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# Nursing on the edge: nursing identity in liminal spaces

A thesis submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies (Health) by Public Works

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# Abstract

This contextual statement is focussed on nursing in clinical practice and higher education encapsulated in a selected body of published work, illustrating a career of over thirty years. This journey spans a political and policy context that includes the expansion of higher education in the 1970s, the closure of the Victorian psychiatric hospitals in the 1990's, the move of nursing from apprentice-style training into higher education in 1995, and the partial decoupling of nurse education from the NHS.

Drawing on theories of liminality and Michael Lipsky's Street Level Bureaucracy, the statement proposes innovative approaches to raising the profile of nursing, beyond a liminal position. The public works are produced from liminal spaces in clinical practice to the liminal space occupied by nursing in higher education.

Whilst accepting the essence of nursing as a caring profession, the statement suggests how societal views about nursing are stereotyped and heavily influenced by the position of women generally. This is compounded by the reluctance of feminism to embrace nursing, and nostalgic views about the profession portrayed in the media and articulated at all levels, including in government. The works indicate how this has contributed to nursing occupying a liminal space in higher education.

Focussing on nursing at the margins of society, early papers cover the period of deinstitutionalisation from the large psychiatric hospitals. Further papers focus on influencing the education, identity, and values of nurses, including how the rise of service user involvement can transform curricula. Later papers consider the views and experiences of nurse academics and students about professional identity and how this is expressed in learning and teaching; with insight into how identity and values are shaped by both clinical and educational experiences. The liminal experience of nursing in higher education is explored, alongside the dual identity experienced by nurses who move from clinical practice to the academy.

The final group of papers examine the place of work-based learning in higher education, with the paradoxical discovery that although learning in healthcare is abundant, identifying learning opportunities can be elusive.

Produced on the margins of clinical and academic practice, the works illuminate hidden areas that are not sufficiently valued. The statement and works provide a platform to raise the position and profile of nursing overall.

# Acknowledgements

I would like to thank my advisors at Middlesex University, Dr Gordon Weller, and Professors Betsy Thom and Hemda Garelick, for their inspiration, patience, advice, and interest in my journey and public works.

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This contextual statement would not have been written without the support and encouragement of the Dean of the School of Health Sciences at City, University of London, Professor Debra Salmon, who helped me visualise what was possible, believed in me and supported me to get on with it! I also thank Maura Callan for her endless patience, support, and ability to create order in my working life.

There have been many inspirational nurses in my career who have shared the joy and pain of the journey, and truly know the meaning of nursing a grudge. Thank you, Lisa Reynolds; Chris McCree; Christine Carter; Cha Power and Liz Cort.

I would like to thank my friends and family, who have supported me throughout the trials and tribulations of this journey. Jane Ramsey for tolerating endless ranting about the meaning of uniforms; Chris McCree for walking miles with me and listening to all the arguments. My husband, Steve Warren, who has patiently endured the entire journey, encouraged and supported me, celebrated the successes with me and helped me to think through the challenges, thank you for everything. Thank you to my lovely children; Edward, Matthew and Phoebe who continue to inspire and amaze me, I am proud to be your Mum.

Finally, I acknowledge the generosity of the Bart's League of Nurses who supported me to undertake this doctoral journey.

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# CHAPTER ONE: INTRODUCTION

## 1.1 MY JOURNEY

In this chapter I discuss my education and experience of clinical and academic nursing and how this has influenced the public works presented in this contextual statement. Illustrating both my involvement in the environment and subjective investment in the works produced; it demonstrates where the works came from. As such it is a reflective account that reveals perspectives developed from my circumstances and situation, drawing on self-reflexivity (Diers 2004; Hallam 2000).

This journey is divided into four phases encompassing my adult life, from 1978 to 2020. The first phase is as an undergraduate studying for a BA (hons) in Politics at the University of York; the second is as a mental health nurse, employed in a total psychiatric institution and in community mental health nursing, working with substance users and homeless people. The third phase is as a university lecturer, head of department and educational developer in higher education; the fourth is as a senior manager and leader in higher education. The publications presented in this contextual statement were produced in the second, third and fourth phases, but the first phase is fundamental to the story.

### *1.1.1 STARTING OUT*

I undertook an undergraduate degree in politics in the 1970s, a time of social mobility, with the expansion of university education in the 1960s contributing to the economic, social and modernisation agendas of the Wilson government (Dorey 2015). The first of my family to go to university, I realise now that the only person I knew then who must have undertaken a university degree was the family doctor. Exacerbating the challenge was my rather naïve choice of institution, I enrolled at what is now a Russell Group University, built in the expansion of the higher education sector in the 1960's. I had attended a state school where most of my friends did not progress to higher education; I entered an entirely different world, where most of the students had the advantage of a private education. This experience was captured by Linda Grant in her novel '*Upstairs at the Party*' (2014), set in the University of York in the 1970s.

> *'I passed through the glittering gate to knowledge, to the concrete campus and its plastic-bottomed lake, its ducks and drakes and population of girls and boys with immaculate examination records and me the imposter, trying to learn how to speak and dress.'* (Grant, 2014: p5).

I identify with Grant's description of the alienation experienced by state school entrants to the expanded university system in the 1970s; a major social experiment driven by a progressive government. The experience was both terrifying and inspiring. Reflecting on this experience, it was the first time I had encountered the use of literature to develop an argument and although I was in awe of the academic staff who developed books and papers it gave me a fundamental appreciation and respect for how knowledge is *produced.*

### *1.1.2 One giant leap: mental health nursing*

The link between my politics degree and the nursing career I embarked on is both obvious and hidden, the connection between the policy agenda and health is apparent in funding for health and social care, social policy and its links to health outcomes and health inequalities. Often this is not apparent; the policies that most affect health care and health outcomes are not always health policies; but could be housing or health and safety policies for example.

Despite this connection, at the time the leap to mental health nursing was unusual. I was educated or 'trained' in one of the large mental health institutions in West Yorkshire (the West Riding Pauper Lunatic Asylum). I undertook this training two years after graduating; one year spent as a volunteer in a women's refuge and the second as a nursing assistant. I had volunteered at a women's refuge throughout my time at university and was heavily involved in the politics of women's liberation, something which has influenced me ever since. The mental health problems experienced by the women in the refuge were overwhelming, the refuge was staffed entirely by volunteers, without training and this undoubtedly influenced my choice to move into mental health nursing. Working with vulnerable women and children reinforced my emerging ambition to influence and change systems, and I developed increased understanding of the oppression and alienation of both people with mental health problems and women experiencing domestic violence.

The training to be a Registered Mental Nurse lasted for three years, was largely experiential and exposed me to people with a range of mental health problems across the lifespan. The bleakness of the asylum, which was controlled by a nursing hierarchy with little input from other professions, had total authority over the lives of patients. At my interview the panel expressed surprise that I was not related to any of the employees in the hospital; this appeared to be problematic (it transpired that most employees were related to at least one other), the insular effect of this is recognised elsewhere (Nolan 1993; Burns 2013).

The experience of working in a total institution was profound. The lack of choices and poverty of existence of patients in the long-stay Victorian hospitals is well established, evidenced and documented in the literature as both positive and negative, and is especially vivid through the testimony of patients, relatives and staff (Beresford 2012; Goffman, 1961; MacDonald et al 2018; Nolan 2020). I recognise these accounts, in particular the dehumanising of patients described by Goffman and the nurses' perspective from Nolan. Treatment often amounted to a choice between medication and restraint; as student nurses both fell to us to administer. Some of this experience has been documented in an article by a mental health nurse, Professor Peter Nolan (Nolan 2020). Nolan was conscious that the historical experiences of working in mental health services has been largely recorded by retired psychiatrists. The article is Nolan's account of being a student mental health nurse in the 1960s. Nolan describes the poverty of existence of many long-stay patients and describes some who had a lasting effect on him. Nolan articulates the hierarchy of the asylum, with nurses placed just above the patients, at the bottom of the hierarchy.

However, in the early 1980's a movement of radical nursing emerged making the links between nursing leadership, policy and the position of women. In 1985 Jane Salvage published a ground-breaking and challenging book, *The Politics of Nursing* (Salvage 1985) calling for change in how nursing was perceived and making strong links with the position of women more generally. Over thirty years later Salvage and White noted:

> *'While policy and politics determine health and nursing practice, most nurses just want to get on with their day job. They carry out decisions made by others but have little say in them, and weak influence or status, although they are increasingly knowledgeable and skilled. In settings where policy decisions are made - parliaments, governments, and boardrooms - nurse leaders are often neither heard nor heeded.'* Salvage and White, 2019: 147

Without the support of peers undertaking the training with me I would not have successfully completed the course. The importance of peer support and developing collaborative networks was established during this period of my career. I became determined and resilient, learned when to be silent and when to speak up and above all the importance of working with others to try to effect change. Interestingly while Nolan reports that half of his cohort in the 1960s did not pursue a career in mental health nursing, by the 1980s most of my cohort did, perhaps something was already changing?

The course was predominantly work-based, and I was greatly influenced by the people I worked with and learned from. In my current role I have drawn on this experience in a research project about work-based learning in the current context of healthcare provision in the present day, drawing on Eraut's '*continuum of formality*' (2004, p250) to study, publish and develop resources to support the development of work-based learning in clinical practice (Attenborough et al 2018; Attenborough et al 2019; Attenborough et al 2020).

### *1.1.3 On the edge of clinical practice: working with drug and alcohol users*

After qualification, I practiced clinically as a mental health nurse for eleven years. The policy drive to deinstitutionalise mental healthcare, relating to the neoliberalism of the 1980s in the United Kingdom (MacDonald et al 2018), gave opportunities to work outside of a psychiatric hospital. Away from institutionalised care, I specialised in working with one of the most marginalised groups; drug and alcohol users within services separated from mainstream provision, structurally and psychologically. My work with intravenous drug users (IVDU) between 1986 and 1990 coincided with the discovery of a new blood borne virus. The virus did not have a name (it was identified as HTLV 3) and was subsequently identified as the Human Immunodeficiency Virus (HIV). Groups considered initially vulnerable to contracting the virus were men who had sex with men, IVDUs and the recipients of blood products. I encountered considerable fear and ignorance among intravenous drug users themselves, the public and healthcare professionals, these issues were described and examined by Kelly et al (1988), in particular the hostility of some nurses towards working with people who were HIV positive.

One immense challenge was to try to reduce the spread of the virus by encouraging safer drug use and sexual behaviour. This involved giving IVDUs access to clean injecting equipment and condoms. The scheme was supported financially by the government; and its impact reported by Stimson et al (1988). This was the first time I was knowingly involved with new public health initiatives. I realised the potential of nursing to operate outside of a task-based model and independently of the medical hierarchy. Working directly with IVDUs we established what would work for them, contacted local pharmacies to ask if they would assist by dispensing the drug using equipment. We produced small packages that included advice about safer injection and safer sex, and injecting equipment, including a leaflet co-designed with the service users (see fig 1).

The Police Drug Squad agreed not to arrest people accessing the clean injecting equipment or returning the used needles and syringes; therefore, negotiating an agreement that the Drug Squad were prepared to see articulated in the leaflet was paramount to its success. This illustrated cooperation of all parties with a harm reduction model, signalling that HIV disease carried more risk to the public than drug use (Ball 2007).

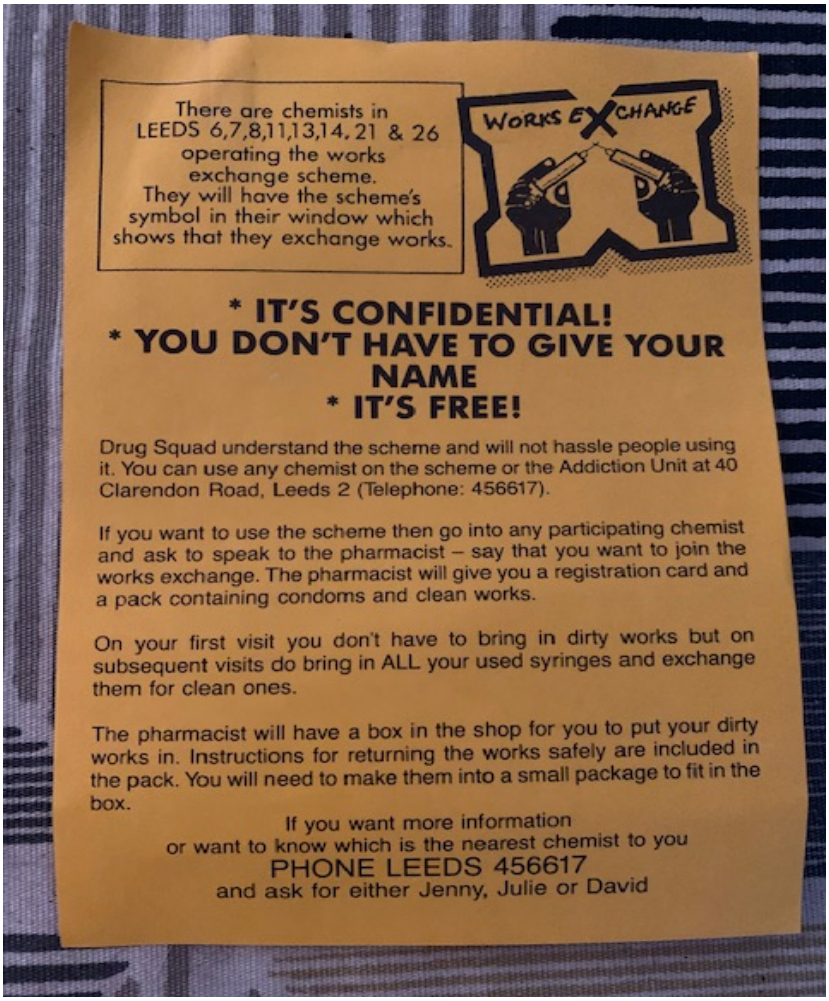


**Figure 1: Leeds Works Exchange leaflet, 1989**

The concept of service user involvement is now an established part of service development for health services (Craig 2008), but in the 1980s it was unusual. This project illustrated how effective service user involvement is when working with marginalised groups, to ensure that their voices are heard. Service users supported the safer injection clinics and outreach work we undertook, by recruiting participants and engaging with them in health education about safer drug use. Importantly, we were able to pay them for this essential work.

Although nurses collected data to support the work, this was where our involvement in the research and dissemination of the work ended. It never occurred to me that I could be involved in the actual development of published work. It was twenty years before I would have the opportunity to lead projects involving service users and carers in service development and in education, leading on a national project, developing and publishing materials (Attenborough et al 2007).

### *1.1.4 On the edge of clinical practice: homeless people with mental health problems*

The appeal of working with people at the very margins of society was further reinforced when I became a Community Psychiatric Nurse with the Homeless Mentally Ill Initiative (HMII) in 1991, a project funded by the Department of the Environment and the (then) Department of Health consisting of four specialist outreach teams based in London. My role was to offer treatment and accommodation to homeless people not already engaged with mental health services. Our patients were marginalised from mental health services and society, due to the difficulties of engaging in both, for example registering with a general practitioner is challenging without an address, and mental health services were generally accessed through the gateway of general practice (Perry and Craig 2015).

My first educational role was created within the HMII following an appalling consequence of this marginalisation. Jonathan Newby, a lone volunteer worker in a Cyrenian hostel for homeless people was killed by a service-user diagnosed with schizophrenia and alcohol problems. This violent killing shocked the mental health community and the general public; it exposed the vulnerability of volunteer workers and the lack of organisation or training undertaken to support people with mental health problems outside of specialist services (Peay 1995). The inquiry into Jonathan Newby's death recommended that education be provided to voluntary and third sector organisations to reduce risk and improve the care of homeless people with mental illness (Davies et al 1995). My earlier learning about the power of alliance and teamwork, service user engagement and support informed me of the importance of increased collaboration and communication between the voluntary and statutory sectors. This was challenging but gave me insight into the power of education to inspire decision-making and increase control and confidence through knowledge.

### 1.1.5 BACK TO UNIVERSITY

Whilst undertaking this role I completed an MSc in Mental Health Studies between 1991 and 1993. This was personally very challenging; I had a young family and a demanding full-time clinical role. I was pregnant with my second child in the first year, gave birth in the summer break and completed the course with a baby and a two-year old. Looking back, I must have been very determined; I often wonder why I did it then, why didn't I wait for a year, take a break, defer? Developmental opportunities for nurses were extremely rare and I feared that if I didn't do it then I would never have the chance again.

Completing the MSc was a major turning point in my career for two reasons- firstly, I had the opportunity to undertake empirical research associated with my clinical work and to join a small research team for my final dissertation; secondly, by successfully completing the course I was able to move into an academic role. My research project focussed on the homeless men I was working with and led to two peer reviewed publications. This was my first experience of publishing my work in academic journals (Attenborough 1998; Attenborough and Watson 1997) and inspired me to continue researching and publishing about mental illness and homelessness even after moving to an academic post (Cort et al 2001; Power and Attenborough 2003). Writing for publication required different skills to my undergraduate degree with the necessity to be succinct, to synthesise literature and importantly to accept the reviewers' comments without taking them personally- the latter taking longer to achieve! This early experience encouraged me to publish throughout my academic career as a way of building an evidence-base in under-researched areas, recording my own contribution, and more recently to communicate innovations and promote good practice.

The impetus to move to an academic post came from my MSc dissertation supervisor- a Professor of Psychiatry who encouraged me to join his team in the medical school. This was a difficult role to fulfil alongside my clinical and educational roles. On reflection this was probably due to the position of nurses in medical schools at the time, following the hierarchy of clinical practice, typically collecting specimens for medical research, with little involvement in actual investigation; excluded both clinically (from other nurses) and marginalised in the academic world (Kunhunny and Salmon 2017). As nursing moved into higher education, I applied for a role in one of the newly founded Schools of Nursing and Midwifery within a university. This was more recognisable to me, but as I would discover more liminal in the context of higher education.

I moved to a substantive post in higher education in 1997 as a lecturer in mental health nursing specialising in substance use problems. As part of this role, I undertook a Post Graduate Certificate in the Education of Adults. This course enabled me to consolidate and develop the theoretical basis of my educational practice; whilst having support and guidance to evaluate structures of higher education, develop and implement curricula and gain knowledge about the complex policy context. At the time this course was a compulsory element of being an educator of nurses and midwives, but it also formed the foundation for my future development and leadership in HE, by instilling a student-centred, evidence-based approach from the outset. In 1997, an increase in investment in the education of the NHS workforce resulted in nursing courses growing rapidly and consequently there were more opportunities for people wishing to study nursing and midwifery.

The School of Nursing and Midwifery had been created two years previously when nursing moved from an apprentice-style training into higher education. Situated physically, materially and psychologically at the very edge of higher education, the place of nursing in the academy was and remains controversial, with a dual identity for academic staff and a lack of acceptance of the need for nurses to be educated by wider society (Andrew, 2012; Gillett, 2014; Thompson et al, 2017). There is a still the belief as reported, but not endorsed, by Oliver (2017) that too much education is the cause of the problems in nursing. The position of nursing is closely linked to the position of women more generally; 90% of the nursing and midwifery register are women (NMC 2019). In 2016 the All-Party Parliamentary Group on Global Health produced the triple impact report, calling for more investment in nursing to support health improvement, gender equality and economic growth (APPGGH 2016), and a global campaign was launched called *Nursing Now*. The momentum for change is building with the World Health Organisation declaring 2020 the year of the Nurse and Midwife. The position of nursing both in the academy and in clinical practice has been brought into sharp focus by the role of nursing in the Covid-19 pandemic (Thompson and Darbyshire 2020), which is discussed later in this statement.

### *1.1.6 From the margins of society to the edge of the academy*

Moving into higher education might appear to be the most conventional choice of my career, but it is here that I recognise an interesting pattern. On the face of it eleven years in clinical practice, a professional qualification, an undergraduate and post-graduate degree and a post-graduate teaching qualification equipped me to deliver professional education within higher education and to move away from working at the margins of society, in peripheral services with disenfranchised groups. Yet I moved into one of the most liminal, marginalised spaces I have inhabited, the space occupied by nursing in the academy. In clinical practice I was working with groups of patients in

liminal spaces (Chamberlain and Johnson 2018). When I moved to the academy, I found myself marginalised by the position of nursing in universities. This influenced both my professional identity and the published works I produced in this period.

I have held three senior managerial roles in higher education. First, as a Head of Department and subsequently two roles as an Associate Dean. These roles have given me extensive experience of leading on innovation, managing staff, curriculum development and strategic leadership. They also represented a move away from nursing- the three roles spanned a school that included midwives, radiographers, optometrists and speech and language therapists, a role less liminal perhaps. Conversely, by becoming head of the Educational Development Unit and moving away from research and clinical practice I had entered the occupational liminality described by Bamber et al (2017) in relation to the education/research divide in universities. Reconciling this presented a dilemma. My transition into a stronger education and pedagogic profile developed after returning from a period of unpaid leave in 2003, which I had taken to care for my three children. When I returned, I undertook the role of programme director for a new online healthcare education course in collaboration with two other universities.

The world of WebCT and the virtual learning environment was emerging- I decided to consider it an opportunity, but with trepidation; my psychological state certainly fulfilled Hannabuss' criteria for '*conscious incompetence'* (Hannabuss, 2000 p402). It also presented learning opportunities and different approaches to deliver education. This led to exciting projects and further pedagogical research, including a project and publication with a medical school producing online tools to enhance communication skills in medical and nursing students. I was invited to work with the National Centre for Clinical and Academic Workforce Innovation to develop a toolkit for primary care professionals working with common mental health problems (Attenborough et al 2007). Published as a reference book this resource was disseminated to all UK GP practices, and is considered a core text, used across the sector by students from a variety of disciplines. It was a significant period in my career-managing an important project with a national reach, script writing and producing videos and text. I realised that being more outwardly focussed changed my perspective, working across disciplines and with other senior leaders was an experience of both leadership and followership. Subsequently I have learned that these two singularities are closely interlinked- in this project I undertook the follower role within the national steering committee, whilst adopting a leadership role at a local level. Hollander (1992) considers followers undertaking leadership functions, and the importance of the follower role in contributing to successful leadership. In this project my follower role was as active as my leadership role, and it involved

extensive and sometimes problematic communications with others in the same situation, as followers and leaders.

### *1.1.7 LEADING AT THE EDGE OF THE ACADEMY*

I was appointed to the role of Associate Dean Education Innovation and Technology (ADETI) in 2011. I chaired the school's learning and teaching committee, introduced a showcase event, developed a technology-enhanced learning strategy and worked on cross-institution projects. This role required inspirational leadership to promote followership in academic and administrative staff to achieve transformational change. It was in this role that I identified the important interaction or co-production that produces successful leadership, working towards specific outcomes (Cartsen and Uhi-Bien 2012). By utilising a champions model, whereby academic staff volunteered to inspire others to adopt new technologies and ways of working we were able to co-produce effective leadership. The management and leadership literature is helpful in articulating and interpreting this process. For example, Collinson (2006) suggests, followers might impact on leaders' identities, and leaders should increase their appreciation of followers' identities and experiences. This, in turn relies on leaders letting go of their 'self-preoccupations' (Collinson, 2006: p187) which may inhibit their relationship with followers and effective practice. Hollander and Kelly (1990) found that interpersonal abilities divided good from bad leaders in the minds of followers, and that understanding, warmth and praise were important factors. This has resonance with my position, both as a woman in a leadership role and as a nurse, remembering Salvage's words:

> *Any occupational group dominated by women will be subject to society's value-judgements about supposedly female attributes and capabilities.* Salvage, 1985, p5

It has made me question what sort of leader I should be, to be appreciated and respected by staff who might be followers, or collaborators, whilst retaining my interpersonal style and understanding their perspective against a backdrop of targets and strategies. My decision was to champion the work of others (through developing showcase events) to invest and develop others' skills and competencies, their projects and innovations at a strategic level. Concurrently I was leading on projects such as student preferences in assessment, m-learning, learning spaces and the introduction of on-line role-play and developing a portfolio of publications.

For the last five years I have been the Associate Dean: Director of Undergraduate Studies. This is a substantial role that includes regulatory duties, leading on procurement and tenders and negotiating substantial contracts with government departments. My remit includes accountability for the entire student journey from application to graduation. I undertook this role in the context of the biggest policy shift in the funding and delivery of professional healthcare education for 20 years; the introduction of fees for healthcare courses, higher apprenticeships and the introduction of a new healthcare role; latterly in the context of a global pandemic.

My focus has become more outward-facing towards education in the health-care economy, representing the university at the Council of Deans for Health, chairing the London Health Education Group for *London Highe*r, Health Education England and the Nursing and Midwifery Council. I have been supported by specific leadership courses and coaching, and I have learned how to better prioritise and to appraise my career and trajectory. Applying for this DProf through Public Works was an outcome of this coaching. Though some of my leadership is transformational, there is much that could be described as transactional, with the introduction of workload modelling and performance review. I am mindful that the latter is associated with increased levels of stress in employees (Rowold and Schlotz, 2009), and this presents a dilemma. My inclination is towards a style of inspirational leadership as described by Rowold and Schlotz, holding a vision, expressed values and a role in creating the evidence-base through research and publication.

In 2017 I became a Principal Fellow of the Higher Education Academy and in 2018 an Associate Professor, representing internal and external validation of my achievements in education, scholarship and academic leadership.

## 1.2 TIMELINE: IDENTIFICATION OF PHASES

The public works chart my career in clinical practice and academic nursing. The works are divided into four phases, there are therefore four sets of publications. Inevitably the timelines overlap, and themes are developed across roles and throughout my career:

**1997-2003** The early papers focus on exposing stigma and challenging practitioner assumptions about sexuality, mental health and homelessness. These papers were written in the 1990s during a period of deinstitutionalisation of mental health services, as patients were moved from hospital and hostels to community settings with inconsistent and often inadequate support. The papers

focus on exploring and describing the role practitioners could play in mitigating such disadvantage and investigate what could be achieved.

**2007-2018** The second set of papers focuses on influencing the education, and pedagogical values in nurse education. The papers explore how the experience of service users and student nurses inform curricula that are patient-centred, values-based and clinically relevant. Incorporated within this is an investigation of how those with mental ill-health could best communicate their experiences to shape the educational and professional practice of student nurses.

**2017-2020** The third set of papers considers the views and experiences of nursing academics and students of professional identity and how this is expressed in teaching, learning and assessment; with insight into how identity and values are shaped by both clinical and educational experiences and techniques such as storytelling. The works relating to the role of professional revalidation in an educational context, the role of credibility and its relationship to nurse identity illustrate the experience of being a nurse academic in the UK today.

**2018-2020** The fourth set of papers focuses on work-based learning in clinical environments, noting the change to healthcare education delivery, the expansion of the nursing workforce, and the embedding of different ways of learning.

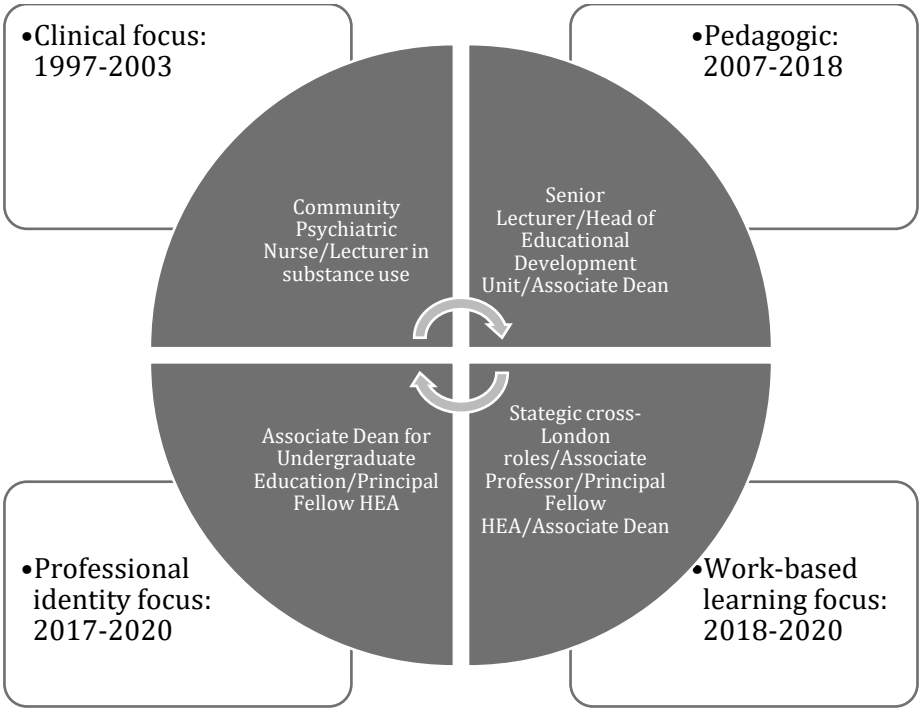


**Figure 2: Relationship of focus to roles**

## 1.3 STRUCTURE OF THIS CONTEXTUAL STATEMENT

The first chapter of the statement outlines my journey, the roles I have undertaken and the background for the basis of the works. The second chapter examines the method and rationale used for selecting the works. Chapter three is a summary of the works and chapter four introduces the themes emerging from the works that are developed in this statement. In chapter five I explore two explanatory theories that underpin the works, and the methodological approaches used in the research reported in the papers. This chapter also discusses the ethical considerations associated with both the works and this statement.

The following eight chapters discuss the public works, the political and policy context from which they emerged and the changing position of nursing that is revealed. Each collection of works is discussed in relation to its impact and contribution. The final chapters discuss the overall significance of the selected works to nursing's story; the limitations of the works and this statement, future considerations, and the impact of the Covid-19 global pandemic as an unexpected traumatic influence. Finally, the statement considers what it means to be a nurse today.

# CHAPTER TWO: SELECTION OF WORKS

Selecting the public works to form the focus of this contextual statement was a more difficult task than I had envisaged. There are twenty-six works spanning twenty-three years and encompassing clinical and university projects: education, policy, individual and collaborative endeavours with clinical practice. The collection includes peer reviewed journal publications, book chapters, and manuals with accompanying DVDs. Selecting the works was a thought-provoking process, establishing the common themes and the links between them. Some of the works reflected clinical and policy priorities at the time of writing or formed the basis for later studies, while others explore a concept or support an intervention in education or clinical practice. Establishing, and at times disentangling the '*golden thread of connectivity*' (Smith 2015, p81), to place the works in the policy and practice contexts and the overall contribution was challenging based on an expansive portfolio. The works fall broadly into a chronology that maps across my career, from clinical practice through to higher education. In this section I describe the process I employed for selection of the key works that form the basis of this contextual statement.

## 2.1 METHODOLOGY: THE SELECTION PROCESS

I started by constructing a physical exercise whereby I placed hard copies of the works in chronological order around my kitchen table and then using post-it notes identified the themes in the works. What emerged was a map of my journey, see below figs 3-6. Through this exercise I was able to omit articles and book chapters that had less bearing and connection to others, had less originality or the findings were covered elsewhere. I focused on how the individual works had contributed to knowledge in the field, the quality of the output and whether the works were based on original data. What emerged had more coherence, but the volume of works remained unwieldly.

I then conducted a second exercise (without the kitchen table) to select works that aligned closely to my journey, had originality and impact and supported the themes that had emerged from the first exercise, using four criteria:

1. The relevance of the themes in the works to the '*golden thread of connectivity*' (Smith 2015, p81)
2. The contribution to knowledge and dissemination of the works through citations and other markers such as selection for reading lists.
3. The originality of the paper or chapter.
4. The coherence of the work to the central theme.

The decision to use explicit criteria was based on an acknowledgement that this was a subjective process, and I was aware of the possibility of bias. Although the works were selected through discussion with my advisors, a retrospective analysis inevitably leads to the possibility of subjective bias; I have attempted to minimise this as far as possible.

Some of my favourite papers for example, those I had written in collaboration with close colleagues or as part of a successful or rewarding project were omitted because they fell short of these criteria; the process highlighted the value of systematic appraisal of my work, which, though painful, has produced a more focused and coherent collection. Furthermore, the process helped to refine the linking theme and helped to conceptualise the statement in my mind. Interestingly, by introducing a structure I was able to reflect more systematically on the value of the respective works and my professional development.

Where themes in the works have been further developed in subsequent works these have been omitted, see below (fig 7). Twelve public works were omitted; 14 public works were selected for inclusion.

### *2.1.1 IMPACT*

The older works have demonstrated impact, both nationally and internationally through Google Scholar and Scopus citations (see appendix four). More recent works, unsurprisingly, have fewer citations; therefore, although I did take this into account it did not form one of the criteria. In addition to citations, *altmetric* (alternative metrics) can give an indication of interaction and dissemination through *Twitter* or print media, for example reference to a research paper in a newspaper article. Additionally, they are used by librarians in the decision process about subscriptions. The advantage of *altmetrics* is the speed of analysis or data mining, there have however been criticisms of the use of the metric- most notably from Colquoun and Plested (2014), who cite similar arguments to Jeffrey Beal, the American librarian who has campaigned against predatory publications and conferences, that the system is open to manipulation and predatory *almetrics* are emerging.

## 2.2 DIAGRAMS ILLUSTRATING SELECTION PROCESS

### 2.2.1 TIMELINE WITH THEMES: KITCHEN TABLE EXERCISE


**Figure 3: Phase 1- Clinical Practice**


**Figure 4: Phase 2- Pedagogy**

## Public Works

- Attenborough J (2017) **Enabling revalidation for registrants working in an education setting.** *Nursing Times 113* (4), pp. 34–35.
- Attenborough, J.A. and Abbott, S. (2018). **Building a professional identity: views of pre-registration students.** *Nursing Times*, *114*(8), pp. 52–55.
- Attenborough, J. and Abbott, S. (2019)**The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution: A qualitative study.** *Nursing Open 6*
- Attenborough, J., Reynolds, L. and Nolan, P. (2019). **The Nurses That Roared: Nurses From History Who Found Their Voices and Challenged the Status Quo.** *Creative Nursing*, *25*(1), pp. 67–73.
- Attenborough, J. and Abbott, S. (2020). **Using storytelling in nurse education: The experiences and views of lecturers in a higher education institution in the United Kingdom.** *Nurse Education in Practice*

## Context

- These works consider the views and experiences of nursing academics and students about professional identity and how this is expressed in teaching, learning and assessment; with insight into how identity and values are shaped by both clinical and educational experiences.
- The works consider the position of nurses in clinical practice and in the academy, how this has been shaped and how it can be influenced and changed.
- These works examine approaches to nurse education, including how clinical experience influences nursing academics to inspire the future workforce and maintain their own clinical credibility. Understanding the role of professional revalidation in an educational context, the role of credibility and its relationship to nurse identity illustrates what it is to be a nurse academic in the UK today.

## Themes

- The dual identity of nurse academics in higher education; the 'good academic' versus the 'good clinician', how nursing lecturers are perceived and how their self-perception influences their progression in the academy.
- The liminality of nurse academics
- Staff and student perceptions of credibility, how lecturers develop and shape professional identity and values in students, whilst retaining their own professional credibility and identity.

**Figure 5: Phase 3- Professional identity**

## Public works

- Halse, J., Reynolds, L. and Attenborough, J. (2018). **Creating new roles in healthcare: lessons from the literature.** *Nursing Times 114 (5) pp34-37*
- Attenborough, J., Knight, R.A. and Brook, J. (2018). **Developing and sustaining a community of practice through twitter for work-based learning.** *Evidence-Based Nursing*, *21*(4), p. 115.
- Attenborough, J., Abbott, S., Brook, J. and Knight, R.A. (2019). **Everywhere and nowhere: Work-based learning in healthcare education.** *Nurse Education in Practice*, *36*, pp. 132–138
- Reynolds, L., Attenborough, J. and Halse, J. (2020) **Nurses as educators: creating teachable moments in practice.** *Nursing Times 116(2) pp25-28*
- Attenborough, J., Abbott, S., Brook, J. and Knight, R.A., 2020. Pioneering new roles in healthcare: Nursing Associate students' experiences of work-based learning in the United Kingdom. *Work Based Learning e-Journal*, *9*(1), pp.35-60.

## Context

- The focus of this collection of works is on the clinical workforce; the works make recommendations for the introduction of new roles, explore the use of social media to support introduction of new pedagogies and investigate how work based learning is being implemented.
- The works report an emerging model to support student nurse educators to create teachable moments in clinical practice.

## Themes

- New directions, new roles, the future of nursing and nurse education
- Developing an effective learning culture
- Identifying learning opportunities
- Developing professional identiity through workbased learning

**Figure 6: Phase 4- Work-based learning: the clinical workforce**

### 2.2.2 First cut

| | | Public work omitted | Rationale for omission |
|---|---|---|---|
| First Cut | 1 | Attenborough, J., Knight, R.A. and Parker, P. (2018). Undergraduate student views about assessment workload. *Educational Developments*, (19.3), pp. 14–16 | Article written prior to data collection for a project and therefore contains concepts and literature rather than data. |
| | 2 | Attenborough, J (2006 and 2015) Motivational Interviewing Chapter in Callaghan, P and Waldock, H (Eds) *Oxford Handbook of Mental Health Nursing* Oxford University Press | Textbook chapter in a widely used but generalist reference book. |
| | 3 | Parker, P.M., Attenborough, J., Cunningham, M., Holland, W. & Perkins, J. (2013). Interim Project Report: Teaching Excellence: what is this and how can we assess and recognise this. *Learning at City Journal*, 3(1), pp. 92-97 | This is a project report, the analysis is somewhat limited, and it does not align closely to themes. |
| | 4 | Attenborough, J (2010) Alcohol and Mood Disorders in Phillips, P., McKeown, O and Sandford, T *Dual Diagnosis: practice in context*. Blackwell. Oxford (Book Chapter) | This is a textbook chapter, though it is clinically based it does not contain original data. Added to the literature base for dual diagnosis at the time but has been superseded and I have not developed the themes to link to other works. |
| | 5 | Attenborough, J (2009) Mental Health Nursing. Chapter in Levett-Jones, P and Bourgeois, S *The Clinical Placement, A Nursing Survival Guide* 2nd Edition Elsevier (Book Chapter) | General piece for nursing textbook, no original data. |
| | 6 | Attenborough J and Reynolds, L (2009) *Heartsounds: the Butabika Project* (DVD and reusable learning object for service user and carer education and training) | Concept covered by other publications. |

**Figure 7: Works omitted, first cut.**

### *2.2.3 Second cut*

| | | **Public work omitted** | **Rationale for omission** |
|---|---|---|---|
| Second Cut | 1 | Attenborough, J., Knight, R.A. and Brook, J. (2018). Developing and sustaining a community of practice through twitter for work-based learning. *Evidence-Based Nursing*, 21(4), p. 115. doi:10.1136/eb-2018-102981. | Limited data, discussion about the evidence base for intervention. |
| | 2 | Halse, J., Reynolds, L. and Attenborough, J. (2018). Creating new roles in healthcare: lessons from the literature. *Nursing Times* 114 (5) pp34-37 | This is a report of a systematic review of literature about the introduction of new roles in healthcare. The findings from the systematic review were uses as a basis for a framework analysis used in an included publication. |
| | 3 | Attenborough J (2017) Enabling revalidation for registrants working in an education setting. *Nursing Times* 113 (4), pp. 34–35. | Limited data, this article introduces the concept of identity in nurse academics, this is developed and evidenced in a later article. |
| | 4 | Abbott, S. and Robinson, A. and Attenborough, J.A. (2014) How would students prefer to be assessed? Report of a pilot research study. *Learning at City Journal* 4(1) | Not first author, this publication relates to students' experiences of assessment, which is not one of the key themes |
| | 5 | Attenborough, J.A., Gulati, S. and Abbott, S. (2012). Audio feedback on student assignments: boon or burden? *Learning at City Journal*, 2(2) | Specific educational intervention- adds to the literature about this intervention and has been cited but does not link well to the themes. |
| | 6 | Abbott, S., Attenborough, J., Cushing, A., Hanrahan, M., and Korszun, A (2009) Patient centred care and compulsory admission to hospital: students consider communication skills in mental health care *Journal of Mental Health Training, Education and Practice* 4 (6): 26-34 | I am not the first author in this evaluation of a specific intervention. Although I designed the intervention and it is a good example of collaborative multidisciplinary working, the article is tangential to the themes. |

**Figure 8: Works omitted, second cut**

## 2.2.4 FINAL SELECTION

Public Works

- Attenborough, J.A. and Watson, J.P. (1997). Staff Perception of Sexual Behaviour in a London Shelter for Homeless Men. *Journal of Sexual and Marital Therapy*, *12*(2), pp. 139–146.
- Attenborough, J., 1998. Sexual relations in a cold-weather shelter for homeless people. *Nursing Times*, *94*(32), pp.50-2.
- Cort, E.M., Attenborough, J.A. and Watson, J.P. (2002). An initial exploration of community mental health nurses' attitudes to and experience of sexuality-related issues in their work with people experiencing mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *8*(6), pp. 489–499.
- Power, C. and Attenborough, J. (2003). Up from the streets: A follow-up study of people referred to a specialist team for the homeless mentally ill. *Journal of Mental Health*, *12*(1), pp. 41–49

Context

- These works focus on exposing stigma and challenging practitioner assumptions about sexuality, mental health and homelessness.
- These works were produced in the 1990s and early 2000s during a period of deinstitutionalisation of those with mental illness, as patients were moved from hospital to community settings with inconsistent and inadequate support.
- The papers focus on exploring and describing the role practitioners could play in mitigating such disadvantage.

Themes

- Liminality and disenfranchisement
- Nursing at the margins
- Sexuality and relationsh342ips in liminal spaces
- Service intervention: Role of clinical staff in mitigating disadvantage working at the margins
- Exposing stigma
- Emerging focus on training and education

**Figure 9: Phase 1 clinical practice**

Public works

- Attenborough, J.A., Goodfellow, B. and Light, I. (2007). **Practice Based Working with Users, Carers and Support Agencies.** In Myles, P. and Rushworth, D. (Eds.), *A Complete Guide to Primary Care Mental Health, Part Two* London: Robinson.
- Simpson, A., Reynolds, L., Light, I. and Attenborough, J. (2008). **Talking with the experts: Evaluation of an online discussion forum involving mental health service users in the education of mental health nursing students.** *Nurse Education Today*, *28*(5), pp. 633–640.
- Attenborough, J.A. and Abbott, S. (2018). **Leave Them to Their Own Devices: Healthcare Students' Experiences of Using a Range of Mobile Devices for Learning.** *International Journal for the Scholarship of Teaching and Learning*, *12*(2)

Context

- These works focus on influencing the education, identity and values of nurses. They explore how the experience of service users and student nurses inform curricula that are patient-centred, values-based and clinically relevant. Incorporated within this is an investigation of how those with mental ill-health could best communicate their experiences to shape the educational and professional practice of student nurses.

Themes

- The embedding of professional values through teaching and assessment methods- developments shaped through the lens of service users, through patient-centred education and care, and how the voices of service users and students are heard.

**Figure 10: Phase 2 pedagogy**

## Public Works

- Attenborough, J.A. and Abbott, S. (2018). **Building a professional identity: views of pre-registration students.** *Nursing Times, 114*(8), pp. 52–55.
- Attenborough, J. and Abbott, S. (2019)**The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution: A qualitative study.** *Nursing Open 6*
- Attenborough, J., Reynolds, L. and Nolan, P. (2019). **The Nurses That Roared: Nurses From History Who Found Their Voices and Challenged the Status Quo.** *Creative Nursing*, *25*(1), pp. 67–73.
- Attenborough, J. and Abbott, S. (2020). **Using storytelling in nurse education: The experiences and views of lecturers in a higher education institution in the United Kingdom.** *Nurse Education in Practice*

## Context

- These works consider the views and experiences of nursing academics and students about professional identity and how this is expressed in teaching, learning and assessment; with insight into how identity and values are shaped by both clinical and educational experiences.
- The works consider the position of nurses in clinical practice and in the academy, how this has been shaped and how it can be influenced and changed.
- These works examine approaches to nurse education, including how clinical experience influences nursing academics to inspire the future workforce and maintain their own clinical credibility. Understanding the role of professional revalidation in an educational context, the role of credibility and its relationship to nurse identity illustrates what it is to be a nurse academic in the UK today.

## Themes

- The dual identity of nurse academics in higher education; the 'good academic' versus the 'good clinician', how nursing lecturers are perceived and how their self-perception influences their progression in the academy.
- The liminality of nurse academics
- Staff and student perceptions of credibility, how lecturers develop and shape professional identity and values in students, whilst retaining their own professional credibility and identity.

**Figure 11: Phase 3- Professional identity**

## Public works

- Attenborough, J., Abbott, S., Brook, J. and Knight, R.A. (2019). **Everywhere and nowhere: Work-based learning in healthcare education.** *Nurse Education in Practice*, *36*, pp. 132–138
- Reynolds, L., Attenborough, J. and Halse, J. (2020) **Nurses as educators: creating teachable moments in practice.** *Nursing Times 116(2) pp25-28*
- Attenborough, J., Abbott, S., Brook, J. and Knight, R.A., 2020. Pioneering new roles in healthcare: Nursing Associate students' experiences of work-based learning in the United Kingdom. *Work Based Learning e-Journal*, *9*(1), pp.35-60.

## Context

- The focus of this collection of works is on the clinical workforce; the works make recommendations for the introduction of new roles, explore the use of social media to support introduction of new pedagogies and investigate how work based learning is being implemented.
- The works report an emerging model to support student nurse educators to create teachable moments in clinical practice.

## Themes

- New directions, new roles, the future of nursing and nurse education
- Developing an effective learning culture
- Identifying learning opportunities
- Development of professional identiity through workbased learning

**Figure 12: Phase 4- Work-based learning- the clinical workforce**

# CHAPTER THREE: SUMMARY OF THE SELECTED WORKS

## 3.1 PUBLIC WORKS DEVELOPED FROM CLINICAL PRACTICE

### *3.1.1 POWER, C. AND ATTENBOROUGH, J. (2003) UP FROM THE STREETS: A FOLLOW-UP STUDY OF PEOPLE REFERRED TO A SPECIALIST TEAM FOR THE HOMELESS MENTALLY ILL. JOURNAL OF MENTAL HEALTH, 12 (1): 41-49*

This article reports on a retrospective case note review of a consecutive series of 100 homeless people. The research was conducted in a mental health team in South East London that was part of the homeless mentally ill initiative. The initial review was carried out between January 1994 and December 1994, the follow-up was conducted between May and June 1998, minimum follow-up time was 40 months, maximum follow-up time 50 months, it was a long study which enabled us to produce meaningful data; in contrast to the short termism of many projects for homelessness people.

The article supports the proposition that with sufficient support from a specialist multidisciplinary service, homeless people with mental health problems can live a settled life. The article analyses data produced from working with people in a liminal state and demonstrates what is possible, while challenging the neoliberalist view, prevalent at the time, that homelessness is a choice made to promote independence and individuality.

### *3.1.2 CORT, E.M., ATTENBOROUGH, J. & WATSON, J.P. (2002) AN INITIAL EXPLORATION OF COMMUNITY MENTAL HEALTH NURSES' ATTITUDES TO AND EXPERIENCE OF SEXUALITY-RELATED ISSUES IN THEIR WORK WITH PEOPLE EXPERIENCING MENTAL HEALTH PROBLEMS. JOURNAL OF PSYCHIATRIC AND MENTAL HEALTH NURSING, 8 (6): 489-499*

This quantitative study was conducted with community mental health nurses in the United Kingdom in 2001. This article builds on work about sexual behavior and attachment investigated in Attenborough and Watson (1997) and Attenborough (1998). This article focusses on meeting the unmet needs of people with mental health problems. Using a sexual ideology scale and additional relevant questions the study recruited participants in an opportunistic sample at an annual Community Psychiatric Nurses conference, additional participants were recruited through

a snowballing exercise. Respondents (n=121) supported the premise that sexuality is a relevant area for community mental health nursing and importantly recognised people with mental health problems as sexual beings, though only 52.4% agreed that a sexual history should routinely be included in an assessment. A significant finding was that 17% had encountered patients becoming sexually aroused when they were administering depot injection in the community. Despite the awareness there was little agreement about how this might translate into actual nursing practice. The paper acknowledges the importance of professional boundaries and conduct in nursing practice.

### *3.1.3 Attenborough, J., (1998). Sexual relations in a cold-weather shelter for homeless people. Nursing Times, 94(32), pp.50-52*

This article reports on a mixed methods study that was conducted in a cold-weather shelter for young homeless people run by the *Crisis* organisation in London in 1996/7. The study builds on previous work with homeless men in direct-access facilities (Attenborough and Watson 1997). There were three aspects to the study, a case note review; the addition of screening questions to assessments by mental health professionals about sexual history and problems; semi-structured interviews with fifteen residents and interviews with fifteen staff.

There was less evidence of sexual coercion in this study than in the Attenborough and Watson (1997) paper. There was evidence of strong attachments after relatively little contact and descriptions of being in love after only a few days of having sex with another resident. There were many reports of sexual abuse in childhood, perpetrated by family members, leading to long standing problems with sexual relationships. The shelter had provided a room for couples, which was used primarily for sex. Only heterosexual people used the room; participants identifying as homosexual said it would be too public a declaration of their sexuality. Staff working in the shelter experienced problems with containing the emotional fall-out from relationships, they observed that the young residents did not have a problem forming relationships but did experience difficulties in sustaining them. The paper identifies a state of psychological homelessness that predates the actual homelessness and relates to childhood and poor attachment.

### *3.1.4 Attenborough, J and Watson, J.P. (1997) Staff Perception of Sexual Behaviour in a London Shelter for Homeless Men. Journal of Sexual and Marital Therapy 12 (2): 139-146*

This qualitative study was conducted in a direct-access hostel for homeless people in London in 1994. Acknowledging the paucity of data about sexual behaviour among hostel dwelling men, the investigation was triggered by concerns about sexual coercion and unsafe sex, risk factors for infections with blood borne viruses. The study was undertaken when the hostel was privatised, part of the reform of the direct-access hostels in the UK, the descendants of the Victorian workhouse system. Semi-structured interviews were used, but due to safety concerns these were undertaken with staff as well as residents. In contrast to the Community Psychiatric Nurses who participated in a later study (Cort et al 2002) staff felt that the sexual behaviour of residents was not their concern, to the point where they did not feel it necessary to report sexual offences to the police. There was limited proactivity, education or knowledge about health services such as genitourinary medicine (GUM) services. The interventionalist approach by health services reported in Power and Attenborough (2003) was not apparent in this area. The article suggests that this could be achieved with staff working towards a secure environment and knowledge acquisition to support residents.

## 3.2 Public works developed from pedagogical studies, resources developed for practitioners and educators

### *3.2.1 Attenborough, J.A. and Abbott, S. (2018). Leave Them to Their Own Devices: Healthcare Students' Experiences of Using a Range of Mobile Devices for Learning. International Journal for the Scholarship of Teaching and Learning, 12(2). doi:10.20429/ijsotl.2018.120216*

This paper reports on final-year healthcare students use of mobile devices and was conducted in a London university in 2013/14. The study took place at the beginning of the transition to Web2 technologies including emerging use of social media technologies in education and the identification of m-learning (mobile learning). The project randomly allocated a device for students to use for all purposes and the study was therefore able to assess the choices make in their use of devices. The impact of 'bring your own device' (BYOD) schemes in higher education and the immediacy of the technology were noted to have the potential to change the delivery of

higher education, and for healthcare students who are away from the university for prolonged periods, to increase their connectedness. The paper reports issues about the devices themselves, such as how they were used, difficulties encountered in clinical practice and the suitability of university systems for m-learning. The students reported great pleasure in using the devices (which were novel in 2013). This paper makes a very early call for support for m-learning and the impact of digital poverty on student access to learning; something which has become most pertinent in the Covid-19 pandemic.

### *3.2.2 Simpson, A., Reynolds, L., Light, I. & Attenborough, J (2008) Talking with the Experts: Evaluation of an online discussion forum with mental health service users and student nurses. Nurse Education Today 8 (5) 633-640*

This paper reports on a mixed-methods study, which was conducted with mental health service users and student nurses in 2007/8 demonstrating how service users could potentially shape education. As one of the first articles examining the potential for co-creation and real involvement in education for service users, the article has been widely cited, and used as a basis for further interventions putting service users at the heart of healthcare education.

Building on the concept of service users being experts about their illness and supported by policy (Department of Health 2006) we prepared a pilot project using WebCT, which was then the university's virtual learning environment (VLE) to facilitate mental health service users and mental health students taking part in a moderated discussion forum. This was evaluated through the impact on student outcomes using an evidence-based learning framework. This article reports on two innovative approaches, the use of the VLE and the integration of service users in student nurse education. The students were recruited through direct invitation and the service users through day centres for people with mental health problems. Training and support were given as this was a new concept and medium for many participants. All activity data were recorded, and students and service users were interviewed about their experience. Students identified many advantages of this form of education including improved communication and IT skills. Moreover, they felt they had improved appreciation of the service user experience of admission to hospital. Service users described an improvement in confidence and IT skills with some therapeutic value. They were hopeful that they were contributing towards better attitudes in future staff.

### *3.2.3 Attenborough, J, Goodfellow, B, Light, I (2007) Practice Based Working with Users, Carers and Support Agencies Part Two of Myles, P and Rushworth, D (Eds) A Complete Guide to Primary Care Mental Health, Robinson, London*

I was invited to work with colleagues in the National Centre for Clinical and Academic Workforce Innovation to develop a toolkit for professionals working with common mental health problems in primary care and general practice). *A Complete Guide to Primary Care Mental Health*, is a flexible learning programme, offering a comprehensive teaching resource both to complement existing course programme delivery within higher education institutions, and also to provide the teaching materials to support the development of reconfigured blended learning programmes. My role in this project was to lead a section about practice-based working with users, carers and support agencies and this included writing scripts, directing video clips, producing text and devising interactive exercises. I worked alongside a mental health service user to produce the materials.

The multimedia reference book with accompanying CDs was disseminated to GP practices across the UK, where it supported the development of a new role in primary care, the Graduate Mental Health Worker (Rushforth 2007).

This resource was produced before online learning was commonplace and this type of programme would now be delivered entirely online to allow updating of policy, guidance and treatment. However, I include it as an example of leading a team with a service user to develop resources that would support the emerging service user involvement movement in education and practice.

## 3.3 Public works focusing on professional identity in nursing

### *3.3.1 Attenborough, J. and Abbott, S. (2020). Using storytelling in nurse education: The experiences and views of lecturers in a higher education institution in the United Kingdom Nurse Education in Practice, 44, https://doi.org/10.1016/j.nepr.2020.102762*

This paper reports on a qualitative study conducted in a higher education institution in London. The study was part of a project to support nurse lecturers in their use of storytelling and was conducted in 2018. Twelve university lecturers participated in the study through semi-structured

interviews asking about how and why lecturers used storytelling and their perceptions of student responses. The paper builds on a previous study examining how nursing and midwifery students develop professional identity (Attenborough and Abbott 2018)

The study found that storytelling plays an important role in promoting nursing internationally while lecturers experienced practicing storytelling as reinforcing their identity as nurses. Storytelling is not recognised in the curriculum and some lecturers felt embarrassed about their use of storytelling, feeling they might be boring or out-of-date. The paper reveals that the practice of storytelling does encourage empathic feelings and has significant implications for education and practice. Lecturers reported wanting to give the impression of being a good nurse and through this to be a role model for student nurses and this was one motivation for storytelling. Storytelling was rarely planned, which could be problematic.

### *3.3.2 Attenborough, J., Reynolds, L. and Nolan, P., 2019. The nurses that roared: nurses from history who found their voices and challenged the status quo. Creative Nursing, 25(1), pp.67-73*

This article explores how nurses from history challenged norms of nursing and society and considers how these examples can influence and inspire nurses today, reinforcing their identity. The research into individual nurses was conducted in 2018 using contemporary reports and archive materials. This article was written in the context of the Triple Impact Report, the WHO international year of the nurse and midwife; an attempt to report the serious history of nursing beyond the well-documented Nightingale story. Several relatively unknown nurses were identified including Catherine Pine, a nurse who cared for the suffragettes after their release from Holloway Prison and protected Mrs Pankhurst against attempted arrest by the police when she was unwell following forced feeding. The paper identifies Mary Rodwell who died while caring for the war wounded on a hospital ship that was struck. Additionally, Elsie Knocker and Mairi Chisholm, two nurses who cared for wounded soldiers in the First World War carrying wounded men from the front on their backs, are little know in the United Kingdom. Of particular note is Mabel Keaton Staupers who campaigned for the inclusion of Black nurses in the army during the Second World War; her success led to the inclusion of African American nurses in the American Nurses Association. The paper includes nurses who changed how nursing is perceived and taught (Annie Altschul and Felicity Stockwell) and modern-day nursing heroes. The paper has been selected for reading lists internationally, including in community colleges in the United States.

### *3.3.3 Attenborough, J. and Abbott, S. (2019). The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution: A qualitative study. Nursing Open. doi:10.1002/nop2.224*

This paper reports on a qualitative study, using a purposeful sample, which was conducted in a London university shortly after the introduction of professional revalidation (2016/17) for all nursing and midwifery registrants by the Nursing and Midwifery Council including those working in higher education. This paper further develops and links to the concepts explored in Attenborough (2017), a paper which raised the question of professional identity and its relationship to revalidation in nurses, and Attenborough and Abbott (2018), which provides data about the self-consciousness of lecturers about time away from practice, professional identity and the revalidation process.

The study specifically aimed to capture the experiences of revalidation in staff and to establish the effect of revalidation of their professional identity. Interestingly, despite having been employed exclusively by a university for up to 25 years participants identified as nurses first and academics second. The process of revalidation itself linked participants to clinical practice as a universal process.

Some participants expressed a lack of worthiness in the academic role, feeling that they had been appointed for their clinical qualifications and were not on an equal footing with academic colleagues. This expression of their perceived worth is not borne out by the perceptions of students (Attenborough and Abbott 2018).

### *3.3.4 Attenborough, J.A. and Abbott, S. (2018). Building a professional identity: views of pre-registration students. Nursing Times, 114(8), pp. 52–55*

This qualitative study was conducted in a London university in 2016/17. The paper develops the concepts previously published in a discussion paper about implementing revalidation in the higher education workforce, where confidence and conflicts over professional identity are factors (Attenborough 2017). Participants in the study reported in this paper are student nurses and midwives and discussion focussed on the clinical credibility of academic staff, the narratives of academic staff about their time in clinical practice, students' own professional identity and

students' knowledge and concerns about professional revalidation. Participants described a split in identity between clinician and student.

Students appreciated being taught by registrants but were not concerned if the registrants were not up to date; students enjoyed lecturers' narratives which gave them hope for their own careers; simulated practice at the university gave students confidence; students agreed in principle with the concept of revalidation.

This paper adds insight into how students develop their professional identity and the value they place on academic staff who are registrants.

## 3.4 PUBLIC WORKS FOCUSING ON WORK-BASED LEARNING IN THE CLINICAL WORKFORCE: RELATIONSHIP WITH HIGHER EDUCATION

### *3.4.1 ATTENBOROUGH, J., ABBOTT, S., BROOK, J. AND KNIGHT, R.A., 2020. PIONEERING NEW ROLES IN HEALTHCARE: NURSING ASSOCIATE STUDENTS' EXPERIENCES OF WORK-BASED LEARNING IN THE UNITED KINGDOM. WORK BASED LEARNING E-JOURNAL, 9(1), PP.35-60*

This paper reports on a longitudinal study using framework analysis about the introduction of a work-based learning approach to education for a new role in healthcare, the Nursing Associate. The framework was derived from a systematic review of the literature pertaining to introducing new roles in healthcare (Halse et al, 2018). A longitudinal study was selected because of the newness of the role; helping to appreciate the participants' experiences over time as both the role and the education supporting it became embedded. This paper builds on previous work about identity (Attenborough and Abbott 2018; Attenborough and Abbott 2019) and work-based learning (Attenborough et al 2018; Attenborough et al 2019). By utilising a framework derived from the recommendations of a systematic review, the paper reported on how students' experiences compared to the recommendations in the literature.

Of the seven categories, engagement with stakeholders; well defined scope of practice; appropriate educational programme; adequate learning time; skilled supervision; robust workforce planning; strong leadership only two categories were not reflected in the study, strategic leadership and workforce planning. This reflects the experiences of front-line workers

and the distance from strategic leadership, despite the influence these factors had on their experience.

The paper demonstrates how crucial preparation of the workforce is for new roles, and the lack of parity in learner's minds between university-based skills acquisition and practice-based skills acquisition. The participants valued their university learning above their practice learning. The phenomena of finding it difficult to identify learning in clinical practice is also reported and replicates the findings reported in Attenborough et al (2019)

### *3.4.2 Reynolds, L., Attenborough, J. and Halse, J. (2020). Nurses as educators: creating teachable moments in practice. Nursing Times, 116(2), pp. 25–28*

This paper introduces a model for providing accessible teaching in the clinical workplace, responding to the findings of two previous studies and one systematic review. The paper uses a technique used more commonly in compulsory education, the development of teaching moments or T moments, that is when teachers grasp an opportunity for learning and exploit it. In one of the previous papers about work-based learning (Attenborough et al 2019) participants noticed that medical staff make the sign of a 'T' with their hands to indicate to medical students and junior doctors that they are teaching. Teaching then becomes a conscious process for student and teacher.

This model draws on theories for bite-sized teaching and suggests that by utilising T moments learning becomes a conscious process which is identified and consolidated. Furthermore, an important issue in healthcare is the evidence of higher levels of anxiety than other students. The paper addresses the stresses and some of the perceived bullying of nursing and midwifery students, including the adage that '*nurses eat their young*' (Darbyshire et al 2019), suggesting this approach as a way of protecting and encouraging student learning in practice.

### *3.4.3 Attenborough, J., Abbott, S., Brook, J. and Knight, R.A. (2019). Everywhere and nowhere: Work-based learning in healthcare education. Nurse Education in Practice, 36, pp. 132–138*

This paper reports a qualitative study that was conducted in 2018 in NHS facilities across London. The main finding was that although work-based learning is ubiquitous in healthcare

practice, it is hard to identify and access- hence the title of the paper. This paper develops the findings of a systematic review about the pre- requisites for introducing a new role in healthcare that I authored with others (Halse et al 2018) and was further developed by a longitudinal study about the implementation of a new role in healthcare which was implemented through work-based learning, the Nursing Associate (Attenborough et al 2020). Participants studying different courses identified threats and opportunities to implementing and accessing work-based learning in a clinical environment. A need for courage was identified especially in life critical situations. Interestingly, areas that are most challenged, in terms of staffing and clinical demands such as critical care environments, gave the better experiences.

# CHAPTER FOUR: INTRODUCTION AND BACKGROUND TO THE THEMES

## 4.1 GENDER AND PROFESSIONAL IDENTITY

This chapter introduces and discusses the main themes running through the works: gender and professional identity.

## 4.2 GENDER AND IDENTITY IN CLINICAL AND ACADEMIC NURSING

The focus of the themes is the developing professional identity of nursing students, the dual identities of lecturers in nursing and the overall identity, image and profile of nursing. There is a significant overlap between identity and gender in nursing, as 89% of registered nurses in the UK identify as female (Nursing and Midwifery Council 2019). Although unsurprisingly much of the literature focuses on women and nursing, there is a growing literature about the experiences of men in nursing linked to the aim to recruit more men into the profession internationally (Brady 2003; Evans 1997; Meadus 2000; Younas et al 2019). There is evidence that the portrayal of both men and women in nursing is stereotyped by the media (Gill and Baker 2019). Furthermore, gender diversity is poorly understood in nursing, to the extent that Merryfeather and Bruce (2014) assert that it is a threat to ethical care.

## 4.3 WRITING ABOUT PROFESSIONAL IDENTITY

My interest in professional identity began in 2016 when as the Lead Nurse for the University I introduced a new system of professional revalidation with the Nursing and Midwifery Council (NMC) across the institution (NMC 2016). The process revealed anxieties and conflicts about professional identity for many academic staff, some of whom asked to be released back into clinical practice in order to meet the requirements. In other words, they no longer identified themselves as being nurses, or at least of meeting the requirements of the nursing regulator without undertaking clinical practice (Attenborough, 2017). This appeared to be a significant part of staff identity in healthcare education but as NMC revalidation was a new concept and process there was no supporting evidence base to consult. I undertook several studies about professional identity development in both nursing students and nurse academics, focussing on revalidation and how identity is influenced by this process. Developing this work drew me into the broader issues of gender, perceptions of nursing and the position of nursing in both higher education and clinical practice.

## 4.4 WOMEN AND NURSING

Closely linked to the position of women in society, nursing identity and gender roles are difficult to separate, this connection linking nurses historically to '*harlots, charlatans and drunkards*' who were not '*practicing beyond their gender remit*', considered to be predominantly that of caring (Adams, 2011, p885). Conversely there is a presentation of nursing that is the heritage of Florence Nightingale and the image of nurses as nuns; up until the 1990s uniforms were clearly derived from nun's habits (Maher, 2008). Nurses in charge of wards retain the title of Sister to denote a nurse in charge of a clinical area, a different positioning of women. Though this positioning is challenged by some remarkable nurses (Salvage 1985; Salvage and White 2019) there remains the underlying belief in society, articulated though not endorsed by Oliver (2017) that the cause of problems in nursing is too much education.

## 4.5 IDENTITY IN ACADEMIC NURSING

The politics of identity is strongly associated with fairness, justice and the fight against domination (Chandler, 2017); additionally, Chandler discusses organisations as a source of identification for workers. The NHS has a strong identity, evidenced in the first surge of the Covid-19 pandemic where on a weekly basis during a national lockdown, citizens of the United Kingdom left their homes every Thursday night to applaud the NHS and other frontline workers. This activity received widespread coverage and high levels of involvement from the public. The Prime Minister, despite being seriously ill with Covid-19 himself, appeared at his front door in Downing Street to join in, shortly before being admitted to intensive care. The high esteem that the NHS is held in has been compared to that of a national religion (Toynbee, 2018). This identification and pride were celebrated across the United Kingdom at the NHS 70-year celebrations in 2019 (Peate, 2019). Universities commonly recruit nurse academics from clinical practice; leaving this strong and definite culture to join higher education is a massive shift described by Andrew (2012), who reports feelings of guilt and difficulty in adapting to the new role.

Furthermore, Murray et al (2014) described a four-phase process lasting between one and three years in which nurses evolved into academics. The four phases range from phase one where lecturers retain their identity as clinicians; phase two where lecturers devalue and abandon this identity in favour of doctoral study, producing research bids and publications- this is not to say that they take part in this activity, rather that they place less value on their clinical background. In phase three lecturers start to enter to self-directed working where they stop treating students as

a clinical caseload until they finally enter a more problematic phase of '*evolving into an academic*' (p393), though they may continue to feel unworthy in the academic role (Farnworth et al, 2010; Smith, 2010).

The NHS has clearly articulated principles and values. It has a constitution and roles within it do not need to be explained or justified to the general public. Contrast this with an academic role which coupled with media hostility to nurses being educated at university produces a threat to identity.

Nursing as an academic subject entered higher education in 1995, when nursing students were required to study at diploma level towards an academic award for the first time. This move had a mixed response. In 2004 the Daily Telegraph described university educated nurses as '*too posh to wash*' (Hall 2004) and this was followed by the phrase '*too posh to wash; to clever to care* (Scott 2004). This phrase was reiterated in the media when nursing became a degree-only profession in 2012, and subsequently attributed with contributing to the failings of the Mid Staffordshire NHS trust, though this was not directly referred to in the public inquiry (Francis 2013). The conflict for nurses along with the anti-intellectualism that accompanies it contributes to imposter syndrome for students entering the profession according to Aubeeluck et al (2016). In 2019, 89.3% of nurses identified as women (NMC 2019); the devaluing of education for nurses and midwives is not waged at other professions that have more gender balance such as physiotherapy, medicine or radiography, for example, is a doctor 'too clever to care'?

The historical position of nursing as women's work and the lack of role models and influential nurses from history (with notable exceptions such as Mary Seacole and Florence Nightingale) is well established (Abel et al, 1990; Bolton 2005; Cook-Gumperz 1997; Davies 1995; Davies 2005). Nearly fifty years ago, in 1972 the Briggs Committee reviewed nurse training and for the first time considered the move from a vocation to a profession, finding that the position of nursing remained similar to that of women in the 19$^{th}$ century, in terms of subservience. Briggs recommended that nursing become a research-based profession focussed on the best patient care with an established evidence base. These reforms were not implemented until 1995, following the Judge report in 1986 (Salvage 1988), when moves began to move nurse education into universities, which was finally achieved in 1995.

In 2018 the Journal of Advanced Nursing issued a call to identify influential 20th century leaders in nursing (Girvin & Maxwell, 2018), which apart from being extraordinary that any profession would need to put out a call such as this, was also valid. I knew that some nurses were involved in the

suffragette movement and I had published an online article in celebration of the anniversary of partial women's suffrage (Reynolds and Attenborough, 2018). By further investigating I discovered an extraordinary collection of women, from civil rights leaders, suffragettes, women who worked on the front lines during World War 1, nurses who challenged authority but are largely written out of history. The Nurses that Roared (Attenborough et al 2019) was an article that was the product of this research.

Raising the profile of nurses from history is connected to nursing today. The public perception of nursing does have an influence on nurse-patient interactions. In a study investigating the impact of media portrayal on nurse patient interactions and nurses' perception of this influence, Hoyle et al (2017) found that nurses perceived a negative representation by the media, linked to bad publicity from a few examples. Hoyle et al recommend that nurse education should equip nurses with the skills to engage with the media. Additionally, as reported by Savage and Stillwell (2018 p1301) '*Nursing is heavily mythologised everywhere, but paradoxically remains invisible*.' Savage and Stillwell are seeking a new story about nursing, where there is global cognizance of the contribution of nurses in improving population health, contributing to gender equality and underpinning economies.

Significantly, Black nurses remain largely invisible; in reported history and in current leadership, largely as a result of oppressive practices and discrimination (Jefferies et al 2018). There is evidence of discriminatory practice in admission to the profession (Phillips and Malone 2014) and there is a lack of education in nursing schools about Black nurse leaders such as Mary Seacole and Sojourner Truth (Staring-Derks et al 2015). Data from the NHS through the workforce racial equality standard (WRES) indicates that the progression of Black staff is an ongoing issue, with inequality more prevalent in London than in the rest of the country, despite the higher proportion of Black and Minority Ethnic staff than elsewhere in the UK (Randhawa 2018).

Add to this complex position the entry of nursing into the academy. I became a lecturer less than two years after nursing and midwifery entered higher education in the United Kingdom. Twenty-five years later the controversy about its position continues (Andrew, 2012; Gillett, 2014; Thompson and Clark, 2017). At best academic nursing remains in a liminal position vis a vis higher education and the demands of the academy towards all academics further challenge its position. The meaning of giving up the identity of nursing for an academic identity, so eloquently described by Ramsdale (2017) in her doctoral thesis versus the contradictions of maintaining it, versus the uncharted journey in the liminal sea.

Healthcare professionals working in higher education have a general desire to keep their clinical identity, and this has been established in several studies (Findlow, 2012; Laurencelle et al 2016; Murray et al 2014; Smith and Boyd, 2012). The position of healthcare professionals in universities contrasts with medicine, where doctors in academic posts who teach medical students or specialist trainees are required to remain in clinical practice (GMC, 2009). Nurses entering higher education as academic staff are reported to be reluctant to take on an academic identity; this was further exposed in nursing during the revalidation process, but lack of confidence or institutional support might make health professionals reluctant to take on an academic role, or at least to embrace it fully (Andrew et al 2014). Chandler (2017 p3) when writing about identity at work describes identity as what we are and what we are not (individually or collectively). This resonates; my published work that spans the period of assimilation into the academy was more pedagogically focussed, rather than clinically or professionally, demonstrating a search for identity through publication and enquiry. Furthermore, Chandler writes about latent identity with the premise that identities are always socially constructed with identification (rather than identity) occurring over time.

# CHAPTER FIVE: THEORIES, METHODS AND ETHICS UNDERPINNING THE WORKS

## 5.1 THEORIES UNDERPINNING THIS CONTEXTUAL STATEMENT

This chapter considers the two main bodies of theory underpinning the works, firstly liminality and secondly an adaptation of Lipsky's street level bureaucracy. The chapter then critically discusses the methodologies used in the production of the works. Finally, reflective practice and ethical considerations are discussed in both the development of the works and of this contextual statement.

### *5.1.1 LIMINALITY*

It may seem curious to begin this chapter by discussing liminality, but it is from this position that many of the works emanate. Interestingly, despite undertaking research about homelessness, professional identity, mental health and roles in nursing and higher education it was only recently when producing a *Review of Learning* for this doctorate that I considered these through the lens of liminality. Liminality was first used by Van Gennep (1960/2004) as a framework to describe rites of passage in tribal societies. Van Gennep's work has been adapted to understand the movement between one social identity and another (Moran, 2013). Beech (2011) describes the liminal process of moving towards an aspirational identity and the conflict with the authentic self and occupying the 'no man's land' or 'betwixt and between' (p287) position, pertinent to the dual identity of nurses entering the academy. Beech provides two ways of applying liminality; as a temporary transition while a new identity is acquired or a lengthier process of ambiguous identity, occupying the liminal space. Furthermore, Kelly (2008) describes liminality as a permanent social space in the context of physical ill health.

For the purposes of my published works I have used Thomassen's definition in Horvath et al (2015, p 40):

> ' the experience of finding oneself in an in-between position, either spatially or temporally'

Therefore, I view liminality as how I dealt with change and my ability to move into different spaces and how these works evidence and contribute to that process. Liminal states can also refer

to things that happen, not necessarily through planning, but through luck (good or bad)- the 2020/21 Covid-19 lockdowns in the United Kingdom being examples of restrictions imposed on people, forcing them into a liminal space. Similarly, Evans and Kevern (2015) when discussing liminality in relation to mental health nursing education describe a '*phase of uncontrollability and, perhaps, disorientation if transformation is to take place*' (p 5) and discuss the liminality of mental health nursing as a profession.

Working within liminal spaces has pertained from the earliest part of my career; from working with drug and alcohol users and the homeless mentally ill to moving into the liminal space occupied by nursing in higher education. It is by considering liminality as a stage of challenge and an opportunity for personal growth and learning to invoke change that I can appreciate it more positively. Forging a new identity as an academic halfway through my career, whilst maintaining my clinical identity has been the greatest of challenges, but the outputs from this liminal space through research and scholarship in teaching and learning and progression in management have also been the greatest achievements. Simmons et al (2013) discuss the specific liminality of the Scholarship of Teaching and Learning (SoTL) and its position outside of the traditional 'academic tribes' in higher education (p10). In a position still outside of the traditional tribes, academic nursing remains liminal, but may have found a place in the cross-disciplinary SoTL environment. To do this there may be some abandoning of identity to fit into the new identity of SoTL scholar. The navigation of contending identities is not charted; Simmons et al (2013) describe '*swimming in the liminal sea*' (p 16). Perhaps, as Simmons et al conclude, my goal might not be to move on but instead to accept or '*be comfortable in the spaces we currently inhabit'* (p17).

Whilst in anthropology liminality is generally considered a temporary state, Bamber et al (2017) consider the possibility of a more permanent state. Furthermore, Horvath et al (2015) contest the notion that coming through liminal states or '*breaking boundaries*' (p7) is inherently a good thing, that boundary breaking is necessarily progress which is the premise of some of my works, especially those concerned with clinical practice and the position of nursing as a predominantly female profession. Frustration about this is evident in the works- the pace of change is very slow.

### *5.1.2 Michael Lipsky's street level bureaucracy*

Michael Lipsky's work (Lipsky 2010) captures the connection between policy, organisational frameworks, resources and individual practitioners. Originally published in 1980, Lipsky updated and expanded his work in 2010 due to its continued conceptual relevance in changing contexts. Though more commonly cited in research about local government, more recently (Hoyle 2014)

there are examples of his framework being used to investigate nurses influencing the implementation of policy set against political, policy and social changes. My interest in Lipsky's work emanates from both clinical work and research and publication about work-based learning. Lipsky's work illuminates the implementation of policy at the frontline or 'street' level. Lipsky's street-level bureaucrats are:

> '*the public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work*.' (Lipsky, 2010, p3)

My early clinical research with homeless people and community nurses illustrates the use of this discretion. It is also a theme running through the pedagogical publications into the more recent works about the development of work-based learning supported by government policy to grow the clinical workforce; what should have happened versus what actually did. How nurses and workers with homeless people interpreted their role through policy and their use of discretion in their interactions with patients and clients is crucial to appreciating the role of nursing in supporting the deinstitutionalisation of mental health care. The later publications illustrate what happens when people have less control over their working lives, such as trainee nursing associate apprentices. Among the studies using Lipsky's framework, there are some examples in healthcare and in the implementation of homelessness policy (Alden 2015; Hoyle 2014). The type of choices open to front-line workers are rule discretions where there are legal, financial or organisational issues; value discretion in relation to fairness and justice or regulatory requirements and discretion over tasks when delivering care to individuals (Taylor and Kelly 2006).

There are examples of this discretion being used in healthcare. The failure to care attributed to the education of nurses in universities by the popular press related to Sir Robert Francis' report about the mid-Staffs Inquiry (Francis 2013). This failure is linked to the inability to use discretion when the goals of the organisation or the target-driven culture have overridden the ability to care. Although not directly attributed by Francis, this was the interpretation by government and the popular press (Beer 2013). Similarly, Hoyle (2014) found that nurses were selective in the implementation of policy, using what they perceived as the values of the organisation in applying policies. There is also the question of moral judgement, such as a young drunk man being judged less deserving of care than an elderly frail woman, something I frequently encountered in working with substance users or the homeless mentally ill.

Furthermore, Hoyle (2014) found evidence of rationing in nursing, when resources were not available, and a complex view of management and workforce, with ward sisters and charge nurses, the traditional first line managers not really identifying as managers, and therefore compromised when held to account about their use of resources.

Alden (2015) used Lipsky's framework to reveal the use of discretion to discriminate in homelessness services, finding that negative use of discretion was linked to resources, so if employees realised resources were insufficient, they used their discretion to ration at a local level. This was sometimes even linked to advising staff to look for reasons why a homeless person should not be offered accommodation, despite housing officers operating within a legal framework. I encountered this discretion being used when investigating the implementation of work-based learning in clinical practice, where resources were limited. Work-based learners found that qualified nurses tended to prioritise certain types of (supernumerary) students, and that consequently work-based learners had limited learning opportunities. This was linked to those learners finding it difficult to recognise learning opportunities in practice (Attenborough et al 2019; Attenborough et al 2020).

Although many of my public works have resonance with Lipsky's work, the service user voice is notably absent, as Lipsky focuses on the public servants' perspectives. Furthermore, Evans (2011) argues that the influence of professionalism is also missing. Evans argues that professionalism's effects on the relationships between managers and the use of discretion by street level bureaucrats should be included. Additionally, because Lipsky's work was produced originally in the 1980s a 'gentler age' (p370) before the rise of managerialism in public services, Evans questions its ongoing relevance, citing the supporting social work literature. Lipsky considers the key regulators of street level work discretion to be managers. However, Evans (2011) introduces the critical question of professional status and identity. Professional identity is strongly linked to ideology, values and standards that should inform decision making; this has relevance to nurses' professional identity and the tortured debates about the position of nursing in the academy, or at least how that is being led by the professoriate. The question might be: does professional discretion override managerial demands, and does it constrain or enable decision making or practice in the context of health services and healthcare education? Participants in Evans' qualitative study reported using professional judgement in their decision making and seemed less bound by resource implications or judgements than Lipsky suggests.

## 5.2 METHODOLOGIES USED IN THE WORKS

Although I adopted a variety of methodologies in the works, I can identify development of my own preferred methodologies and research designs over time. The early works from clinical practice adopted a mixed methods approach, using qualitative and quantitative data. Later works are almost entirely qualitative deriving data from interviews, questionnaires, observations and focus groups. One later paper (Attenborough et al 2020) is a framework analysis of a longitudinal qualitative study. The framework is based on the findings of an earlier paper I had undertaken with clinical colleagues (Halse et al 2018).

In this section I explain the rationale for moving towards qualitative research. This is a position that often needs to be explained or even defended, especially in the area of clinical research, where medical papers dominate, with the dominance of the randomised control trial (RCT) as the gold standard for research; funding for research often follows this (Hallam 2000). The earlier papers reflect a deference to the overriding medical model in healthcare research with a preference for quantitative methods; but overall, as Ball et al (2010) suggest, the position of qualitative research in the hierarchies of evidence (HoE) has haunted the nursing research community as it strives for its place in the academy. Ironically although Florence Nightingale is recognised as the founder of modern nursing it is less well known that she was a statistician, the first woman to be admitted to the Royal Statistical Society (Attenborough et al 2019). Nightingale employed quantitative methods to evaluate outcomes of nursing interventions, such as hygiene for the prevention of cross-infection or the distance between beds (Nightingale 1860).

The use of qualitative methodologies in nursing (and other healthcare subjects) has developed as the importance of context and the voice of the patient have become more important, and this is true of my research projects. For example, using qualitative methods to report on the lived experience of homeless men in direct-access hostels (Attenborough and Watson 1997) or lecturers' experience of using storytelling in teaching (Attenborough and Abbott 2020) produced a rich data set; the findings had implications for both policy and practice. Ball et al (2010) argue that qualitative methods should not be used as an umbrella term however and that dependencies (such as grounded theory, phenomenology or ethnography) should always be established as nursing research seeks to be taken seriously among the other healthcare professions in the academy. In this sense my papers fall short, as I have consistently used Braun and Clarke's thematic analysis of data, which has the flexibility to be applied to a wide range of qualitatively derived data sets, rather than a defining theoretical underpinning.

Braun and Clarke (2006) published a seminal paper establishing a rigour for thematic analysis. *Using thematic analysis in psychology* has been cited 81,729 times according to Google Scholar (August 2020) suggesting the paper is used widely to support the use of thematic analysis in qualitative papers. The 2006 paper outlined six stages of thematic analysis:

1. Familiarisation with the data.
2. Coding.
3. Generating themes.
4. Reviewing themes.
5. Defining and naming themes.
6. Writing up the findings.

I had always approached the thematic analysis in an inductive way, using the data to determine the themes. However, in one paper (Attenborough et al 2020) I used a framework analysis or deductive approach. This was because I was keen to test the implementation of the findings of a systematic review of the introduction of new roles in healthcare, part of a work-based learning project undertaken for Health Education England. I found the deductive approach far less comfortable, the thick description of the dataset more elusive in the writing up of the paper.

In their later work Braun and Clarke (2019) write about the value of qualitative research to provide insight into patients' lives and to give the patient perspective, exploring their experience. Though there is benefit to this approach in both policy and practice development, tensions still exist about the generalisability of results and the representation of the sample, which is often cited as a limitation of research in qualitative papers. Conversely there is rigour in two-stage analysis, where themes are tested against the whole dataset and the coded data. Moreover, a further benefit of thematic analysis, aligned to its flexibility, is that the research question is not necessarily fixed and can be developed through coding and the development of themes (Clarke and Braun 2016).

The volume of data produced from qualitative methods can often be overwhelming and in one study I used NVivo to organise the data- this has been especially helpful when undertaking analysis in a team, something which I wish I had employed earlier in my research journey. I found this method of recording, storing and organising data and analysis intuitive and it supports the rigour of Braun and Clarke's stages, whilst avoiding the need for multiple highlighter pens and post-it notes. Although there is something almost therapeutic about the physicality of the manual method, managing the data with due regard to confidentiality and ethics, ensuring that coding was anonymised is always stressful. Hilal and Alabri (2013) support the use of NVivo for managing

large quantities of data whereas Maher et al (2018) suggest a combined approach to support familiarity with the data, citing the '*deep and meaningful*' interactions with the data that are necessary for analysis that are provided by a more physical approach. Maher et al (2018) suggest that this is related to the limitations of digital recording on reflections, interpretations and contextualisation, due to cognitive functioning of researchers, such as visualising the data. What NVivo does provide is a robust audit trail and associated rigour.

## 5.3 REFLECTIVE PRACTICE AND ETHICAL CONSIDERATIONS

### *5.3.1 REFLECTIVE PRACTICE*

Both nursing and higher education have embraced the concept of reflective practice, though there is a paucity of data about the effective use of reflection on and in practice (Teekman 2000). Coward (2011) suggests that the adoption and overuse of reflective models in nursing has actually obstructed thinking in some aspects of practice, due to its formulaic quality. There is certainly a strong cultural expectation that reflection will be part of clinical practice at least; the Nursing and Midwifery Council (NMC) requiring five reflective accounts as part of the revalidation process (NMC 2017). Throughout my career I have utilised opportunities to reflect on my practice, latterly using aspects of Johns' model (Johns et al 2013). Johns' model is based on five questions which facilitate breaking down an experience and reflecting on the process and outcomes but can also be used to reflect on experience more generally (see fig 13).

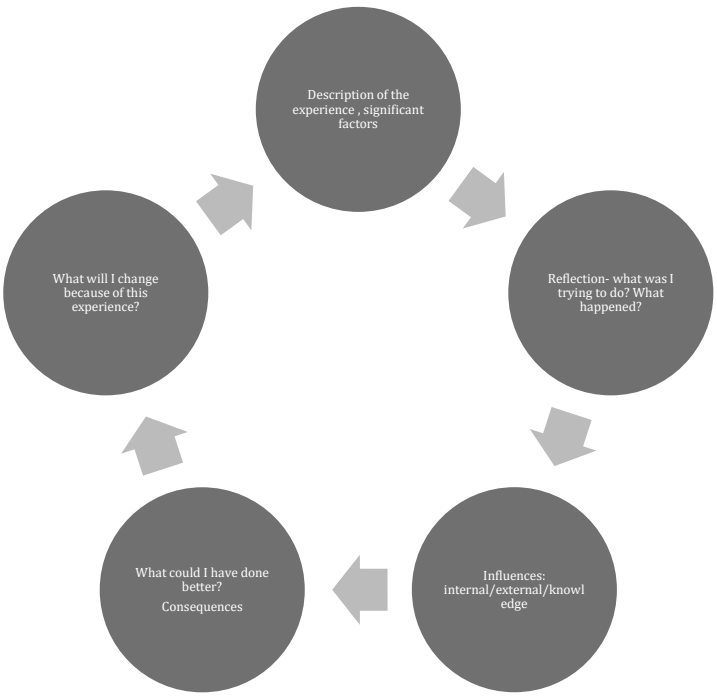


**Figure 13: Johns Model of Reflection**

Johns advocates that reflection happens through a supervisory model and although I have often led on projects, and this has felt isolating to various degrees, I have also sought supervision, either through advisory groups or one-to-one supervision. In particular, Johns advocates ethical mapping, which I have interpreted as self-questioning about whether I did the right thing- and what I would need to know to do the right thing in the future. Coward (2011) questions whether Johns' model can ever be properly understood or utilised without an appreciation of its origins in Carper's (1978) work, in particular the four patterns of knowing, which are aesthetics, personal, ethics and empirics. Johns adds a fifth pattern of knowing which he calls reflexivity, which does allow for learning for future practice, and is also a consideration for insider-researchers. Furthermore, Coward questions the basis of using the model with student nurses without due regard to the origins- its structured approach could be seen as more of an interrogation than a reflective opportunity. My experience is that in many of the chaotic and liminal spaces I have occupied, the structure of a model that incorporates the internal, external, ethical and journal-type implementation, has been helpful.

John's model has prompted me to explore the external factors that have influenced my actions.. For example, the expansion of nurse education in the 1990s and its move to the academy gave me the opportunity of an academic career, while the liminality of the space occupied by nursing in the academy has drawn me away from nursing and into academic administration albeit at a senior level. This has afforded significant opportunities, and ultimately, drawing on Johns' ethical considerations, the possibility to influence practice and promote nursing and healthcare more generally.

### *5.3.2 ETHICAL CONSIDERATIONS*

In all contexts where I have carried out research it has been as a practitioner-researcher. As a Community Psychiatric Nurse, I undertook research with the homeless people and substance users I worked with, and in higher education as an academic with students and colleagues. It was, for example, from the position of insider-researcher that I investigated the position of nursing in the academy, the dual identity of nurse academics and the influence of different mechanisms, through the lived experience of the people I work with.

Working within the community of practice in which I was researching inevitably raises ethical considerations. This was explored by Costley and Gibbs (2006), who describe it as the *'ethics of care'* (p89), that is, caring for others as part of the ethics of undertaking research in a community

of practice the researcher is actually working in. In addition to the lack of distance from the research environment, Costley and Gibbs also note that when researching within organisations it is possible that the findings of that research might be implemented and might impact directly on the participants if the findings are used to influence strategic direction. More personally the findings could give insight into a particular individual's position. For example, when I investigated the impact of Nursing and Midwifery Council (NMC) revalidation on the professional identity of nursing and midwifery students at City, University of London (Attenborough and Abbott 2019), I was also responsible for both implementing revalidation across the institution and confirming the revalidation applications of some of those invited to participate with the regulator. Furthermore, Costley and Gibbs (2006) note the ideological standpoint of the insider-researcher; the influence of the institution or community of practice where the research takes place, and the contribution the research makes to the researcher's own professional development. The study of the impact of NMC revalidation at City has resulted in three published papers (Attenborough, 2017; Attenborough and Abbott 2018; Attenborough and Abbott 2019) which have contributed to my professional development, and to this contextual statement; as such I have benefitted from the research in a personal way. Conversely, this work has established and contributed to the development of a knowledge base in this area, and has been used by other researchers, including doctoral candidates, who have contacted me for advice about their own projects.

The ethical position of insider-researchers is reported by Williams (2009) who refers to the research output as *'guilty knowledge'* (p211) raising the issue of the conflating of the researcher's or the institution's interests being served by the research. Williams refers to the moral code and character of the researcher and in the inquiry identifies five *aporias*, or irresolvable contradictions in practice, unexpected dilemmas that are not addressed by the desire to progress. Firstly, with regard to the lack of agency in the participants, examples given include a lack of awareness of confidentiality, or of risk the participants might be exposing themselves to. Secondly, the overuse of certain participants who in an organisation volunteer repeatedly for internal research projects leading to participant fatigue. I have certainly observed this with academic staff, students, and to a lesser extent, patients. Thirdly participants could feel vulnerable and fear exposure; this was worse when certain media were used for capturing data, such as video or audiotaping of interviews. Fourthly, a situation where the participant may be seduced by the interviewer into disclosing personal experiences that they later wish to retract or feel concerned about- such as criticism of the institution. I have addressed this by offering the transcript to participants after the interview with the understanding that they can withdraw data.

Lastly, Williams refers to the '*fundamental aporia'* (p219), that is not being able to avoid being an insider-researcher for that is an expectation of our working lives and that this might be exposing participants to harm.

Volante et al (2017) report on an annual seminar by Derek Portwood, Emeritus Professor of Work-Based Learning, highlighting the '*situatedness*' (p88) of the researcher and the projected usefulness or impact of the project. The paper explores the idea of addressing situatedness as a pre- curser to the project, an initial stage perhaps one with the potential to explore the ethical considerations and motivations for the project. Furthermore, the question of *'intention'* (p96) is discussed, which is pertinent. The intention of the project should inform the ethical considerations, and to that extent the applied content is intended to actually bring about change, create value but also as Portwood says:

'*you produce your knowledge not by being detached*.' Volante et al 2017: p97

When I was appointed to senior roles in higher education the ethical issues became more complex, an invitation to participate in a research project sent from the Chair of the Assessment Board or the Fitness to Practise Panel raises questions about pressure or even coercion to participate, though this has been reduced since the introduction of an anonymised assessment process. To mitigate this, invitations to participate in the research were sent out by an independent researcher, or outsider-researcher who conducted interviews for many of my qualitative papers, which I then analysed anonymously. These special ethical considerations were also pertinent to carrying out research with colleagues for whom I had indirect line-management responsibility, and a similar strategy was employed.

### *5.3.3 Ethical approval for this contextual statement*

Finally, the ethical considerations for this contextual statement were considered and approved by the ethics committee at Middlesex University (see appendix 1). Although the endeavour is considered low risk there are still the ethical considerations highlighted above and the attribution of work. Essentially, I have sought to be transparent about my contribution to the works submitted, and where I have written in collaboration with others and was not the first author, another author has stated my role in the publication in writing. For each publication where I am not the first author a statement in included (see appendix 2).

# CHAPTER SIX: PUBLIC WORKS DEVELOPED FROM CLINICAL PRACTICE: 1997-2002

This chapter discusses the political and policy context in which the works were produced and the position of nursing at the time.

## 6.1 POLITICAL AND POLICY CONTEXT

Three of the four papers were directly developed from work with the homeless mentally ill (Attenborough 1998; Attenborough and Watson 1997; Power and Attenborough 2003). The policy context they were produced in was one of deinstitutionalisation in mental health services and neo liberalism in government in the United Kingdom. The deinstitutionalisation had been pursued at pace up until the late 1990s- to give some idea of the change; in 1955 150,000 people lived in psychiatric institutions, representing one in 200 of the population (Burns, 2013); in 2019 capacity was one in 3,000 of the population (Strategy Unit, 2019). The reported number of mental health beds fell by 73%, from 67,100 in 1987/88 to 18,400 in 2018/19. This represents a further period of rapid reduction between the mid-1980s and 1990s as the government policy of care in the community took effect.

The impact of the reduction in bed numbers has also to be seen in the context of higher bed occupancy rates, as bed numbers reduced so the quality of service was affected by high bed occupancy. The graph below shows the scale of the decrease in inpatient beds pertinent to the works discussed in this statement, giving an idea of the change:

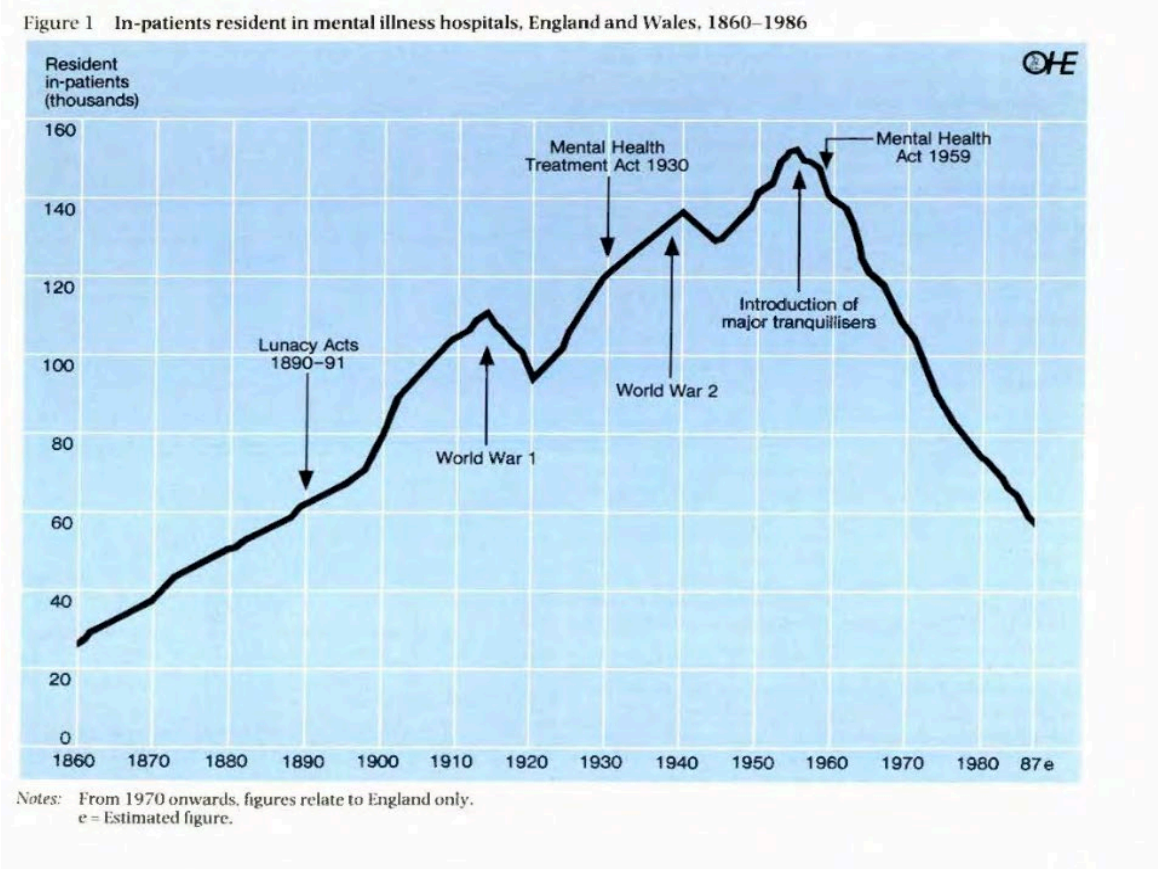


**Figure 14: Reproduced from Taylor, J. and Taylor, D., 1989. Mental health in the 1990s: from custody to care? Series on Health. Available from https://ideas.repec.org/b/ohe/shealt/000372.html; accessed 03/10/2020**

The context was therefore one of decreasing institutionalisation of people with mental health problems.

### *6.1.1 Homelessness and mental health*

In the 1990s there was increased visibility of homeless mentally ill people and growing public concern. Although commonly the perception of growing numbers of mentally ill homeless people is attributed to the closure of the Victorian asylums and the move to community care, there is little evidence to support this (Burns 2013; Craig and Timms 1992). The closure of the long-stay hospitals was supported by assertive outreach and supportive housing teams and the numbers of people becoming homeless because of these measures was very low (Leff 1991). However, there was evidence of numbers of homeless mentally ill people living in direct access hostels (the descendants of workhouses); the conditions and milieu of which were close to that of a Victorian asylum, where socially acceptable behaviour had broken down (Attenborough and Watson 1997). In the United Kingdom there is evidence that the incidence of severe mental illness, which

includes schizophrenia and bipolar disorder, is 25-30% of street homeless people and direct-access hostel residents (Klein et al 1995).

In 1991, the Department of the Environment reported a total of 22,383 hostel bed spaces available for single homeless people in London (Craig and Timms 1992). The support available to people living in these hostels was very low, and the prevalence of mental illness high (Timms and Fry 1989).

In the late 1980s the government decided to close the direct access hostels and resettlement units, in favour of smaller units. The prevalence of mental illness among people living in the hostels, the lack of reprovision when they closed and lower financial support led to increased visible homelessness. The residents of direct-access hostels could be described as the invisible mentally ill, as they were not counted as long-stay psychiatric patients, but when policy dictated the provision be reduced, then this group of homeless mentally ill people became visible.

Two of the papers reported on studies undertaken in hostels for the homeless in London. The first (Attenborough and Watson 1997) is a qualitative study about sexual behaviour among single homeless men, including coercive and high-risk sex and the vulnerability of the homeless mentally ill in this context. I carried out the research for this paper as an insider-researcher in a direct-access hostel for single homeless men where I ran clinics as a Community Psychiatric Nurse (CPN). The second (Attenborough 1998) reports on a study carried out among young people in a cold weather shelter which was part of the government's rough sleepers' initiative. The study included screening questions and semi structured interviews with staff and young people using the shelter. This study was also carried out as an insider-researcher as I provided an assessment service and a therapeutic group for those accessing the shelter, again as a Community Psychiatric Nurse (CPN). The third paper (Power and Attenborough 2003) is a report of the analysis of a consecutive case note review of one hundred people referred to a mental health team for the homeless mentally ill, many of whom lived in shelters and direct-access hostels. This was carried out in the service where I had worked as a CPN but did not involve direct contact with participants.

The fourth paper (Cort et al 2001) built on the theme of the complexity of sexuality as a focus in healthcare for people with mental health problems. This study adapted a sexual ideology scale which was distributed to an opportunistic sample of community mental health nurses at a conference and provided strong support for the concept proposition that the sexuality of people

with mental health problems was a relevant clinical concern. The results indicated that although there was awareness of the issues, the translation into practice for nurses was more contentious.

## 6.2 THE POSITION OF NURSING

In the United Kingdom the 1990s was the decade in which nursing moved into universities (Project 2000) and nurses were educated as a minimum at undergraduate diploma level from 1995. Mental health nursing as a separate speciality, previously taught in as apprentice-style qualification moved into higher education with the adult, child and learning disability fields of nursing, and midwifery. There was fear in the profession that mental health nursing would become subsumed by other fields and strong resistance to a generic nursing course, that had been adopted in other countries, fearing that this could not prepare students sufficiently for mental health nursing (Happell 2006; Hurley and Lakeman 2011). Additionally, it has been suggested that research into the differentials between mental health nursing and other fields was hampered by a reluctance to focus on serious and enduring mental illnesses such as schizophrenia (McBride 1990), with more emphasis on anxiety and mild to moderate depression.

Hurley and Rankin (2008) and Hurley and Lakeman (2011) report on the blurring of boundaries between mental health nursing and roles such as social work, noting the broad range of roles undertaken by mental health nurses and lack of distinction between mental health nurses and others in current practice. The work with the homeless mentally ill described in three of the four papers in this collection is an example of this extended role, working alongside doctors, social workers and occupational therapists to provide access to benefits, housing and physical healthcare in addition to the mental health care and treatment.

### *6.2.1 NURSING IN A LIMINAL CONTEXT: MENTAL HEALTH, SEXUALITY, AND HOMELESSNESS*

The papers included in this phase include the role of mental health nurses in addressing the needs of service users, working in a liminal profession in relation to the nursing establishment (Evans and Kevern 2015) with a marginalised population in a liminal stigmatised state (Chamberlain and Johnson 2018). The interpersonal nature of mental health nursing practice and its lack of focus on tasks and protocols unlike other fields of nursing, means it is an uncertain and sometimes chaotic setting in which to work (Gourlay 2009; Meyer and Land 2005). This is greatly magnified by the environment encountered when working with homeless people, which reaches the threshold of ambiguity referred to in the literature. Mental health nurses are exposed to extremes of vulnerability and are:

> *'expected to deal with hostility, aggression, suicidal acts, acute psychosis, effects of trauma, abuse and addiction'* (Evans and Kevern 2015: p5)

Evans and Kevern (2015) suggest that student nurses need to be prepared for the liminality of life post-registration where, despite transitioning to a qualified nurse, students remain in an ambiguous profession, divided between mechanistic models of nursing versus a more interpersonal approach.

The papers developed in this phase address some of the unmet needs of homeless people and the liminality of their lives. The papers demonstrate the willingness and potential of mental health nurses to work with uncertainty and chaos, challenging prevailing norms in a liminal space. One paper developed from the investigations into sexual behaviour of homeless people and broadened into nursing interventions (Cort et al 2003) gathered data from Community Psychiatric Nurses, who, while acknowledging and sometimes directly experiencing the sexual behaviour of their clients, could not, however, envisage how this could be implemented in practice. Over time there has been much progress in this area (McCann 2000; McCann 2003; Quinn and Browne 2009; Quinn et al 2011; Quinn et al 2013; Quinn 2013); these papers acknowledge the contribution of the original work.

The liminality of homeless people can prevail despite the engagement with services and relatively settled lives described in Power and Attenborough (2003). Chamberlain and Johnson (2018) found that despite leaving the stigmatising liminality of homelessness, a '*psychological dimension'* (p1259) of liminality remained:

> *'People continue to feel embarrassed and ashamed about what has happened to them long after they have been rehoused. They are in mainstream housing like other people, but they do not feel fully accepted because they continue to carry the symbolic burden of homelessness.'* (Chamberlain and Johnson 2018: 1259)

By following up homeless people beyond the resettlement stage Chamberlain and Johnson have captured extended liminality as described by Thomassen (2009); though people may be housed they are not assimilated into society and remain in a liminal state.

This policy and political context, along with the position of nursing when the articles were produced influenced both future publications and is evident in the significance and impact of the selected works, which is discussed in the next chapter.

# CHAPTER SEVEN: SIGNIFICANCE AND IMPACT OF SELECTED PUBLIC WORKS DEVELOPED FROM CLINICAL PRACTICE

## 7.1 OVERVIEW AND INTRODUCTION

This chapter examines the significance and impact of the selected works. Whilst these works were produced 17-23 years ago, they continue to be cited and acknowledged. Using the matrix of Google Scholar or Scopus citations the works in this phase have the largest number of citations of all the works discussed in this statement (see appendix four). This is partly due to the time passage since publication but also due to their place at the beginning of changing practices, others have developed and refined the concepts and ideas.

## 7.2 CONTRIBUTION AND IMPACT OF WORKS FROM CLINICAL PRACTICE

The work that focusses on Community Psychiatric Nurses attitudes to and experience of working with people with mental health problems (Cort et al 2001) demonstrates sustained impact in nursing, social work, occupational therapy medicine, radiotherapy, housing and education publications with international reach. The work is cited in papers that cover the adult life span from youth (Russell 2008) to sexuality and aging (Baldissera et al 2012; Bouman et al 2006; Kasif and Band-Winterstein 2017). The paper is cited in work about nurses' beliefs and attitudes towards sexuality (Saunamaki et al 2010) including a development of the initial finding about barriers to sexual history taking and role development in mental health nursing (Magnan et al 2005; Virgolino et al 2017; Quinn et al 2011). Race (2016) discusses the paper in terms of breaking taboos and Billington (2012) explores the development of nurse education taking into account the findings of the study. Although the ambivalence expressed by participants in the original study is still replicated in these papers (Moore 2018), there is evidence of progression, and papers focussing on mental health nursing demonstrate an expectation that discussing sexuality is part of the nurses' role (Dein et al 2016; Higgins et al 2005; Higgins et al 2009; Quinn and Brown 2009; Quinn et al 2011; Quinn et al 2013), which was not the case at the time of the original study. Furthermore, aspects of responses to the nurses' role in the original paper that required further investigation, such as interventions at the time of administration of depot medication, have been further explored by Phillips and McCann (2007).

The studies about sexuality and homelessness have also been cited internationally. These papers, unsurprisingly, focus on homelessness, sexuality and mental health. There is overlap in the citing

of the study with the development of sexual history taking and sexual health being part of the role of mental health nurses (McCann 2000; McCann 2003).

Briggs et al (2009) examine the lived experience of those in unstable housing and the relationship to health risk behaviour. The impact focusses on vulnerability and how services might intervene (Porter et al 2004).

The longitudinal case note review and follow-up study of 100 people reported in Power and Attenborough (2003) established that homeless people with mental health problems can, with support from specialist services, lead settled lives. This paper has been used in analysis of theoretical and service models internationally (Bowpitt and Jepson 2007; Farrell et al 2005; Moyo et al 2015; Philippot et al 2007; Price 2011). The premise of the Power and Attenborough article was challenged by Blid and Gerdner (2006), who, in a study conducted in Sweden, found that specialised housing services can be a barrier to integration with mainstream services and society, whereas the relationship between care services and homeless people with mental health problems is reported to be crucial to progression to a settled life by Stevenson (2013). Furthermore, Bowpitt and Jepson (2007) identified factors for success for homeless people with mental health problems including engagement with support services and the establishment of a community between staff and residents as reported in our paper.

Several papers that cite our original paper relate to young people with mental health problems who are homeless. In a sociological study undertaken in Canada, O'Reilly et al (2009) report the dilemmas in defining mental health and illness in young people contributing to lack of access to services and feelings of shame associated with the double stigma of being homeless and mentally ill. In a call for specialised services and in support of our original paper, Taylor et al (2006a) report the fragmentation of services and young people's multiple problems linked to the causes of their homelessness such as sexual abuse, drug and alcohol use and self-harm. Furthermore, analysing conducting a survey about how well homelessness services can support young people's mental health needs, Taylor et al (2006b) articulate the necessity to include mental health requirements in the strategies of homeless shelters and for this to be recognised in the commissioning process Finally, the findings of the review were used in a report about homelessness and mental health prepared by Price (2011) for the Welsh Government, with suggestions for service models.

The papers produced in this phase, emanating from clinical practice, demonstrate the impact of nurse-led enquiry and the importance of investigating and disseminating practice, even where this

is undertaken in liminal spaces. In the following chapter, works produced after my move into higher education, including those developed from pedagogical studies and resources produced for educators and practitioners are discussed.

# CHAPTER EIGHT: PUBLIC WORKS DEVELOPED FROM PEDAGOGICAL STUDIES, RESOURCES DEVELOPED FOR PRACTITIONERS AND EDUCATORS: 2007-2020

## 8.1 POLITICAL AND POLICY CONTEXT

The works in this collection span a period of expansion in numbers of people entering higher education and the development of the Scholarship of Teaching and Learning (SoTL) in universities. This was a period of rising university fees with the cost burden falling to students rather than government, though this had a less profound impact on healthcare students until 2017 (Attenborough et al 2019). Since the 1960s, successive governments sought to increase the number of students attending university. In 1999 a target was set by the Blair Labour government that 50% of young people should go to university; this was achieved 20 years later (Brant, 2019). This was considered to be an essential plank of Labour party policy and was announced at the party conference in 1999 by the Prime Minister:

> *'Why is it only now, we have lifted the cap on student numbers and 100,000 more will go to university in the next 2 years, 700,000 more to further education. So today I set a target of 50 per cent of young adults going into higher education in the next century.'* (Tony Blair *Guardian* September 28 1999)

In order to achieve the target, government pursued a widening participation agenda, though evidence persisted that the numbers of students attending the Russell Group of universities was affected by social background, therefore admissions policies continue to be scrutinised, aligned to widening participation and equality in higher education (Office for Students 2018), even after the target had been achieved. The Office for Students set an agenda for change that built on previous aspirations, noting the achievement differentials based largely on social class and race. These included eradicating the difference in entry proportions at high-tariff universities between the greatest and least represented groups; increasing the number of mature students; eradicating the differential in the attrition rate between the greatest and least represented groups and removing the difference in degree outcomes between white and black students and disabled and non-disabled students (Office for Students 2018). By introducing a regulatory framework, monitoring and publication of results this approach appears to have 'teeth'.

Contemporaneously, the Teaching Excellence Framework (TEF) was developed. The aim of the TEF was to improve the information available to university applicants about learning and teaching, a secondary aim was to align the TEF award (gold, silver or bronze) to the charges for undergraduate degrees, linking the outcome of the TEF to permitting universities to raise fees, and raising the profile of universities who excelled at teaching and learning (Gunn 2018). The move towards valuing education in universities had been proposed by David Willetts as Minister for Higher Education in 2013. Willetts felt that there was too much emphasis on research in some universities and pointed out that undergraduate students were cross-subsiding research that was unfunded by external bodies (Willetts 2015).

One consequence of the introduction of the TEF is the increased focus on the educational experience of students and more equal status between research and teaching, an area examined by Lopes et al (2013) in the relationship to academic identity in professional fields of practice. Lopes et al (2013) investigated the research-education divide in lecturers in teaching practice and nursing and compared these, including the motivation to undertake research in newer academic subjects. Lopes et al reported that both groups felt that the lack of opportunity to undertake and publish research had a negative impact on their identity as academic staff indicating the perception of value in research activities.

In the context of the papers presented here, it is important to consider this from the point of view of newly academicized subjects such as nursing- on the one hand the drive to raise the profile of educational excellence might benefit teaching-heavy professional degrees, but the drive towards professionalism and equal status with other subjects is not served by a dearth of research outputs and dissemination of practice through publication (Diers 2004).

## 8.2 NURSING VALUES IN PEDAGOGY

The values articulated through nursing pedagogy have been the subject of debate, observation and enquiry for many years (Nolan 1993). Horsfall et al (2012) call for more effective nurse education through the embedding of values, though much teaching philosophy in nursing is based on skills acquisition (Hewitt 2009). This can lead to information overload in students and has underpinned debates about training vs education from when nursing first entered the academy, when fears about academic drift were first articulated (Glen 1995). A more student-centred approach has been advocated (Candela et al 2006) requiring more active learning, and this is the context in which the articles in this phase were produced. Additionally, the move towards

involving and embedding the service user experience is an important adjunct to the development of a student-centred pedagogical approach to nurse education.

Student-centred learning requires an awareness by academic staff of the power difference between lecturers and students, evaluation and development of teaching practice, including reflective practice in teaching and the acknowledgment that it is students rather than lecturers who have the ultimate responsibility for their own learning (Greer et al 2010). The educational student-centred approach does feed into some of the debates and public perception about nursing's place in the academy, and the place of education for nurses, which has been discussed elsewhere in this statement. The works included in this phase aim to enhance and empower nurses, both to access education through the use of technologies and to address the power relationships with service users.

The issue of power relations is not confined to nursing or healthcare education and has been explored by the wider SoTL community (Seale et al 2015); furthermore, students may be resistant to being autonomous learners (Horsfall et al 2012).

Welch (2011) examines nursing pedagogy from a feminist perspective, calling on educators to encourage students to analyse their experience from the perspective of being women, calling for a dialogue based on lived experiences. This links to the storytelling work reported in Attenborough and Abbott (2018) and Attenborough and Abbott (2020). The move away from didactic teaching and the memorising of facts towards an actual consideration of knowledge, using stories has been demonstrated to increase critical thinking in learners (Diekelmann and Schekel 2004).

Lastly, and importantly for future generations of nurses, Vizcaya-Moreno and Pérez-Cañaveras (2020) examine the distinctive characteristics of Generation Z (those born after 1995), and their unique set of attitudes and beliefs and preference for social media for establishing and maintaining relationships. The authors surveyed 120 students and reported on their preferred learning techniques, linking this to the Covid-19 pandemic and the necessity to develop alternative styles of teaching, with the aim of identifying the preferred mode of learning and how participants facilitated their learning, including through social media. The study found that students used social media throughout clinical placements to support their learning, and to build and sustain learning communities. Students preferred visual stimulation and actual clinical practice to reading and engaging with PowerPoint presentations. This is discussed in a paper

about the use of mobile devices in clinical practice Attenborough and Abbott (2018) and Attenborough et al (2018), which discusses building a community of practice through Twitter for work-based learning.

## 8.3 THE RISE AND INTEGRATION OF STAKEHOLDER ENGAGEMENT

Demonstrating service user and carer involvement is currently a requirement of healthcare education regulatory bodies for universities in the development of courses. This has gradually become widespread since the Chief Nursing Officer's review of mental health nursing education (Department of Health 2006) and was given addition impetus in the Francis Report (2013). There is widespread agreement that this should be encouraged and has been linked to retention of nursing students and an increased sense of professional identity (Attenborough and Abbott 2019; Hurley and Lakeman 2011). Repper et al (2001) identified the aims of including service users or experts through experience in mental health nursing education; including the identification of the strengths of service users rather than their illness, learning from service users how best to provide care; increase appreciation of the impact of mental health problems on service users leading to increased challenge by students (and subsequently qualified staff) of the prevailing cultures in mental health which may not be positive.

Tew *et al*. (2004, p. 54) describe five levels of service user involvement in education, ranging from no involvement to full partnership:

| Ladder of service user involvement (Tew, Gell & Foster, 2004) | | |
|---|---|---|
| | LEVEL 5<br>*Partnership* | Patients work together with teaching staff across strategic and operational areas with an explicit statement of partnership values. Patients with secure contracts. |
| | LEVEL 4<br>*Collaboration* | Patients as full time department members involved as below in THREE major aspects of faculty work. The department has a statement of values. Training and supervision are offered. |
| | **LEVEL 3**<br>***Growing Involvement*** | **Patients involved in TWO of the following: planning, teaching delivery, student selection, assessment, management or evaluation. Payment at normal visiting lecturer rates. Training and support offered.** |
| | LEVEL 2<br>*Limited Involvement* | Service users invited in to 'tell their stories in a designated slot. No opportunity to shape the course. Payment offered. |
| | LEVEL 1<br>*No involvement* | Curriculum planned, delivered and managed with no patient involvement. |

**Figure 15: Ladder of Service User Involvement, Tew et al. (2004, p. 54)**

The paper developed in this section reporting on an innovative project involving student nurses and mental health service users (Simpson et al 2008) was developed with a full-time member of staff who was a service user, as was the reference book (Attenborough et al 2007). As such the paper emanates from an environment that fulfilled all criteria for level three and was progressing within level four.

## 8.4 THE SCHOLARSHIP OF LEARNING AND TEACHING: THE LIMINAL SPACE BETWEEN DISCIPLINES

The papers in this section contribute to the scholarship of teaching and learning (SoTL) in the academy. SOTL was identified by Simmons et al (2013) as a liminal zone, where research and inquiry are in addition to, or in conflict with disciplinary research. Although other papers explore academic identity development in nurses (Attenborough and Abbott 2018; Attenborough and Abbott 2019), the papers produced in this phase contribute to the delivery of professional education.

The struggle for nursing in joining the academy is discussed throughout this statement, and it may be a consequence of this that many nurses move into SoTL to undertake research and scholarship, especially when they have limited contact with clinical practice (Astle 2011). SoTL positions itself as an interdisciplinary field, therefore nurses can join on an equal basis to other disciplines but it

remains an alternative liminal space. By drawing on social identity theory it is possible to perceive how this has happened. Tajfel and Turner (1979) suggest possible responses to a challenged identity, including abandoning it in favour of an identity with higher status. This is an uncomfortable position to occupy as higher education pedagogical research has been identified as undervalued in the academy and certainly in the Research Excellence Framework (Cotton et al 2018), increasing the marginal position of academic nursing.

This pattern is evident in the pedagogical research papers presented here, relating to my engagement with research and scholarship in the academy. After initially maintaining links with clinical practice and producing papers in relation to this, in order to fully integrate as an academic, I had to reinvent my identity. To do this requires navigating a liminal space:

> *'Most of us position ourselves as still in this liminal space as we navigate our SoTL identities. We confront external tension in terms of our acceptance and position within our discipline-specific scholarship…'* Simmons et al 2013: p11

The context in which the papers produced in this phase is the expansion of the higher education sector, the increased focus on learning and teaching and the introduction of the Teaching Excellence Framework (TEF). In this chapter I have explored the influence of the research-teaching divide on the establishment of nursing in higher education, the development of values in nursing pedagogy and the move away from skills acquisition in nurse education, linked to increased professionalisation and student-centred learning. The move towards service user and carer involvement underpins many of the papers discussed, having been produced over a span of time that saw implementation of this practice, which altered the way teaching and research is approached in healthcare education. Finally, this chapter has introduced the scholarship of teaching and learning, as a liminal space between disciplines in higher education, a space that has embraced academic nursing, but sits on the margins of academia.

In the next chapter I discuss the significance and impact of the works produced in this context.

# CHAPTER NINE: SIGNIFICANCE AND IMPACT OF PUBLIC WORKS DEVELOPED FROM PEDAGOGICAL STUDIES AND RESOURCES

## 9.1 OVERVIEW AND INTRODUCTION

The three works presented in this phase focus on learning and teaching, including the development of educational resources.

## 9.2 CONTRIBUTION AND IMPACT OF THE WORKS

*Practice based working with users, carers and support agencies* (Attenborough et al 2007) is part two of *Primary Care Mental Health. A Complete Guide to Primary Care Mental Health: The Essential Reference and Learning Resource* (2007) a reference book and CD-ROMs, linking to policy and the latest data to support those working in primary care to work with people with mental health problems. The format of the resource is now dated, any similar resource would currently be web-based. The impact of the reference book was through its dissemination into primary care across England and the role of the materials in the development of the role of graduate mental health workers (Harrison et al 2009). This role was introduced between 2004 and 2006 and most people recruited to undertake the role had no prior experience of health or social care. Therefore, the resource was designed to support both the new workers and their supervisors during the training period. Furthermore, the reference book contained materials about the culture and processes of primary care and had a wider reach beyond the new role (Rushforth et al 2007). Rushforth et al discuss the development of the role and the place of the reference book in the integration of user and carer involvement in primary care mental health.

Coventry et al (2015) utilised the patient interviews outlined in the book in a cluster randomised controlled trial testing the efficacy of an integrated shared care model for people with depression and long-term physical conditions. The impact on further development of skills in the healthcare workforce is evidenced by a citation in the *ABC of Anxiety and Depression* (Baguley et al 2014), in a section about brief psychological interventions. Furthermore, Falbe-Hansen et al (2009) explored the role of guided self-help in primary health mental health citing the explanatory model of stepped care in the reference book to explain the positioning of the intervention.

The range of influence of the article *Talking with the Experts* (Simpson et al 2008) is both global and enduring, the article continues to be cited and included in systematic reviews and concept analysis about the involvement of mental health service users in education (Crookes et al 2013; Happell et al 2014; Rhodes 2012; Terry 2012). The project was devised and implemented before service user involvement in education was commonplace; it has subsequently formed the basis for what might be possible- to involve service users with profound mental health problems in shaping students' understanding of their experiences. The impact of the paper and its implications for practice and education are reported extensively. Additionally, the paper has contributed to the development of both blended and online learning in nurse education (Rigby et al 2012).

Smithson et al (2012) report on the development of an online community of service users and students citing the paper as an early example; recontextualization and the link between theory and practice afforded by service user involvement is described by Crookes et al (2013) and Rigby (2012). Other papers develop the theme of the impact of involvement on service users, for example, increased confidence and improved self-esteem (Rhodes 2012) from the original paper. The promotion of service user involvement and its influence is developed in many papers, notably Jack (2020) in an impact study of a module delivered in collaboration with service users and Franklin et al (2014) in the development of social media use to increase involvement in education.

*Leave them to their own devices,* (Attenborough and Abbott 2018) investigated healthcare students' use of mobile devices and the rise of mobile learning (m-learning). The paper is cited by Baldwin and Ching (2019) in their *Guidelines for Designing Online Courses for Mobile Devices,* the authors utilise the findings of the original paper as evidence of students' perspectives about mobile devices and the need for universities to consider the use of mobile devices when designing their learning. Similarly, Grant (2019) utilises the original paper to illustrate the use of mobile devices in higher education and in clinical placements; the effectiveness of mobile devices in different and changing learning environments is also cited by Alajmi (2019). Two of the papers citing *Leave them to their own devices* are published in technology focussed journals, the contribution of the paper is the pedagogical and student perspective, this informs the conclusions of the three subsequent papers.

One area highlighted in the original paper that has become topical in the Covid-19 pandemic is the issue of digital poverty, i.e., lack of student access to devices, or data, as more learning is delivered online. This has been highlighted by the Office for Students (2020), with a call for universities to do more to support access to digital learning through supplying data and devices.

Digital poverty was highlighted in the original paper in the observation that students volunteered in numbers to take part in the study that informed the paper- one possible reason was access to a device which they could keep after the study had completed, which would have otherwise been unaffordable.

This chapter has focussed on learning and teaching, and the impact of the published works to support learning, explore new concepts and approaches and contribute to new ways of working. The following chapter explores identity in nursing students and academics.

# CHAPTER TEN: PUBLIC WORKS FOCUSSED ON PROFESSIONAL IDENTITY IN NURSING STUDENTS AND ACADEMIC NURSES: 2017-2020

## 10.1 POLITICAL AND POLICY CONTEXT

The works produced in this phase overlap with the timeline in the second and fourth phases. This is discussed in detail in Chapters 8 (8.1) and 10 (10.1); in particular the long-lasting impact of the Francis Report into Mid Staffordshire NHS Trust (Francis 2013) and the subsequent regulatory reform that has influenced these works. Additionally, the context is one of health services emerging from a period of damaging austerity due to the global economic crash (Burke et al 2015). This had a significant impact on continuous professional development for both clinical and academic staff (Glasper 2016). The reductions in commissions for nurse education in 2012 in England, combined with cuts in funding to support nurses' development and an aging workforce contributed to a workforce crisis (Buchan and Seccombe 2012). The long-term consequences of this are evident today with 43,000 nursing vacancies in the United Kingdom (Nuffield Trust 2019).

## 10.2 THE POSITION OF NURSING

In 2012 nursing in the United Kingdom became an all-graduate profession. Given that nursing had been part of the academy since 1995, it is notable that for seventeen years nurses had been qualifying with HE diplomas rather than degrees. In 2015 the government announced the end of the NHS student bursary scheme in England; henceforth students would fund their own education in nursing through student loans, putting them in the same position as other undergraduate students. In 2016 as a response to a recommendation from the report by Robert Francis QC into the care of patients in mid Staffordshire NHS Trust (Francis, 2013), the NMC introduced revalidation for nurses (NMC 2016). The inquiry shocked the public and the healthcare establishment. The inquiry revealed that an estimated 400 to 1,200 patients had died as a direct result of the poor care they had received and reports from relatives of mistreatment and neglect were harrowing. The enquiry made 290 recommendations and the Chief Nurse for mid Staffordshire was suspended and subsequently removed from the NMC register (Francis 2010).

The final report (Francis 2013) focussed strongly on caring and compassion in relation to nursing and the education of nurses, the gendered interpretation of this is discussed in the introduction to themes part of this statement. The print media responded with outrage to both reports

(Chapman and Martin 2013; Lilley 2010). Ultimately Francis' inquiry led to a revised Code of Practice for Nursing and Midwifery, the end of self-regulation in the profession, and the introduction of periodic revalidation. Furthermore, there is evidence that the press reporting of the Francis Report led to a negative view of nursing (Girvin 2015).

## 10.3 IDENTITY AND GENDER IN NURSING

Identified as a main theme running through the works, in this section I consider the impact of gender in nursing and consider the influence of societal views about women in relation to the development of nursing as a profession. This fundamental influence on the development of nursing is not directly investigated in any of the works but suggested as an explanation for both the lack of progression of clinical nursing, and the lack of confidence in nursing's place in the academy (Attenborough and Abbott 2019; Attenborough and Abbott 2020).

Despite the progress made by nursing in the United Kingdom, including degree-level registration, continuous professional development, professional regulation and revalidation, the public perception of nurses remains outdated, and images of nurses continue to be gendered stereotypes (Gill and Baker 2019; Girvin et al 2016; Takase et al 2002). Takase et al (2002) established that nurses develop a part of their professional identity and self-concept from their public image. In as much as public perceptions can shape political and policy in relation to nursing, they can also shape nurses' view of themselves (Girvin et al 2016). A poor perception of nursing may affect whether people choose a nursing career (Miller and Cummings 2009) and there have been calls for nurses to use social media to try to change perceptions (Girvin 2015; Gill and Baker 2019; Hoeve et al 2013).

Hoeve et al (2013) identify gender stereotypes as a major reason for the lack of appreciation of the core of nursing. The lack of images of autonomous practitioners and the length and type of preparation for nursing through universities is not apparent in sexualised images of nurses (Gill and Baker 2019; Summers and Summers 2015). Similarly, the portrayal of nurses as doctor's handmaidens has influenced the development of nursing in the minds of the public, despite nurses being independent from doctors in management and regulatory terms (Berry 2004). Additionally, it is important to consider that despite the dominance of women in nursing, they are disadvantaged compared to men who join the profession. By interrogating the workforce datasets in the United Kingdom, Punshon et al (2019) demonstrated that men are over-represented in higher pay bands reaching the higher pay bands at a faster pace than women. Furthermore, Pushon et al established that in specialist nursing roles, men reached the higher pay banding five

years earlier than women, and that women were prepared to take a lower grade job in order to move into their chosen specialism.

### *10.3.1 FEMINISM AND NURSING*

Given the predominance of women in nursing it is surprising that nursing is not more closely associated with feminism. Summers and Summers (2015) describe nursing as '*the work feminism forgot*' (p190), in that nursing is perceived as limiting women's aspirations (to be doctors or serious scientists). The position reported, though not endorsed, is that while nursing was an important route to independence for women in the past, women no longer have to limit themselves to being nurses (Kane and Thomas 2000). This view reflects the portrayal and societal beliefs about nursing, that it is a limited role with low status. This position drove a wedge between nursing and feminism:

> *'As a result of this lack of respect for the nursing profession, nurses who made significant contributions to the women's movement were identified as feminists, not nurses.'* (Kane and Thomas 2000 p18)

The lack of synergy between feminism and nursing is compounded by feminism's focus on the lived experiences of white, middle class educated women, while nursing has a much more diverse base (Thompson 2002).

Kane and Thomas (2000) identify the invisibility of feminism in nursing, calling on nurses to embrace feminism in their practice and in the education of nurses.

More recently, sociologists such as Julia Hallam have studied the professional identity of nurses through the lens of feminist cultural studies and autoethnography (Hallam 2002; Hallam 2012), giving vivid accounts of the experiences of nurses and the cultural world they inhabit, revealing oppression and inequalities.

## 10.4 REPRESENTATION OF NURSES

This section includes seven images of nurses and explains the context in which they were created. The images convey the portrayal of nursing in popular media in the twentieth and twenty-first centuries. The association between images of nurses/nursing and public perception of the

profession has been investigated and examined extensively (Gill and Baker 2019; Girvin, 2015; Hallam 2012; Hoeve 2013; Summers and Summers 2015).

The images, some of which are iconic, all include gender stereotypes. These representations of nurses are fundamental to the context in which the works were produced, the image of nurses and the potential impact on their identity and self-concept as suggested by Gill and Baker (2019). Even historical images of fictional nurses are still quoted by politicians in proposing policy and reform, often with nostalgic references to the past. The most recent reference to Hattie Jacques as a model matron, based on her performance as a fictitious matron in the Carry-On comedy films, in the UK Parliament was in 2017 in a debate about the NHS (see appendix 3).

### *10.4.1 Game Changer by Banksy (2020)*

Banksy depicts a nurse becoming a superhero in the Covid-19 pandemic, the image is of a child discarding previous superheroes such as Batman in the bin and holding the nurse aloft. The image is displayed in Southampton General Hospital. Although this was welcomed as a positive image of nursing during a pandemic by some, others criticised the traditional stereotyped uniform, and the nurse as hero message (McAllister et al 2020; Stokes-Parrish et al 2020).

**Figure 16: Game changer by Bansky (2020) accessed from https://www.theguardian.com/artanddesign/2020/may/06/banksy-artwork-superhero-nurse-nhs-coronavirus-covid-19-southampton-general-hospital 3rd June 2020**

### *10.4.2 Nurses in novels- Louis Berg: Prison Nurse (1934) and Lou Marchetti: Nurse Todd's Strange Summer (1965)*

The two images chosen are from books written in the 1930s and the 1960s. The main aim of books in this genre was to encourage young women to consider a career in nursing; the depiction of nurses in these popular novels was generally of young white women, with the exception of *Mary Ellis Student Nurse* (Anthony et al 2019). The books portray nursing as exciting, thrilling and occasionally dangerous, with romantic interest, sometimes in the form of a relationship with a doctor. *Prison Nurse* covers the more exciting, potentially dangerous elements and *Nurse Todd's Strange Summer* is a romantic book


**Figure 17: Louis Berg-Prison Nurse (1934) Accessed from http://vintagenurseromancenovels.blogspot.com 01/07/2020**

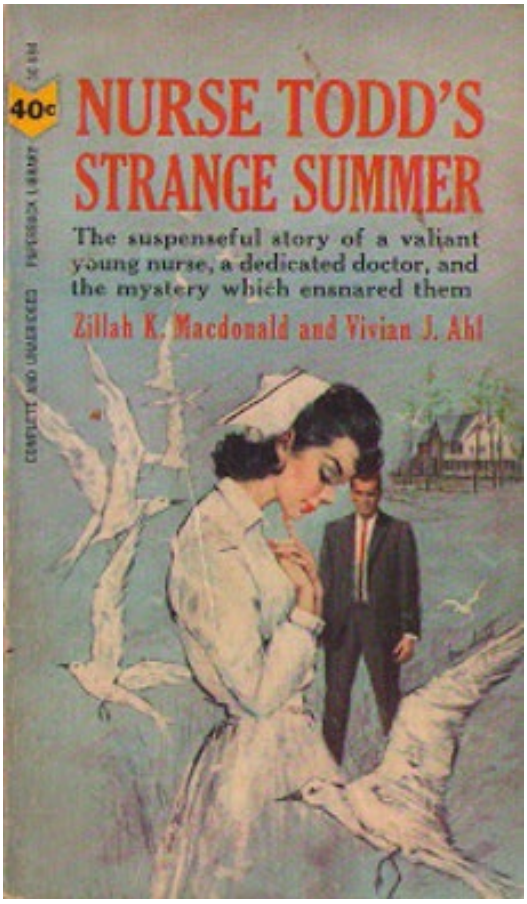


**Figure 18: Lou Marchetti: Nurse Todd's Strange Summer (1965) Accessed from http://vintagenurseromancenovels.blogspot.com 01/07/2020**

### *10.4.3 Ken Kesey: One flew over the cuckoo's nest (1975)*

Nurse Ratched is the main nurse featured in Ken Kesey's film *One flew over the cuckoo's nest* (1975). Portrayed as lacking in warmth, empathy and sensitivity, Nurse Ratched (played by Louise Fletcher) was based on a nurse who was a head of a psychiatric unit where Kesey worked (Kirkpatrick, 2001). The absolute power commanded by Nurse Ratched is portrayed strongly in the film, her depiction is also gendered. Nurse Ratched's subsequent downfall is through being sexual assaulted by the film's central character (McMurphy played by Jack Nicholson), which reduces her power as the patients are no longer afraid of her.

**Figure 19: Ken Kesey One flew over the cuckoo's nest (1975) Accessed from https://www.imdb.com/title/tt0073486/characters/nm0001221 15/07/2020**

### *10.4.4 Norman Hudis: Carry on Nurse (1959)*

In this film the actor Hattie Jacques portrays a matron; a controlling and harsh disciplinarian. This image became synonymous with senior nursing figures and has been invoked as a reason to reintroduce matrons to nursing in the UK (see appendix 3). Forty-four years after the film's release, on 22nd May 2003 in the House of Commons the MP for Ealing North, Steve Pound said:

> *'I make no bones about admitting that I have a sentimental attachment to a health service run by Hattie Jacques and would be happy if that were the case now.'* (Health and Social Care (Community Health and Standards) Bill Deb, 22 May 2003, column 354)

**Figure 20: Norman Hudis Carry on Nurse 1959 Accessed from https://www.imdb.com/name/nm0415150/?ref_=tt_cl_i4 01/10/2020**

### *10.4.5 Gerald Thomas: Carry on Doctor (1967)*

In *Carry On Doctor* the actor Barbara Windsor portrays a '*naughty nurse*' (Summers and Summers 2015).

> *'Naughty nurse images add to the chronic underfunding of nursing research, education and clinical practice. Healthcare decision makers- many of whom are sadly uninformed about what nursing really is- are less likely to devote scarce resources to a profession that has become so degraded in the public mind'*
> (Summers and Summers 2015: 159)


**Figure 21: Gerald Thomas Carry on Doctor (1967) accessed from https://www.imdb.com/title/tt0061450/ 10/10/2020**

### *10.4.6 Jessica Anderson and the Guinness World Records (2019)*

In 2019 Jessica Anderson, a senior sister at the Royal London Hospital, sought to beat the record for running a marathon in a nurses' uniform. Wearing her uniform, she beat the record by 22 seconds but was told by *Guinness World Records* that she did not meet the criteria because she was not wearing 'a blue or white nurse dress, a white pinafore apron, a traditional white nurse's cap. Tights are optional.' After protests Guinness World Records was forced to reverse its decision (Ford 2019).


**Figure 22: Jessica Anderson 2019 accessed from https://www.bbc.co.uk/news/newsbeat-48161466 26/07/2020**

## 10.5 NURSING A GRUDGE: EATING OUR YOUNG IN CLINICAL PRACTICE, IDENTIFICATION OF THE KILLER ELITE IN THE ACADEMY

There is an adage that '*nurses eat their young'*, used to describe a culture of bullying within the profession. Although this is not something I have systematically investigated I discuss it here for completeness in considering nursing as a profession, its identity and future in the academy.

Darbyshire et al (2019) describe this phenomenon as creating an undermining and a hostile environment for young nurses and explore its relationship to a perception of a lack of resilience in the newly qualified workforce. In a study of horizontal violence in nursing, Longo (2007) asked participants whether they had heard the expression 'nurses eat their young'; 31 (66%) of respondents had heard the statement and 34 (72%) believed it to be true. In a blog about bullying of nursing, Brunworth (2015) refers to eating our young as '*nursing's dirty little secret*', and asks '*are we full yet*?', before discussing some approaches to eradicate the problem. There are many authors who have investigated bullying in nursing, suggesting it isn't exactly a secret (Gillespie et al 2017; Sauer, 2012). Rowe and Sherlock (2005) investigated the types and frequencies of abuse towards nurses and reported that although abuse towards nurses was mainly from other nurses, participants were also subject to verbal abuse from doctors and patients and their families. This phenomenon potentially relates to the self-esteem of nursing as a profession, and the self-identity and resilience of nurses. In a longitudinal qualitative study of nursing students, Randle (2003) reported bullying across all fields of nursing, from clinical staff towards students and patients. Randle suggests that as an oppressed group, student nurses through socialisation repeat

the pattern of their experience and become rigid controlling bullies when they become qualified nurses.

Linked to the perception of nursing and the behaviour of nurses towards each other is the position of nursing in the academy. Wieland and Beitz (2015) investigated bullying in academic nursing and found this to be widespread, leading to trauma and long-lasting problems in participants.

In 2010, two well-known Professors of Nursing published an editorial in the *Journal of Clinical Nursing* about the *h-indices* and research performance of named professors of nursing in the United Kingdom (Thompson and Watson 2010). This included publishing the *h-indices* of 16 current nursing and midwifery professors and comparing these in the narrative to professors in other specialisms, such as psychology. Although the data was already in the public domain, the public shaming of the nursing professoriate was shocking. The authors called for action to address this perceived weakness in the academic profile of nursing. Furthermore, in an editorial in the *Journal of Advanced Nursing*, one of the most influential and high impact nursing journals, Thompson and Darbyshire (2013) called for the end of the 'killer elite'(p3) in academic nursing:

> *'Nursing is now suffering the consequences of the professorial mediocrity of a small but overly influential minority wielding excessive influence and of too few people prepared for senior academic posts.'* Thompson and Darbyshire 2013: p2

> *'The fiefdoms of the elite are critique-free zones, virtually devoid of any spirit of inquiry, ethos of debate or culture of scholarship. So tyrannical are some of the 'killer elite' that the only notes of dissent heard will be the whisperings (under a cone of silence) of their staff and students when they are far enough away at a conference or anonymous enough online.'* Thompson and Darbyshire 2013: p3

This article sparked debate across the nursing professoriate internationally and clearly resonated with some academic nurses, whilst others issued rebuttals arguing that nurse academics are caught between two masters, the NHS and the university (Gallagher 2013). It is in this context of self-criticism that much of my work has been produced. Though not defensive I conclude that some of my publications may serve as apologists for the state of morale and self-belief in nursing. In particular my work about identity (Attenborough and Abbott 2018; Attenborough and Abbott 2019) and storytelling by academic nurses (Attenborough and Abbott, 2020). Does the lack of self-

belief explain some of the reluctance to embrace an academic career described in the literature? Does the self-identified perception of mediocrity explain the lack of immersion in the academy? It does illustrate the complexity of being a nurse academic today. There is a lack of evidence in both clinical and academic nursing of Chandler's (2017) assertion that when a profession is under attack it unites together to reinforce its professional identity.

## 10.6 PROFESSIONAL IDENTITY IN NURSE ACADEMICS, LIMINALITY OF NURSING IN THE ACADEMY

Professional identity in academic nurses has been explored in a number of studies; in particular the transition from clinical practice to becoming an academic (Andrew 2012; Andrew and Robb 2011; Evans 2013; Logan et al 2016; Smith and Boyd 2012; Weidman 2013). Duffy (2013) explored the academic role of a lecturer in nursing and how this contributed to developing an academic identity. Duffy's analysis revealed concern among participants about the right of nursing to be part of the university, the restrictive nature of being a nurse academic, not really feeling included, and having to justify their position in the university *per se*.

The papers I produced in this phase focussed on concern about professional identity revealed by the NMC revalidation process. The anxiety caused by the need to revalidate necessitated a support package for academic nurses and midwives (Attenborough 2017). Much of the support available more widely focused on the clinical workforce; the academic workforce constituting less than 2% of the professional register (NMC 2019). Professional revalidation had revived many of the anxieties about lecturer's perception of their own legitimacy in the academy, compounded by anxieties about the genuineness of owning the nursing title, when many had not worked in clinical practice for several years.

Whether the feeling of not being welcomed reported in the literature is justified is explored by Jackson et al (2011) through the lens of academic achievement- the PhD. Jackson reports difficulties in nurse academics securing a permanent appointment in a university without a doctorate, and the lack of support to achieve a doctorate in the first place. The challenge for nurse academics is being simultaneously required to be clinically up to date, engaged in research and scholarly activity, have a large teaching portfolio, and to provide education to students in practice. Additionally, many lecturers have a long clinical career and have undertaken an undergraduate degree, a master's degree and a number of clinical courses to support their clinical careers prior to entering the academy; however, they enter the academy as a novice with

qualifications which may not be valued and without a substantial publication portfolio. Sustaining a dual identity when clinical credibility is doubted, impacts on the role progression of nurse academics (Andrew and Robb 2011).

This chapter has explored the policy and political contexts for nursing, alongside public perceptions and images, and the relationship between nursing and gendered stereotypes. The chapter also considers how self-criticism and bullying has affected the development of nursing identity and how it might influence the future. Finally, the chapter considers the position of nursing in higher education and the professional, dual identity of nurse academics. In the following chapter, I discuss the public works that focus on professional identity in different contexts.

# CHAPTER ELEVEN: SIGNIFICANCE AND IMPACT OF PUBLIC WORKS FOCUSSED ON PROFESSIONAL IDENTITY IN NURSING STUDENTS AND ACADEMIC NURSING

## 11.1 OVERVIEW AND INTRODUCTION

The works in the third and fourth phases were produced relatively recently, this is reflected in the number of citations (see appendix 4) versus the impact measured in altmetrics or through readership in ResearchGate.

## 11.2 CONTRIBUTION AND IMPACT OF THE WORKS

The paper raising the profile of courageous nurses from history, *The Nurses that Roared* (Attenborough et al 2019), was a development of an online article Reynolds and Attenborough (2018), written for the *Nursing Standard* to commemorate 100 years of partial women's suffrage in the United Kingdom. The 2019 paper has an *altmetric* index of 40, which means it is in the top 5% of all research outputs scored by *altmetric*. The paper was welcomed across the online nursing community and internationally and has been used as a text for a PhD in nursing programme in the United States; hence the *altmetric* score is significant as the article was discussed on social media at a significant time for nursing globally. Furthermore, Domenech-Climent (2020) cites the paper in an article in a Spanish nursing oncology journal about the impact of Covid-19 on the World Health Organisation's Year of the Nurse and Midwife. The aim of the work was to move beyond the stereotyping of nurses, though some the nurses featured in the article do fit the hero stereotype, the nurses featured are lesser-known heroes, from more diverse backgrounds (Gill and Baker 2019).

*Building a professional identity: views of pre-registration students* (Attenborough and Abbott 2018) has been cited in the nursing literature, including an editorial in the *British Journal of Cardiac Nursing* (Olson 2018), promoting the use of storytelling by nurse academics and how this supports students to develop their identity, the academic acting as a role model for students, developing confidence through relating their own experiences. In the *Journal of Gastrointestinal Nursing,* Harrison (2018), cites the article as evidence of how exposure to experienced nurses is effective in developing professional identity, in clinical and academic settings. Harrison also links the research reported in the paper to national projects to reduce attrition in students and newly

qualified nursing staff. Similarly, in the *Journal of Perioperative Practice,* Jones (2018) links the paper to recruitment and retention in a perioperative care, often considered to be 'a hidden identity' (p277). In all three papers the use of role modelling in developing identity is linked to the paper. Jones (2018) goes further in linking it to dissemination of what nurses do, specifically in perioperative practice, but in informing and disseminating widely about an unseen role.

The practice of storytelling identified in the 2018 paper is developed further in *Using storytelling in nurse education* (Attenborough and Abbott 2020) investigating the practice and its links to identity in nurse academics. Hardie et al (2020) compared the use of storytelling through virtual reality with the conventional use investigated in the original paper, finding similar effectiveness. Sabeti et al (2020) investigated the use of storytelling in assessment of optometry students, demonstrating that engagement with a storytelling assessment was positively associated with improvement in grades from a written test, indicating increased engagement with the topic area. This paper cites the original article as an example of storytelling enhancing clinical education, particularly where a difficult topic tends to be rote learnt and cannot then be easily recontextualised in clinical practice.

However, Vizcaya-Moreno and Pérez-Cañaveras (2020) challenge the findings of the paper with respect to Generation Z (the population born after 1995) nursing students. Whilst acknowledging the experiences of lecturers about storytelling, the student participants reported in Vizcays-Moreno and Pérez-Cañaveras' study preferred working with virtual learning environments, watching videos and interactive online learning, to storytelling from lecturers for building identity. This is an important finding and links to the discussion in our storytelling paper, that the practice may be of use to lecturers in maintaining their identity. As more Generation Z students enter universities this may become further apparent, and the position of lecturers as role models should be re-evaluated in this context.

Finally, *The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution* (Attenborough and Abbot 2019) builds on previous work about revalidation as a new process and concept (Attenborough 2017), and has been reported in the work of Fisher et al (2019). In a paper reporting an investigation into registrants' experiences of revalidation and the preparation of students for revalidation, Fisher (2019) cited three of my publications as forming the majority of the evidence-base for revalidation in the UK. Fisher's findings both replicated and developed the findings of Attenborough and Abbott (2019) and Attenborough and Abbott (2020), while expanding

knowledge about the experience of revalidation. Although there is literature about the operational implementation of the process, with the exception of Fisher there has been no further published research about the impact of revalidation on the profession, in respect of its standing and status. This may be because the process has more meaning for professional identity in educators, especially those working in areas on the margins of clinical services such as education.

This chapter has focussed on the impact of works about identity in nursing students and academic nurses, in the context of the position of nursing in universities and in clinical practice. In the next chapter I discuss the move from university-based education to employer-led higher apprenticeships and the increased focus on work-based learning.

# CHAPTER TWELVE: PUBLIC WORKS FOCUSSED ON WORK-BASED LEARNING IN THE CLINICAL WORKFORCE, RELATIONSHIP WITH HIGHER EDUCATION

## 12.1 POLITICAL AND POLICY CONTEXT

The works focussing on work-based learning reflect a move away from university-focused courses to an apprenticeship style of learning, in the context of up to 40,000 nursing and midwifery vacancies across the UK (Nuffield Trust 2019). The origins of this can be identified in the ending of student bursaries for healthcare courses in England, which was operationalised in 2017, leading to a fall in applications for courses leading to professional registration, for example, applications to nursing degrees fell by 23% in 2017 (Ford 2017). This, coupled with publicity about adverse events in the NHS (Francis 2013) led to a loss of attractiveness of nursing as a career (Rosser 2017). Furthermore, Buchan and Seccombe (2019) cite a long-term lack of investment in nurse education and high rates of attrition from nursing courses as contributing to the workforce crisis. For example, 24% of the 16,544 UK nursing students who began degrees due to finish in 2017, left their courses before completion or took a break from the course. This attrition level has not altered significantly since 2008 (Buccan and Seccombe 2019).

The introduction of the apprenticeship levy in 2017, whereby employers with salary costs of over £3 million pay 0.5% of these costs into a central fund, to be drawn down to pay fees for apprenticeships, gave a strong incentive for employers to engage in apprenticeships. This in turn presented new opportunities for people to access courses leading to registration without the necessity to pay fees- students would be paid while studying (Halse et al 2018). Whilst this has undoubtedly enabled some people to access education and a professional qualification who had previously been unable to, concern was expressed by the Council of Deans for Health about the suitability of apprenticeships to address the workforce crisis, and the potential adverse impact on traditional university education for nursing (Merrifield 2017). Rosser (2017) notes the long struggle for nursing to achieve its degree entry and supernumerary status and raises the importance of education supporting evidence-based practice. Ultimately the government's ambition of 100,000 NHS apprenticeships by 2020 (Department of Health, 2016) was not achieved due to problems with regulation and the high cost of implementing the policy. In 2018 despite the impetus from government very few people started the apprenticeship; there were thirty apprentices across two universities in the United Kingdom (House of Commons Education Select

Committee 2018). Significantly, the Select Committee acknowledged the financial and organisational barriers to nursing apprenticeships, whilst calling on the NMC to review its policy about the hard fought for supernumerary status of nursing students.

The focus in my published works is on work-based learning in healthcare education, developed in this context. There are three papers in this phase, one focuses on the identification of learning (Attenborough et al 2019) examining the experiences of supervisors and students; the second is a longitudinal study using a framework developed from a previous paper (Halse et al 2018) about the experiences of work-based learners over time (Attenborough et al 2020); and the third is the presentation of a model for implementing work-based learning, capitalising on teaching in practice and drawing on learning from the other studies (Reynolds et al 2020).

## 12.2 INTERPRETING THE POLICY CONTEXT: LIPSKY'S STREET LEVEL BUREAUCRACY

The move towards work-based learning was driven by policy and changes in funding, such as the introduction of the apprenticeship levy. The implementors of the policy were ultimately the NHS trusts who chose to engage with it, as employer-led programmes they were required to engage at both the employment stage in recruiting apprentices, and the programme development stage when apprenticeship standards were set. In the works however I would identify the street level bureaucrats as those health staff who are much closer to the student, the supervisors and ward managers who enable or prevent the policy from being implemented successfully. This is where the tensions are demonstrated in my work-based learning publications.

Lipsky's work (Lipsky 2010) captures both this interface between policy, organisation, resource and practitioners and additionally, the discretion that frontline workers are able to use in their implementation of policy.

Hoyle (2014) in a paper about nurses' use of discretion in policy implementation, notes that nurses are constantly adapting to changes in policy, and their practice is greatly influenced by politics and social developments. This sometimes leads to nurses using their discretion about whether or not to apply policy, especially when this might affect their work in other ways.

Taylor and Kelly (2006) describe the three ways in which street level bureaucrats can operate; using discretion in applying rules; using discretion when their values are undermined by the policy and discretion over tasks, such as delivering treatment or care.

My works reveal that work-based learners do perceive the use of discretion in their managers, when certain groups of learners are prioritised to participate in learning opportunities. In Attenborough et al (2020) for example, participants believed that their learning experiences were curtailed by supervisors who prioritised the experiences of the more traditional learners who were not part of the workforce. Given the shortage of nurses and the impact of this on the supervisors and ward managers, the government's policy of increasing the number of apprenticeships and the commitment of the NHS trusts at board level to implement the policy, this appears on the face of it to be an irrational response. Furthermore, the supervisors and ward managers have all been learners and experienced the challenges of work-based learning, which logically should lead to a more empathic reaction. Lipsky (2010) goes some way to explain this through identifying the alienation of the street level bureaucrats. He acknowledges the bureaucratic burden on the street level bureaucrats, affecting their ability to perceive the end results of their input.

Lipsky (2010) also addresses empathy between workers towards clients who have a similar background to them (in this case work-based learners), asserting that bureaucracy has removed the satisfaction in supporting clients, and the ability to see the reward of their efforts. This alienation in turn leads to an acceptance of organisational change over relationships with clients, ultimately separating the learner from the supervisor. Additionally, Lipsky (2010) cites lack of control over the pace of work, the timing of decisions and decisions to spend more or less time with an individual leading to rationing of time, which was also demonstrated in the works (Attenborough et al 2019; Attenborough et al 2020)

## 12.3 RECONTEXTUALISATION IN LEARNING AND TEACHING

Although learning theory is often dismissed by healthcare educators as not being relevant to the complexities of learning in practice (Brown 2020), the theory of recontextualization is a significant underpinning for the work undertaken in this phase of my journey and is especially relevant to my work about storytelling, both with students and lecturers (Attenborough and Abbott 2018; Attenborough and Abbott 2020). Recontextualisation is a basis for supporting the change that happens when healthcare learners put their theoretical learning into practice, placing the learner in the context in which they learn. Evans et al (2010) explain how information, proficiencies and

ideas are shaped and changed by learning in practice learning, listing these in four levels. Firstly, content recontextualization, that which is included in curricula and the primary sources such as textbooks; secondly, pedagogic recontextualization, how that information becomes accessible to students enabling them to learn; thirdly, workplace recontextualization, how students learn through role models, mentorship and teaching in a real environment, greatly influenced by the learning culture of the workplace. Lastly, Evans et al (2010) describe learner recontextualization, that is how students consolidate this. The proposition of a model encapsulating this is made in Reynolds et al (2020).

The influence of the culture of the workplace is explored in Attenborough et al (2019), where paradoxically the most challenged workplaces such as accident and emergency or critical care were perceived by participants as being the most supportive and rich learning environments, due to a commitment to learning leading to an effective learning culture. Allan et al (2015) conducted an ethnographic observation and case study review of newly qualified nurses over two years and suggests that they learn to delegate and supervise unqualified staff by recontextualising the knowledge from their pre-registration programme in a liminal space. Allan observed the liminal space and suggests the pedagogical trial this presents in supporting students in healthcare subjects to recontextualise their learning. In Allan's study the support and tolerance of more experienced qualified staff was crucial to success, as identified in the works produced in this phase.

## 12.4 IDENTIFYING AND PRIORITISING LEARNING IN THE CLINICAL WORKPLACE

A major finding of Attenborough et al (2019) was the paradoxical discovery that although learning was undoubtedly abundant in health care environments, the identification of learning opportunities was more elusive. Several explanations have been given for this, including reticence and lack of confidence in learners (Jedaar et al 2009) and learners being given basic tasks to complete that distract from learning opportunities (Kemp et al 2016; Attenborough et al 2020). A subsequent publication in this phase (Reynolds et al 2020) presented a model that could be used to facilitate learning in busy workplaces. Additionally, the Royal College of Physicians (Basheer et al 2018) published a guide to maximising learning opportunities in the clinical workplace, entitled *Never too busy to learn,* reinforcing the belief that clinical workplaces can be supportive learning environments, but focus and intervention is needed to identify learning opportunities.
This chapter has discussed the newly emerging (or re-emerging) context of work-based learning for healthcare, the challenges and opportunities and identification of the workforce issues from

whence this has arisen. In the following chapter I discuss the contribution of the works developed in this context.

# CHAPTER THIRTEEN: CONTRIBUTION AND IMPACT OF WORKS DEVELOPED FROM WORK-BASED LEARNING IN THE CLINICAL WORKFORCE, RELATIONSHIP TO HIGHER EDUCATION

## 13.1 OVERVIEW AND INTRODUCTION

These are my latest works, reflecting the change in focus in healthcare education and my position as a leader both across systems (the cross fertilisation of the NHS and higher education) and in the academy. The works in this section were supported by a grant from Health Education England which also enabled me to develop a website supporting work-based learning across London https://workbasedlearninglondon.com.

## 13.2 CONTRIBUTION AND IMPACT OF WORKS

*Everywhere and nowhere* (Attenborough et al 2019) has been cited in '*A worldwide bibliometric and network analysis of work-based learning research'* (Bezerra et al 2020), indicating global reach, two articles about capacity building in clinical practice, one in rheumatology and one in health visiting (Brook 2019; Lewandowski 2020). The work is also cited in a book (Standing 2020) about clinical judgement and decision making, and an article Holder (2020) about supervision in clinical practice.

Two key findings of *Everywhere and nowhere* (Attenborough et al 2019) were the difficulty in identifying learning in clinical practice and the time available to educate learners in a busy clinical environment. The paper about nurses as educators by Reynolds et al (2020) was developed in response to this finding, suggesting a model of working to maximise learning opportunities. This paper was published in the *Nursing Times,* a monthly journal with peer reviewed education, clinical and research articles. The *Nursing Times* has a circulation of 30,000 and is the most visited website for nursing outside of the United States, making the article available to a large number of nurses in clinical practice (Nursing Times 2020)

The most recent work in this phase *Pioneering new roles in healthcare* (Attenborough et al 2020) is a report of a qualitative longitudinal study about the experiences of learners enrolled on an apprenticeship working towards a new role in healthcare, the Nursing Associate. The paper demonstrates the necessity of preparation of the workforce for new roles and the improvement

in this over time as new roles become gradually embedded. This important finding adds to previous work (Halse et al 2018). Additionally, the paper discusses the lack of parity between work-based learning and learning undertaken in universities; learners in the study preferring university-based education. Lester and Costley (2010) identified the change in approach in higher education towards work-based learning, recognising the different roles of teacher and facilitator necessary in this type of course, and the role of increasing confidence and improving access to learning. Essentially by moving from expert teacher to facilitator of learning it is not only the identity of the learner that is different but the identity of academic staff supporting the process. I have presented the research in the papers in this phase at an international conference, the Advance HE NET International Conference 2019 (https://www.advance-he.ac.uk/programmes-events/conferences/NETCon19). Additionally, I was invited by the editor of *Evidence-Based Nursing* (BMJ publications) to write an editorial about the use of Twitter and Twitter chats in establishing a new community of practice for work-based learning across London (Attenborough et al 2018). This article has been downloaded 1,811 times from the BMJ website (December 2020).

Overall, the papers in the final collection contribute to the evidence-base about the changing face of healthcare education. The adoption of new technologies, necessitated by a global pandemic has yet to be fully evaluated in this context, but the move towards harnessing the abundant learning in the workplace and addressing the global shortage of qualified nurses alongside the introduction of new roles has already changed learner's experiences. By utilising the findings of previous studies in producing models for education in practice and evaluating implementation through the existing evidence, the papers provide insight into an emerging and more open world of healthcare education, where access is not limited by geography, or prior qualifications, and experience is valued.

# CHAPTER FOURTEEN: DISCUSSION

## 14.1 FINDING NURSING: THE GOLDEN THREAD

The works included in this doctoral statement were produced over a span of twenty-three years. Much about nursing has changed during the time but essentially the issues remain constant. Over a decade ago, Liam Clarke in Cutliffe and Ward (2006) suggested:

> *'We need to dispose quickly with the question of what nursing is. We mustn't dwell on it: it's been 'done to death' over the years and we are no closer to finding a definition than we were fifty years ago- albeit more confused.'* (Cutliffe and Ward 2006: 70)

Reflecting on Clarke's words I questioned whether this contextual statement and the works described had further '*done to death*' the identity of nursing. I also wondered whether by positioning myself on the edge of nursing and the academy I have actually been trying to avoid it for thirty-five years? Essentially the identity of nursing, rather than the identity of nurses throughout history has been of a role that provides care for people. Over years of practice this has been refined and advanced through the development of an evidence-base and the move to graduate-level education. Furthermore, the development of technical skills and extended roles has led to career advancement for some nurses, and professional status has been established through regulation. However, Girvin (2015) highlights the influence of media and the public perception of nurses:

> *'**everybody** knows what a nurse is. Or at least, everybody **thinks** they know what a nurse is….Viewing nursing as merely the selfless care of the sick is partial and unimaginative.'* Girvin (2015) 3341- author's emphasis.

Girvin's observation that when nurses investigate and disseminate their findings about nursing and nursing practice we have been '*mainly talking to ourselves'* (Girvin 2015 p3342) and advocates a public conversation to move public perception away from the images of nursing so often portrayed.

Whilst this statement does not speak directly to the unique defining basis for nursing addressed by nursing theorists such as Henderson (1966) and Roper (1976), the statement does focus on gender and identity, and this is where the fundamental basis of nursing as a caring role becomes

problematic, and links to Girvin's theory. The association between caring and gender is very strong, culturally there is a belief that caring is women's work and as such it has been undervalued, sexualised and considered to be impossible to teach (Eliason 2017; Salvage 1985). Similarly, the ability to nurse is considered to be innate. The position of nursing and the struggle to establish a positive identity both in academic and clinical arenas is stubbornly linked to this cultural belief.

By working with and studying people at the liminal reaches of society as a mental health nurse working in one of the peripheral fields of nursing, this statement promotes nursing as having capacity to address the complex needs of those who remain in a peripheral position despite intervention (Couch 2017). By exploring these aspects of nursing, I have highlighted the impact of identity and gender on the professional progression of nursing.

One of the findings discussed in this statement about the role of nurse academics is their perception of responsibility for the future of nursing (Attenborough and Abbott 2019; Attenborough and Abbott 2020). Although most of the literature about nurse academics focusses on the transition from clinical practice to higher education (Logan et al 2015; Smith 2010; Smith and Boyd 2012; Weidman 2013), Singh et al (2020) undertook a systematic review of the literature about nurse academics' experiences, with the aim of gaining further insight into the stress involved in their work. Singh et al's review noted the paucity of literature associated with mid to late career nurse academics. One important finding was the high level of emotional exhaustion in nurse academics, leading to a third intending to leave higher education within five years. Given the well-documented problems in recruiting and retaining academics in health care (Evans 2013; Laurencelle 2016) this is very concerning.

Furthermore, an aspect of role modelling and identity in nursing students and academic staff is the issue of bullying (Randle 2003; Weiland and Beitz 2015). Bullying in nursing is described in the literature and discussed in this statement, linked to self-esteem, oppression and to some extent liminality and threshold concepts. Kofoed and Stenner (2017) develop the concept of bullying causing an extension of the liminal period- for example from student to qualified nurse, from clinical nurse to academic nurse. Describing the experience of bullying as a *'liminal hotspot'* (p178), Kofoed and Stenner discuss a case of cyberbullying in a Danish school; identifying a phase of disturbed evolution where transition is protracted. The victims of bullying want to belong, and extended transition can lead to extreme reactions. The continued anxiety and extended feeling of not belonging experienced by nurse academics (Attenborough and Abbott 2019; Attenborough

and Abbott 2020) was resolved for some by incorporating storytelling into their academic practice, something which is further explored by McDonald (2016). This can be framed as a positive reaction; other reactions might be more harmful:

> *'the liminal hotspot seems to hold both frailty and strength, both stasia and transformative potential, and both conservative tendencies and possibilities for creative change.'* (Kofoed and Stenner 2017: p179)

Similarly, the works that address pedagogic advances in nurse education and embedding nursing values into the learning and teaching of nursing give insight into the importance of service user and carer involvement in shaping, delivering and evaluating education for future generations of nurses, Kofoed and Stenner's '*possibilities for creative change*' (p179). These works were produced from the liminal position of academic nursing, the question of whether nursing actually belongs in higher education is especially pertinent to the progression and status of nursing (Andrew et al 2009). That nursing has embraced the SoTL agenda albeit identified as liminal space itself (Simmons et al 2013), is part of its transition into the academy, aiding the socialisation process (Andrew et al 2009). The works discussed in this statement contribute to that transition, focussing on the distinctive contribution that nursing makes to clinical practice, education and research.

Hoeve et al (2013), while acknowledging the varied and inconsistent images of nurses suggest that this is partially promoted by nurses themselves, due to a reluctance to promote the profession and to disseminate their work. The implications of this reluctance are discussed by Diers (2004):

> *'To write about nursing, or patient care, would not be to contribute more junk to the literature. We moan a good deal in nursing about how little we are understood by the public, or other professionals….We won't be better understood until or unless we put some energy into communicating in public form what our work is like, how it looks, how it feels, how it works or doesn't*…(Diers 2004: p272)

## 14.2 EVERYTHING CHANGES: THE IMPACT OF COVID-19

When I started my doctoral journey, I could not have predicted that I would be preparing this contextual statement during a pandemic, which hit the UK at a time when the NHS was already struggling with a shortage of healthcare staff, in particular nurses (Appleby 2019). The role of

health sciences faculties in universities in the Covid-19 pandemic is far-reaching, including work to develop a vaccine and train staff at pace and volume; my position in a healthcare education faculty has inevitably drawn me in at many levels.

Universities have provided healthcare education staff to support the clinical response, resulting in a reduced workforce. Additionally, the requirement under the Emergency Standards (NMC 2020) to deploy undergraduate students into the clinical workforce required considerable planning and communication. Compounding the logistical difficulties was a complete shutdown of the physical space in the university, staff working entirely remotely. My role as the Associate Dean responsible for undergraduate studies was pivotal to the university's response and this period has been the most challenging of my professional life. In addition to my Associate Dean role, I also chair two strategic health groups in London. Firstly, the London Health Education Group for *London Higher* (part of Universities UK) and secondly, a collaborative group of NHS trusts and higher education institutions in the capital, the Pan-London Healthcare Alliance. These groups were called upon by the NHS England (NHSE) and Health Education England (HEE) to assist in the deployment of students into employment in clinical practice and to represent the higher education response.

In March 2020, as deaths among healthcare staff began to be reported and deaths among the population started to rise, emergency powers were given to the health regulatory bodies to adjust their standards to support the response. As a consequence of this change, I was responsible for deploying students, who had previously undertaken unpaid placements, into the workforce as paid employees. Communicating with frightened students who, although they had a choice about whether to be deployed (this was not initially the case), felt a sense of duty to volunteer to be part of the workforce. War metaphors abounded, as a fragmented and chronically under-resourced health service struggled to respond. Once again, the concept of resilience in nurses became a fundamental part of the narrative (Traynor 2018). Furthermore, there was concern about the psychological well-being of nurses in relation to the pandemic (Maben and Bridges 2020).

My capacity for thinking, reflecting and writing during the initial period was certainly affected, and reflection-in-action as described by Donald Schon (1983; 1987) was not immediately apparent- my ability to draw on previous experiences and challenges was tested, especially in providing leadership to others who were anxious or frightened. I was reminded of the work of Michael Eraut (1995) who challenged Schon's assertions about reflection-in-action in a paper interestingly entitled 'Schon-shock'. Although I recognized Schon's description of reflection-in-action from the

perspective of being in a poorly defined situation, with a complicated problem; drawing on tacit and embedded knowledge to address the problem was more elusive. Eraut's challenge to Schon is partly about how reflection in action works when the situation is unfamiliar and outside of a person's prior experience; the capacity for reflection is inhibited, despite Schon's assertions. As Eraut states:

> '*When time is extremely short, decisions have to be rapid and the scope for reflection is extremely limited. In these circumstances, reflection is best seen as metacognitive process in which the practitioner is alerted to a problem, rapidly reads the situation, decides what to do and proceeds in a state of continuing alertness*.' (Eraut, 1995; p 14)

Throughout the pandemic I have continued in Eraut's state of continued alertness; my working days are long and exhausting and I am grateful for the support and forbearance of my advisors in completing this statement. I have no doubt that this experience has affected my thinking, in some ways I have adjusted to it, in other ways it has changed everything. I am able to reflect on my actions and realise that my knowledge and experience has expanded, when each new hurdle emerges.

In the *Journal of Clinical Nursing*, Phillip Darbyshire (2020), asked '*What use are words at a time like this*?'. Reflecting on the enormity of the task and what was being asked of the clinical workforce Darbyshire encapsulated many of my feelings about writing this contextual statement:

> *'We stand at the edge of the precipice of fear, afraid to look down lest we become mad and lose all hope. The spread of this virus is not only threatening lives, livelihoods, industries and entire communities but our very notion of society.'*
> (Darbyshire 2020: p2767)

It felt as if my papers were irrelevant and self-indulgent, that the only significant work was directly related to patients affected by Covid-19, that no time was available to reflect and develop strategies in a proactive way; it was in this context that I selected the papers for inclusion. As time has gone on I have been able to consider that perhaps this a time when the liminality of nursing is being broken down- that arguments about the nurses' appearance described by Darbyshire (2020 p 2767) as '*obscene*' in the current context, and the general barriers to progression for academic nursing articulated in this contextual statement, through my publications and elsewhere are being

swept aside and this has enormous potential for the progression of nursing, recognised by Thompson and Darbyshire (2020) in the context of the International year of the Nurse and Midwife. The works therefore do have relevance, but the context has shifted. The challenge will be keeping up the momentum for change, whilst preserving the fundamental values and purpose of nursing.

The link with the position and identity of nursing is also of relevance here; Stokes-Parish et al (2020) raising concerns about the angel-hero narrative that has accompanied the pandemic. Seizing the positivity of images such as that produced by the street artist Banksy to illustrate the contribution of nursing in the pandemic (see fig 16) has to be counterbalanced with further developing the established position of the profession and enhancing public appreciation of the skill, knowledge and education of nurses (McAllister et al 2020).

# CHAPTER FIFTEEN: CONCLUSIONS AND FURTHER CONSIDERATIONS

## 15.1 LIMITATIONS

This contextual statement is reflective of my experience as a clinical and academic nurse and is a subjective account. The works span a long period of time, and although this brings some strengths, inevitably there have been substantial changes in thinking and the political and policy context at the time of writing for some works is quite different to today. This is most pertinent with the rise of service user involvement in clinical practice, curriculum approval and development and research, which is not apparent in some of the earlier papers.

The research reported in the papers was undertaken entirely as an insider-researcher, though this brings many opportunities, as discussed in the statement, there are also challenges in this approach. The limitations of this were not articulated at the time, reflecting the prevailing norms. The research was undertaken entirely in London, and although many of the findings are replicated elsewhere, the participants and environments studied cannot be assumed to be typical of all clinical and educational environments.

Research into students' and lecturers' experiences and identity development took place in a pre-92 university in the United Kingdom, however, most nursing and midwifery courses are delivered in post-92 universities. The experiences of staff and students in pre- and post-92 universities may be different as proposed by Lopes et al (2014), reflecting the different requirements for research outputs and learning and teaching responsibilities. The works would be enhanced by studying a more diverse sample of participants in different locations.

## 15.2 SHINING A LIGHT: WHAT IT MEANS TO BE A NURSE TODAY

Describing or explaining nursing or even owning the title of 'nurse' is not straightforward. Diers (2004) considers the responses nurses receive at social gatherings when they reveal their profession, from horror at the bodily function aspect of the role, sexual advances, stories of illness or polite indifference. These, Diers asserts are evidence of nursing as a metaphor, the nurse treated as a symbol:

> *'Nursing is a metaphor for the class struggle…for the struggle of women for equality….. Nursing is also a metaphor for motherhood….it makes some people nervous to have awakened in a social scene the regressive feelings of being a child. Nursing is a metaphor for the kind of power the Amazons used….thus nurses evoke in others an atavistic fear of women, based in the remembered or fantasied experience of lying in bed with a woman in white towering over us….Nurses have confronted death, have heard the late night secrets, been present at birth, and have seen mutilation, pain, terror, agony, and hope. Those who have seen such things are untouchable…'* (Diers: 2004 p157).

What nursing means and what it means to be a nurse today is full of contrasts and contradictions, borne of gender politics and convention. The public's perceptions of nursing and nurses' own identity contributes to the progression of the profession. The works included in this submission seek to guide, document and inform the practice of nursing, through scholarly pursuit, education and enquiry, whilst also contributing to a positive image of nurses. Working 'on the edge' in liminal spaces alongside service users, students and academic staff to illuminate areas that are hidden and not sufficiently valued, has provided a platform to raise the profile and position of nursing in practice and the academy and ultimately to improve the place of nursing overall.
The papers discussed in this statement, produced at the margins of nursing and academic practice suggest positive possibilities for nursing. Engagement with public images of nursing and progressing beyond nostalgic descriptions, owning our agenda and producing our own narrative will make nursing a positive prospect for the future.

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# APPENDIX 1

## ETHICAL APPROVAL

Middlesex University London

Health and Social Care Sub-Committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

16/06/2020

**APPLICATION NUMBER:** 14421

Dear Julie Anne Attenborough and all collaborators/co-investigators

**Re your application title:** Contextual statement: nursing identity in liminal spaces

**Supervisor:** Gordon Weller

**Co-investigators/collaborators:**

Thank you for submitting your application. I can confirm that your application has been given APPROVAL from the date of this letter by the Health and Social Care Sub-Committee.

The following documents have been reviewed and approved as part of this research ethics application:

| Document Type | File Name | Date | Version |
|---|---|---|---|
| Methods and data | Full list of publications | 12/06/2020 | 1 |

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Co-chair Ruth Miller



Health and Social Care Sub-Committee

# APPENDIX 3

## PARLIAMENTARY REFERENCES RECORDED IN HANSARD TO HATTIE JACQUES, 1995-2020

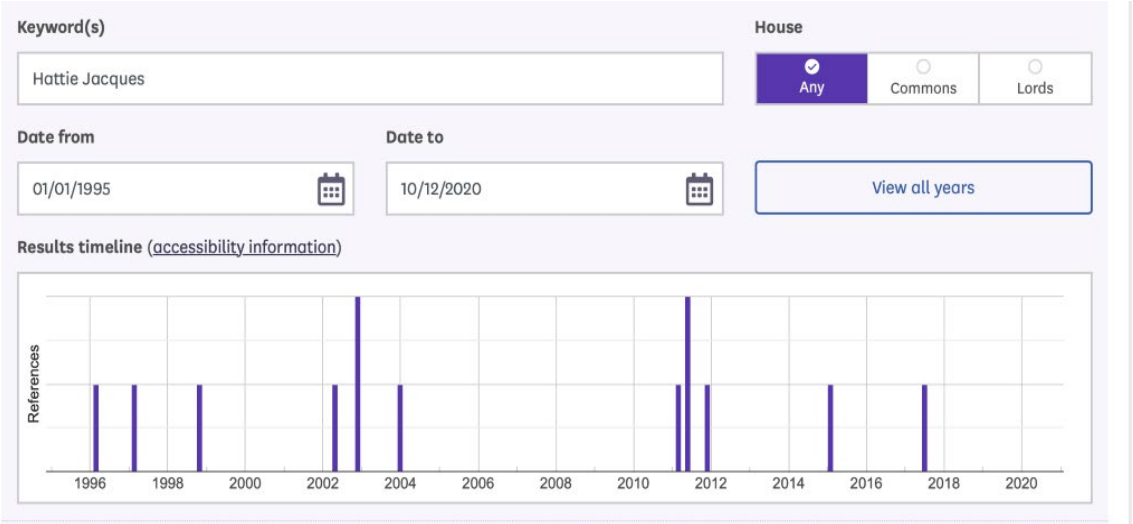


**Figure 23: References to Hattie Jacques in Hansard accessed from https://hansard.parliament.uk 10/12/2020**

1. 11/02/2015: Francis Report, Update and response
2. 28/03/1996: British Film Industry
3. 18/03/1997: Chief Nursing Officers Debate
4. 26/11/1998: Health and Welfare
5. 08/05/2002: NHS
6. 19/12/2002: Adjournment debate (with reference to health)
7. 19/12/2002: Adjournment debate (with reference to reintroducing traditional matrons)
8. 13/01/2004: Hospital Acquired Infections (Hattie Jacques lives on)
9. 15/03/2011: NHS (Essex)
10. 28/06/2011: Higher Education White Paper (questioning the reliability of a statement about 'Carry On up the Kyber')
11. 01/11/2011: Nursing
12. 20/07/2017: Future of the NHS

# APPENDIX 4

## GOOGLE SCHOLAR CITATIONS FOR PUBLIC WORKS (JANUARY 2020)

Cort, E.M., Attenborough, J. and Watson, J.P., 2001. An initial exploration of community mental health nurses' attitudes to and experience of sexuality-related issues in their work with people experiencing mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *8*(6), pp.489-499.

Google scholar citations: 80

Simpson, A., Reynolds, L., Light, I. and Attenborough, J., 2008. Talking with the experts: Evaluation of an online discussion forum involving mental health service users in the education of mental health nursing students. *Nurse Education Today*, *28*(5), pp.633-640.

Google scholar citations: 55

Power, C. & Attenborough, J. 2003, Up from the streets: A follow-up study of people referred to a specialist team for the homeless mentally ill, *Journal of mental health, 12* (1), pp. 41-49.

Google scholar citations: 18

Attenborough, J and Watson, J.P. (1997) Staff Perception of Sexual Behaviour in a London Shelter for Homeless Men. *Journal of Sexual and Marital Therapy* 12 (2): 139-146

Google scholar citations: 9

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Google scholar citations: 7

Attenborough, J.A. and Abbott, S. (2018). Leave Them to Their Own Devices: Healthcare Students' Experiences of Using a Range of Mobile Devices for Learning. *International Journal for the Scholarship of Teaching and Learning*, 12(2)

Google scholar citations: 5

Attenborough, J. and Abbott, S., 2020. Using storytelling in nurse education: The experiences and views of lecturers in a higher education institution in the United Kingdom. *Nurse education in practice*, *44*, p.102762.

Google scholar citations: 4

Attenborough, J.A., Goodfellow, B. and Light, I. (2007). Practice Based Working with Users, Carers and Support Agencies. In Myles, P. and Rushworth, D. (Eds.), *A Complete Guide to Primary Care Mental Health*, Part Two London: Robinson.

Google Scholar citations: 4

Attenborough, J. and Abbott, S. 2019. The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution: A qualitative study. *Nursing Open* 6 (2), 434-442

Google scholar citations: 2

Attenborough, J., Reynolds, L. and Nolan, P., 2019. The nurses that roared: nurses from history who found their voices and challenged the status quo. *Creative nursing*, *25*(1), pp.67-73.

Google scholar citations: 2

Attenborough, J., Abbott, S., Brook, J. and Knight, R.A., 2020. Pioneering new roles in healthcare: Nursing Associate students' experiences of work-based learning in the United Kingdom. *Work Based Learning e-Journal*, 9(1), pp.35-60.

Google scholar citations: 0

Reynolds, L.M., Attenborough, J. and Halse, J., 2020. Nurses as educators: creating teachable moments in practice. *Nursing Times*, *116*(2), pp.25-28.

Google scholar citations: 0

Attenborough, J., (1997). Sexual relations in a cold-weather shelter for homeless people. *Nursing Times*, 94(32), pp.50-52.

Google scholar citations: 0