicine - is gendered male.

While, in this study, ANPs were considered better placed than other nurses to behave in a less emotional, and by implication more rational, way, they were not thought to do this to the same extent as GPs. In this way the professional hierarchy was extended rather than flattened (Charles-Jones et al., 2003). It was not only the redistribution of workload that was increasingly stratified, but professional identity. Similar findings were identified within medicine when GPs with a special interest (GPwSI's) were perceived as encroaching on roles of specialist medical consultants, resulting in the creation of a new hierarchical layer and an expert professional identity (Currie et al., 2012; Martin et al., 2009). In this study, the complex partnership and clinical speciality structures developed within the practices served to extend the healthcare hierarchy and situate ANPs within their own hierarchical space, which remained subordinate to GPs. Accordingly, unless ANPs were prepared to behave in a similar way to GPs, to undertake the same role commitments, and by implication invoke a philosophy dissonant from traditional nursing values, they were unlikely to access strategic decision-making roles. This has implications for whether multi-disciplinary contributions can be fully effective in an environment where individuals are encouraged to adopt similar philosophies because, by design, multi-professional workforces offer a variety of views and characteristics, underpinned by differing professional identities (Wackerhausen, 2009). For such working to be effective, the maintenance of distinct professional identities is necessary and needs to be equally valued (Fiol et al., 2009; Reay and Hinings, 2009).

While both study sites claimed a flattened hierarchy, behaviour displayed and narratives played out indicated that hierarchy was clear and implicitly understood by all members of the primary healthcare team. Previous studies indicate that traditional healthcare hierarchies were often present but unrecognised (Baxter and Brumfitt, 2008; Burford et al., 2013). Chulach and Gagnon (2016 p54) attribute this to 'colonial patronage', which privileges the biomedical model, while others are positioned subordinately. From this viewpoint hierarchy normalises 'othering' (p56), which minimises ANPs' contributions, making these invisible and thus maintaining the status quo. In this study, while some team members did not consciously recognise hierarchical patterns, these were continuously preformed and were evident in how others talked and behaved in relation to ANPs. This

impacted on how teams worked together and, as a consequence, how care was delivered. Observations showed professional groups sat in silos at meetings and conducted themselves in ways which reflected traditional nurse-doctor relations, while subtle reinforcement of positioning was evidenced in how people talked and behaved. For colleagues such as receptionists, while they overtly stated they considered ANPs to be similar to GPs, this was not played out in behaviour which privileged GPs over ANPs, for example by reallocating rooms to doctors and unevenly distributing workload towards ANPs. Because of their established status as nurses, other team members appeared to be uncomfortable aligning ANPs with GPs, rather they extended the hierarchy to position ANPs between GPs and practice nurses, thus reflecting the findings of the wider website study. This was important because, consistent with Charles-Jones et al., (2003), findings from the website study indicated patients were positioned at the bottom of an ever extending hierarchy within which they were expected to fit, often with little guidance about how to achieve and access this.

Moreover, patients were further implicated in the healthcare hierarchy as GPs and managers, although not other members of the primary healthcare team, perceived that patients preferred to consult with GPs, particularly for more serious or complex issues. This had organisational implications for the utility of ANPs and there is some evidence in the literature to support this assertion (Redsell et al., 2007; Niezen and Mathijssen, 2014). In this study, the sites appeared to circumvent patient preferences by not clearly and consistently informing patients they were consulting with an ANP. This has implications for both ANP role clarity and visibility, but also questions commitment to patient-centred care which seeks to engage patients in decision-making (BMA, 2011). This was also reflected in the website study, which found lack of ANP visibility and role clarity, making it difficult for patients to understand what ANPs offer and consequently make decisions about care providers. The website study also suggested that changing the relationship between medicine and nursing potentially had the consequence of changing medicine's position in relation to patients. This concern appeared to be supported by GPs in this study who argued patients preferred to consult with doctors because they were more knowledgeable. Positioning ANPs similarly to GPs can be seen to undermine the perceived primacy of doctor-patient relationships and therefore ANPs were not positioned in this way.

For their part ANPs could be seen to contribute to, rather than challenge, traditional professional hierarchies and nursing narratives. This is seen by some as a strategy for effective collaborative working, as performing within traditional nursing identity can be seen to be less challenging to doctors (Schadewaldt et al., 2016). In this study ANPs positioned themselves within holistic, patient-centred, caring narratives consistent with traditional perceptions of nursing identity, while simultaneously presenting themselves within anti-business narratives. This they positioned as being counter to patient care narratives, in contrast to both GPs and managers who associated efficient business practices and leadership with quality of patient care and service delivery. In this way ANPs can be seen to exclude themselves from strategic decision-making roles.

This study identifies that the construction and maintenance of power differentials and professional hierarchies are contributed to by all members of the primary healthcare team, ANPs themselves and potentially by patients. This is grounded in traditionally accepted notions of what it is to be a nurse or doctor, within which ANPs do not comfortably fit. In order to address this, it is necessary for ANPs themselves to consider how they contribute to the maintenance of healthcare hierarchies and ways they can effectively participate in the highest levels of strategic decision-making. Wackerhausen (2009) suggests that professional identity exerts itself at a subconscious level, therefore in order for professional identity to be addressed and challenged, it requires raising to a conscious level. It is anticipated that this study contributes to this. To enable ANPs to fully engage in strategic decision-making at the highest level, it is necessary for professional identity to be reflected on at a conscious level by all stakeholders. However, it is essential to recognise that professional identity is not negative per se, but plays a positive and important role in codifying, stabilising and underpinning professional behaviours and practices, as well as providing consistent outward-facing parameters of practice to patients and the wider public (Hamilton, 2008, Monrouxe, 2010). Thus professional identity and healthcare hierarchies themselves need to be carefully considered when seeking to alter them.

8.2.3. Negotiating Professional Relationships

ANPs negotiate their relationships with a number of different co-workers, such as reception and administration team colleagues, managers, other nurse colleagues, GPs and outside agencies. It was the complexity of these relationships that this study aimed to highlight and explore. In this study ANPs implemented a strategy, purposeful or otherwise,

within which to negotiate and maintain a professional space for their role. This was grounded in past experiences and hard-learned lessons gained from socialisation within professional healthcare hierarchies at inter and intra-professional levels. Divergent from the experiences of ANPs in other studies (Poronsky, 2013; Woods, 1998), in this study ANPs did not feel they had necessarily struggled on their transition to becoming an ANP, or were ill equipped to deal with the political and interpersonal aspects of advanced practice at a general practice level (MacLellan et al., 2016). Rather they felt these lessons, and the resilience required to negotiate professional relationships, were built up over a professional lifetime. This meant that when they came to embed the ANP role in practice, previous knowledge of working with doctors and powerful others, as well as political astuteness and knowledge of the culture of general practice, meant that skills had already been acquired within which to negotiate professional relationships. Furthermore, because all but one ANP in the study was previously known to the practices where they were employed, personal and professional relationships already existed, which may have ameliorated some of the difficulties reported elsewhere. Nevertheless, it was clear that ANPs had learned valuable lessons throughout their experiences as ANPs and they were aware that it was incumbent on them to continue to negotiate a professional space for advanced practice long after they as individuals, and advanced practice as a concept, had been established.

The strategies ANPs employed drew together several strands including taking on roles doctors did not want (Reay and Golden Biddle, 2008), performing roles that would financially benefit practice owners and behaving in a way that underpinned rather than challenged professional stereotypes of nursing and its position within professional healthcare hierarchy (Schadewaldt et al., 2016). This encompassed both the concept of professional dirty work and aspects of the Doctor-Nurse Game, linked to the framing of advanced practice as different to medicine, but also different from nursing. It positioned ANPs as superior to GPs in emotional, caring and communicative roles while GPs retained clinical superiority. In this way mainstream professional identities of medicine and nursing were preserved and the divergent philosophies underpinning them maintained. It appeared both professions were more comfortable with formally positioning roles within a framework of traditional professional identity.

Despite Stein himself declaring the emergence of more egalitarian working relationships between doctors and nurses the Doctor-Nurse Game (Stein et al., 1990) appeared to be active in this study, both for nurses in general and ANPs specifically. Similarly Apker et al., (2005) described nurses continuing to use indirect suggestions and the appearance of passivity in negotiating relationships with medical colleagues. While in a recent study of ANP collaboration with medical practitioners in the Australian primary care system, Schadewaldt et al., (2016) found ANPs deliberately employed a strategy of unassertive behaviour and 'cautious competence' (p10), often reverting to traditional doctor-nurse roles within joint consultations. What both this study and Schadewaldt et al's (2016) study identified was that nurses working at an advanced level continued to engage in relationships formed on a basis of medical hegemony and nursing subservience and actively utilised this to negotiate their role in a non-threatening way. However, advanced practice requires that ANPs are active decision-makers and leaders, and this contrasts with the Doctor-Nurse Game and conventional perceptions of medicine and nursing. It has been suggested that this disconnect between ideals and realities creates identity dissonance (Hallam, 2000; Monrouxe, 2010). This may lead to unclear role expectations because different parties base their understanding on what they think others want, rather than actually what is required. For example, in a study of non-ANP nurses, Apker et al., (2005) found doctors stated they wanted nurses to be active decision-makers and equal collaborators, while nurses understood that doctors would react negatively if they behaved in this manner. As a result doctors thought nurses were poor at making decisions and derided their emotion-led behaviour, while nurses continued to position themselves subordinately within the professional healthcare hierarchy. Similarly, in this study ANPs continued to position themselves within emotional nursing narratives, while GPs and managers criticised their emotionality and tolerance to risk. In both this and Apker et al's (2005) study it appeared that traditional perceptions of medicine and nursing framed current behaviour and led to a disconnect between expectations and reality of role enactment. It also contributed to limitations placed on ANP practice.

However, it was also apparent that some ANPs and other nurses derived an element of pleasure from achieving objectives by subversive means. Indeed it appeared that a level of satisfaction was elicited from their part in the Doctor-Nurse Game, in the taking on of professional dirty work and in their subordinate position within the healthcare hierarchy, although it is acknowledged that this was not representative of all ANPs in the study.

Pleasure was not only derived from being well thought of and praised by doctors as described by Stein (1968), but from the feeling of getting one up on powerful others and in the gaining of recognition of their heavy workload and their level of skill from others, including non-clinical colleagues. Indeed, it was of note that some ANPs appeared to utilise non-clinical colleagues to transmit their narratives of subordination. This was achieved through storylines and behaviours in which ANPs reflected nursing stereotypes of being overworked, underpaid and subordinate to medicine, which were repeated by others. In this way ANPs were able to exert a form of power in a relatively powerless environment. It is striking that elements of the Doctor-Nurse Game persist many years after it was first identified, despite repeated attempts to raise the professional status of nursing. The contention here is that deep-seated conceptualisations of professional identities of different members of the healthcare team, as perceived by self and others, at micro, meso and macro levels of identity create a pervasive culture from which nurses, even those working at advanced levels, find it challenging to break. That ANPs and other nurses appeared to derive emotional benefit from their subordinate identity resonates with Traynor and Evans' (2014) assertion that nurses gain pleasure from their subordination because it fits with historical and gendered notions of nursing identity as vocational, self-sacrificing and quasi-religious. That is, if nurses are oppressed and subordinate they are correctly 'doing' nursing. Thus, to become more overtly assertive would be to disavow their identity as nurses, something the ANPs in this study were reluctant to do, despite the obstacles and difficulties such an identity posed.

While some ANPs adopted professional dirty work and the Doctor-Nurse Game as overt strategies, for others it remained at a subconscious level. Therefore it is unclear whether this was the most appropriate strategy within which to embed advanced practice or rather that ANPs and medical practitioners simply did not know, and had not thought about, how to behave in any other way. Wackerhausen (2009) suggests that professional identity is so deeply embedded at a subconscious level that other ways of thinking are rarely countenanced. Consequently, through a process of workplace and professional socialisation, hidden practices (Hafferty and Franks, 1994) perpetuated behaviours which failed to allow for alternative ways of thinking and behaving. Rather they followed a well-worn path with which all parties felt comfortable (Wackerhausen, 2009). However, if ANPs as a profession are to reach their full potential, other ways of working are necessary (Chulach and Gagnon, 2016). This is because negotiating the tension between the

subordinate status of nursing and the requirement to act as collaborative decision-making partners causes a disconnect which is likely to be stressful to maintain (Apker et al., 2005). Without a shift in such practices the scope of advanced practice is likely to remain limited.

There is a small but growing body of evidence to suggest that the profession of nursing, and individual nurses acting within it, may be complicit in undermining and inhibiting advanced nursing practice which may impact on the experience and retention of ANPs. For example, studies of ANPs' experiences of role transition have identified a deliberate misuse for power by other nurses who withhold information, dismiss, demean and behave in a passive-aggressive way towards ANPs (Brown and Draye, 2003; MacLellan et al., 2016; Martin and Hutchinson, 1999). In an Australian study, MacLellan et al., (2016) identified that novice ANPs felt unsupported by other ANPs, which contributed to a wider turf war which was exacerbated by lack of funding and therefore competition over a small number of ANP roles. In this study, however, practice leaders reported a shortage of nurse practitioners, which can be seen to create a supply side advantage for ANPs in the current employment climate (McMurray, 2011), while ANPs both as individuals and as a concept were long embedded into the study sites. Therefore, it could be anticipated that such 'horizontal violence' (McLellan et al., 2016 p4) may be avoided. Indeed, the overt turf wars and aggression described by McLellan et al., (2016) were not evident in this study. However, subtle undermining of ANPs was demonstrated by some nurses, both within and external to the study sites. They ignored ANP contributions, made negative comments, questioned competence/qualifications and expressed dislike of carrying out work to support ANPs. This constitutes what Martin and Hutchinson (1999) term as discounting and, in this study, was usually covertly insinuated while portraying outward support for ANPs.

While it is acknowledged in parts of the nursing literature that 'nurses eat their young' (Daiski, 2004 p460) this is usually understood as a downward trajectory where more influential nurses behave negatively towards new or inexperienced nurses. However, in this study ANPs who were well established at the practice sites and held senior positions, still appeared to be exposed to discounting. This can be seen to be underpinned by group level professional identity in a number of ways.

The study demonstrated that the lack of a strong, coherent ANP identity made it easier for ANPs to be positioned as an out-group in comparison to others with stronger group identity. It was of note that other nurses in this study drew clear distinctions between ANPs and nurses, while some implied that advanced practice was not reconcilable with traditional nursing identity. By implication, ANPs were letting the profession of nursing down by pursuing what were seen by some as non-nursing agendas. It appeared that the historical, political and gendered context from which nursing originated proved difficult to shake off (Davies, 1995). ANPs reinforced this by positioning themselves very clearly within a nursing identity. However it remained that there was a distinct dissonance between what ANPs and some non-ANP nurses considered to be the core of nursing identity.

It has also begun to be contemplated in the nursing literature that jealousy may play a part in the relationships between ANPs and other members of the nursing profession (Lowe et al., 2013; MacLellan et al., 2016). Although there is no empirical evidence to pinpoint the motivation for negative intra-professional behaviour, this may have some theoretical basis. Evans et al., (2014), draw on a psychoanalytical framework to argue that nursing provokes feelings of anxiety, envy and jealousy and suggests that jealousy is related to feeling that others are getting what you deserve and hence rivalry occurs. This can result in negative behaviour and ill-will aimed at spoiling what the other has. Evans et al., (2014) contend that nurses experience feelings of jealousy for the privileges afforded to doctors, which has the potential to distract nurses from the main focus of service delivery with potentially negative consequences. Furthermore nurses' jealousy of doctors is seen as taboo and therefore never raised to a conscious level or explored. While further research is necessary in this area, it is possible that this can be extended to the suggestion that envy, jealousy and rivalry may occur in relation to advanced practice. Consequently the perceived treatment and status differentials of ANPs relative to both GPs and other nurses may underpin professional relationships.

However, as Miceli and Castelfranchi, (2007) suggest, it is empirically difficult to demonstrate jealousy and envy. It is methodologically problematic because both are taboo, rarely admitted and consequently remain at an unconscious level. It can, though, be related to professional identity. McNeil et al., (2013) theorise that professional identity becomes more salient when it is perceived to come under threat, for example if one group

of professionals are seen to be privileged over another. This increased salience leads to fractures in relationships. In this study the primary healthcare teams appeared to work together effectively on a superficial level and there were no overt conflicts related to ANPs. Furthermore, advanced practice had been established for some time at both sites and, therefore, it may be assumed that threats to professional identity may be less salient. However, evidence of discounting from all member groups of the primary healthcare team, though not from all individuals, was apparent at some level. It is suggested here that it is feasible that the weak professional group identity of ANPs may be enough to trigger professional identity threat and may contribute to the experiences of ANPs as they enact their roles in primary care.

This study also paid attention to the attitudes and behaviour of ANPs. There was a demonstration of low level negative, ambivalent and discounting attitudes and behaviours towards other nurses and ANPs from some ANPs through both narratives and actions. In addition, some ANPs sought to control the jurisdiction and employment of other ANPs, for example through recommendation of others and the shaping of other's roles. In this way they could be seen as gatekeepers to ANP practice. Discounting and its antecedents therefore have consequences and it remained that ANPs as individuals positioned themselves as different to other ANPs, and nurses more generally, as a mechanism to defend their position and this has been more widely observed (Piil et al., 2012; Woods, 2000). In this study, some ANPs positioned themselves as elite amongst other ANPs which influenced how others, including powerful decision-makers, perceived ANP practice at a professional group level.

Why ANPs appeared to be ambivalent and sometimes negative towards other ANPs was unclear. Lack of professional group level identity might create a threat of being compared to other ANPs, where there is no established framework for comparison. Because ANPs in England come from disparate backgrounds and there is no standardised level of training and no established professional group identity, ANPs may not have felt confident in their individual capabilities and this in itself may be enough to create identity threat. Chulach and Gagnon (2016) argue that advanced practice occupies a space between the cultures of nursing and medicine, which in itself creates instability and uncertainty, therefore, this too may increase identity threat. Additionally, by positioning themselves as path-breaking and innovative, practices may also contribute to a culture of professional

identity threat because other advanced roles such as physician associates, advanced physiotherapists, pharmacists etc. may prove an underlying threat even for established ANPs in relatively stable practice environments. Furthermore, as reflected globally, primary care in England is in a significant state of flux and this may exacerbate professional identity threat.

Intra-professional relationships within nursing may play a significant, but underexplored, part in shaping ANP practice. It is therefore necessary that further research is conducted to explore whether these findings are identified elsewhere and to what extent this influences the roles, level of practice and critical mass of ANPs. Furthermore professional relationships more generally, and professional identities underpinning them, have been demonstrated to significantly influence ANP roles and practice in this study. While ANPs have proved adept at negotiating some professional relationships, these remain framed within traditional notions of what it is to be a nurse and within socialisation processes underpinned by traditional nursing identity and professional hierarchies. By raising this to a conscious level, alternative ways of negotiating professional relationships may be explored which expand, rather than inhibit, ANP practice and allow it to be situated beyond traditional, mainstream and sometimes inaccurate perceptions of nursing.

8.3. Summary

The study identified that traditional expectations of professional nursing identity at a group/societal (macro) level subsumed relational and individual level identity. That is, while individual characteristics and personal relationships played a part, ANPs predominantly continued to be positioned within a conventional professional identity of nursing and within established, although expanding, professional hierarchies. Both professional identities and the hierarchical nature of practices were largely invisible to those working within them. Because ANPs appeared to have been unable to develop a strong group identity, they had little in-group cohesion, which was capitalised on by groups with stronger identities. In this way different members of the primary healthcare team, including ANPs, contributed to ANP role enactment in primary care. This shaped advanced practice in a number of ways

- The direction and level of advanced practice was largely framed by expectations of medicine and management, grounded in traditional notions of nursing and medical identity. This allowed the ascription of roles, rights and responsibilities to ANPs. ANPs were largely positioned as risk averse and lacking higher level decision-making and critical reasoning skills. Exposure to ANPs appeared to consolidate rather than challenge these views, at one site particularly.
- Exposure to individual ANPs did not increase acceptance of ANPs as a group. Rather individual ANPs were positioned as different to mainstream nurses and other ANPs, who were seen as being of variable quality. As a consequence employment was predominantly restricted to ANPs who were known, or recommended, to practices.
- ANPs were unofficially excluded from the highest levels of strategic decision-making. This was linked to the perception that nurses generally did not have the skills to fit such role requirements.
- Negative past experiences of ANPs and other team members had greater impact on current practice than present neutral or positive experiences. This reinforced ANPs' feelings of vulnerability and practices' reticence in employing ANPs, even in the face of counter-evidence.
- ANPs utilised accepted notions of nursing identity as a mechanism to shore up their own position in the workplace, by positioning themselves as different to other nurses and other ANPs. Some ANPs discounted other nurses, including other ANPs, even to the extent of expressing ambivalence and negativity. This was achieved by drawing on perceptions of traditional nursing identity, through which they labelled and positioned other nurses, and some other ANPs, negatively. This meant ANPs sometimes contributed to the negative role and positioning of other ANPs and nurses.
- Nursing as a profession was demonstrated to discount (ignore or mistreat) ANPs in a number of ways. By exploring this through a lens of professional identity it can be explained that nursing as a profession may see advanced practice as a threat

to the professional identity of nursing, because ANPs were (or were perceived to be) treated as different to other nurses. There is also the potential that some nurses and ANPs experience jealousy or envy, again as a consequence of the perception of different treatment.

- Some ANPs and other primary healthcare team members negatively positioned non-nurse advanced practitioners and physician associates.
- Most nurses in this study did not want to become ANPs. This was linked to advanced practice not being considered as nursing, while some nurses felt advanced practice left them vulnerable and unsupported, and others indicated medicine may be a more viable career option. While not generalizable, these findings have potential implications for future development of advanced practice roles, of which policy makers should be aware. It remains unclear whether there is a viable critical mass of nurses willing to undertake advanced roles.

This study has shown different ways identity can be 'narrated', for example through room allocation, where people choose to sit in meetings and through dress and documents. This added to the depth of insight gained and situated such positioning within broader societal contexts. Most significantly, this study demonstrated the novel use of Positioning Theory in analysing ANP representation on general practice websites. This allowed a depth of analysis which went beyond the descriptive in order to expose potential underlying assumptions and beliefs which contribute to the development of such documents.

The outward-facing public image and macro level professional identity of ANPs, as represented on general practice websites, was underpinned by traditional perceptions of nursing identity. This study identified that

- ANPs lacked representation and visibility on general practice websites, both absolutely and in relation to other professional groups.
- Their roles were unclear and not well explained.

- Professional groups were assigned differing levels of professionalism.
- Website information lacked quality, both in relation to what was being said and how it was presented.
- Pre-defined templates and pre and practice-populated text segregated professional groups, despite increased role/level of practice cross-over and blurring. This indicated broader societal level perceptions of medicine and nursing which fail to reflect current practice.
- Traditional professional hierarchies were maintained and extended, with medical practitioners at the apex. Hierarchy was also stratified intra-professionally.
- Patients appeared to be positioned at the bottom of the practice hierarchy and often negative messages about expected patient behaviour were included on practice websites.
- It may be difficult for patients to know what ANPs offer, or decide the most appropriate practitioner to consult with, from the information provided.
- Changing the relationship between medicine and nursing may have the consequence of changing the balance and primacy of doctor-patient relationships. This may provide an additional explanation of why traditional professional roles and identities appear to be maintained on practice websites.

The following sections discuss methodological issues, strengths and limitations, recommendations and implications for future healthcare workforce and nursing policy and practice.

8.4. Methodological Issues, Strengths and Limitations

This study exemplifies the strength of using an in-depth ethnographic study design and analysis in order to gain a micro level understanding of complex relationships and working practices. The use of professional identity as an a priori theoretical framework underpinning the study allowed a nuanced and focused exploration of the lived experience

of ANPs within primary healthcare teams, which went beyond description while allowing for emerging concepts and themes. In this way, the findings of this study have been able to cast light on why advanced practice roles remain poorly understood and utilised, both in terms of scope of practice and critical mass, despite being established in healthcare systems for a significant period of time.

This thesis is a report on a small qualitative study which cannot be considered, nor was it intended, to be generalizable in a quantitative sense. However, while features of practices, and the individuals within them, may not be directly generalizable to other workforces, analysis at this level allows identification of patterns of behaviours and attitudes which may resonate with other institutions, practices and ANPs. As identified by Hammersley (1998), qualitative studies can be assessed through establishing consistency between findings and wider knowledge, credibility (recognisability) of the account to readers, the extent to which findings are relevant to those in similar settings and reflexivity. Therefore, drawing on similar findings within the literature contributes to the veracity of study findings, while transparent reflexivity and documentation of the research process allows judgement of credibility. In this way this study may contribute to understanding the influence of professional identity on ANP roles and practice. The insight gained from such in-depth analysis may help inform policy planning at a structural level, organisation at a workplace level and help support ANPs at an individual level in negotiating ANP roles in practice.

While this study explored advanced nursing, it may also inform advanced practice relating to other professional groups such as physiotherapists, pharmacists and paramedics, which all have distinctive professional identities and places within existing professional hierarchies. It may also inform planning of new professional roles within the English NHS such as physician associates, who have yet to establish professional group level identity and a place within traditional professional hierarchies. Furthermore, the makeup of nursing is changing with extended roles of healthcare assistants and assistant practitioners, as well as the soon to be implemented nursing associate (HEE, 2015c). Findings from this study may contribute to knowledge that may inform the assimilation of such roles within the shared identity of nursing. They may also provide a cautionary note that unless issues of identity are addressed and accounted for, role implementation may not be achieved in the manner policy devisers might anticipate.

The study aimed to explore professional and organisational relationships and, as a consequence, direct involvement of patients was not part of this study. This can be seen as a limitation and further direct exploration of patient perceptions of the identity of ANPs, nursing and other professional groups may be of benefit to elicit the influences of professional identity on patient relationships with, and utilisation of, ANPs.

8.5. Recommendations and Implications for Future Healthcare Workforce and Nursing Policy and Practice

Because professional identity was grounded in complex processes of socialisation and enculturation, drawing on experiences of past events and pre-existing expectations and from perspectives of different team members, it largely remained at an unconscious level. In order for issues raised in the findings of this study to be addressed, it is necessary to raise professional identity to a conscious level, both at policy, practice and individual levels.

1. POLICY LEVEL

In order to address professional identity issues underpinning ANP practice, it is necessary to

- Develop policy to directly address wider societal understanding of nursing. For example through media campaigns, including use of new media, to promote positive and accurate public images of nursing more broadly, and advanced practice specifically. This may help counter inaccurate, unrealistic and out-of-date perceptions of nursing which underpin underlying master-narratives. These ultimately play a central role in how both ANPs and others, including the wider public, understand advanced nursing and nursing more broadly.
- Develop educational strategies both at undergraduate and postgraduate level which make explicit professional identities of different groups. The aim is to avoid misunderstandings, superficial understanding and to challenge enduring stereotypes of other professional groups.

- Promote advanced practice roles at undergraduate level, so student nurses see it as a viable career opportunity. This should involve exposure to ANPs through clinical placements.
- Consider the impact of professional identity on advanced roles when developing and implementing policies relating to workforce organisation and different ways of working.
- Professional leadership should support active reflexivity for practitioners in relation to professional identities, so that pre-existing master-narratives are not continually and unquestioningly re-enforced, but are challenged and develop as the changing healthcare professional landscape moves. Such reflection requires structural support as deviation from established professional identities can be challenging to the individual, professional groups and to wider healthcare communities.
- Professional nursing associations should work to form a cohesive and strong ANP identity and set out visible and clear support for ANPs.
- Develop policy in ways which do not privilege one professional group over others. In this way threats to professional identity may be minimised.

2. PRACTICE LEVEL

- Consciously explore how professional identities, practice hierarchies and the culture of the organisation impact on the roles and positions of different professional groups and primary healthcare team members, including ANPs.
- Develop strategies which do not privilege one professional group over others. For example, strategic leadership roles at the highest level should be meaningfully open to different professional groups, while decision-making re the introduction of new professional roles may benefit from input from multidisciplinary team members. In particular caution is required in the differential treatment of ANPs and other nurses, if professional identity threat is to be minimised.

- Consider strategies such as different group members chairing multi-disciplinary team meetings and actively working to ensure all contributions are supported. This requires a step change rather than superficial application.
- Better utilisation of general practice websites and forms of new media to enhance patient understanding and allow patients to make choices based on clear and accurate information. Improving website information may help practices to direct patient flow more effectively.
- Ensure that professions are represented fairly and accurately on practice websites, for example by setting out qualifications, special interests etc. in the same way for all practitioners so these can be easily understood and compared.

3. INDIVIDUAL LEVEL

- Consciously engage in reflexivity in relation to professional identity, not only from the perspective of the professional group to which the individual belongs, but by separation and questioning of group ideals and accepted norms.
- If experiencing discounting or other negative treatment, it is useful to consider from where this behaviour derives. This may support ANPs to develop more useful strategies in addressing these issues. It may be that by addressing perceived inequalities and differential treatment, ANPs may be able to navigate both inter and intra-professional relationships more effectively. It is also necessary for ANPs to reflect on their own discounting behaviour.
- If ANPs are to gain strategically stronger positions in practices they may need to set aside their own reliance on aspects of traditional nursing identities, for example by engaging in business aspects of general practice.
- ANPs as individuals and as a professional group should address issues around lack of support for other ANPs because, until this is addressed, ANP practice is potentially limited to the level of the individual, both in terms of level of practice and critical mass of ANPs.

8.6. Future research

This study raises insights which require further exploration. It has demonstrated that professional identity is a useful framework within which to situate the study of advanced practice and future research could seek to extend this to gain further insight, for example in other areas of advanced practice. The impact of the profession of nursing on advanced practice nursing requires further exploration as it is an emerging contributor to the inhibition of ANP roles. Specifically, further study of the influence of ANPs in circumscribing the practice of other ANPs, and the utilisation of mainstream nursing identity to shore up their own position to the detriment of other ANPs and nurses, is necessary in order to explore whether this finding is salient in other studies and the extent to which this is an issue. It is also of value to conduct research to further understand the underlying mechanisms and antecedents of threats to professional identity, as is the consideration of the place of taboo notions of envy, jealousy and rivalry in relation to impact on ANP practice.

8.7. Conclusion

This study set out to explore the influence of professional identity on established ANP practice within a multi-professional context. It found ANP roles and levels of practice were shaped by the identities of primary healthcare team members and their perceptions of ANP identity, underpinned by deep-seated notions of nursing and medicine. Experience of working with ANPs did not appear to change these perceptions, but rather reinforced them. Professional identity was negotiated at individual, interactional and group/societal levels, with the latter appearing to hold greatest influence through underpinning other lower order levels. In this way individual ANPs were accepted as they were positioned as different to their professional group. ANPs worked hard to develop their roles and, as experienced nurses, had learned to adeptly negotiate within traditional professional identities and hierarchies, but remained stymied to a considerable extent, not least by nursing itself. They were also constrained by their own fundamental understanding of professional identity situated within unconsciously accepted structures. By raising professional identity to a conscious level, it is anticipated this study will contribute to the further development of advanced practice by encouraging policy makers, organisations and individual practitioners to reflect on the role professional identity plays in shaping practice and address threats to identity which may impact on the delivery and utilisation of advanced practice.

Appendices

Appendix 1 – Study Information Leaflets



Professional Identity and the Advanced Nurse Practitioner in Primary Care Information Leaflet (General)

Introduction

We would like to invite you to take part in the above named research project. Before you decide, it is important for you to understand why the research is being done and what it involves for you. Please read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please ask.

Who is conducting the study?

This study is part of a PhD project by Helen Anderson at the University of York. (Email hca506@york.ac.uk). Helen is the chief investigator and is a registered nurse and advanced nurse practitioner with experience of working in primary care. The study is being supervised by Professor Yvonne Birks (Social Policy Research Unit, University of York) and Dr Joy Adamson (Department of Health Science, University of York). It is funded by the University of York.

What is the purpose of this study?

The purpose of this study is to look at how members of the primary healthcare team work to develop the role of the advanced nurse practitioner (ANP) in general practice in England. Studies suggest that how professionals work together may be influenced by professional identity (how colleagues perceive themselves and others). Some research has been conducted looking at how ANPs create their own professional identity, but we know less about how the ANP role is affected by other groups with different professional identities, particularly in general practice. In addition, how ANP roles continue to develop after initial training, and the influence of patients and wider society on the role, requires further study. The University of York has funded this study to explore in detail how the primary healthcare team and wider social and professional contexts influence the role of the ANP in two general practices in England. We would like you to consider taking

part in this study.

Who is being asked to take part?

Two general practices in the north of England will take part in the study. Each practice needs at least one experienced ANP within their team who is interested in contributing to the study. Other members of the primary healthcare team are also asked to take part, although individual team members can decide not to take part if they prefer. The study gives the opportunity for representatives from various groups within the practice team to contribute to this research.

Those eligible to take part include:

- Advanced Nurse Practitioners
- Registered Nurses
- General Practitioners
- Health Care Assistants
- Administration and reception team members
- Practice/Business Managers
- Wider clinical team members

Do I have to take part?

No, it is entirely up to you to decide whether you would like to take part. If you have any questions about taking part you can talk to Helen Anderson, the chief investigator. Even if you have agreed to take part you are free to withdraw from the study at any time without giving a reason. This will not affect you in any way. However, any data already analysed may still be used in the study.

What will happen if I take part?

There are several parts to this study. ANPs will be asked to take part in the most detailed part of the study and this will be described in a separate information leaflet. Some members of staff will be asked to take part in interviews, and information about this is also provided in a separate leaflet. Members of the Practices' Patient Participation Group may be asked to take part in a group discussion about how they perceive the role of ANPs in general practice

The researcher will spend time observing ANPs to see what different activities they do and how they interact with others. Members of staff will be asked to contribute to the study by allowing the researcher to observe them going about their usual work and interacting with ANPs, for example in meetings, when discussing something with the ANP, when booking appointments etc. Notes will be taken by the researcher. If you are happy to take part you do not need to let the researcher know. However, if you do not want to take part, please inform the researcher at the time she is observing the ANP or observing usual practice activities and you will not be included in the study.

What are the possible benefits and risks of taking part?

The findings of this study will develop a better understanding of how ANPs work with others in general practice. We hope that this will contribute to broader knowledge about ANP work which will benefit practitioners, practices and patients more widely. The study also allows practices and individuals to broaden their research experience by taking part in the study.

There is a potential for inconvenience as the researcher will be conducting the study within the workplace environment. As an experienced ANP who has worked in general practice, the researcher will try to minimise any inconvenience by communicating appropriate information to support the smooth running of the practice and arranging suitable study schedules.

Will information obtained in the study be kept confidential?

Yes, the study will be conducted in line with the Data Protection Act (1998). Data will be confidential and anonymous. Handwritten notes will be taken by the researcher during the course of the study. They will not contain any personal details and will be kept in a locked filing cabinet until they have been transferred to a secure computer at the University of York. Handwritten notes will then be destroyed.

If during the course of the study the researcher observes any activity which they consider potentially affects patient safety or other professional misconduct, this will be reported via usual practice/CCG incident reporting mechanisms.

What will happen to the results of the study?

The study will be academically assessed as part of a PhD project. Parts of the study will be submitted for publication in peer-reviewed and professional journals and may be presented at conferences. While every effort will be made to ensure that participating practices will not be identifiable, this cannot be guaranteed. Data collected from the study will be archived at the University of York on completion of the PhD project for at least one year and no more than five years and then be securely destroyed.

Who has reviewed this study?

The Department of Health Sciences Research Governance Committee, University of York

Who do I contact in the event of a complaint?

Please contact PhD Programme Lead:

Professor Catherine Hewitt, Deputy Director, York Trials Unit, University of York, Heslington, York, YO10 5DD. Tel 01904 321374 Email: catherine.hewitt@york.ac.uk

PhD Supervisors:

Professor Yvonne Birks, Social Policy Research Unit, University of York, Heslington, York, YO10 5DD. Tel: 01904 321328 Email: yvonne.birks@york.ac.uk.

Dr Joy Adamson, Department of Health Science, University of York, Heslington, York, YO10 5DD. Tel 01904 321378 Email: joy.adamson@york.ac.uk

If you would like to take part in the study, would like more information or have any questions or concerns about the study please contact Helen Anderson, Chief Investigator and PhD Student, Department of Health Sciences, University of York, Heslington, York YO10 5DD. Email: hca506@york.ac.uk

Thank you for taking the time to read this information sheet.

Introduction

We would like to ask you to take participate in an interview as part of the above named study being conducted in your practice. An overview of the study has already been covered in the study information leaflet. This leaflet gives you more information about what to expect in the interview process. Before deciding whether to take part, please read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please ask.

What is the purpose of interviews?

Interviews are designed to get more detailed information about the role of the ANP in your practice and how the practice team works together.

Why am I being asked to participate?

You have been asked to participate as you have valuable information and knowledge which will contribute to finding out more about how your practice team works together.

Do I have to take part?

No, it is entirely up to you to decide whether you would like to take part. If you have any questions about taking part you can talk to Helen Anderson, the chief investigator. Even if you have agreed to take part you are free to withdraw from the study at any time without giving a reason. This will not affect you in any way. However any data already analysed may still be used in the study.

What will be involved if I take part in an interview?

If you agree to take part in an interview you will be asked to sign a consent form which will be stored securely at the University of York. You will be given a copy of the consent form.

The interview will take place in your practice and will last approximately 30-60 minutes (depending on your time constraints). It will be conducted by the chief investigator (Helen Anderson) and at a time that is convenient for you. The interview will be audio-recorded. This will be transcribed word-for-word onto a secure computer at the University of York, then the audio-recording will be deleted. All data will be made anonymous by assigning a unique identification code to each practice and participant. This will only be known to the chief investigator.

It may be useful for the researcher to have follow-up discussions with you in order to clarify or expand on information gained in interviews, however you have the right to decline such follow up questions if you chose. You don't have to give a reason.

What are the possible benefits and risks of taking part?

We hope that this study will contribute to the broader knowledge base about ANP work which will benefit practitioners, practices and patients more widely. Taking part in the study may also broaden your research experience.

It is unlikely you will experience any harm as a result of participating in the interview. However, the interview may reveal issues about working practices and behaviours. Exploration of working practices and relationships may be sensitive for some individuals. In the unlikely event that you become upset while participating in the interview, the interview will be stopped and only resumed if you are happy to continue.

Interviews are estimated to last approximately 30-60 minutes. Inconvenience will be minimised by arranging a suitable time and date convenient for you and by conducting interviews at the practice. No participant expenses have been allocated for this study.

Will information obtained in the study be kept confidential?

Yes, the study will be conducted in line with the Data Protection Act (1998). Data will be confidential and anonymous. The interview will be audio-recorded and then transcribed onto a secure computer. Audio-recordings will then be deleted. Handwritten notes may be taken by the researcher during the course of the interview. They will not contain any personal details and will be kept in a locked filing cabinet until they have been transferred

to a secure computer at the University of York. Handwritten notes will then be securely destroyed. Direct quotations may be used in the completed study and subsequent publications. These will be anonymised by using a pseudonym for both participant and practice. If during the course of the study the researcher observes any activity which they consider potentially affects patient safety or other professional misconduct, this will be reported via usual practice/CCG incident reporting mechanisms.

What will happen to the results of the study?

The study will be academically assessed as part of a PhD project. Parts of the study will be submitted for publication in peer-reviewed and professional journals and may be presented at conferences. Data collected from the study will be archived at the University of York on completion of the PhD project for at least one year and no more than five years and then be securely destroyed.

Who has reviewed this study?

The Department of Health Sciences Research Governance Committee, University of York

Who do I contact in the event of a complaint?

Please contact PhD Programme Lead:

Professor Catherine Hewitt, Deputy Director, York Trials Unit, University of York, Heslington, York, YO10 5DD. Tel 01904 321374 Email catherine.hewitt@york.ac.uk

PhD Supervisors:

Professor Yvonne Birks, Social Policy Research Unit, University of York, Heslington, York YO10 5DD. Tel: 01904 321328 Email: yvonne.birks@york.ac.uk

Dr Joy Adamson, Department of Health Science, University of York, Heslington, York, YO10 5DD. Tel 01904 321378 Email: joy.adamson@york.ac.uk

If you would like to take part in an interview, would like more information or have any questions or concerns, please contact Helen Anderson, Chief Investigator and PhD Student, Department of Health Sciences, University of York, Heslington, York YO10 5DD. Email: hca506@york.ac.uk

Thank you for taking the time to read this information sheet.

UNIVERSITY *of York*
The Department of Health Sciences

Professional Identity the Advanced Nurse Practitioner in Primary Care
Information Leaflet (ANPs)

Introduction

We would like to ask you to take participate in the above named study being conducted by the University of York in your practice. This leaflet is designed to give you more detailed information about what to expect from the study. Before deciding whether to take part, please read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information, please ask.

Who is conducting the study?

This study is part of a PhD project by Helen Anderson at the University of York. (Email hca506@york.ac.uk). Helen is the chief investigator and is a registered nurse and advanced nurse practitioner with experience of working in primary care. The study is being supervised by Professor Yvonne Birks (Social Policy Research Unit, University of York) and Dr Joy Adamson (Department of Health Science, University of York). It is funded by the University of York.

What is the purpose of this study?

The purpose of this study is to look at how members of the primary healthcare team work to develop the role of the ANP in general practice in England. Studies suggest that how professionals work together may be influenced by professional identity (how colleagues perceive themselves and others). Some research has been conducted looking at how ANPs create their own professional identity, but we know less about how the ANP role is affected by other groups with different professional identities, particularly in general practice. In addition, how ANP roles continue to develop after initial training, and the influence of patients and wider society on the role, requires further study. The University of York has funded this study to explore in detail how the primary healthcare team and wider social and professional contexts influence the role of the ANP in two general practices in England. We would like you to consider taking part in this study.

Who is being asked to take part?

Each practice taking part in the study needs at least one experienced ANP within their team who is interested in contributing to the study. As ANPs are the main focus of the study we would like to explore the ANP role in detail. Other members of the primary healthcare team will also be asked to contribute to the study.

Do I have to take part?

No, it is entirely up to you to decide whether you would like to take part. If you have any questions about taking part you can talk to Helen Anderson, the chief investigator. Even if you have agreed to take part you are free to withdraw from the study at any time without giving a reason. This will not affect you in any way. However any data already analysed may still be used in the study.

What will happen if I take part?

As ANPs are the main focus of the study we would like to explore the role in detail. We also want to explore how other members of the primary healthcare team influence the ANP role. Therefore the following study methods will be used: observation, interview and analysis of documents relating to the ANP role. A group interview may also be held with representatives from the practice's Patient Participation Group.

You can decide whether you want to take part in observation, interviews or both. To help you make your decision, please read the information below.

Observation

In order to find out about the everyday work and interactions of the ANP, the researcher will shadow you for 2 hour periods at different times and during different activities e.g. attending meetings, liaising with other staff, organising care and in clinical consultations. The exact time the researcher will spend with you depends on the number of ANPs taking part in the study, but it is considered a maximum of 10 hours per ANP will provide sufficient information.

Observations will take place at a time convenient for you. Field notes will be taken about what you are doing and how you go about your working day. However, there will be no audio-recording. All data will be made anonymous by assigning a unique identification code to each practice and participant. This will only be known to the chief investigator.

If you agree to be observed, you will be asked to sign a consent form which will be stored securely at the University of York. You will be given a copy of the consent form.

Interview

Information about interviews is provided in a separate information sheet. Please read this information before agreeing to take part in an interview. You will be asked to sign a separate consent form to take part in an interview.

Document Analysis

Practice documents relating to the ANP role will be collected and analysed by the researcher to provide background information about the ANP role in the practice.

What are the possible benefits and risks of taking part?

We hope that this study will contribute to the broader knowledge base about ANP work which will benefit practitioners, practices and patients more widely. Taking part in the study may also broaden your research experience.

There is a potential for inconvenience as the researcher will be conducting the study within the workplace environment. As an experienced ANP who has worked in general practice, the researcher will try to minimise any inconvenience to you by communicating appropriate information to support the smooth running of the practice and arranging suitable study schedules. Observations and interviews will be arranged a suitable time and date convenient for you. No participant expenses have been allocated for this study.

It is unlikely you will experience any harm as a result of participating in the interview. However, the study may reveal issues about working practices and behaviours.

Exploration of working practices and relationships may be sensitive for some individuals. In the unlikely event that you become upset while participating in any part of the study the process will be stopped and only resumed if you are happy to continue.

Will information obtained in the study be kept confidential?

Yes, the study will be conducted in line with the Data Protection Act (1998). Data will be confidential and anonymous. Handwritten notes will be taken by the researcher during the course of the study. They will not contain any personal details and will be kept in a locked filing cabinet until they have been transferred to a secure computer at the University of York. Handwritten notes will then be destroyed. Audio-recordings will be dealt with as described in the interview information sheet.

Direct quotations may be used in the completed study and subsequent publications. These will be anonymised by using a pseudonym for both participant and practice.

If during the course of the study the researcher observes any activity which they consider potentially affects patient safety or other professional misconduct, this will be reported via usual practice/CCG incident reporting mechanisms

What will happen to the results of the study?

The study will be academically assessed as part of a PhD project. Parts of the study will be submitted for publication in peer-reviewed and professional journals and may be presented at conferences. Data collected from the study will be archived at the University of York on completion of the PhD project for at least one year and no more than five years. Data will then be securely destroyed.

Who has reviewed this study?

The Department of Health Sciences Research Governance Committee, University of York

Who do I contact in the event of a complaint?

Please contact the PhD Programme Lead:

Professor Catherine Hewitt, Deputy Director, York Trials Unit, University of York, Heslington, York, YO10 5DD. Tel 01904 321374 Email catherine.hewitt@york.ac.uk

PhD Supervisors:

Professor Yvonne Birks, Social Policy Research Unit, University of York, Heslington, York, YO10 5DD. Tel: 01904 321328 Email: yvonne.birks@york.ac.uk

Dr Joy Adamson, Department of Health Science, University of York, Heslington, York, YO10 5DD. Tel 01904 321378 Email: joy.adamson.@york.ac.uk

If you would like to take part in the study, would like more information or have any questions or concerns about the study please contact Helen Anderson, Chief Investigator and PhD Student, Department of Health Sciences, University of York, Heslington, York YO10 5DD. Email: hca506@york.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 2 – Ethical Considerations, Consent Process and Consent Forms

Consent Processes Reflecting Different Components of Participation

The consent process varied in complexity depending on the level at which the individual participated in the study. It is acknowledged that consent is not obtained at a single point in time, but is an ongoing negotiation with participants (Holloway, 2008). The three consent processes are explained below.

Level 1: Consent when Encountering Different People during Observations

During observations of ANPs and more generally while at the research sites, a range of people were encountered throughout the study. Staff were provided with study information and invited to a meeting to explain the study methods. It was explicit in the study information that primary healthcare team members should inform the researcher if they did not wish to take part in that part of the study at the time the researcher was observing the ANP. They were also able to request that a particular discussion or interaction should not form part of the study. At such requests the individual would not be included in the study, otherwise consent was implied. No members of staff declined to take part or asked for removal of data. Verbal consent was obtained from patients during observation of ANP consultations. Written field notes were made about the explicit area of study (i.e. ANP role and professional identity) but no other data were recorded.

Level 2: Consent to Interview

Written consent to take part in an interview was obtained from each healthcare professional/member of staff, after having time to read the interview information leaflet and prior to being interviewed. Time was allowed at the start of the interview to answer any questions or clarify details as required. Permission to audio-record interviews was explicit within the consent form.

Level 3: ANP Consent

ANPs who chose to take part in the study could decide to take part in observations, interviews or both. Observation was covered in one consent form, while those taking part in an interview were asked to sign the interview consent form. Written consent was obtained prior to commencing interview/observations and any queries clarified. All ANPs were interviewed, one ANP was not observed in consultation as she was in training. One ANP was interviewed from a different practice and therefore was not observed.

Right to Withdraw from the Study

Information leaflets and consent forms advised participants that they had the right to withdraw from the study at any point, without sanction. Interview participants could withdraw from a point in the interview or withdraw all interview material already recorded. Explanation of the withdrawal procedure was detailed in the consent form. Data collected from observation could be withdrawn by the ANP or the individual interacting with the ANP and was explained in the consent form. No individuals withdrew from the study.

Confidentiality and Anonymity

It is necessary to explicitly set out what anonymity and confidentiality mean within a qualitative context. This is because they are often conflated and healthcare practitioners' understanding of confidentiality may differ from confidentiality within a research context (Goodwin, 2006). For Holloway (2008) anonymity is concerned with protecting the identity of participants, while confidentiality is protection of information given to the researcher by participants, which they do not want to be disclosed to others. In this study the parameters of confidentiality and anonymity were clearly set out in the study information provided. Confidentiality related to disclosure connected to potential threats to patient safety, while anonymity was addressed by ensuring any potentially identifiable information, such as name and workplace, was removed from study output. Examples, extracts from field notes and quotations of narrative are features of qualitative research and is established practice, providing permission is gained from participants and steps are taken to protect identity (Holloway, 2008). Study information and consent forms explicitly stated direct quotations from qualitative interviews may be used in the thesis and subsequent publication, along with information gathered from observations. This was reiterated prior to gaining consent to observation and interview. In this way participants were able to make an informed decision about whether they wanted to take part in the study.

Threats to Patient Safety and Disclosure

This study was considered unlikely to reveal threats to patient safety or information requiring disclosure. However, as the study was related to working practices there was a potential for inappropriate or concerning behaviour to be revealed. As a registered nurse, the researcher was bound by a professional code, as well as by ethical research conduct, to report any practice seen as unsafe or raising cause for concern. The information leaflets and consent forms provided explained that information gained about serious

issues during the course of the study may require disclosure in line with appropriate procedures and would be reported through practice/CCG procedures for raising and escalating concerns.

Consent to Interview

Research Title: Professional Identity and the Advanced Nurse Practitioner in Primary Care

ID Code allocated.....	Please confirm agreement to the statements by putting your initials in the boxes below
I have read and understood the participant information sheet [Dated 27/02/15 Version 1.0]	
I have had the opportunity to ask questions, discuss the study and have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary, that I am free to withdraw from the study without having to give a reason and <ul style="list-style-type: none"> i) If I withdraw from the study up to seven days after the interview, I can request my interview data will not be used in the study. This data will then be destroyed. ii) If I decide to withdraw from the study more than seven days after the interview, data gathered may have been initially analysed and cannot be removed from study findings. 	
I understand that the interview will be audio-recorded and hand-written notes may be taken by the researcher during the course of the interview.	
I am aware I may be asked by the chief investigator to clarify or expand on information raised by the study process at a later date. I am aware I have the right to decline participation in this.	
I understand that data collected during the study may be seen by researchers supervising the study (Professor Birks, Dr Adamson) and give permission for this.	
I understand that any information I provide, including personal details, will be kept confidential, stored securely and only accessed by those carrying out the study.	
I understand that if at any time the researcher becomes aware of any activity which they consider potentially threatens patient safety or indicates professional misconduct, this would be reported via routine incident reporting mechanisms.	
I understand that any information I give may be included in published documents but all information will be anonymised.	
I agree to take part in this study	
Participant Signature:	
Date:	
Name of Participant	
Researcher Signature	
Date:	
Name of Researcher: Helen Anderson	

Consent to Observation of ANPs

Research Title: Professional Identity and the Advanced Nurse Practitioner in Primary Care

ID Code allocated.....	Please confirm agreement to the statements by putting your initials in the boxes below
I have read and understood the participant information sheet [Dated 27/02/15 Version 1.0]	
I have had the opportunity to ask questions, discuss the study and have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary and that I am free to withdraw from the study without having to give a reason for withdrawing. I am aware that data collected before my withdrawal from the study may have been analysed and may not be able to be removed from study findings.	
I give permission for the Chief Investigator (Helen Anderson) to observe me during patient consultations and other general working practices that form part of my role. I understand that hand-written field notes will be taken.	
I understand that data collected during the study may be seen by researchers supervising the study (Professor Yvonne Birks, Dr Joy Adamson) and give permission for this.	
I understand that any information I provide, including personal details, will be kept confidential, stored securely and only accessed by those carrying out the study.	
I understand that if at any time the researcher becomes aware of any activity which they consider potentially threatens patient safety or indicates professional misconduct, this would be reported via routine incident reporting mechanisms.	
I understand that any information I give may be included in published documents but all information will be anonymised.	
I agree to take part in this study	
Participant Signature:	
Date:	
Name of Participant:	
Researcher Signature:	
Date:	
Name of Researcher: Helen Anderson	

27/02/2015

Version 1

Appendix 3 - Data Management, Protection and Record Keeping

Data management was compliant with the Data Protection Act (1998) and the Department of Health Sciences Data Security Policy (2014). All data was anonymised by assigning a unique identification code to each site and participant. This was recorded on the participant's consent form in the case of ANPs and interview participants. It was the only document linking identifiable information to the assigned unique identifier and was known only to the researcher. Signed consent forms were stored in a locked filing cabinet in a restricted access room at the University of York and were only accessible to the researcher. Interview data were recorded on an encrypted audio-recording device and deleted following verbatim transcription. No information which might identify individuals was included in interview transcripts.

For other members of the primary healthcare team, an identifier was assigned at the time of recording field note observations, ensuring they were anonymised at source. Copies of relevant documents were scanned onto a password protected computer as soon as practicable and the original destroyed. Potential for loss of data during transportation was minimised by keeping electronic devices and paper-based data, such as handwritten field notes, consent forms and printed documents in a locked bag and in the presence of the researcher during transportation. These were then stored in a locked filing cabinet until transcribed onto a secure computer and then securely destroyed. All electronic anonymised data were securely stored on a data storage folder on a University of York computer, which was located in a locked restricted access room at the University of York. Study data was password protected. A reflexive diary was kept as part of the qualitative research process. Handwritten reflections were transcribed into a password protected word document and no site/participant identifiable data was documented in this process.

Appendix 4 – Initial Coding Example

<p>202 P Or we're trying to be something that we're not really. I honestly don't know</p> <p>203 sort of demographically whether it's something that will be successful but I</p> <p>204 think we are, I think we've demonstrated our competencies at it and our ability</p> <p>205 and again there's always going to be good and bad in each isn't there.</p> <p>206 There's always going to be some really good ones and some that think they're</p> <p>207 all right and that's the same with medics. What I do think is that it boils down</p> <p>208 to our protection that we've got because I do think we're a lot more vulnerable</p> <p>209 and I think you feel you've got pretty less backup than a medic would have</p> <p>210 and it's when things go wrong you're pretty much on your own. It's not really</p> <p>211 happened to me but I've had situations where you think you're going to be</p> <p>212 supported and you're not by the medics if something untoward occurs and I've</p> <p>213 had that once in a clinic where I was newly established. I could run a clinic</p>	<p>Helen nursing unsupportive</p> <p>Helen Competency</p> <p>Helen Variable quality of ANPs</p> <p>Helen Lack of professional support Lack of support from doctors – past event MN</p> <p>Helen As above Safety narrative Vulnerability Risk/responsibility</p>
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Appendix 5 – ANP Coding Example (Positioning Theory)

NARRATOR IN RELATION TO AUDIENCE [REFLECTS EMBEDDED IDENTITY NARRATIVES]			
CODE	EXAMPLE	ROW	Comments
Vulnerability Support (lack of)	it's a scary place out there.	53	Safety narrative-dangerous nurse trope Frightened/cautious nurse tropes Emotional nurse narrative Evidence of support Despite having support, continues to feel vulnerable ? related to past events/perceived lack of support from professional body
	It frightens the life out of me. It frightens the life out of me that I don't have a governing body that will stand up and understand what I do	185	
	it frightens me because we have no professional body. I feel like I've nobody	199	
	They do try and push me, they do try and push me	326	
	maybe it's my way of holding myself back and not trying to do too much, trying to get too confident in what I do because you could very easily. Oh man you could wreak havoc couldn't you, you really could.	464	
	I'm in charge on a Friday which is horrendous, I hate it. It frightens the life out of me	501	
	I hate being in this room on my own	508	
	The practice look after me, I think, you know, menopausal women we get emotional sometimes don't we, I get a bit upset sometimes if patients – if things haven't gone the way, if I've had a consultation that didn't go well, you know, I can go talk to somebody and say, I really didn't think that worked and then, you know, its guidance, it's support, emotional support hugely	564	
	It made me feel very, very vulnerable because as a nurse you never have to go through anything like that	577	
	they had a solicitor there that grilled me for an hour and a half and that was absolutely horrendous. It was the worst experience. I could have walked away. I could have walked away from the whole job but the support I got from the practice and, you know, everybody looked through everything that I did and just said, "look you did more than we would have done".	586	

Appendix 6 – Example of Thematic Matrix

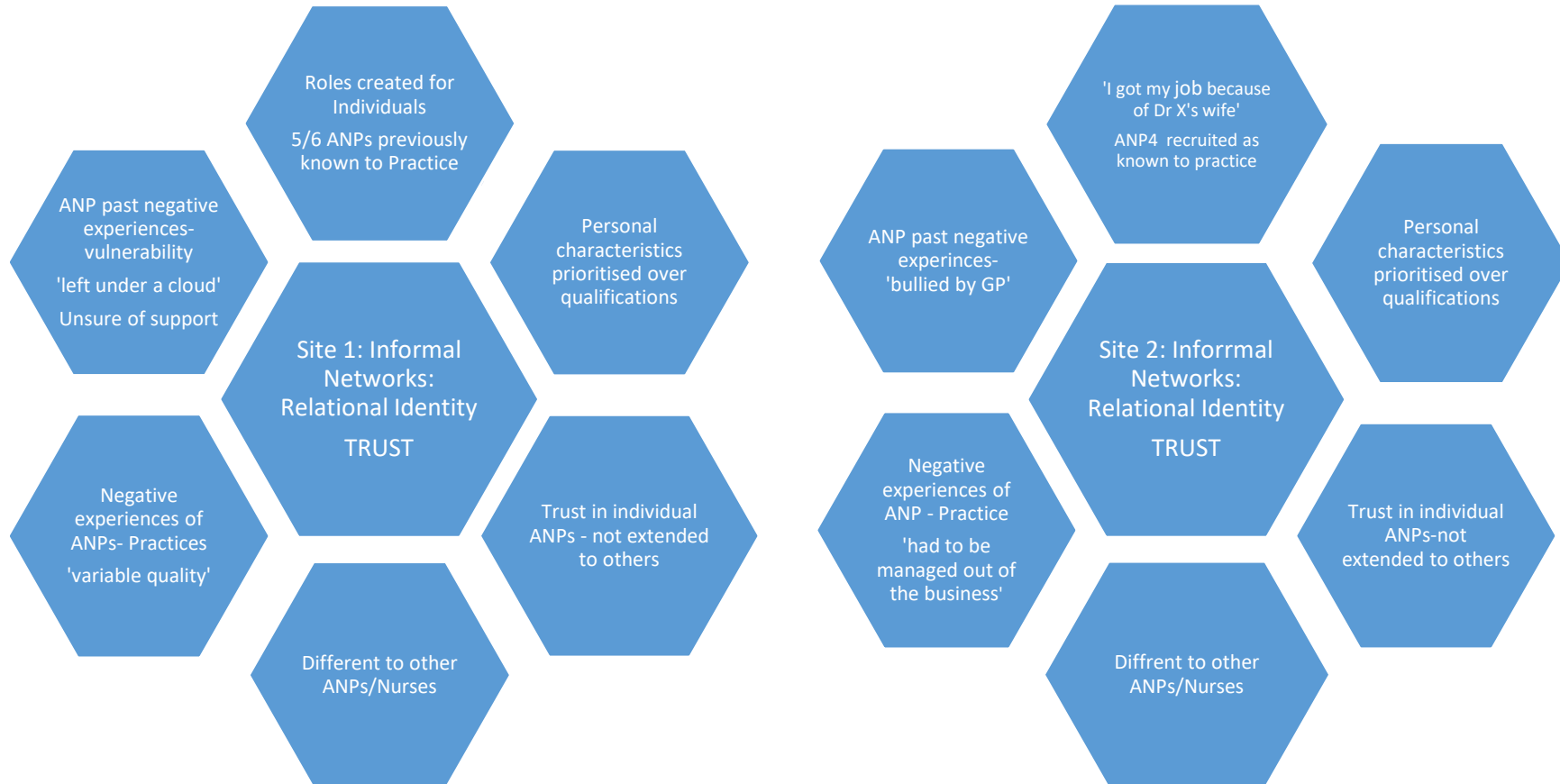
TRUST									
CODE	ANP1	ANP2	ANP3	ANP4	ANP5	ANP6	ANP7	ANP8	ANP9
ANP VARIABILITY	46, 54, 104, 476	110, 129, 292 515, 741	29, 53, 70, 82, 441, 491	162, 439	47, 77, 97, 103, 431, 457, 569	44, 59	22, 48, 76, 102, 191, 198, 276, 283, 406 , 618	191, 205	53, 82, 174, 289, 546
DIFFERENT TO [BETTER THAN] NORMAL ANPS [INDIVIDUALISTIC]	4, 8, 121, 167, 189, 228, 249, 274, 284, 285, 330, 436	37, 110, 108, 186, 200, 292, 495, 521, 587, 682	129, 210, 491,	50, 65,	47, 77	5, 14, 18, 22, 27, 30, 82, 89, 97, 109, 130	102, 11, 36,	191	47, 53, 82, 86, 114, 152, 174, 178, 289, 546
GP GOLD STANDARD	113, 130, 476	490, 504,	81, 129, 476,	31, 392,	163, 261, 482, 579, 601	625, 630	110, 145, 153, 217, 238, 254, 262, 490	167, 278, 291, 306, 494,	135, 138, 172, 249, 302, 430, 529, 647
IDENTIFIES GOOD ANPs	143	281	432	265	457	166	119		311
LACK OF SUPPORT FROM PROFESSIONAL BODIES	24, 54, 463, 494	124, 129, 139, 172, 175	69, 105	138, 146, 200	69, 123,	43, 192, 201, 218, 399, [197 disconfirming]	105, 271, 276, 238, 288, 291, 307, 311, 322, 325	95, 108, 207	222, 185, 199, 213, 219, 222, 536, 546

LACK OF SUPPORT FROM NURSES	167, 335	32, 186, 317, 322, 328, 277, 302, 312, 676, 682	157, 365	380, 386, 392	592 [gender]	210, 368, 374, 381	368	119, 133, 161, 202, [266, 271, 365, 373 disconfirming]	
ROLE OF MANAGEMENT IN SUPPORTING ANP	132, 138, 468,	420, 428, 440, 448, 553	61, 534	505	223, 236	178, 516, 535	339, 471, 480,		56, 284, 407, 564,
FEELS SUPPORTED BY DOCTORS[TO AN EXTENT]	130, 291,	481, 535, 759	141, 453	206, 214,	130, 168, 261,	167, 178,	582	254, 260, 278, 318	349, 501, 564, 574, 588, 688
LACK OF SUPPORT FROM DOCTORS	118, 124	489, 495, 752, 758	426	9, 183, 192, 200,	163, 171, 279	170, 183, 483,		207, 215, 220, 233, 246, 251, 254, 323,	443, 550, 654,
PATRONAGE	138 [PM]	448, 551	18, 27	12, 264,			390	20, 400,	30, 34, 47
PERSONAL CHARACTERISTICS AND RELATIONSHIPS	130, 143, 198, 212,	281, 292, 80, 563	18, 27, 29, 210, 272, 275, 342, 365, 421, 423, 491	12, 192	90, 103, 292, 303, 320, 495, [89 disconfirming],	[no ref in interview, but field notes states she was recommended	187, 382, 386, 390, 402, 599,	20, 400, 519, 558,	30, 34, 47, 53, 93, 70

						by PN]			
PRIOR NEGATIVE EXPERIENCES/NARRATIVES	274 275, 282, 401, 432, 411	58, 84, 88, 98, 538	53, 61	9, 183, 192, 200, 380,	89, 446,	156, 170, 183, 487, 540	645	207, 236, 245, 254, 287, 291,	22, 168, 654
NURSING IDENTITY INFLUENCES TRUST	403	88	87	183, 192, 521	103, 261	221, 483	187	233	47, 53, 56, 82, 86, 433, 452, 582, 594
SUSPICION ANPS WANT TO BE DOCTORS	411	489			616	389		161, 236	314,
[ALLOWED TO BE] AUTONOMOUS	11, 43, 390, 394, 403	150,	45, 49, 132, 212, 216	130, 231, 234	56	35, 39, 141, 273	164, 471	22, 452, 456, 465,	181
PROVING YOURSELF	189, 274,	200	87, 90, 99, 206, 423		9, 20, 26, 32		187, 191, 490		208, 546
SAFETY NARRATIVE	464, 89	120, 237, 306	70, 90, 109, 503	183, 192, 560	297	211, 257	311, 317,	58, 69, 104, 183, 278	209, 332, 464, 470, 514, 529, 536, 586, 698

CONFIDENCE	46, 49, 237,	243	129, 132	148, 175, 183, 214, 177		191	191, 582, 618	48, 58, 69, 104, 278	14, 53, 104, 135, 178, 299, 340, 352, 390, 457, 464, 514, 536
FEELING VULNERABLE	253, 313, 330		141, 204	60, 146, 175, 214,	244,	170, 211, 218, 399	157, 164, 177, 191317, 322, 618,	207, 211, 246, 251, 254, 271, 287, 330,	53, 185, 199, 501, 564, 577, 582, 586, 594
ATROCITY STORIES	401, 440	59, 73	See field notes	183, 192, 198, 380, 386,	90, 446,	170, 183,		207, 211, 215, 229, 233, 246, 260, 263, 291, 318	577, 582, 586

Appendix 7 – Diagrammatic Mapping Comparing Study Sites



Appendix 8 – General Practice Website Study Pro-Forma

General Practice Website Study

Social Identity Theory (SIT) Positioning Theory (PI)

General Information:

Name of General Practice	
Description (e.g. Medical Centre, Health Centre)	
Size of practice population	
NHS Choices user rating	<i>Stars out of 5</i>
% Patients who would recommend Practice*	<i>'Among the worst' =bottom 25% of scores nationally 'In the middle range' = middle 50% of scores nationally 'Among the best' = top 25% of scores nationally</i>
Patient Survey Scores for Consultations : Doctors*	SIT/PT: Where are ANPs positioned within this survey
Patient Survey Scores for Consultations: Nurses*	
Deprivation Decile (Public Health England Website)**	(Scale 1-10. 1=more deprived 10=less deprived)
Date information extracted	

*NHS Choices Website **accessed May-September 2015

Data mapped to Social Identity Theory/Positioning Theory:

	GP	ANP	RN	Other/ Comments
Number of clinicians <i>[Question primarily devised to show the extent to which ANPs are working in general practice]</i> SIT: Do ANPs have a 'group' or individual/single practitioners?				
Number of partners PT: Are ANPs partners?				
Staff information present on website? y/n SIT: Are all professional groups represented? Is any group more prominent?				

<p>Staff information present on homepage ?y/n</p> <p>PI & SIT: Are professional groups represented equally? Is any group more prominent than another?</p>				
<p>Is information presented in section for GPs/ANPs/Nurses/other?</p> <p>SIT: is information divided into groups (e.g. using tabs)? Is one group privileged/prioritised over another?</p> <p>PT: is information presented hierarchically (implicitly or explicitly)?</p>				
<p>Is each clinician named?</p> <p>SIT & PT: Is method of presenting clinician the same (equitable) for each professional group?</p>				
<p>Is information presented for each named individual or as a professional group?</p> <p>SIT & PT: Is method of presenting information in the same way for each professional group (equitable)? Implicit or explicit hierarchy?</p>				
<p>Is clinician's gender stated?</p> <p>PT: directed to clinicians on gender lines?</p>				
<p>Professional qualifications stated?</p> <p>SIT & PT: professional status. Is this presented in same way for each group? Is one group privileged/prioritised over another?</p>				
<p>Does site state where clinicians qualified? y/n</p> <p>SIT & PT: as above</p>				
<p>Does site state when clinicians qualified? y/n SIT & PT: as above</p>				
<p>NMC/GMC number stated? y/n SIT & PT: as above</p>				
<p>Are patients signposted to specific clinicians/professions/ level of practitioner? PT: Relates to positioning of both workforce and</p>				

patients				
Is clinician's role described? <i>SIT & PT: What are the similarities and differences in the way each clinician/group's role is presented? Is one group privileged/prioritised over another?</i>				
Comments and quotes about role description <i>SIT & PT: How is the ANP presented compared to other clinical roles? What is implicitly or explicitly being said? Is one group privileged/prioritised over another?</i>				
How does information provided position the clinician within the practice team? <i>SIT: Is one group privileged /prioritised over another?</i> <i>PT: Is positioning appropriate? What is implicitly or explicitly being said?</i>				
Can the practice booklet be downloaded from website? y/n. If yes, does it provide further/different information from website?				
Additional comments				

ANP specific data:

Does ANP have minor illness/injury/triage role?	<i>PT: Is role presented as advanced/mid-level? Mini-doctor or maxi-nurse? Is ANP fulfilling an advanced level of practice?</i>
What other roles does the ANP have? E.g. management position, LTC, research, teaching	Evidence of ANP(s) fulfilling wider role? How are ANPs utilised? Any evidence of role limitations?
How does the role of the ANP described on the website relate to NMC (2005)/RCN (2012) and DH "Higher levels of practice" (2010)?	<i>SIT & PT: Does macro policy fit with micro practice?</i>
Does the Practice train ANPs? What does the website say about ANP training and who is involved?	<i>SIT & PT: positioning of GPs in relation to ANPs. Are GPs responsible for training/supervision of ANPs? Do ANPs train other ANPs, medical students etc.?</i>

Appendix 9 - Example of Thematic Table (Competence)

Code	Evidence	Practice
Assumed/ implied competence of GP	Training for PNs but not GPs	59, 69, 76
	States RNs “experienced”/”highly qualified”/”trained”, but doesn’t say same for GPs	3, 4, 13, 51, 52, 71, 73
	ANP described as “highly qualified” but GPs not	49
	“highly skilled ANP”, “ PN with specialist knowledge” Doesn’t say same for GP	81
	“We offer weekly clinics by our highly trained and qualified diabetic nurse to monitor this condition” BUT GPs not described as highly qualified – assumed competence	49
	Diabetes clinic with “Doctor or specially trained nurse”	27
	GP role assumed “In addition to GP consultations the practice offers a range of clinics and services”	35
	“As well as the doctor...”	56
	“We have an ongoing training programme for the Practice Nurses” what about GPs?	63
	“We have 3 NPs all trained to advanced levels”, “The practice nurses (who all have special interests and qualifications) play a key role in this important project.” Doesn’t say same for GP	82
PN “appropriately qualified” (who decides what is appropriate?)	84	

GP vouches for nursing competence/ qualifications/skills	“Our highly qualified ANP”	49
	“highly qualified nurse practitioner”	78
	“highly skilled ANP”	81
	“We have 3 NPs all trained to advanced levels”	82
	“our highly skilled nurses”	1
	“We are lucky to have a highly-skilled, extensive Practice Nursing Team” [Are some nurses not highly skilled?] No qualifications so can't judge how highly skilled/qualified they are	2
	“We have an excellent team of experienced nurses...”	3
	“All our sisters are fully trained” (by whom?)	3
	“highly qualified” PN (RN qualification only)	4
	“Our asthma clinic is run by specially qualified practice nurses”	5
	“We are very fortunate to have a highly skilled team of nurses” (Are some nurses not?)	5 (newsletter)
	“We have a dedicated nursing team (1 PN) to look after all your nursing needs”	25
	Practice nurses “trained in diabetes”	29

	“Our practice nurses are qualified...” but no qualifications stated	39
	“Practice nurses are qualified and registered nurses.” Template text	40
	“Our patients love our nursing staff”	45
	“Our nurses are qualified to diploma level...”	46
	Practice nurse “very well qualified”, but doesn’t state any qualifications	46
	ANP “trained to an advanced level”	49
	“We offer weekly clinics by our highly trained and qualified diabetic nurse to monitor this condition”	49
	ANP “additional training at a high level”	48
	“highly skilled female nursing staff”	51
	“our highly trained nursing staff working to locally agreed protocols”	51
	“Our commitment to personal development enables our staff to become effective members of a caring, friendly, approachable team providing health promotion and prevention services to all patients.”	52
	“our trained asthma nurse”	52
	“In addition to the doctor, X and X are our Nurse Practitioners. They can deal with most problems.”	56

	“our asthma care specialist nurse/ our practice nurses/our Diabetic Nurses”	59
	“Employed by the practice, they are fully trained to help you with family planning and sexual health, cervical smears, advice on breast self-examination, advice on minor illnesses, travel advice and immunisations”	60
	Template text: “Practice nurses are qualified and registered nurses.”	61
	“Our excellent nurses and HCAs have a wide range of skills”.	62
	“We have an ongoing training programme for the Practice Nurses”	63
	“X is a very experienced practice nurse...”	63
	“Sisters [Surname] and [surname] are fully trained to deal with all aspects of womens health.”	68
	“our specially trained practice nurses” (Nurses need to be “specially trained” to undertake LTC roles, but GPs don’t).	69
	“our trained nurse”	71
	“X is a highly qualified practice nurse” (only RGN stated)	73
	RAC: “trained clinician”	76
	“Practice nurses have become significantly more skilled over the recent years...”	78

	“The practice nursing team...are specialists within their own field.”	80
	“practice nurse with specialist knowledge”	81
	“The practice nurses (who all have special interests and qualifications) play a key role in this important project.”	82
	“our appropriately qualified PN”	84
Implication that nurses not fully skilled as standard	Receptionist triage (see separate section)	e.g. 36, 80, 81
	Asthma clinic- GPs see under 16s (under 5s)	49, (81)
	“To ensure you see a suitably qualified nurse you will be asked the reason for your appointment.”	57
	“fully trained”	60
	“Although you may ask to see the practice nurse of your choice, the reason for the appointment may determine which nurse you need to see. The receptionist, following Practice Protocol, will book your appointment with the appropriate nurse.”	68
	PNs need to be “specially trained” to perform some roles	69
	“The Practice nurse's job...”	70
	“our appropriately qualified PN”	84

Appendix 10 – Diagrammatic Representation of Theme



Abbreviations

AAPE	Association of Advanced Practice Educators
ANP	Advanced Nurse Practitioner
BMA	British Medical Association
BPS	British Psychological Society
CCG	Clinical Commissioning Group
CoDH	Council of Deans of Health
CHRE	Council for Healthcare Regulatory Excellence
CNS	Clinical Nurse Specialist
CSP	Chartered Society of Physiotherapists
DH	Department of Health
FTE	Full Time Equivalent
GMC	General Medical Council
GMS	General Medical Services
GP	General (medical) Practitioner
GP Registrar	Qualified Medical Practitioner undergoing GP training
GPwSI	General Practitioner with Special Interest in specific area of practice
HEE	Health Education England
HSCIC	Health and Social Care Information Centre
ICN	International Council for Nurses
MDT	Multidisciplinary Team
NHS	National Health Service
NMC	Nursing and Midwifery Council (UK Regulator of Nurse and Midwifery Registrants)
PA	Physician Associate/Assistant
PCT	Primary Care Trust
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial
QoF	Quality and Outcomes Framework
RCN	Royal College of Nursing (UK professional association for nurses)
RPS	Royal Pharmaceutical Society
SGHD	Scottish Government Health Department
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing and Midwifery (UK nursing regulator prior to NMC)
WHO	World Health Organisation

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