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'A Juggling Act'!

A Socio-Material Analysis of the role and identity of practice teachers in the UK
National Health Service

Karen Lesley Adams

A thesis submitted to the University of Huddersfield in partial fulfilment of the
requirements for the degree of Doctor of Education

July 2017

Abstract

Practice teachers within the UK National Health Service have had an unstable history during which their status has fluctuated. They belong to that category of occupations where there is a dual role identity, the practice teacher element being subordinate or secondary to a clinical role which is often aligned to additional leadership and management responsibilities. The secondary nature of the role contributes to the liminal status of this small professional group and this affects the professional identity of practice teachers and the extent to which the role can maintain itself and achieve recognition. This study seeks to reconcile identity and socio-material theory in order to offer innovative and original insights into how the practice teachers dual professional identity develops and how they learn and enact their role.

This study develops empirical insights into the role and attributes of practice teachers and the context in which they work in order to produce a body of knowledge which could inform their preparation for the role. One to one interviews were carried out with ten practice teachers, four managers and eight specialist community nursing students in one region of the UK. In addition a focus group interview was conducted with six specialist community nurse educators drawn from a national organisation, and one to one interviews were conducted with the chair of a body representing nurse educators and a regulatory body representative. The analysis was framed by the socio-material literature and this illuminated the broader range of factors influencing learning and their impact upon professional roles.

The findings suggest that health service reforms in recent years have led to the development of an efficiency driven model of health care and this impinges upon practice teacher roles and practice learning. The evidence indicated an absence of an infrastructure to support the practice teacher role in all its aspects and as a consequence the role is ambiguous and diffuse. A range of differing socio-material factors influence the specific localised contexts in which practice teachers experience and learn their role. As a consequence practice teacher roles are assembled in different ways and they are thus not a homogenous group. A corollary of this is that the professional identity of practice teachers is unstable and they have struggled to develop a shared identity. The findings depict practice teachers who have a capacity for self-determination and who are proactive in attempting to establish a more stable professional identity.

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Acknowledgements

I would like to thank every participant who generously shared their professional experiences and gave up their time to contribute to this study. I hope I have represented your perspectives successfully.

To my supervisor Professor Pete Sanderson who has offered me immeasurable encouragement and academic guidance I express my sincere gratitude.

To Dr Ros Ollin who supervised me through the early stages of my work. Thank you for your expert guidance and insights.

To my husband Kevin, son Oliver and my mum who have all encouraged me to believe in myself and keep going, despite the challenges along the way. Thank you for your love and confidence in me.

Thank you

Abbreviations

ANT	Actor-Network Theory
CHAT	Cultural-Historical Activity Theory
CPT	Clinical Practice Teacher
CT	Complexity Theory
DH	Department of Health
HEE	Health Education England
HEI	Higher Education Institution
NHS	National Health Service
NMC	Nursing and Midwifery Council
PT	Practice teacher
PWT	Practical Work Teacher
QAA	Quality Assurance Agency
SCPHN	Specialist Community Public Health Nurse
SPQ	Specialist Practice qualification

Chapter 1: Introduction

This thesis contributes to an understanding of the complex status and identity of community nurse practice teachers, as a basis for exploring their learning needs and the implications for curriculum design. It also contributes to the body of theory surrounding emergent professions by analysing the liminal status of practice teachers and the organisational factors which give rise to it in the increasingly complex field of medical and nursing professions.

Practice teachers are all qualified nurses or midwives who have undertaken further educational preparation in order to work in specialist community nursing roles such as health visiting, district nursing and school nursing in a primary care setting. In order to take on the role of practice teacher the specialist community nurse must have practised for a minimum of two years in their specialist community nursing discipline and have undertaken a Nursing Midwifery Council (NMC) approved practice teacher preparation programme (NMC 2008). Practice teachers learn and enact their role in the United Kingdom National Health Service (NHS) alongside a clinical role where they engage in a complex web of networks, social relations and material features which influence how the role is learned and enacted. Learning and becoming a practice teacher involves an identity shift and the transitional process creates instability as they seek mastery of their new teaching role whilst continuing to maintain their clinical expertise, negotiate role boundaries and work out a way for the dual roles to interact.

Practice teachers have a significant role in the preparation of post-registration specialist community nursing students, being responsible for co-ordinating a complex programme of student experience in clinical practice and contributing towards summative assessment (NMC 2004 p.17). This practice element constitutes 50% of the students programme and practice teachers are responsible for 'signing off' the student at the end of their programme (NMC 2008). The NMC (2008) defines this role in more detail and this represents what the regulatory body believes a practice teacher should look like. According to the NMC (2008) practice teachers are required to use a range of teaching, learning and assessment strategies to support the student in

integrating theoretical knowledge into practice. Practice teaching is underpinned by a contractual agreement negotiated with their designated student based upon the individual student's learning needs. The nature of the teaching role draws upon reflective processes where students explore practice based issues with the practice teacher and the practice teacher supports the student in making theoretical links. In addition to their role in supporting students, practice teachers are required to take the lead for education in clinical practice, provide support for mentors and function as a leader within their specialist field of community nursing (NMC 2008). Practice teachers and students are normally paired for the duration of the student's course (one year full time or two years part time) and practice is normally taught and assessed by the same practice teacher.

'Practice teacher' is the term used throughout this thesis to describe the practitioners that are the focus of this study. This term has been selected for reasons of consistency as it is the term used by the NMC (2008), though it is acknowledged that a number of other titles are applied to the role and are referred to by participants in this study. These include 'clinical practice teacher', 'practice educator', 'specialist practice teacher' and 'practical work teacher'.

1.1 Significance of the study

Practice teachers are an unusual occupational group. Whilst they have a defined status in policy (NMC 2008) they differ in terms of some of the other characteristics normally associated with professions. Professions have traditionally been characterised by the possession of a body of expert specialised knowledge (Carr-Saunders and Wilson 1933). Practice teachers have a dual role where the teaching element of their role is generally perceived to be secondary or subordinate to a clinical role and the emphasis is on supporting learning and on practice itself. As a consequence of this, factors that distinguish the practice teacher role from others are difficult to isolate. The clinical role has differing caseload responsibilities (for example health visiting, school nursing or district nursing) and practice teachers are often assigned a range of additional leadership responsibilities by their employing organisations. Practice teacher numbers in any one organisation are normally relatively small

and are spread across a number of community nursing disciplines. Indeed it is not unusual for a practice teacher to have little or no day to day contact with other practice teachers. It is therefore evident that they are not members of a distinct profession nor are they a homogenous group.

Identifying the learning needs of practice teachers is dependent upon an understanding of their lived experiences and the context in which they are employed. The purpose of this study was to provide a substantive insight into the role and the context in which they work in order to produce a body of knowledge which could underpin their preparation and inform what the role could become over the next ten years. In order to elicit a deeper understanding of the socio-material factors influencing how the role is understood and assembled this study includes the perspectives of a broad range of stakeholders from different community nursing disciplines.

Productive Systems literature (Felstead et al 2007) was drawn upon in order to provide insights into the UK National Health Service and how the nature of reforms aimed at increasing efficiency and cost effectiveness impact upon occupational roles, identity formation and placement learning. The findings will have relevance both nationally and internationally in terms of understanding the impact of an efficiency driven health care system on practitioner roles and practice learning.

The study is of benefit to specialist community nursing students and practice teachers as it provides insights into how the role is understood by a range of stakeholders and explores the contextual factors that have shaped practice teacher roles. The findings will inform the preparation of student practice teachers and therefore potentially improve the learning environment and educational opportunities available to students in clinical practice. It additionally has the potential to improve the professional development of the future practice teaching workforce and secure a more clearly defined and understood role and professional identity.

Although the focus of this study is on specialist community nurses with a practice teaching remit the study is likely to shed light on the issues faced by professionals in other occupations who have a dual role.

1.2 The research context

This study took place during a period of unprecedented change and financial constraint. The number of qualified district nurses had been in rapid decline for over 10 years (Queens Nursing Institute (QNI) 2013) and this was in a context of increasingly high workloads and a government commitment to provide increasingly more complex care in the home (QNI 2014). District nurses (including practice teachers) were therefore leading increasingly skill mixed teams of community staff nurses and support workers and fewer district nurses were being trained. The demand for preregistration nursing placements, however, was increased (QNI 2013).

The number of health visitors employed in the NHS had been falling steadily since 1988, and since 2004 had declined rapidly (DH workforce statistics information centre 2009) impacting upon the quality and safety of care provision (Adams & Craig 2008). In response to a growing recognition of the need to increase health visiting workforce numbers the Department of Health published plans to deliver a new and enhanced model of service to families and to increase the number of Health Visitors nationally by 4200 by 2015 (DH 2011). This was a significant increase and it impacted on the workload and profile of practice teachers who were responsible for achieving targets related to clinical activities as well as supporting health visiting students and this included the period of data collection.

In 2004 the Government committed to increasing the School Nursing service to one qualified school nurse per secondary school and its cluster of primary schools, around 3000 in total (DH 2004). By 2008, however, only 1447 qualified school nurses were in post (Centre for Workforce Intelligence 2012). Whilst the increase in workforce numbers had been significant it still fell far short of the 2004 pledge and the average school nurse was carrying a caseload of around 2500 children across seven schools. In 2009 just over 1600 school nurses were in post but this fell back to 1467 in 2010 (CFWI 2012). It was evident therefore that during the period that the study was conducted that the school nursing workforce was small and workload demands were challenging (RCN 2012).

1.3 Personal rationale for the study

The research subject that I explore in this thesis emerged through my interest in health professional education. My role is an educator of practice teachers and my principal concern was designing a curriculum for this group. It was therefore essential to understand their learning needs. I was reluctant to take a narrowly functional view of the learning needs in terms of competencies or standards as I wanted to understand the role in terms of networks that practice teachers are involved with, their sense of self as a practice teacher, their professional identity and their sense of the pressures to which they were subjected. In addition I wanted to understand the perspectives of those who could influence and shape the role and gain insights into how they understood it.

I have a career spanning over thirty years in nursing, of which the vast majority has been in health visiting practice and health visitor education. After training as a general nurse in the early 1980's I worked as a staff nurse on a spinal injuries unit and then subsequently trained to be a midwife. This stimulated my interest in working in a public health role with families in a community setting. I took up a community staff nurse post in the late 1980's working alongside health visitors and school nurses and subsequently undertook the certificate in health visiting. During the 1990's I was employed in a number of health visiting posts across West Yorkshire and worked as a health visitor for a two year period with British armed services families stationed in northern Germany. On returning to the United Kingdom I undertook a post-graduate qualification in health care studies and a programme described as 'advanced mentorship' which was during a period where the role of the practice teacher had been diminished to that of a mentor by the Nursing and Midwifery Council (NMC). I took responsibility for the practice preparation of 3 health visiting students during my time as a health visitor and mentor / practice teacher and found this to be an incredibly rewarding aspect of my role. At the time though, I remember feeling a great sense of responsibility towards meeting the students' needs and my accountability for ensuring that they were 'fit for purpose', as described by the NMC (2008), at the end of their programme. In addition I also had a sense of feeling undervalued by the organisation which failed to recognise the time commitment required to undertake the role and which removed the additional

financial remuneration that practice teachers had traditionally been awarded. Undertaking the additional role of a practice teacher awakened my interest in health professional education and I subsequently took up a senior lecturer post. Since moving into higher education over fifteen years ago I have been responsible for designing and delivering both the specialist community public health nursing programme, which has health visiting and school nursing routes, and the practice teacher programme, both of which are regulated by the NMC (2004 and 2008 respectively). The design of these programmes has also needed to take account of the needs of students from differing specialist community nursing disciplines including school nursing, health visiting and district nursing who share some of the modules. Thus it was important that this study included interviews with participants from all three community nursing disciplines.

1.4 **The aims of the study were to:**

1. To critically explore the context for the preparation of practice teachers
2. To examine the perceived role and professional identity of the practice teacher from the perspectives of different stakeholders.
3. To critically examine the socio-material factors that influence how practice teachers learn and enact their role
4. To discuss the implications of the study's findings for institutions.

1.5 The structure of the thesis

The thesis consists of five chapters and is presented in a traditional format in order to ensure coherence. The review of the literature is therefore presented in chapter two though it must be acknowledged that literature was reviewed throughout the study and this is evident in how it is woven into the analysis.

Chapter 2: Literature review

Practice teachers are an interesting example of those who occupy a dual role that is apparently without a clear place in the organisational structure. This study makes an original contribution to knowledge by drawing on a blend of theoretical perspectives in order to develop new and original insights into how practice teachers dual professional identity develops and how they learn and enact their role. In addition the findings from this study have the potential to inform understandings of how other liminal occupational roles might be bolstered.

2.1 Reviewing the literature

Traditionally in evidence based practice, attention is paid to the rigour of the literature review. The strategy adopted in this study however, is distinct for the following reasons. The initial review of the literature did not seek to frame the current study since the aim was to develop new insights and initially drew on grounded theory principles (Charmaz 2006). In addition a predetermined search strategy is considered by some to be inadequate for conducting theory building qualitative research (Finfgeld-Connett and Johnson 2012). Glaser and Strauss (1967) suggest that reviewing literature in the substantive area relating to the research should be delayed until the data analysis is complete. Categories are then allowed to emerge naturally from the data (Dunne 2011) and this avoids imposing extant theoretical frameworks and forcing the data into pre-existing categories (Charmaz 2006). It was unrealistic, however, to attempt to avoid reviewing all literature relating to the substantive area of interest since the boundaries of the research were not clearly defined at the outset (Dunne 2011). In addition the chosen area of study related to my own area of practice and it was therefore inevitable that existing knowledge and experience would be drawn upon in the study. A decision was therefore made to undertake a focused search of the literature at the outset in order to identify existing research and policy related to practice teachers and how they learn their role.

2.1.1 The search strategy

MetaLib was used to generate the evidence that informed the background to the study. MetaLib is an information service which enables access to a broad range of databases including CINAHL and Medline. Summon, however, was used to generate the majority of evidence that informed the data analysis. Summon is a search engine that offers a single interface enabling users to access all library resources with one search. It is a gateway to an extensive range of databases including Science Direct, Wiley Online Library, Sage Online and SpringerLink, and in addition it includes e-books, e-journals, the library catalogue as well as DH and NMC publications. In addition an unpublished PhD study was requested through the inter-library loans service, the reference lists of relevant studies were scrutinised and The Community Practitioner Journal was hand searched.

The quality of retrieved information is dependent upon the specific search strategy that is applied (Volpato et al 2013). Since the body of literature relating to practice teaching was relatively small the search term “practice teacher” was used to retrieve relevant literature published from 2001 onwards that could inform the background of the study. Mentor literature was excluded since the role was determined to be sufficiently different to that of a practice teacher. As well as identifying literature on practice teachers in the UK NHS, this search strategy identified literature relating to clinical nurse educators both in the UK and abroad and also literature on social work and teacher educators. This literature offered insights into the experiences of other public sector workers who occupy a dual practitioner / educator roles. As the study started to take shape an iterative approach to the search strategy was adopted (Finfgeld-Connett and Johnson 2012). During the analysis of the data I returned to the literature in order to identify a conceptual framework and to seek insights into the emerging themes and categories. Search terms such as “practice teacher”, “professional identity”, “dual identity”, “socio-material”, “productive system”, “governmentality”, “new public management”, “nursing” and “health care” were linked using the Boolean logic of combining key words with ‘or’ / ‘and’ (Aveyard 2007). Through this approach literature relevant to the aims of the study and

the emerging theses was identified and subsequently used to frame the analysis.

2.1.2 Literature identified

The literature on socio-material theory shed light upon the influence of the context of practice and the complex networks of human and material interactions through which learning is enacted and identity is formed. I was concerned to gain insights into the ways in which policies, practices, histories and cultures within NHS organisations have influenced learning and role enactment and I was equally keen to understand how practice teachers responded to these factors and their capacity for self determination. My attention was therefore drawn to literature that examines identity complexity and multiple identities and the findings are thus framed by a synthesis of both.

The literature review commences with an analysis of what is known about practice teachers and how the role is defined and enacted alongside a clinical role in the NHS. NHS reforms aimed at increasing efficiency and cost effectiveness impact upon professional roles, identity formation and practice learning. Practice teacher roles are embedded in a productive system which concentrates on achieving health care related identifiable outputs thus creating the potential to marginalise roles not involved in such activities. In order to more fully understand such a context the review appraised the literature on New Public Management and on productive systems and this revealed the nature of the pressures that influence practice teachers learning and enactment of their role in clinical practice.

Literature which examines the nature of professional learning was scrutinised in order to gain insights into how practice teachers come to understand the role and socio-material literature is included here. In order to illuminate the dual identity of practice teachers and to seek insights into their capacity for self determination, literature on overlapping identities and identity complexity were reviewed. This literature offered an alternative perspective on how practice teacher's identity develops through group membership and captured the influence of the perceptions of others. The two contrasting theoretical

perspectives were subsequently synthesised and used to frame the analysis and present the data.

2.2 Practice teaching

Despite the significant role that practice teachers play in supporting practice learning and acting as a gate-keeper to specialist community nursing professions they are under-represented in empirical research. A literature search revealed a dearth of research relating specifically to this small and unusual occupational group and international comparisons are difficult to make since there are few directly comparable roles.

Practice teachers are employed on the basis of their clinical expertise rather than their teaching skills and maintaining specialist knowledge in a clinical role is imperative in order for them to retain clinical credibility (Adams 2010). As a result their primary identity is of a discipline specific clinical expert. The teaching element of the role is normally relegated to a secondary position and as a consequence there is the potential to impinge upon practice teacher identity development. Social work education practices both in the United Kingdom and Australia, teacher educator roles in further education, and clinical teaching roles in Australia are organised in a similar way and evidence suggests that they continue to identify primarily with their subject field (Orr 2009, Stone 2016, Zuchowski 2014, Manias and Aitken 2005). Subject expertise rather than skills as an educator are assumed to be the main determinant of the quality of teaching and learning as professional credibility had been gained through craft knowledge rather than their teaching skills (Orr 2009). This literature sheds some light on the experiences of UK practice teachers and the secondary / subordinate nature of the teaching element of the dual role.

2.2.1 Responsibilities aligned to the practice teacher role

The literature on practice teachers stresses, amongst other issues, that the nature of the role is one involving a dual identity; a clinical role and that of a learning facilitator (Newland 2009, Mannix 2012, Brook 2015, Carr and Gidman 2012, Sherwin and Stevenson 2010). The role however is not just a dual role.

Practice teacher roles vary and it is difficult to identify core role descriptors. A range of additional and differing responsibilities are aligned to practice teacher roles including that of team leader, practice development lead, support to a variety of other students, preceptorship of newly qualified staff and acting as a safeguarding supervisor (Newland 2009, McInness 2013, Mannix 2012, Sherwin and Stevenson 2010, DH 2012). These circumstances are similar to the experiences of hospital based clinical nurse educators in Australia where role descriptors and boundaries varied between and within employing institutions, and responsibilities aligned to the role were inconsistent across different categories of nurses (Conway and Elwin 2007). As a consequence it affected the development of their professional identities and presented challenges in overcoming mistaken expectations of other members of staff in relation to their role and responsibilities (Conway and Elwin 2007).

During the Health Visitor Implementation Plan (DH 2011-15) the health visitor practice teacher role specifically was developed further and alternative models were put forward to enable practice teachers to support the increased number of student health visitors in training (Devlin 2013, McInnes 2013 and Brook and Salmon 2015). Traditionally a one-to-one approach had been used to support students but during this period the NMC (2011a) set out arrangements to enable practice teachers to support and sign-off more than one student through a 'long-arming' model whereby the students were supported on a day to day basis by a mentor who was overseen by a practice teacher, often based elsewhere. Such practice teachers had a duty to support each mentor via one-to-one supervision processes and regular meetings, and take overall responsibility for ensuring the students were fit for practice at the end of their course (McInnes 2013). As a consequence there was the potential for a negative impact upon the quality of the placements provided and it also had implications for the level of supervision and support that practice teachers were expected to provide in addition to meeting the demands of their caseload. There is resonance here with off-site supervision practices in social work education both in the United Kingdom and Australia where austerity, market pressures and neo-liberal policies were reported to have impacted upon the capacity of field educators to support practice learning (Zuchowski 2016). A

consequence of the model was that off site supervisors needed to spend significantly more time preparing and supervising placements than internal supervisors and as a corollary there were implications for managing the dual responsibilities of the role (Zuchowski 2016).

The Government drive to expand the health visiting service (DH 2011) also led to an increased focus on the role of health visitor practice teachers and how their knowledge and skills could be best utilised to lead in the delivery of the new service. McInnes (2013) described how heavy caseloads during this period created a barrier to teaching for some whilst others practice teachers were relieved of their caseload responsibilities and benefitted from being able to focus entirely on their teaching role. These were new and significant changes to health visitor practice teacher roles and they occurred during the data collection period and were taken account of in the analysis of the data. In 2012 the Department of Health published a document designed to enhance the understanding of the important role of the health visitor practice teacher, their responsibilities and their preparation (DH 2012). The document endorsed the NMC (2011a) model where the practice teacher would oversee up to 3 student / mentor partnerships and in addition it sought to clarify the position of practice teachers in the health visiting workforce in terms of supporting the current workforce's developmental needs in regard to delivering the new service vision and facilitating preceptorship for newly qualified practitioners. Whilst this document provided some clarity about the role its reference only to health visitor practice teachers limited its applicability to practice teacher roles in other disciplines. In addition its status as a guidance document was insufficient to influence employers to implement the proposed model.

A Queen's Nursing Institute report (2014 p.19) acknowledged the vital role district nursing practice teachers had in supporting students on district nursing programmes and training and developing the wider workforce but other than this there has been no similar consideration of the practice teacher role in other specialist community nursing disciplines. The NMC (2011a), however, did update its circular (08/11) in 2014 to clarify its application to all Specialist Community Public Health Nurses (SCPHN) and Specialist Practice Qualification

(SPQ) students and practice teachers thus enabling practice teachers from all specialist community nursing disciplines to support more than one student.

2.2.2 The attributes of practice teachers

It is perhaps unsurprising, given the subordinate nature of the role and the lack of common role descriptors, that there is only a limited range of literature to draw upon in terms of understanding the attributes that are important for the role. Being a skilled and expert practitioner is an essential requirement (Sayer 2007, Newland 2009) and indeed the NMC (2008) requires all practice teachers to maintain and develop their clinical expertise in addition to their teaching skills. Practice teachers have an extensive knowledge base to underpin their clinical practice and, according to surveys by Newland (2009) and Mannix (2012), practice teachers are academically well qualified with the majority holding at least three professional qualifications, and over 50% having studied at Masters degree level. Practice teachers draw upon a range of teaching and learning strategies including role play, scenario work, reflection, supervision, assessment and the giving of clear constructive feedback in order to fulfil the requirements of their role (Sayer 2007).

The ability to establish nurturing relationships with students is significant since they have an important role in the professional socialisation and development of students. They therefore need to be approachable, confident, reassuring and have effective communication skills (Sayer 2007). In addition, according to Kelsey and Hayes (2012), emotional intelligence, self awareness, a capacity to self evaluate, an ability to motivate others and an understanding of clinical governance and educational audit are fundamental leadership attributes required for safe and effective practice teaching. The NMC (2008) require practice teachers to provide practice leadership and expertise and in addition to this the NHS Clinical Leadership Competency Framework (NHS Leadership Academy 2011) articulates a requirement for leadership at all levels in the organisation.

2.2.3 Historical context of practice teaching

Practice education makes an important contribution to the development of health care workers (DH 2000a, DH2000b, DH2001, QAA 2007, NMC 2008, DH 2012, QNI 2014). Practice teacher education has undergone significant change over the last 50 years and the status of practice teachers has fluctuated. The role has existed since the 1960s when they were known as field work teachers (FWT) (health visitors) and the Council for the Education and Training of Health Visitors (CETHV 1978) defined their role. The comparable role for district nurses was described as a practical work teacher (PWT). In the 1990s they became known as community practice teachers (CPTs) following the completion of a two year preparation programme. Their status subsequently declined and by the mid 1990s the role was redefined as one of mentoring by the NMC, a role title normally applied to nurses supporting pre-registration students. Some parallels can be drawn here with the role instability described in more recent literature (McInnes 2013) and may reflect the lack of common role descriptors and the need to prioritise care related activities which has been a common feature throughout the history of practice teaching in the NHS. In the intervening years practice teachers expressed feelings of being undervalued and in response to such disquiet the NMC carried out a consultation which subsequently led to the development of The Practice Teacher Standard which was first published as a circular in 2005 (NMC 2005). In 2006 the Nursing Midwifery Council (NMC) incorporated this within the document Standards to Support Learning and Assessment in Practice (NMC 2006). These were subsequently modified in 2008 and The Practice Teacher Standard (NMC 2008) is now a mandatory minimum requirement for teachers supporting nurse registrants undertaking NMC programmes to achieve a Specialist Community Public Health Nursing (SCPHN) qualification or a Specialist Practice qualification where it is a local requirement. Despite efforts to clarify the role in regulatory body requirements it is apparent that these have been insufficient in securing practice teachers a clearer position within the professional hierarchies of the NHS. The practice teacher role is mediated by what happens in management systems and as a consequence images of practice teachers

portrayed in professional journals don't bear out the experiences of those occupying the roles.

2.3 The context of practice

'Technologies of governmentality, specifically hospital policies and protocols or the lack thereof, shape professional identity in nurses'
(Blundau 2014 p.877).

2.3.1 Instability

The context in which employees work affects their sense of professional identity and has implications for practice and learning (Hallam 2000, Kirpal 2004, Blundau 2014, Fenwick et al 2012). The United Kingdom National Health Service (NHS) has been subject to frequent re-organisation by successive governments and literature suggests that such instability impacts upon employer's commitment to their staff, challenging employees to redefine their professional roles and identities (Kirpal 2004). Health policies, aimed at improving quality of care and reducing costs, impinge upon and reconfigure professional roles and relationships. Work identities are thus composed, decomposed and restructured in order to cope with increasing demands for flexibility, changing work situations, and new professional roles and expectations (Kirpal 2004, Doherty 2009). For some practice teachers this instability invoked feelings of a loss of identity (McInnes 2013).

2.3.2 Market principles

In common with many western health care systems New Public Management (Siltala 2013, Simonet 2013) has become progressively embedded since the 1990s when an internal market was created following the publication of the government white paper 'Working for Patients' (DH1989). New Public Management is the term used to describe how market principles and business management techniques have been applied to public sector organisations in order to increase efficiency and contain costs (Siltala 2013, Simonet 2013). In 2005 the UK Government published 'Commissioning a Patient Led NHS' (Crisp 2005). This policy document made provision to allow a greater diversity of providers to enter the health care market and consequently health care services

have become organised along business lines and care is now commissioned and provided by separate organisations. NHS care providers compete alongside social enterprises and the private sector to secure contracts to deliver the most cost effective health care services. Further changes proposed in 2010 (Department of Health 2010a) were some of the most far reaching and significant that the NHS had ever faced. These included proposals to devolve power and responsibility for the commissioning of health care to the health care professionals closest to the patient and the development of quality outcome measures related to effectiveness, safety and experience. In addition to this the NHS was tasked to achieve £20 billion efficiency savings by 2014, and critical to this was improving health care productivity and reducing its management costs (Moffatt et al 2014).

The shift from internal control mechanisms towards an externally regulated and performance driven structure is apparent across a number of sectors in society including health care. These have implications for professional autonomy, constraining discretionary decision making and as a consequence impact upon professional identity (Adams 2010). The literature on New Public Management (Siltala 2013, Simonet 2013) suggests that effectiveness and value for money should be determined based on output measures and this has the potential to subordinate and marginalise roles where outcomes are less tangible, such as practice teaching.

2.3.3 Standardised labour

The NHS has increasingly become characterised by technologies of governmentality such as policies, procedures, protocols and targets which control and shape work practices. Standardising labour leads to uniformity and discipline, creating 'normative rules' of governmentality (Blundau 2014). Governmentality is a term coined by Michel Foucault (Peters 2014) to describe how the State exercises control or shapes the conduct of its populace at a distance. The art of governing occurs indirectly through various social policies, institutions and ideologies and these indicate how people are expected to act. Specific examples within community nursing practice include firstly the Commissioning for Quality and Innovation Framework (CQUIN) set up in 2009

which provides a mechanism for commissioners of health services to reward, incentivise and sanction care providers with the aim of improving health care. Secondly, National Service Specifications that detail the services that have been commissioned and determine how performance will be monitored. In a market based health care system nurses must discipline themselves to meet the expectations and constraints of the work environment (Blundau 2014). Practitioners are expected to 'work according to script' to maximise efficiency rather than make autonomous judgements based upon their expertise (Fuller et al 2006 and Felstead et al 2007). For some nurses this context has the potential to increase autonomy as nurses are able to use these tools as decision support packages rather than referring to medical colleagues (Blundau 2014). Too much standardisation, however, can lead to a loss of autonomy (Blundau 2014, Fuller et al 2006 and Felstead et al 2007). The protocols and procedures relate to clinical activities and this has the potential to constrain the enactment of the practice teacher role where no similar technologies of governmentality exist. This may explain how the role has become subordinated or secondary to the clinical role. In an environment with limited opportunity to strengthen their practice teacher identity these expert clinicians are likely to continue to identify strongly with their clinical identity (Pratt et al 2006 and Manias and Aitken 2005).

A way of understanding this is to apply Felstead et al's (2007) conceptual framework of the productive system. Productive systems literature examines the interplay between workplace learning, the organisation of work and performance in a range of economic sectors (Felstead et al 2007). This literature helped frame the context in which practice teachers work and appraise the factors that influence work roles and practices in the UK health care sector. Productive systems differ in the degree of standardisation of work practices and approaches to increasing productivity through training (Felstead et al 2007). At one end of the spectrum the specialist knowledge resides with the script writer and the aim is to standardise and brand the product leaving limited scope for creativity. This is managed through training programmes and, for example, an affiliation to the organisation. A prerequisite might be a recognised qualification which demonstrates appropriate underpinning knowledge. Decisions are not

made by the employee themselves and this has implications for their learning (Felstead et al 2007). At the other end of the spectrum the employee retains the autonomy to plan their work and this enables them to draw on their underpinning scientific knowledge and this facilitates learning through work.

2.3.4 Reward and recognition

Groups in large organisations tend to be depersonalised and may be organised on the basis of material features which provide symbolic attachment to the group such as pay grade or job title rather than relationships (Roccas and Brewer 2002). Pay differentials make it possible for employees to distinguish between each other in terms of status, giving legitimacy to seniority and supporting the construction of professional identity (Hallam 2000). This is particularly important in the new market economy where practice teachers must be able to differentiate themselves from their clinical role. Practice teachers have traditionally been awarded a higher pay grade (band 7) and whilst this has given recognition to their seniority it has been insufficient in terms of strengthening the boundaries of the practice teacher role and securing a stable professional identity. Existing literature (Newland 2009, Mannix 2012, Brook and Salmon 2015, Carr and Gidman 2012, Sherwin and Stevenson 2010) indicates additional non-educational responsibilities are often aligned to practice teacher roles on the basis of their pay grade since the Knowledge and Skills Framework (KSF) on which the pay bands are based aligns generic leadership and management responsibilities to band 7 posts.

2.4 The nature of professional learning

Professions, including nursing, have traditionally defined themselves on the basis of a specific body of shared expert knowledge and practices and their public accountability for what they do. As both Neo-Weberian critics (Larson 2012) and trait theorists (Carr-Saunders and Wilson 1933) argue this claim to an exclusive knowledge base has contributed to the power and status of the profession. Individuals have typically acquired discipline specific knowledge and problem – solving competencies through decontextualised education processes which are still apparent in many of today's training programmes (Fenwick and Nerland 2014).

In the 1980s Government and government agencies began to demand greater accountability and scrutiny of professional knowledge and started to define the regulatory parameters of professional education and performance (Ashford et al 1998). These tended to focus on workplace competencies rather than on critical reflection. In recognition of the need to consider how professionals should be educated authors such as Donald Schön (1991) began to focus on the nature and quality of the professional expertise that is within and that grows out of practice. Schön, whose work has been particularly influential in nurse education (Young and Muller 2014 and Ashford et al 1998), contended that many professionals work in complex and uncertain conditions where the context can be unstable and where systematic knowledge is rarely agreed. In these situations traditional problem solving approaches do not apply and professionals have to engage in alternative forms of enquiry more akin to research in order to resolve the issue. Schön (1991) defines this as 'knowing in action', the artistry of professional practice and this is somewhat different from the 'technical rational knowledge' taught in the academic setting which can only provide general explanations and procedures for practice (Ashford et al 1998).

2.4.1 Learning the role

Learning the role involves an identity shift and thus student practice teachers commit to entering a liminal socio-cultural space (Turner 1964) where their status is socially and structurally ambiguous and where there is little to demarcate them from their clinical peer group. These learners exist between two or more social groups as they attempt to grasp how their multiple roles interact. In order to become a practice teacher, student practice teachers undertake a structured programme in an educational setting which is supplemented to a large degree by learning in clinical practice. Practice learning is supervised by a tutor and an experienced practice teacher with whom they engage in reflective discussions regarding their experiences. This involves practical and emotional engagement with the learning and as such is a social activity. Learning is context related and it is the setting rather than the individual that is the focus of learning. Learning involves both practical and mental engagement and may also be understood as a cultural practice (Hodkinson et al 2004). Teaching and learning in clinical practice could be

described as 'authentic learning' since the concepts, activities and practices are in harmony as opposed to an educational setting where there is a basic discordance between the subject matter, the activities and the context of learning (Hodkinson et al 2004).

Existing research suggests that practice teachers learn and enact their role with students and develop their professional identity in a socio-cultural context (Sayer 2007, Sayer 2011). Knowledge is co-constructed through student experiences and learning is seen as social, taking place through participation in activities and / or through belonging to communities (Sayer 2007 and Sayer 2011). This approach, whilst acknowledging the value of formal education, recognises that a more complex range of factors can contribute to learning including the dispositions of students and tutors, the location and resources of the site, the course specification and assessments, and the interrelationships between students and tutors and time spent together. In addition to this the academic culture and wider social and cultural values are important.

Learning takes place as part of an ongoing relationship between an individual and their social context (Lave and Wenger 1991 p.29). Student practice teachers participate as newcomers within the context of clinical practice through being assigned a student to support. The student practice teacher engages with an experienced practice teacher who provides both formal and informal guidance and support in facilitating their learning of the role. This is often done at a distance and alongside both parties continuing in their specialist community nursing practice roles. Legitimate peripheral participation describes the role of the newcomer to the group and their journey to become full participants. Through legitimate peripheral participation in the community of practice the student practice teacher moves towards mastery of the knowledge and skills required to become a practice teacher and full participant in the community of practice. Lave and Wenger (1991 p.29-31) suggest that this process contextualises learning and enables the learning of knowledge and skills to become an entwined and inseparable aspect of social practice. The appointment to the role of student practice teacher, the allocation of a student and the commencement of the practice teacher course all provide the

necessary legitimacy to enter the Community of Practice and give some recognition for the role.

Practice teacher students have a limited range of immediate contextual sources to draw upon in terms of understanding the requirements of their role. There is little in terms of history to give them an insight into the role and there are limited opportunities for co-location of practice teachers. Some understanding of the role may be derived from when they were socially situated as student health visitors, district nurses or school nurses. In addition the relatively small numbers of practice teachers in any one organisation limits the opportunities for learning the role in a social context, other than 'learning through doing' in their role supporting students as described by Sayer (2007). It is therefore possible that practice teachers have derived a sense of their role from sources other than or in addition to the immediate setting or belonging to a community. Socio cultural theory and communities of practice theory can provide insights and a partial explanation in understanding how the practice teacher role has evolved differently across organisations and disciplines, because they are socially situated in nursing teams, but isolated from their practice teacher peers. As Fenwick et al (2012) point out, however, the focus is primarily on the social aspects and there is insufficient attention paid to the tools, technologies and activities that shape learning and work practices, nor the power relations that make possible or constrain certain practices. This study addresses an important gap in the literature by illuminating the broader socio-material determinants that influence how practice teachers learn their role and develop their professional identity.

2.4.2 The contribution of socio-material literature to our understanding of the nature of professional learning

In 1992 a new theoretical model was proposed (Orlikowski 1992). Known as the structurational model of technology, it sought to provide a framework for understanding the interaction between technology and organisations, including both human and non-human aspects. It is upon these foundations that socio-material theory is based. Socio-material theories emerged in order to acknowledge the previously largely ignored impact of materiality on

organisations, providing a framework for understanding the entanglement of the social and the material aspects of organisational life and allowing the researcher to study both simultaneously (Orlikowski 2007).

A number of authors that have examined the socio-material contend that an analysis of approaches to learning is not complete without consideration of the network of people and systems that individuals are learning to be a part of. Unlike socio-cultural theories (Hodkinson et al 2004) and 'Communities of Practice' theory (Lave and Wenger 1991) which remain human centred, socio-material approaches to professional learning de-centre the human being and suggest that individuals are learning to be part of a network of people and systems. Fenwick and Nerland (2014) are critical of approaches to learning which emphasise the individual practitioners mind as the focus of learning and de-contextualise learning and knowing from the networks of people and systems in which professions operate. Socio-material theory contends that learning is influenced by what those systems and people allow it to be. Fenwick and Nerland (2014) argue that learning is inseparable from professional practice and knowing occurs in a tangled web of material action and interaction that can be drawn upon to facilitate learning. This approach encompasses consideration of the tools, technologies and objects of practice intertwined with human aspects. Understanding the socio-material features that are used to categorise individuals as practice teachers may be significant for practice teachers in supporting them to develop a more stable and clearly defined identity. To better understand the relevance of socio-material theories to practice learning four socio-material theories, which draw attention to differing aspects of human learning and have different theoretical origins, are illuminated here in order to provide a lens through which to examine the professional learning of practice teachers.

Communities of practice literature relates well to socio-material theory since learning is described as integral and inseparable from social practice. Lave and Wenger (1991) describe the types of social engagement that provide the context for effective learning. Learning is situated in social co-participation and the learner acquires skills through engaging in the actual practice of an expert in a limited legitimised way. Learning takes place in a participation framework and

is therefore mediated by the perspectives of co-participants. Effective peripheral participation requires the newcomer to have access to mature practice, for example through an apprenticeship position in the workplace, and gradually is given opportunity to move towards full participation by taking on increasingly more difficult tasks and thus increasing the sense of identity and mastery of the role. This literature focuses primarily on the social aspects of learning which provides a partial understanding of how learning occurs. Alternative socio-material theories are considered below and these shed light on how tools, technologies and activities shape learning and work practices, and how power relations make possible or constrain certain practices (Fenwick 2012).

Actor-network theory extends our understanding of learning and knowledge production beyond the social aspects that were described by Lave and Wenger (1991). It recognises learning that occurs through networks that may extend over multiple sites (Mulcahy 2013) in a way that reflects the context of learning for many practice teachers. Mulcahy (2013) asserts that since networks are construed through relations it has the potential to provide insights into 'learning as becoming' rather than about knowledge transfer. People move and it is through this movement and involvement in physical practices that they undergo a learning transition. Knowledge is a social product of a network of actors which include humans as well as texts, tools, technologies, buildings and the environment, that influence how effective practices and social networks are formed, and thus what counts as knowledge.

In contrast to Lave and Wenger's (1991) work, cultural-historical activity theory (CHAT) focuses on 'activity' as the unit of analysis (Fenwick 2010). Material artefacts mediate social interaction and contribute to the consolidation of knowledge. The histories and cultures within which these artefacts are embedded are argued to be as significant as the social and material context with regard to knowledge production (Fenwick 2010). In this study cultural-historical activity theory facilitated an examination of how social and cultural experiences shaped learning and enactment of the practice teacher role, taking account of historically developed rules and connections in addition to the cultural norms of the environment (Arnseth 2008).

Finally, complexity theory (McMurtry et al 2016) supports the recognition of the multi-faceted realities of health care practice in terms of seeking an understanding of the factors influencing learning and professional identity development. In particular it illuminates the potential for the production of new collective knowledge, generated through team work, which extends beyond what could be achieved by individuals working in isolation and without collaboration.

As noted above this study seeks insights into how practice teachers see themselves and how the role is understood by others. It examines the complexities inherent in a dual professional identity and explores how practice teachers negotiate the boundaries of their dual practitioner and teacher roles. It therefore draws on the literature which illuminates professional identity formation and the complexity of social identity in order to understand practice teachers sense of self and how this influences learning and enactment of the role. Using the concept of identity in conjunction with socio-material might appear problematic to some since socio-material theory was precisely developed to decentre the significance of human agency and individuality and to make roles understood largely in relation to the networks and roles that they are engaged in. In its purest form socio-material theory proposes that professional roles are enacted by assemblages of texts, protocols, machinery, and human networks. Whilst socio-material theory is useful for drawing attention to the fact that people are not unencumbered agents free to do and think as they want, equally they are not just helpless victims of the system that they are in. Indeed Blunden (2007) is critical of CHAT, suggesting that the theory needed to better reflect an individual's capacity for self-determination alongside larger social forces. Individuals work within and struggle with the systems with a sense of what they want to achieve and the obstacles that are in the way of that. These issues are all aspects of their sense of self and their sense of identity and identity theory can offer insights into this less well understood influence. This study therefore seeks to reconcile identity and socio-material theory in order to offer innovative and original insights into how practice teachers learn and enact the role.

2.4.3 The contribution of identity theory to our understanding of the nature of professional learning

In contrast to socio-material literature (Fenwick and Nerland 2014, Lave and Wenger 1991, McMurtry et al 2016, Arnseth 2008, Mulcahy 2013), social identity theory (Tajfel 1978) illuminates an alternative perspective of how practice teacher's identity develops through group membership. This literature sheds light on the individual's capacity for self determination and captures the influence of the perceptions of others on identity development. Social identity theory facilitates an examination of the complexity of practice teachers identity development and the challenges imposed by being a small and disparate liminal occupational group with a dual identity. It too, however, only pays scant attention to the material factors which influence practice learning and identity development.

Social identity relates to an individual knowing that s/he belongs to specific social groups and that one's identity is defined by the characteristics of these social groups (Hogg and Abrams 1998). The work context is therefore significant in terms of an individual developing a social identity as it provides some socio-material parameters within which to develop. If a role is understood and valued then it is more likely to be internalised and an individual is more likely to define him or herself in terms of that identity (Ashforth et al 2000). This is only likely to occur, however, when individuals have an appreciation of what the role entails (Ashforth et al 2000). Kirpal (2004 p.276) suggests that conforming with role expectations reaps benefits in terms of recognition and acceptance and this social affirmation acts as external guidance that enables the individual to develop the dimensions of their social identity. The socio-material features of the work context of practice teachers, however, differ and they have struggled to establish a set of core characteristics that distinguish the role (Newland 2009, McInness 2013, Mannix 2012, Sherwin and Stevenson 2010, Sayer 2007, Sayer 2011, Carr and Gidman 2012, Haydock et al 2011). Therefore, whilst the clinical role is likely to confer a good degree of social affirmation it is possible that the practice teacher role could be marginalised and indeed literature indicates that practice teachers feel undervalued and need extra support (Carr and Gidman 2012). Practice teachers are assigned a range

of differing additional responsibilities and the core specialist body of knowledge that they draw upon to inform their teaching role relates to their clinical expertise. As a consequence they will be influenced by a differing range of factors specific to their unique context and these are likely to be at variance with other practice teacher roles. They might therefore be categorised as practice teachers and their roles might have some material features in common, such as supporting a specialist community nursing student, but they may not share a common role identity and may not be seen or see themselves in the same group as one another, particularly where their clinical roles differ.

Identity is formed through a process whereby reflexive individuals identify with or categorise themselves in relation to other social categories or classifications (Stets and Burke 2000). This could be likened to the characteristics of a profession with its shared body of knowledge and practices with which group members identify. According to Currie et al (2010) individuals are viewed as interchangeable within the social category rather than as unique persons and they enact activities congruent with the salient features of the identity. Hogg and Abrams (1998) suggest that this identification is a psychological state that has significant self-evaluative consequences. Social identity theory proposes that a positive social identity is derived from making favourable comparisons with the in-group and relevant out-groups. Where individuals struggle to find favourable comparisons they may attempt to leave the group or find ways of making it more distinctive. Extant literature (Newland 2009, McInness 2013, Mannix 2012, Sherwin and Stevenson 2010, DH 2012) suggests that a range of differing additional responsibilities are aligned to practice teacher roles and this lack of uniformity may inhibit opportunities to identify favourable comparisons and activate their practice teacher identity. In addition, the core body of specialist knowledge that is integral to the practice teaching role differs according to discipline. As a consequence, though they are all categorised as practice teachers, they may not share a common understanding of the role. The liminal status of the practice teacher role may thus give rise to individuals attempting to create their own meanings and expectations for the role. As a corollary to this they may start to behave in a way that conforms to their understanding of the role and the expectations of individuals around them.

These expectations are likely to differ according to the socio-material features of the context in which they are located (Stets and Burke 2000). The group is thus made up of interrelated individuals performing a range of integrated activities. This may provide insights into the individual's capacity for self determination and explain why roles have evolved differently. The number of individuals sharing the group identity is likely to be small and so less likely to be activated in a particular situation (Stets and Burke 2000).

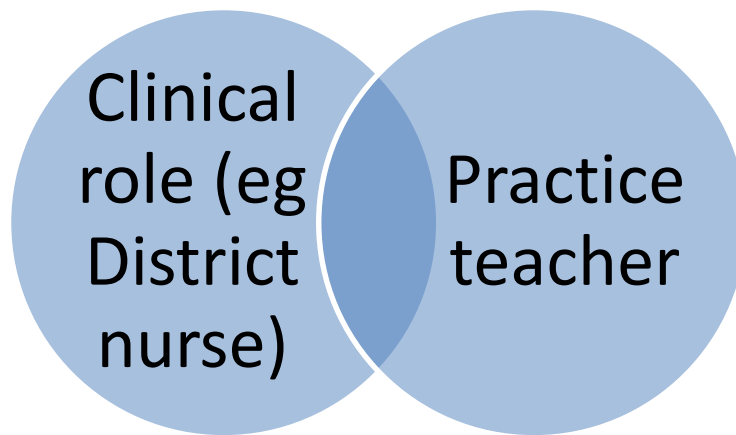
The impact of a dual role on identity formation merits further consideration as practice teachers may be categorised as members of two or more groups. The degree of overlap between these groups however may not be perceived in a homogenous way. Stangor et al's (1992) work on the effect of multiple categorisation on the perceptions of other people, and Roccas and Brewer's (2002) work on social identity complexity which relates to an individual's subjective representation is particularly pertinent in relation to individuals such as practice teachers who have a dual role.

Physical artefacts such as clothes and other possessions are of significance in constructing professional identity (Pratt et al 2006). Individuals are often categorised on the basis of these immediately apparent physical (material) features (Stangor et al 1992). Students and others observe the practice teacher undertaking discipline specific clinical work and may not readily acknowledge the integration of practice teaching into this activity since there are no physical artefacts or salient features to distinguish them from their clinical role identity. This is interesting in terms of considering what materialities are used to provide information with which to categorise practice teachers. Colleagues, managers, students and others may attempt to combine membership of categories in order to provide more information about the subjects (Stangor et al 1992). This is problematic in relation to attempting to categorise practice teachers where the more salient and visible identity is that of the dominant clinical role. The secondary or subordinate practice teacher role is prone to becoming subsumed under the features of the more visible identity. Stangor et al (1992) suggest that an individual who is clearly a member of a well understood category is likely to be perceived as such regardless of any specific features that they might have. Clinical roles are clearly embedded and well understood in contrast to

practice teacher roles where, as indicated earlier, there is a lack of common role descriptors and a differing range of responsibilities are aligned to it.

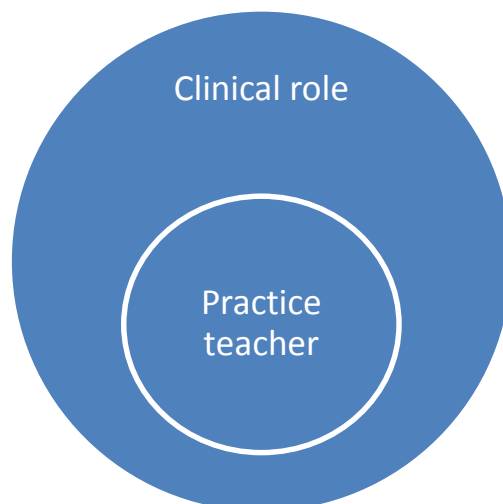
As noted previously practice teachers are a small occupational group and their dual identity is not a common duality. Social identity complexity refers to 'the degree of overlap that exists between groups of which a person is simultaneously a member' (Roccas and Brewer 2002 p.88) and this literature has the potential to offer insights into the challenges faced by student practice teachers. Social identity complexity (Roccas and Brewer 2002) acknowledges that individuals may align themselves to a particular in-group on one dimension whilst also recognising that they are a member of a different in-group on another dimension. Where this is the case their separate 'in-groups' will be small and therefore their specific social identity is potentially less likely to be activated and this may provide insights into why the role is considered to be subordinate to the clinical role. A district nurse practice teacher, for example, might perceive herself to be a member of a district nurse in-group whilst simultaneously acknowledging membership of a practice teacher in-group that contains practice teachers from other disciplines. This partial overlap creates challenges for constructing professional identity. A different district nurse practice teacher might only perceive herself to share in-group membership with other practice teachers that are also district nurses. This reflects Roccas and Brewer's (2002) intersection model (figure 1) where only those who share both identities are classified as the in-group (shaded dark blue in figure 1). Whilst this simplifies group identification a consequence is that the group is likely to be small. The practice teacher role is embedded in the clinical role and this may impede perception for some in terms of recognising that they are part of a broader in-group that contains other disciplines, particularly where differing responsibilities are aligned to the practice teacher role.

Figure 1 Intersection model (Roccas and Brewer 2002)



An alternative model presented by Roccas and Brewer (2002) suggests the dominance of a particular social identity over all other identities (figure 2). The subordinated identities are embedded within the dominant identity and considered aspects of self rather than an alternative identity. Existing literature suggests that practice teachers have a dual identity where the clinical role identity dominates the secondary or subordinate practice teacher identity (Newland 2009, McInness 2013, Mannix 2012, Sherwin and Stevenson 2010). It is therefore possible that some practice teachers might continue to define themselves in relation to their dominant clinical role.

Figure 2 Dominance model (Roccas and Brewer 2002)



Where there is consensus on what behaviours and work practices are appropriate for a role this supports the creation and maintenance of role boundaries and the identities within them (Ashforth et al 2000). Clinical roles are well understood and are clearly reinforced with a range of tools including protocols, pay grade and job descriptions. Extant literature suggests that these are significant in maintaining the boundaries of professional roles (Newland 2009, Mannix 2012, Brook 2015, Carr and Gidman 2012).

Where individuals undertake a dual role it is worth examining the materialities that support the boundaries of each role in order to determine their potential influence on enactment of the role. Both roles are situated within an efficiency driven organisation with sophisticated monitoring and audit systems. The clinical role is prescribed in job descriptions, guidelines, protocols and service specifications. In addition the nurse is bound by regulatory body requirements (NMC 2015) to prioritise the needs of her clients or patients. These inflexible boundaries reduce individual practitioner autonomy, and are likely to prioritise enactment of the clinical role and subordinate enactment of the practice teaching role (Blundau 2014). The practice teacher role is less stable, role boundaries are unclear and there are few materialities to support it. Common role descriptors and job descriptions, for example, are difficult to locate, other than for their role in supporting the specialist community nursing student and a differing range of additional responsibilities are aligned to the role. There is therefore the potential for inter-role conflict and a likelihood that the clinical role will take priority in being enacted over the practice teacher role where fewer materialities exist to support its boundaries.

The degree of segmentation or integration facilitated by the materialities outlined above is also of significance since there are costs and benefits associated with creating and maintaining boundaries between roles and also of crossing those boundaries (Ashforth et al 2000). Where roles are more integrated it is easier to cross the role boundaries, however this blurring of roles can cause confusion and boundary violation (Ashforth et al 2000). Practice teachers are attempting to juggle or simultaneously enact two or more roles (Newland 2009, Mannix 2012, Brook and Salmon 2015, Carr and Gidman 2012, Haydock 2011). The extent to which these roles can be integrated differs

according to the range of responsibilities aligned to individual practitioner roles. Practice teachers are expected to teach alongside carrying out their clinical role and indeed practice learning for specialist community nursing students is dependent upon this integration since student learning relies heavily on experiential learning. It could be argued that integration is the norm for this aspect of the role and the way that it is integrated disrupts the clinical role only to a limited extent. This may be because it is the best understood and materially visible aspect of the practice teacher's remit. Other responsibilities aligned to practice teacher roles are likely to be more difficult to integrate due to the nature of the responsibilities.

The practice teacher is committed to a dual role where the teaching role is bolted on to a core clinical role. It is an additional role undertaken on top of a full clinical caseload and few are afforded any protected time to undertake it (Newland 2009, Mannix 2012, Brook and Salmon 2015, Carr and Gidman 2012, Haydock 2011). Segmented roles are associated with specific settings and times, so a district nurse, for example, going into a patient's home to provide care and for a practice teacher to meet with a student in order to plan their learning would be symbolic indicators of which identity to activate (Ashforth et al 2000). A lack of protected time however is likely to reduce opportunities to segment the practice teacher role and this is likely to have the greatest impact on the broader and less stable aspects of the practice teacher role. Practice teachers attempt to defend the boundaries of their roles using temporal or spatial techniques (Newland 2009, Mannix 2012, Brook and Salmon 2015, Carr and Gidman 2012, Haydock 2011) however it is likely that these boundaries will be difficult to maintain. For practice teachers the clinical role is more likely to interrupt the teaching role rather than vice versa since the context of practice prioritises care related activities (production) over teaching related activities (reproduction) in a health care system struggling to meet increasing client needs. Practice teachers need to work hard to maintain the boundaries of their roles as there are no structures or standardised work practices to support them in sustaining their dual identity (Newland 2009, Mannix 2012, Brook and Salmon 2015, Carr and Gidman 2012, Haydock 2011).

The dual roles have asymmetrically permeable and flexible boundaries. Permeability refers to the extent to which a physically located role allows the behaviours associated with a second role into that domain (Ashforth et al 2000). Where role boundaries are more permeable and flexible it can help overcome inter-role conflict but conversely it can create confusion amongst group members as to which role is or should be most salient (Ashforth et al 2000). The greater the degree of contrast apparent between the core and peripheral features of each of the roles the greater the magnitude of the transition (Ashforth et al 2000). Whilst the clinical role has distinctive disciplinary features and boundaries, it is difficult to distinguish any strong and distinctive boundaries around the practice teacher role other than their one to one role with their assigned student. These asymmetrically permeable role boundaries may mean that practice teachers have to create and maintain boundaries around the practice teacher role in order to defend against encroachment by the clinical role.

2.5 Conclusion

The literature review appraised what is known about practice teaching and how the role is learned and enacted alongside a clinical role in the NHS. The review illuminated instability in the NHS caused by frequent re-organisations and the development of a market based system aimed at improving efficiency and containing costs. The NHS has become characterised by technologies of governmentality including policies, procedures, protocols and targets which standardise work practices and the literature suggests that these impact on professional roles, practice learning and identity formation (Hallam 2000, Kirpal 2004, Blundau 2014, Fenwick et al 2012). Literature on new public management (Siltala 2013, Simonet 2013), governmentality (Blundau 2014) and productive systems (Felstead et al 2007) was thus examined in order to understand the consequences of this in greater depth. This literature suggested that professional autonomy is constrained in such contexts and this impinges upon practitioner roles and opportunities to learn through work.

The review examined literature which provided insights into the nature of professional learning (Schön 1991) and learning that occurs in a socio-cultural

context (Hodkinson et al 2004) and this afforded a partial explanation of how learning occurs. As a basis for understanding the broader range of factors that might influence practitioner work roles and practice learning socio-material literature (Fenwick and Nerland 2014, Lave and Wenger 1991, McMurtry et al 2016, Arnseth 2008, Mulcahy 2013) was also scrutinised and was subsequently used as a theoretical framework to inform the data analysis process. This study seeks to reconcile the tensions between identity theory and socio-material theory in order to reflect an individual's capacity for self-determination and to offer innovative and original insights into how practice teachers learn and enact the role. In particular the literature relating to social identity complexity (Roccas and Brewer 2002) and Stangor et al's (1992) work on multiple categorisation was useful in illuminating the complexities of dual / multiple identities.

Extant literature (Sayer's 2007 and 2011, Carr and Gidman's 2012, Haydock et al 2011, McInnes 2013, Brook and Salmon 2015, Devlin 2013) draws upon the perspectives of practice teachers themselves and focuses on their role in supporting students. This study includes an analysis of the perspectives of other stakeholders and extends beyond an examination of the practice teacher's role in supporting students to consider how the broader remit of the role is understood and the contextual factors that influence the responsibilities aligned to it and how it is enacted. This study aimed to illuminate the practice teacher role and to develop further insights into how practice teachers can best be prepared to effectively undertake their role.

Chapter 3: Design and Methodology

This section will provide an overview of the design of the study and provides a rationale which justifies its appropriateness in terms of addressing the aims of the research.

3.1 Rationale for the design

The research aims arose from personal experience relating to the ambiguity of the practice teacher role. It was therefore important to select an approach that enabled exploration of the broader context in which practice teachers are situated in order to offer new insights and explanations into how social interactions and the material context impacted upon practice teachers learning and enactment of their role. The research aims sought an insight into the subjective understanding of participants who were knowledgeable in their field about the role of the practice teacher and the educational needs of student practice teachers. As such an inductive approach, which sits within the constructivist / naturalistic paradigm (Denzin & Lincoln 2008 p.32), offered the greatest potential to construct an insightful and incisive understanding of the range of perspectives or 'truths'. This paradigm assumes that reality is constructed by the individuals participating in the research and that many constructions of reality exist (Polit & Beck 2006 p.15).

3.2 Reviewing the literature

The chosen area of study is one related to the researcher's own area of practice and therefore pre-existing knowledge and experience was drawn upon in the study. In this study it was important to establish what work had already been done in order to determine what others were saying, what had not yet been explored and find out whether other perspectives were possible. For the purpose of this study a review of relevant literature was conducted at the beginning and this confirmed the extent of current knowledge, justified the need for the current research study and helped to formulate the aims of the research. The literature review also offered an insight into the contextual issues related to practice teaching and was a requirement in order to obtain ethical approval. The review revealed that whilst there was a significant amount of literature in

relation to mentoring there was a paucity of research specifically in relation to practice teaching. Importantly there was a gap in the literature in relation to how practice teachers viewed themselves and how their role was perceived by other relevant stakeholders including students and managers. In order to provide insights into the experiences of practice teacher's dual role, literature which explored the experiences of other health and social care practitioners with dual roles was examined. Literature on mentorship was not included in the review since the nature of the role was deemed to be different as mentors normally facilitate the learning of preregistration students over a shorter duration of time and share responsibility for teaching and assessment with other mentors.

The NHS has increasingly become characterised by policies, procedures, protocols and targets which standardise work practices in order to maximise efficiency and contain costs. Literature on productive systems suggests that organising work in this way constrains professional autonomy, for example in relation to planning work priorities (Fuller et al 2006 and Felstead et al 2007). This context had implications for the design and method of the study and prompted the inclusion of managers who could provide insight into the organisational context and the nature of the pressures.

For practice teachers work life is entangled with clinical practice in a diverse range of settings, working in teams but often in isolation and this experience is significant in constructing and shaping their professional identity. In addition the productive system influences and shapes how practice teachers see themselves and how they are perceived by others. Literature on overlapping identities and identity complexity provided insights into the difficulties faced by practice teachers in managing a dual identity and role (Stangor et al 1992 and Roccas and Brewer 2002) and supported the data analysis contributing to the formation of new and innovative insights into how practice teachers learn and enact the role.

3.3 Sampling strategy

In this study an insight into practice education was required and the thematic categories identified were not known in advance (Charmaz 2006 p.100). Only

those with specific knowledge and expertise would be able to provide relevant data and thus a purposive sampling strategy was employed (Holloway 2005 p.152 and Yates 2004 p.27). Purposive sampling requires critical thinking about the parameters of the population of interest and then selecting participants that reflect it (Silverman 2010 p141). This sampling strategy carries a risk of sampling error (Holloway 2005 p.151) and therefore, in order to counteract this, sampling criteria were developed (Charmaz 2006 p.100). A diverse range of participants from different specialist community nursing disciplines with differing levels of experience employed in a number of organisations were thus included. This sampling strategy aimed towards theoretical sensitivity and whilst facilitating some degree of transferability, will not result in findings which can be generalised to a wider population (Bowling 2002 p.188).

Ethical issues related to accessing students led to a compromise being made in terms of the sampling strategy. These participants were purposively selected following a written request emailed to all students studying a community nursing programme at the host institution seeking volunteers to participate in the study. The sample was thus taken only from those who had self-selected to participate. It is possible that these students may have had a particular motivation for participating and thus may not be representative of students more broadly. The diversity of the characteristics of the participants and the candid way in which they spoke, however, gave me some confidence in the findings.

The focus group members volunteered to participate in the study. This sample selection method was employed in order to assure ease of access to a geographically disparate group of nurse educators within the time and resource constraints of the study. This method of sampling is described as convenience or volunteer sampling (Bowling 2014 p.217). These participants may have had differing reasons for volunteering to participate or may have just wanted to help me out, since being involved in education and research themselves they would have been aware of some of the challenges faced in recruiting participants. Either way these participants may not have been representative of community nurse educators and practice teacher educators more broadly, particularly since the group from which they were drawn (UKSC) represented public health nurse educators (health visitors, school nurses and occupational health nurses). The

participants that were included in the focus group, however, did include educators involved in district nursing programmes.

In order to facilitate access to participants within the agreed timescale for the study only practice teachers and managers employed within five health care provider organisations within the region where the study was based were approached to request their participation. Only students enrolled on specialist community nursing courses at the host university were invited to participate. Conducting research mainly in one geographical region was appealing since it facilitated easier access to participants. There are, however, some specific drawbacks. In this study it is acknowledged that the unique combination of socio-material features present in each of the research sites are likely to be at variance with those present in other regions. As a consequence of these disparities roles may be construed differently. The inclusion of participants in different clinical roles based in five health care provider organisations, a nationally distributed group of nurse educators and the chair of a national forum of nurse educators (UKSC) offers some potential to triangulate findings and to understand whether the themes identified were common to practice teacher roles more broadly. In addition my familiarity with the field and the extent to which I am tied into networks of people in similar roles provides an alternative source of verification and puts things into a broader national context.

The second drawback of researching in one geographical area was identifying participants that were not known to me or me to them. Whilst I did not know the four district nurse practice teachers (PT4, PT5, PT6, PT8) they were aware of who I was. The two district nurse students (ST1, ST5) were aware of whom I was but I had previously had no direct contact with them. Of the four managers that participated three (M1, M2, M3) were not known to me, though we were aware of one another's roles. I had only brief contact with the fourth manager (M4). Four out of the six focus group participants were not known to me though they were aware of my role. The remaining two focus group members were based in the same region as me and hence I had previously had some minimal professional contact with them. The UKSC chair (UKSC1) was aware of who I was but other than that, did not know me. The only participant who did not know me at all was the NMC representative (NMC1). Hence eighteen (60%) of

the thirty participants had minimal or no knowledge of me. The remaining twelve (40%) participants had previously had contact with me through courses that I had taught on, my role in supporting students through tri-partite meetings in clinical practice that included practice teachers and practice teacher meetings that I facilitated. Being acquainted with or having knowledge of me had the potential to influence what participants were willing to say and additionally might have influenced the way in which they communicated it. This may have affected interpretations and constructions of meaning in the data and must therefore be acknowledged as a limitation of the study. I do believe, however, that the diversity of participants in terms of their role, level of experience and geographical location ameliorates this to a great extent. In addition participants spoke with assurance and openness during the interviews and this gave me confidence that my interpretations of the data were valid.

3.4 The participants

It was anticipated that practice teachers would be key informants in this study. I aimed to gain an insight into the lived experience of practice teachers, how they learned, enacted and understood their dual role, and the factors that shaped and impinged upon it. I sought to capture accounts of how practice teachers viewed their role and identify whether there were variations in perception according to location and between participants occupying different clinical roles. I sought to uncover the differing range of responsibilities aligned to practice teacher roles and endeavored to gather insights into how the role was managed alongside a clinical caseload.

Ten practice teachers employed by five different provider organisations were purposively selected from registers of practice teachers held by partner primary care provider organisations (appendix 5). The sample included four district nurses, four health visitors and two school nurses all of whom were female and whose experience of practice teaching extended from supporting one to several students. Some of these practice teachers also held management and leadership roles alongside their caseload responsibilities and supporting a student.

Managers are in a position to influence and shape the responsibilities aligned to practice teacher roles and have responsibility for the recruitment and selection of practice teachers. It was anticipated that managers would be able to shed some light on the contextual and external pressures influencing and impinging upon the role and I sought insights into how managers perceived the practice teacher role and the types of attributes that they might be looking for when selecting individuals to move in to practice teaching roles.

Managers who were known to have an insight into and responsibility for managing specialist community nurses and practice teachers were identified through local networks in partner provider organisations that provided placements for students at the host academic institution and others in the region. Four managers from three different provider organisations were purposively selected and interviewed (appendix 5). These managers were responsible for overseeing practice teachers in one or more specialist community nursing disciplines in their organisation. The relationship between the practice teacher and manager participants offered the potential for triangulation of the data gathered.

As students are the 'raison d'être' for practice teachers it was essential to include their perspectives in this study. The views of students were important in order to gain an insight into their expectations of practice teachers and to explore whether there were variations in perception of the role according to their backgrounds and specialist community nursing discipline. This was significant since student expectations of their practice teacher have the potential to influence enactment of the role. Working alongside a practice teacher for the duration of the course they were also in a good position to observe what practice teachers do on a day to day basis, the responsibilities aligned to the role and the factors impinging upon it.

In order to select a broad range of students including those from different specialist community nursing disciplines (health visiting, school nursing & district nursing) the participant information sheet (appendix 2) was initially emailed to all students registered on specialist community nursing programmes at the host institution requesting expressions of interest to participate in the

study. The participant information sheet included an invitation to participate in the study and a request to provide some biographical data if students wished to be included in the study. From those responding to this initial request a range of students were identified at differing points in their educational programme from the three specialist community nursing disciplines. Four health visiting, two school nursing and two district nursing students (seven female and one male) were purposively selected (appendix 5). These students differed in their previous professional experience ranging from a student who entered the specialist community nursing programme straight from a preregistration nursing programme to experienced nurses working in senior roles. Six students were studying their respective programmes part time and two were studying full time. Students' also differed in relation to the number of years since they had last undertaken any academic study. This ranged from nine months to thirteen years (mean = two and half years).

The final two participants were purposively selected for inclusion in the study. The perspective of a representative from the regulatory body (NMC) (appendix 5) was sought in order to gain insights into the NMC's role in developing the standards for practice teaching (NMC 2008) and how the role was understood by the organisation. Secondly the chair of a national forum of Specialist Community Public Health Nurse Educators whose members are drawn from across the United Kingdom (UKSC) was interviewed in order to provide insights into the role of practice teachers nationally and identify any major regional variations (appendix 5).

Nurse educators have the potential to influence how the practice teacher role is understood by those learning the role. I therefore wanted an insight into how nurse educators themselves understood the role and the responsibilities aligned to it. It was also anticipated that these participants might also provide insights into regional variations in terms of the role and responsibilities aligned to it.

A focus group interview with six nurse educators from five higher education institutions in England was carried out later on in the study (appendix 5). These participants were identified through a national forum of Specialist Community Public Health Nurse Educators which meets three times per year and of which I

am a member. Whilst the forum represented Specialist Community Public Health Nurse educators the participants included those involved in the education of practice teachers and specialist community nursing students from the range of disciplines represented in this study and they volunteered to participate.

Exploring the nature of practice teaching from the perspective of a range of different stakeholders located in their own unique environment was important in order to obtain a broader sense of the socio-material context. Whilst it was important to incorporate the perspective of a range of stakeholders in relation to addressing the research aims it must be acknowledged that sampling error can occur leading to tensions and inconsistencies in the data. This is particularly apparent where, for example, a specific group of stakeholders may have a more limited insight than other stakeholder groups into a particular phenomenon. These are explored and triangulated in the data analysis section and this added to the richness of the data.

3.5 Ethical considerations

The British Educational Research Association (BERA 2011) guidelines informed all aspects of the conduct of this study in order to assure best ethical practice and thus support me in reaching an ethically justifiable position. These guidelines assert that educational research should be conducted with respect for

'The person, knowledge, democratic values, the quality of academic research and academic freedom' (BERA 2011 p.4).

Despite an emphasis on biomedical ethics, Beauchamp and Childress' (2001) ethical framework also informed this study. Four ethical principles are articulated and these were used to help identify and guard against a number of potential ethical issues posed by this study. The ethical issues are appraised in the discussion below and this is followed by an explanation which articulates the actions taken to guard against the identified concerns.

The principle of respect for autonomy (Beauchamp and Childress 2001) primarily relates to an individual's freedom to make reasoned informed choices.

In this study it is relevant in terms of considering participants freedom to consent or not to participate in the study. Bourgeault et al (2010 p.591) describes a sense of 'institutional vulnerability' that can be experienced by study participants when the setting in which they are approached makes them feel compelled to participate. In this study practice teachers might have felt obliged to participate in the study because of perceived power differentials, particularly if they had a student on placement from the host university or perhaps wished to take one in the future. Equally students might have felt obliged to participate in the study again because of perceived power differentials and fear that refusal might disadvantage them in their studies.

'Institutional vulnerability' (Bourgeault et al 2010 p.591) was most likely be felt by students. As a requirement for ethical approval the participant information sheet (appendix 2) was emailed to all students registered on specialist community nursing programmes at the host institution requesting expressions of interest to participate in the study. Student participants were selected from those who replied to this invitation thus assuring that students had the freedom to participate or not in the study. It was equally important to consider those students who chose not to participate and reassurance was given within the participant information sheet that they would suffer no disadvantage from not participating in the study.

All participants were provided with a participant information sheet (appendix 2) which explained their rights and how participation in the study could impact upon their position. This was documented on a consent form (appendix 1) and a copy of this was retained by the participant.

The purpose of the study was clearly explained to all participants and details were provided in terms of how the information was to be used. An explanation was provided in terms of maintaining anonymity where quotes would be used and a guarantee of a right to withdraw from the study at any time was offered. Confirmation of this was recorded on the consent form. An explanation was given in terms of my positioning as a researcher and as a course leader and a commitment was given to maintaining confidentiality and anonymity. Data gathering was in the form of an informed participant discussion using an

interview guide and the opportunity to share the outcomes of the research with the participants was offered.

Researchers should seek to prevent harm to participants (Sarantakos 2005 p.19). Beauchamp and Childress (2001) describe this as non-maleficence and contend that interventions must not be disproportionate to the benefits. In this study questions focusing on the attributes of a good practice teacher might have prompted practice teachers to reflect upon their own attributes and question their own competency and this might have impacted upon individual self esteem. Exploration of how practice teachers should be educationally prepared and supported to undertake their role might have provoked nurse educators to reflect upon the quality of education and support that they provided and this might have resulted in potential distress if participants identified any inadequacies. In this study a decision was made that the risk of such harm was relatively small and thus could be justified in terms of the potential benefits expected through the findings of the study. In order to mitigate the potential risk of distress to participants, information was included within the participant information sheet (appendix 2) indicating where they could obtain support if any part of the interview process created any emotional distress.

Beneficence refers to balancing the benefits of the intervention against the potential costs (Beauchamp and Childress 2001). In this study consideration was given to the costs of participation and this related mainly to inconvenience in terms of the time taken to conduct the interview and the potential for emotional distress outlined above. The benefits of the study, however, had the potential to improve the position of practice teachers in the workplace and inform how practice teachers are prepared for their role. In addition the interview itself had the potential to provide a valuable reflective opportunity which could lead to improvements in practice based learning. On balance I believed the benefits of participating in the study outweighed any risks.

The fourth ethical principle described by Beauchamp and Childress (2001) is justice. In this study it relates to the importance of ensuring that those who participate, and thus give their time and attention to the study, will benefit from the outcomes of the study. Participants in this study were offered the

opportunity to hear and read about the outcomes of the research. In addition there will be the potential to benefit through the publication of the findings from this study. There is little empirical research which focuses on practice teaching. This study provides new insights into practice teacher roles and practice learning and makes recommendations which could secure a more clearly defined role for practice teachers in the future.

The research proposal was given ethical approval by The University of Huddersfield in April 2010 at the School of Education & Professional Development (SEPD) Graduate Education Group.

As the study involved participants employed within the NHS, ethical approval was also sought via the Integrated Research Application System (IRAS). This was submitted in December 2010 following a complicated and lengthy application process and approved on 10th March 2011.

As the intention was to interview practice teachers and managers in five NHS provider organisations, research management and governance permission was also obtained. This included a right of access letter from each NHS organisation and obtaining a research passport to enable access to potential participants.

3.6 Qualitative interviewing

The aim of this study was to shed light on how practice teachers learned and enacted their role and sought insights into the socio-material factors that influenced it. I wanted to understand a range of stakeholders' perspectives regarding the context in which the practice teacher role was situated, what the role 'looked' like and the knowledge, skills and attributes required. This aim necessarily influenced the data collection method. Participants may attach multiple meanings to their experiences and due consideration was therefore given to how I might engage with a range of stakeholders and establish trust so that I could successfully capture these accounts (Charmaz 2006 p15).

Interviews with a range of stakeholders offered the potential to illuminate the differing perspectives regarding the contextual influences on the role and thus

enrich my understanding of practice teacher roles and the factors that impinged upon them. This study sought to explore the conditions faced by practice teachers on a day to day basis and also the broader range of socio, political and historical conditions in which the role was situated (Corbin and Strauss 2008 p.230). Qualitative data gathered through one to one semi-structured interviews had the potential to obtain rich material particularly by using open-ended and carefully shaped interview questions. This process, if skilfully conducted, can avoid imposing preconceived ideas on the data and lends itself well to accessing the meanings participants place on their experiences.

The use of interviews does have limitations. Interviews happen at a defined point in time and can therefore only explore how the participant feels from the position of the present, even if he or she is being asked about something that happened retrospectively (Silverman 2014 p.171). Equally the process of sharing the experience in an interview can impact upon the participants understanding of the experience (Darlington and Scott 2002). Interviews are intentionally created conversations which provide an opportunity to discuss something that the interviewer is interested in (Dingwall 1997 p59). Even where questions are open-ended the interview content is still framed by the interviewer. Researchers do convey their emotions to participants during the gathering of data and participants react and adjust their position in response to it (Corbin and Strauss 2008 p.31). Additionally participants may be concerned to portray themselves as competent members of the group that they represent and can be preoccupied with self-presentation or with persuading others rather than presenting the facts (Hammersley 2008 p.90). Knowledge and meaning is thus co-created through a two way dialogue and this reciprocal influence could be construed as the researcher and participants co-constructing the data (Corbin and Strauss 2008 p.31, Hennink et al 2011 p.109 and Dingwall 1997 p59). These factors have led to criticisms in the literature relating to the ability of an interview to capture the 'genuine voice' of the respondent (Silverman 2014 p.172, Hammersley 2008 p.90, Gomm 2008 p.222). What participants said about practice teaching could therefore not give me direct access to the experience of being a practice teacher. This study however, sought to elicit

participants' perceptions of the practice teacher role and to understand the socio-material factors that impinged upon it. The aim was thus not to get direct access to the experience, but rather construct a narrative based on representations of what participants understood to be the role (Silverman 2010 p.48). The use of semi-structured interviews can therefore be justified within this study.

Focus groups are likely to elicit information on the norms of the particular group rather than individual perspectives (Hennink 2011 p.111). This approach was a useful and a more feasible strategy to elicit the collective views of nurse educators from across the country on how practice teachers learned their role, the role itself and the factors impinging upon it. This approach enabled triangulation of the data obtained in the one to one interviews and enabled me to identify where the findings could have relevance beyond the local region. Focus groups would have been problematic for exploring practice teachers, managers and students views since the aim was to illuminate their differing perspectives and in addition if participants had felt uncomfortable sharing their perspectives with others they might have refused to participate in a focus group (Charmaz 2006 p15).

Participants need to feel confident in order to share frank, sensitive and personal information necessary for gathering valid and reliable data. It is therefore important that the researcher is able to develop a rapport with the participants (Darlington & Scott 2002 p.53 and Cicourel 1964 p.86). There is however a risk that researchers and participants may develop shared understandings about some aspects of the subject and that this might subsequently lead them to skip over some important details of a story so that these are not recorded (Darlington & Scott 2002 p.53). In addition interviewers may misinterpret or fail to clarify what the participant means (Darlington & Scott 2002 p.53 and Cicourel 1964 p.76). It was therefore important in this study that explanations of the purpose of the study were provided skilfully in order to put participants at their ease. In addition the questions were introduced in groups under subheadings which were indicated to participants and additional clarification was provided as necessary.

There is the potential for the introduction of bias through over-identification and this familiarity can lead to things being taken for granted (Spradley 1979 p.50). In order to avoid this, an alternative option might have been to opt for a more business-like detachment (Cicourel 1964 p.86). Some participants, however, may not have responded to a very detached interviewer and a degree of rapport was therefore considered preferable. I elected to conduct the interviews myself and this supported the establishment of a rapport with the participants since I shared a professional background with them and knew some of them on a professional level. In order to guard against over identification with the participants a level of formality and professionalism was maintained in the conduct of the interviews and care was taken to avoid communicating any sense of status inequality. Whilst being friendly and thanking participants for taking part it was important to make sure that all planned processes for the interview were followed and I endeavoured to respect the timeframes that participants had set aside for participating in the study. Each interview is a unique event and as Cicourel (1964 p.87) states, it is not possible to create an environment where each participant is exposed to precisely the same conditions. As such it must be accepted that comparability cannot be achieved to the same extent as with an experimental design.

Interviewing is a skilled social process and interviewers and participants vary in their ability to maintain detachment from the social impact of the interview (Cicourel 1964 p.82). The interviewer's perceptiveness plays a role in developing a rapport and the interviewer can school him / herself to convey approval and interest through the use of facial expressions and other non-verbal communication, whilst inwardly perhaps feeling some negativity. Equally the respondent can also elect to withhold feelings and ideas about the questions posed (Cicourel 1964 p.83) or could be tempted to give what they perceived to be socially desirable responses rather than being frank and honest. The participants in this study were all experienced clinicians employed in roles that required them to be able to convey professional behaviours whilst hiding on occasions, negative feelings towards clients or colleagues. It was therefore likely that these participants had the skills to hide true responses and could have elected to withhold their real feelings and ideas about the focus of the

study. In this study some of the participants were known to me in a professional capacity prior to the commencement of the study. They would have been aware of my professional interest in practice teacher education and I believe that my genuine interest in the subject was conveyed to them both verbally and in written communication. Whilst informing participants about the nature of the research can affect their behaviour and potentially introduce bias (Bourgeault et al 2010 p.595) it was ethically appropriate to assure informed consent (Beauchamp and Childress 2001). Participants were made aware of the importance of the study via participant information sheets (appendix 2) distributed along with an invitation to participate in the study. By conveying the importance of the study and the potential benefits of participation it was anticipated that this would enhance the likelihood of gathering valid data.

3.7 Reflexivity and my position as a researcher

Reflexivity reveals how we see ourselves and how we are perceived by others and this positionality, which shifts within differing social contexts, has an effect on the process of knowledge production (Youdell 2010). Reflexivity within qualitative research acknowledges that the way in which data is collected, analysed and interpreted is significant in terms of the claims being made (Altheide and Johnson 1998 p.284). Since these claims supplant the truth and replace alternative explanations there is an obligation to interpret the words of others as accurately as possible (Pillow 2003).

Reflexivity formed a crucial part of the research process. In this study self reflexivity drew attention to the implications of my position in constructing the research aims, selecting the research settings and collecting and interpreting the data. Reflexivity was used during the interviews to focus upon developing reciprocity with participants and deconstructing my authority in the research (Pillow 2003 p.179). It was drawn upon to inform adjustments made to the interview guide throughout the data collection process and it subsequently helped me avoid forcing my ideas and theory onto the data. Memos were used throughout the study to record my ideas and thinking about concepts and how they related to each other as the research progressed. These reflective memos enabled me to observe myself and identify my own subjectivity (Peshkin 1988

p.17). I recorded how extant knowledge was drawn upon and integrated into the new data and these memos provided an audit trail of my decisions.

Researchers must be critically conscious of how self location, position and interests influence the research process (Pillow 2003). In this study it was important to be cognisant of my own personal and professional history in order to be aware of how this might impact upon the research process. This was also of importance in order to maintain the integrity of the study and to ensure transparency. Reflecting on my own experiences of practice teaching helped situate my understanding of the subject and enabled me to reflexively connect with the experiences of participants (Pillow 2003 p 183). This may offer some reassurance to the reader that the thesis is informed by my own lived experiences and thus the result is a richer and more complex insight into practice teaching than might otherwise have been achieved. I reviewed and recorded my own baseline assumptions in memos. My experience of being a practice teacher was a positive and fulfilling one and this undoubtedly influenced how I saw the role. This, together with a close professional contact with a large number of practice teachers, practice teacher students and specialist community nursing students over twenty six years has further developed my insight and baseline assumptions about the role. My belief was that practice teachers are expert practitioners and teachers, and I have witnessed over the years how they have effectively facilitated the learning of countless numbers of specialist community nursing students. My perception has been that practice teachers often struggle to meet the simultaneous demands of their caseload and their student and that the practice teaching element of the role is not valued by the employer. Over the years I have also observed how practice teachers workloads have increased through the addition of a number of competing areas of responsibility. In my view this has challenged them in fulfilling the broader remit of the practice teacher role as determined by the NMC (2008).

Key to legitimacy and validity claims is being able to understand the subject of the research. Reflexivity helped to raise my awareness of my own social identity and background and changes to my thinking as a consequence of exposure to extant literature (Dunne 2011 p.118). As a qualified nurse teacher,

course leader of a practice teacher course and health visiting / school nursing programme, and with a professional background in practice teaching and health visiting, I approached this research with pre-existing knowledge, expertise and insights into the socio-material context of health care. I have discipline specific theoretical knowledge and had undertaken a partial review of the literature. In a constructivist / naturalistic paradigm (Denzin & Lincoln 2008) knowledge is perceived to be maximised when the distance between the researcher and the participants in the study is minimised. The voices and interpretations of those under study are seen as key to understanding the phenomena of interest (Polit & Beck 2006) and pre-existing knowledge can increase the researchers sensitivity to what participants are saying, enabling them to understand the significance of what is happening in the data more quickly (Corbin and Strauss 2008 p.33). As I moved between data collection and analysis the significant issues and meanings in the data started to emerge through the interplay of my existing knowledge and the data. Sometimes this can occur at a subconscious level (Corbin and Strauss 2008 p.32) and I was therefore mindful to engage in reflexivity in order to uncover this.

3.8 Designing the interview guide

As a novice researcher, and in order to be permitted access to appropriate participants by the NHS research ethics panel an interview guide was used. This was beneficial in helping manage problems associated with the 'interviewer effect' as it standardises the interview process (Gomm 2008 p.222). Researchers face challenges, however, when trying to balance the gains in reliability that might be achieved through standardising the interview process against some potential loss of validity that may be a consequence of inflexible procedures (Cicourel 1964 p.74). The design of the interview questions was influenced by the constructivist approach (Charmaz 2006 p.130) and questions posed sought out insight into how participants viewed the role of the practice teacher. '

Using interviews to gather valid and reliable data can be problematic as both the researcher and the interview questions can be misinterpreted (Cicourel 1964 p.76). In an attempt to manage this, interview questions were grouped in

themes and subheadings were used to provide prompts where required and in order to clarify meanings, for example: how, what, why and 'could you give me an example'. This also ensured that each group of respondents were asked the same questions but it additionally made it possible to rephrase questions in order to clarify meanings and use probes to gather further detail (Parahoo 2006 p.329). This strategy reduced the potential for asking leading questions and for the respondents to pick up cues regarding what they perceived to be a desirable response. This strategy should therefore enhance the validity of the data gathered.

Whilst waiting for final NHS ethical approval a pilot interview was carried out with a practice teacher who was also a student at the University. This was useful in order to test out the interview guide, assess how long the interviews might last and also to become familiar with the digital recording equipment. It was important that the interview guide enabled collection of substantial data relevant to the aims of the study and it was important to ensure that the questions were easy to understand and not misinterpreted. The pilot interview was also helpful in providing an opportunity to practice interviewing techniques since I was a novice researcher with no experience of carrying out in-depth interviews.

The interview lasted fifty five minutes. Listening to the recorded interview afterwards I was able to reflect on my interviewing style. I had felt quite anxious to ensure that my interviewee was providing data relevant to the aims of the study and had to restrain myself from asking leading questions or interrupting. At times during the interview I felt that the discussion was drifting away from the focus of my study and I felt a sense of frustration regarding this. Upon transcribing and reflection however, I was able to identify the relevance of the data and recognised that this study is about developing new and original insights. This has taught me that I must be open to all information in order to develop a theory which has truly emerged from the data.

I recorded the pilot interview using a hand held digital recorder. This ensured a high quality recording which could be listened to repeatedly without fear of diminishing quality. Good quality sound was important in enabling me to capture

not only what participants said but also the way in which they said it. I elected to transcribe the pilot interview myself in order to be able to immerse myself in the data and to better understand what might be gained through self transcribing rather than employing someone to do it for me. Transcribing the interview took considerably longer than I anticipated however it was a valuable exercise in helping me to identify adjustments that I needed to make to my interview guide.

The pilot interview was successful in gathering some rich and detailed data which related well to the aims of the study. It became evident however, that there was insufficient data relating to examining the perceived role of the practice teacher. The interview guide for each participant group was therefore revised to address this. Supplementary questions such as *'could you give me an example of what a practice teacher's day might look like?'* were added in italics. This facilitated further probing when immediate responses were not forthcoming or where during the pilot further clarification of the meaning of responses had been required. The layout of the interview guide was also adjusted to add clarity and facilitate quicker identification of where I was up to in terms of the interview itself. Each section was more clearly spaced and headings indicating the theme of the subsequent questions were included in order to be clear to interviewees about the nature of the subject. For example one main theme heading related to preparing and supporting practice teachers. The questions in this section were focused on the preparation of practice teachers, supervision processes and the support available. Beneath these questions further probing questions were included in italics such as *'in what ways did it (the education programme) prepare you for the role'*. The aim of this was to ensure the gathering of richer explanatory data.

During concurrent data collection and analysis it was necessary to make modifications to the interview guide in order to better reflect participant's experiences (Charmaz 2006 p.29), to clarify meaning in the data and to direct the course of the interview and ask more focused questions. Version 2 of the practice teacher's interview guide (appendix 3), for example, asked *'could you tell me about the preparation that you undertook for your role as a practice teacher?'* The phrasing of this led to participants focusing on formal educational

processes rather than others factors that might have been significant for them, though I noticed that these emerged elsewhere in the data. In version 3 (appendix 3) the question was amended to *'how did you learn your role as a practice teacher?'* and this more open ended question supported participants in identifying the broader range of factors in addition to the education programme that had been significant for their learning.

How', 'what' and 'why' questions encourage participants to reflect on a phenomenon afresh and this can yield rich data (Charmaz 2006 p.33). Open ended questions were used as little was known about the subject and therefore unanticipated responses were likely. So whilst the questions were standardised the open ended nature of them enabled participants to discuss their own experiences and perceptions. One question, for example, asked *'how would you describe what practice teachers do?'* Participants were able to share their perspectives on the role and this subsequently highlighted a range of socio-material factors that influenced the role and the factors that impinged upon enactment of it. A second group of questions commenced with *'how did you learn your role as a practice teacher?'* This was followed by *'what factors stand as the most important factors influencing your learning?'* These questions were sufficiently open ended to enable participants to reflect on the broader range of factors that influenced their learning.

3.9 Data collection

Including the pilot interview a total of twenty four one to one interviews and one focus group interview with six course leaders of practice teacher and specialist community nursing programmes were conducted.

The interviews were recorded electronically and written notes were additionally taken. The interviews lasted approximately one hour and took the form of an informed participant discussion. The interview guide provided some structure to the process but also allowed flexibility so that if a respondent moved on to discuss a different aspect of the study it was possible to follow this lead without breaking the flow of the interview. This was initially quite challenging but became easier as the research progressed and interviews became more conversational.

The interviews all took place in a location selected by the participants. Students elected, in the main, to be interviewed at the University whilst practice teachers and all but one manager chose their workplace. Two interviews with students were conducted in the home environment. For convenience purposes the focus group interview was conducted following a regular meeting with participants at the same venue.

Interviews with students commenced first. This decision was made in light of the rapidly changing role expectations of the practice teachers. The Government announced in its Health Visiting Implementation Plan (DH 2011) that it would be significantly increasing in the number of health visitors nationally. This had implications for health visiting practice teachers in terms of capacity. Subsequently the NMC issued guidance regarding how this could be managed locally in terms of practice teachers overseeing more than one student, who would be managed on a day to day basis by a mentor (NMC 2011). It was therefore felt appropriate to interview practice teachers and other stakeholders once the implications of these changes became clearer. It was felt that students' perspectives were less likely to be affected by the changing context of practice.

A focus group interview with six community nurse educators from five higher education institutions in England was carried out later on in the study to test preliminary research findings. Early findings drawn from the one to one interviews with practice teachers, managers and students were used to facilitate discussion around how practice teachers learn the role. The focus group enabled participants to explore their understandings of practice teaching and of practice teacher education and generated ideas about the most effective strategies to prepare practice teachers for their role. This method benefitted from the group interactions and revealed insights which might not have emerged so readily from one-to-one interviews (Darlington and Scott 2002 p.62) and exposed areas of inconsistency and conformity (Gerrish and Lacey 2006 p.353).

The interview with the NMC representative was reluctantly conducted by telephone as logistical issues necessitated it. The setting in which interviews

are conducted and the timing of the interview can influence the quality of the data gathered (Hammersley 2008 p.100). Participants who are interviewed on the telephone have less opportunity to develop a rapport with the interviewer and this is a significant factor in relation to what participants are willing to reveal in an interview situation (Darlington and Scott 2002 p.54). In addition telephone interviews prohibit observation of non-verbal behaviour and this can limit, to some extent, confidence in the findings. On the other hand however it may make it easier for participants to respond to awkward questions when they cannot see the interviewer's reactions and interviewer effects are likely to be reduced (Cohen et al 2007 p.380). In order to mitigate the impact of these factors greater attention was paid to organising the interview at a time convenient to the participant, taking time prior to the interview to clarify any issues raised by the participant information sheet and seeking to put the participant at ease through the use of a relaxed conversational approach.

Some aspects of the interviews with the NMC representative and the UKSC Chair were not very satisfactory. In particular these participants struggled to represent the views of their respective organisations as a whole. This resulted in them tending to recite the content of policy documents rather than offering an organisational perspective. On reflection I should have realised that this would be a problem and framed my questions differently. The evident gap however between the national representation of the role (NMC 2008) and realities of practice is illuminated and this provides insights into the lack of support for the practice teacher role.

3.10 Data analysis

This study falls within an interpretivist paradigm where the researcher aims to make sense of the subjective data that has been gathered. Analysis was inductive and sought to generate new theory from an analysis of data. In inductive analysis the researcher attempts to identify patterns in the data which then become a conceptual category (Charmaz 2006 p.188) and this is in contrast to a deductive approach where the researcher seeks to test a predetermined hypothesis (Hammersley 2008 p69). It must be acknowledged however that an inductive analysis does employ deductive strategies for

example deductive code development and deductive comparison and reasoning influence subsequent theory building (Hennink 2011 p.206).

This study was undertaken by the author working independently with the support and guidance of an academic supervisor. Decisions around the aims and design of the research, the sampling, data collection and analysis strategy were unique to the study and determined by the author. These were approved by the academic supervisor and the Integrated Research Application System (IRAS) and this confers some credibility to the conduct of the study. In qualitative research there is little in the way of standardised instrumentation and thus the researcher acts as the measurement device (Miles and Huberman 1994 p. 7). Analysis is therefore not an exact science and there is no such thing as an absolute truth but rather what feels to be a logical interpretation of the data by the researcher after being immersed in it.

Analysis in this study was done through words. Words provided a vehicle to organise the data in ways that enabled the researcher to compare, contrast and identify any patterns (Miles and Huberman 1994 p. 7). The experience of practice teaching, however, differs from the words that describe the experience and there is always the potential for ambiguity, however carefully questions have been phrased and responses coded (Altheide and Johnson 1998 and Fontana and Frey 1998). There is no single reality and in order to increase confidence in the findings of this study and guard against any analytical bias which might deny an alternative explanation a range of procedures were employed in the data analysis process (Hammersley 2008 p.48) and these are outlined below.

3.10.1 Maintaining anonymity of participants

In order to maintain confidentiality and anonymity during the data analysis phase codes were assigned to each participant at the point of transcribing the raw data. These codes were known only to me and were prefixed by letters which identified the group from which the participant was drawn, for example manager codes were prefixed with 'M' and practice teacher codes were prefixed with 'PT'. The nature of focus group interviews negates assuring anonymity, however participants agreed that the shared discussion would be remain

confidential. Data storage complied with the Data Protection Act (1998). All electronic data was stored on a password protected computer and all other data was stored in a locked filing cabinet. Data will be destroyed upon completion of the study in order to comply with the Data Protection Act (1998).

3.10.2 Transcribing

A transcriber was employed to word process the data primarily in order to manage the work load and progress the study within the agreed timeframe. Verification of the accuracy of the transcriptions was made through comparison of the recording and the transcription and adding further detail where necessary. The recordings facilitated the retention of accurate records of the content of what was said and additionally the way it was said.

3.10.3 Thematic analysis

Thematic analysis was employed to interpret the data and consider possible codes and categories. Thematic analysis is a tool which is unbounded by theoretical commitments and can usefully be applied to a number of theoretical frameworks. It is particularly appropriate for use within a qualitative paradigm as it has the potential to provide a rich account of complex data (Clarke and Braun 2016). Through systematic procedures thematic analysis facilitates the generation of codes from the data which can subsequently lead to the identification of patterns or themes which extend across the interview or the wider data set. This approach is particularly appropriate where there is little existing empirical data relating to the subject as was the case in this study.

Preliminary analysis consisted of reading and rereading the paper transcripts in order to become familiar with the data and record initial ideas. The key features that initially emerged related to the diverse ways in which the dual clinical and practice teacher roles were construed and this led to an examination of literature on overlapping identities and identity complexity (Stangor et al 1992 and Roccas and Brewer 2002). In addition a range of socio-material factors appeared to be impinging upon the two roles and subjugating the practice teacher role to a subordinate position that received little recognition. Literature on socio-material theories (Fenwick and Nerland 2014) and productive systems

literature (Fuller et al 2006 and Felstead et al 2007) was thus scrutinised in order to understand the significance of factors external to the individual that are influential in terms of how roles are construed. This literature subsequently informed the data analysis and the development of codes and categories as the study progressed.

3.10.4 Coding

Coding refers to describing conceptually, in a word or two, what the researcher thinks is suggested by the data (Corbin and Strauss 2008). Data was analysed manually and initially line by line coding was undertaken. This involved naming each line of data, a strategy which Charmaz (2006 p.50) suggests enables the researcher to remain open to new ideas which might otherwise have been overlooked and enables the identification of nuances in the data. It can also reduce the risk of the researcher imposing their preconceived ideas on the data (Charmaz 2006 p.160). In this study some of the codes were more abstract than others and some came close to the words used by the participants themselves. Coding each segment of the data was valuable in extracting meaning and this approach led to the emergence of some tentative theoretical categories (Bazeley 2007 p.32). These were noted in the margins and served to spark a number of ideas which were recorded as memos to pursue further in subsequent interviews.

Participants frequently used metaphors to make sense of their experiences and researchers do the same when examining the data. Metaphors have a significant place in theory development (Miles and Huberman 1994) and in this study helped connect findings to theory. PT7, for example, described how 'the practice teacher role, as far as they're concerned (managers), comes at the bottom of the list'. The 'bottom of the list' metaphor draws attention to the perception by practice teachers that their practice teaching role was not valued by managers. The metaphor de-centred the participant and prompted analytical thought around the external factors in the environment that might be responsible for this.

It is important to recognise that the identification of themes is dependent upon something having occurred a number of times in a similar way (Miles and

Huberman 1994). We are thus counting, sometimes unconsciously, in order to determine the degree of significance. In this study, for example, all thirty participants concurred that the practice teacher role was subordinate or secondary to a clinical role and that it included supporting a specialist community nursing student. These findings prompted exploration of this phenomenon in greater depth in order to understand it better and identify nuances in the data.

As the transcripts were analysed the coded data obtained in each interview was compared with data from other interviews in order to detect commonalities and differences. This iterative process led to grouping of the data into preliminary categories which aimed at understanding the phenomenon better. Patterns in the data can intuitively feel right and thus plausible conclusions might be drawn (Miles and Huberman 1994). This intuition can lead to researchers more readily detecting confirming rather than disconfirming data. It was therefore important to employ additional tactics to ensure that any conclusions drawn were verifiable. The data was thus scrutinised to detect disconfirming as well as confirming data and this enabled consideration of other factors that might be at play influencing learning and role enactment. This strategy offered the potential to present a richer analysis of these complexities and test the conclusions drawn.

It was important to partition variables and this occurred at several points during the data analysis (Miles and Huberman 1994). Codes that had initially been categorised together were subsequently divided in order to more effectively explore their properties. In this study for example, an initial code related to reward and recognition for the practice teacher role was subsequently partitioned into codes which gave recognition to the role and those which didn't. As the analysis progressed, however, it became clear that a much more complex range of socio-material factors in the environment affected the way that the practice teacher role was recognised and rewarded and further partitioning of the data was required. A separate table was subsequently used in order to organise the data into tentative categories and subcategories. Under each category and subcategory related conceptual codes were identified, together with an indication of the source and location of it. This facilitated

subsequent ease of access to the original data source and enabled review of the data in context and comparison with what different participants were saying.

The themes were reviewed periodically as the analysis progressed in order to clarify the specific content of each category and name it in a way that was inclusive of everything in the data set. The codes and themes that emerged suggested that a range of social and material factors were at play in the environment and were perceived by participants to be shaping learning and practice teacher roles.

3.11 Selecting a theoretical framework

The research aims sought an insight into the views of participants who were knowledgeable in their field about the perceived role of the practice teacher. An approach based on grounded theory methodologies (Charmaz 2006) informed the data collection and coding scheme and was appropriate to the aims of the study since the existing body of knowledge relating to the subject was limited. As the study progressed, however, I was drawn to the socio-material literature (Fenwick and Nerland (2014) since it related well to the content of the emerging codes and categories and offered a logical approach to analysing and organising the data.

3.12 The theoretical framework – A socio-material analysis

The analysis was thus framed in the socio-material and this literature facilitated an in depth scrutiny of the interview transcripts in order to identify further evidence which could illuminate the broader range of factors influencing learning and their impact upon professional roles (Fenwick and Nerland (2014). A socio-material analysis also offered the potential to contribute to the body of theory surrounding emergent professions by analysing the liminal status of practice teachers, and the organisational factors which give rise to their position in the increasingly complex field of medical and nursing professions. Specific socio-material theories were drawn upon in order to identify concepts relevant to professional learning and offer new insights into how practice teachers learn and enact their role through social interactions and active engagement with the material context.

Socio-material theory, which is described in more detail in the literature review, proposes that learning is influenced by the network of people and systems that individuals are learning to be part of (Fenwick and Nerland 2014). Practice teachers are employed in health care organisations which are driven by targets and protocols. Fuller et al (2007) describe organisations that are structured in this way as productive systems and they discuss the impact that this culture can have on employees' experiences. Socio-material theory provided a conceptual model that could be used systematically and objectively to analyse the data gathered in a way that could illuminate the contextual factors influencing the role. It enabled the categorisation of rich data using codes drawn from socio-material theory in a way that offered the potential to provide new insights into the conditions faced by practice teachers on a day to day basis and also the broader range of socio, political and historical conditions impacting upon how they learn and enact their role (Corbin and Strauss 2008 p.231).

3.13 The contribution of identity theory

There are two concepts worthy of examination in this study. The first relates to the socio-material factors that influence what practice teachers do and this is articulated above. The second is how practice teachers respond to this. The emerging data suggested that practice teachers do have a capacity for self determination and in rereading the transcripts I was able to specifically look for data which provided insights into practice teachers self determination. Though individuals are influenced and constrained by socio-material factors in their environment they do seek to overcome these obstacles in order to achieve their goals. This self determination is an aspect of their sense of self and their sense of identity. This study therefore additionally drew on identity theory (Roccas and Brewer 2002, Stangor et al's 1992) to inform the development of codes and categories related to identity development and becoming a practice teacher and this illuminated the liminal status of practice teachers. Learning and becoming a practice teacher involves an identity shift and the transitional process creates instability as they seek mastery of their new role, negotiate role boundaries and work out a way for the dual roles to interact. Identity theory provided a conceptual framework which enabled objective analysis of these complexities. This study sought to reconcile some of the perceived tensions between identity

theory and socio-material theory that are highlighted in the literature review, in order to offer innovative and original insights into how practice teachers learn and enact their dual role.

3.14 Testing the findings

The findings from this study have been presented to a group of around thirty practice teachers and to clinicians and academics at four national and international research conferences. Feedback indicated that academics and clinicians identified with the findings, recognising also a broader relevance to clinical teaching roles in other settings.

3.15 Summary

This study used an inductive approach (Denzin & Lincoln 2008 p.32) in order to construct an insightful and incisive understanding of the range of perspectives or 'truths' about the role of the practice teacher and their educational needs. Interviews with purposively selected participants aimed towards theoretical sensitivity and some degree of transferability, but it must be acknowledged that the findings cannot be generalised to a wider population (Bowling 2002 p.188), particularly since the data was mainly gathered in one geographical region. Socio-material theory (Fenwick and Nerland 2014) influenced the way in which the data was analysed and presented and extracts of the data were subsequently selected to provide compelling evidence in response to the research aims and to support the conclusions and recommendations drawn.

3.15 Timeframe for data collection and Gantt chart

Following the pilot interview in January 2011, data was collected over a sixteen month period as shown in table 1 below. This allowed time for transcribing as the interviews progressed and the comparing of data to identify codes and themes.

Table 1: Timeframe of data collection:

Interviews	March - April 2011	May- June 2011	July - Aug 2011	Sept - Oct 2011	Nov - Dec 2011	Jan - Feb 2012	March - April 2012	May - June 2012
Students	5	3						
Practice Teachers		1	1	1	2	3	1	
Managers & others	1			1	2		1	1
Focus group (6)							1	

Table 2: Gantt chart of thesis schedule

2010	2011	2012	2013	2014	April 2015 - January 2017	2017
Literature review	Obtain NHS ethical approval & research governance	Focus group (early 2012)	Literature review	Write up research	Suspended	Complete writing up research
Design interview schedule & pilot	Data gathering / interviews / concurrent data analysis	Concurrent data analysis	Data analysis			Submit July
Submit IRAS for NHS ethics						

Chapter 4: A socio-material analysis of the factors influencing the learning and enactment of the practice teacher role

Paltridge (2002) posits that there are a range of approaches that can be taken to structuring a thesis, and in this study a pragmatic decision was made to present the findings and discussion together. The aims sought to develop new insights and build theory. As a consequence the emerging data and analysis did not fit easily into a conventional thesis format. The findings are thus organised thematically and each is presented under a chapter heading alongside an analysis its significance in relation to the aims of the study.

The literature review illuminated severe financial constraints and frequent reorganisation of health care services in the United Kingdom since the 1990s. Health care has increasingly become organised along business lines and a range of 'technologies of governmentality' such as policies, procedures, protocols and targets have become embedded in the system and these control and shape the delivery of health care. Literature on productive systems (Felstead et al 2007) was therefore examined in order to shed light on the interplay between workplace learning, the organisation of work and performance. This literature helped frame the context in which practice teachers learn and enact their dual role. Existing research on practice teachers has focused on learning that occurs in a socio-cultural context, however, practice teacher students have a limited range of immediate contextual sources to draw upon in terms of understanding the requirements of their role and there are limited opportunities for co-location of practice teachers. The review therefore turned to an examination of the literature which focuses on the socio-material aspects of the workplace and their significance for shaping learning and practitioner roles.

This chapter draws upon insights from socio-material literature to provide a theoretical framework to support an analysis of the factors influencing how practice teachers learn and enact their role and manage their dual identity. The analysis includes an examination of the tangled web of human interactions in the workplace and the material features, including technologies of

governmentality, which are influential in shaping the learning and professional identity of practice teachers.

In this study there was evidence that whilst work structures shaped individual practice teacher roles, practice teachers believed that to some extent they could shape work processes and structures. The starting point of the analysis thus drew on identity theory to explore identity development. Further into the analysis it was blended with the socio-material literature in order to provide a framework which could explain the forces shaping identity and offer new and original insights into practice teachers capacity for self determination.

4.1 A dual identity

It was noted in the literature review that practice teachers belong to that category of occupations where there is a dual role identity similar to teacher education and social work education. According Orr (2009) it is common for one category to be dominant over another and this was reflected in the responses of participants in this study. All participants concurred that the practice teacher role was subordinate or secondary to a clinical role and this was often aligned to additional leadership and management responsibilities. The secondary nature of the role limits the symbolic capital attached to the role and this affects the extent to which the role can maintain itself and achieve recognition. This is reflected in the findings of this study which revealed that the practice teacher element of the role was less stable and appeared to be more prone to being enhanced or diminished depending upon a range of socio material factors and the political and economic climate.

Practice teachers' dual roles were found to be assembled in different ways as a consequence of local organisational structures and discipline specific clinical priorities. Ten (including the pilot interview) practice teachers participated in this study and all were paid at a band 7. All four district nurse practice teachers (PT4, PT5, PT7, PT8) and both school nurse practice teachers (PT1, PT6) managed a clinical caseload and a team of staff in addition to their practice teaching responsibilities. All four health visitor practice teachers (PT2, PT3, PT9, PT10) managed a clinical caseload and were involved in supporting an increased number of students in order to achieve government targets to

increase the health visiting workforce numbers (DH 2011). One of these health visitor practice teachers (PT3) also had a clinical leadership role in addition to her clinical caseload, and another (PT10) had a role coordinating placement learning for nursing students in the organisation.

District nurses and school nurses typically lead skill mixed teams and it is therefore inevitable that there will be operational management responsibilities aligned to their role. Health visitors on the other hand have traditionally worked autonomously alongside peers with minimal skill mix apparent in teams. The evidence suggested that the different ways in which their roles were assembled affected their professional identity. District nurse and school nurse practice teachers tended to refer to their responsibilities for managing a team as their primary role. *'I'm a district nursing sister... I manage a district nursing team...I'm also a practice work teacher'* (PT8). PT7 stated *'I'm a district nurse team leader and added on to that I also have a role as a practice teacher'*. She described her role as leading a team, managing rotas, workload allocation and appraising staff as well as patient care responsibilities and audits for the Trust. PT1, a school nurse stated *'I manage a team of eleven people, so I'm responsible for day to day practice issues...of a school nursing team...I do have some caseload responsibility ...and still have one student'*. Health visitors tended to refer to their clinical role as their primary identity. *I'm just a practitioner as part of the team. I certainly don't big myself up as a practice teacher ...I'm a health visitor fundamentally. I see the practice teacher as an additional role* (PT9). PT3 however was the exception to this, she explained *'I'm a health visitor and a clinical lead....part of my caseload is I am a clinical practice teacher'*. PT3 described how her practice teaching role related primarily to planning the learning, teaching and assessing her assigned student alongside her caseload work which she undertook in half of her week.

4.2 Managing the dual role

Juggling the dual role of practitioner and teacher is a struggle for practice teachers (Carr and Gidman 2012), and this challenge is common to other dual clinical and teaching roles both in the UK and abroad (Manias and Aitken 2005). Clinical priorities impinge upon practice teaching roles which rarely have

allocated protected time (Haydock et al 2011). Students observed how the full time clinical and management priorities impinged upon the practice teacher role. ST5 (district nurse student) explained *'My practice teacher was running a caseload on top. So their day would actually be come in and the first priority wouldn't probably be me ... it would be to the team making sure service needs are met ... so it would be split her management, her team and in between would be doing and looking after me'*. ST8 stated *'She's doing a normal role (health visitor), obviously on top of that being a practice teacher'*. ST4 explained *'It's (a practice teachers day) no different to any other health visitors, there's just like general, like health visiting contacts in the diary. It's more towards 100% caseload plus fitting in everything else around it'*. ST1 explained how *'Most of them are team leaders as well as practice teachers ... managing staff, year budgets'*. *'Being expected to do a full time job of a district nurse and have a student on top'* (ST1). This evidence suggests clinical roles are perceived by the students to be a full time occupation and that the practice teacher role is extra to this. Students perceived that clinical priorities took precedence over the teaching role and it is likely that this relates to the context of practice where achievement of health care outcomes is the core business. Students appeared to accept this secondary position and were willing to be flexible on how their learning needs were met and this may reflect their existing insights into NHS care gained through their nursing careers.

Students described how practice teachers attempted to manage the dual role by sometimes integrating the roles and at other times segmenting them. *'She tries to arrange things (clinical activities) that would be of benefit to me. We fit in my practice days with her (caseload) or my learning needs really, so we kill two birds with one stone'* (ST7) and ST8 described how her practice teacher set aside *'a lot of protected time to go through what we had done'*. ST2 described how her practice teacher juggled the two roles *'she'd probably set the student on the way so she could go off and do her work but being available for the student'* (ST2).

Practice teachers comments reflected the pressure on individual practice teachers to accommodate the practice teaching role on top of clinical and managerial responsibilities. PT4 explained that *'you only have to have 25%*

clinical ...it's making sure that when your student is with you, you do more clinical time on that day' (PT4). PT8 described how she created space for her teaching role. *'It's up to us to make adjustments within our own team so that I've got space for the student'* (PT8). These examples suggest that the time taken to support the student was allocated to the individual practice teacher and it was taken for granted by the organisation that this would be accommodated.

4.3 Supporting the specialist community nursing student

This study found that there was a shared understanding across all participants that the practice teacher role included supporting the specialist community nursing student. The NMC representative (NMC1) explained that being a good practice teacher is *'all about giving the student time'* (NMC1) and *'it's a more sort of professional relationship with somebody who is looking to sort of extend their practice'* (NMC1). This would indicate that the focus here is about meeting the individual student's needs and this reflects the dominance of this aspect of the role in the NMC standards for practice teachers (NMC 2008).

Nurse educators emphasised the teaching and assessing aspects of the practice teacher role and described how *'they are translating the theory into the practice demonstrating practice for students and helping them to put their new skills into practice and supervise them ... they are continually assessing and they're having to do all that facilitating and actually also having to be the assessor'*. (FG)

Managers described how practice teachers were *'vital to the organisation ... supporting nurses to go on and do a specialist practitioner course'* (M2). The role was described as being about teaching and facilitating learning (M4, M2, M3), relating theory to practice (M4, M3) and making sure that they are fit to practice (M1). *'It's about exploring both sort of clinical and non clinical issues, using a CPT, as a ... 'safe pair of hands' (for the student) to explore those issues, grow as a professional'* (M4) and become a self reliant autonomous practitioner (M3). Managers described the role as one of nurturing the student through an intense one to one relationship (M1, M2, M1) and explained how *'the student / CPT relationship has to be initially sort of a daily full working together immersion'* (M4), *'giving them the tools of the trade'* (M1). This evidence

emphasises the significance of the one to one teaching element of the practice teacher role with the student and this teaching role was described as being a longer term arrangement at a more advanced level than that required for pre-registration students.

All students concurred that the practice teacher role included supporting students, for example ST4 explained, *'They're there to support students ... to assess what you're doing along the way. To help you gain an understanding (of) what your role should be'*. ST1 described the practice teacher role mostly in terms of the responsibility towards supporting the needs of specialist community nursing students. *'They need to sort of be able to identify where I need to build on things ... I think the practice teacher is much more about developing you'*. ST2 described her understanding of the practice teacher role primarily focusing on supporting the individual health visiting student. *'Practice teachers have 2 roles as I see, one mainly sort of like a mentor ... and then the other part of their role ... assessing practice and making sure you're fit for purpose'*. ST8 and ST7 gave examples of how the practice teacher role modeled practice and facilitated learning. *'She's showing me best practice ... she identifies my learning needs along with me ...she'll try and arrange things that can match identified needs'* (ST8).

PT1 described her practice teacher role as one which focused on the education and support needs of an assigned school nursing student. Similarly PT9 explained *'I see my responsibilities as a practice teacher are to go through the clinical aspects of delivering the health visiting service and preparing the students to be able to undertake visits ... getting them up to a level where they're fit for practice'* and *'you have to plan things and you have to make sure that you've got a variety of stuff on the day to show your student (PT9). It's a much more intense in terms of your relationship ... and also ultimately I'm responsible for signing them off (PT9)*. Embedded within these quotations there is evidence of the significant amount of responsibility and emotional labour that is invested in supporting the specialist community nursing student, some of which goes unrecognised.

4.4 Lack of other disciplinary distinctive features of the practice teacher role

This study found that whilst it was commonly understood that the practice teacher role included supporting a specialist community nursing student, other disciplinary distinctive features were difficult to define and there was ambiguity about the role (PT2). NMC1 indicated that anything above a caseload and supporting a specialist community nursing student tended to be locally determined *'I suspect there are teaching commitments ...perhaps they work on projects for their local Trust'*. Disciplinary distinctiveness according to Young and Muller (2014) is important for the survival and development of the profession and strong, yet permeable boundaries need to be established in order to secure this. The evidence in this study suggests that practice teachers have struggled to establish an unambiguous professional identity and clear role boundaries. Practice teaching roles were found to vary across organisations and disciplines and this created difficulties for practice teachers in establishing a group based identity.

The managers that were interviewed recognised that practice teachers did not view their role in the same way as one another and acknowledged that there were variations in the responsibilities aligned to the role. *'I think they probably all view it (the practice teacher role) quite differently'* (M1). *'Some have got (an) extra role like breast feeding ... or screening leaders'* (M1). M3 described it as a leadership role but acknowledged that they were not a homogenous group. *'The team leaders for school nursing are in practice at the moment for 50% of their time, as well as team leading, as well as CPTing ... In health visiting that isn't the same, you do have some team leaders who are CPT's but not many but you do then have CPT's who are band 7 for that role but had they not have been a band 7 in that role they would be a band 6 in a caseload'* (M3). M4 described how district nurses had more opportunity to manage a team because of the greater degree of skill mix in the district nursing service compared to the health visiting service where practitioners worked in a more autonomous role with less opportunity to develop the skills required to lead and manage people. M2 described how school nurses, similarly to district nurses, had team leadership responsibilities but in addition she described how *'they contribute more than do other school nurses to things like writing of standards'* (M2).

Students also recognised that there were a differing range of responsibilities aligned to the practice teacher role and that practice teachers were often contending with a number of competing priorities. ST1 explained that *'They have a very busy (district nurse) caseload and they have their own team of staff that they have to manage and the Practice Teacher (role) is sort of on top'*. ST6 (school nurse student) described how *'My practice teacher ... it was quite a senior role because she was a coordinator, so not only did she have the team to manage, she was on the coordinators meeting as well, so it might be an area to manage ... she was also leading in practice, so being on university forums on the academic side ... juggling numerous things from clinical practice ... and if the students on placement that day how ... they are going to oversee their workload as well'*. ST4 (health visitor student) concurred recognising that her practice teacher was managing a number of competing priorities ... *'I know she attends a lot of meetings ... she's involved in a lot of things within the Trust ... she's on lots of committees and I know she was involved with the KSF (Knowledge & Skills Framework) ... and she does teaching as well, the staff nurses ... she does all like a day teaching and she teaches immunisation and things like that as well'* (ST4). ST7 (school nurse student) described how practice teachers in her area who were all *'Team leaders ... have portfolios ... areas of responsibility ... like hers was risk management'* (ST7) and ST1 (district nurse student) described how her practice teacher had a role in supporting the continuing professional development of her team. *'My practice teacher (goes) on the course (in service training) and then she will arrange times to teach the rest of the team rather than the whole team going on the course'* (ST1).

PT9, a health visitor, stated that the practice teacher role is perceived in a diverse range of ways by practice teachers themselves in her organisation. *'We have a lot of CPT's (practice teachers) in this organisation and I think people do practice very differently ... I don't think the organisation uses its CPT's, from my point of view, enough to do more of the leadership and change management stuff'* (PT9). This would suggest that while she perceives herself to have a leadership role this is not necessarily so for all health visiting practice teachers in the organisation. It also indicates some frustration that the organisation is not

making the best use of the leadership skills of practice teachers, indeed she goes on to state that the organisations expectations of the practice teacher only relate to supporting students *'that we produce highly skilled well trained students'* (PT9). PT3 described her aspirations for the role. *'We're looking at (practice teachers) being involved in developing pathways and we're there to see how that impacts on practice ... so it's not management of staff ... it should be about support, quality and looking at delivering good practice'*. PT2 also described how practice teachers in her organisation were reviewing their role *'we realised that we were each doing individual things and we weren't getting together and discussing it ... so it was a good opportunity to sort of say 'this is what needs doing, who's best to do it and who's best placed'*. The recognition by practice teachers themselves of the ambiguity of their position is evident in this data extract. These individuals occupy a liminal socio-cultural space and appear to be grappling with a sense of how they believe the role ought to be enacted. The responsibilities aligned to the practice teacher role, beyond supporting the specialist community nursing student, evidently differ within and across organisations and disciplines. This has resulted in a lack of disciplinary distinctive features of the practice teacher role. The mediating factors contributing towards this are explored in the following analysis.

4.5 A Socio-material analysis of learning the role

As noted in the introduction to this thesis, whilst practice teachers have a defined status in policy (NMC 2008) they differ in terms of some of the other characteristics normally associated with professions. Professions have traditionally been characterised by the possession of a body of expert specialised knowledge (Carr-Saunders and Wilson 1933) and for practice teachers the emphasis has been on supporting learning and on practice itself. Factors that distinguish the practice teacher role from others are difficult to isolate since it is undertaken in addition to a clinical role. In this study no common core practices relating to the role other than their one to one role supporting a specialist community nursing student were identified.

Fuller et al (2007) contend that productive systems can bring about diverse forms of knowledge creation and use. Some of the approaches to learning are drawn upon to benefit the employee and the organisation however others are subsumed and embedded in everyday work activity. A useful way of analysing the factors that influence the professional learning of practice teachers and how they understand their role is to consider it from a socio-material perspective (Fenwick and Nerland 2014). As described in the literature review socio-material approaches to professional learning contend that learning is inseparable from professional practice and individuals are learning to be part of a network of people, practices and protocols. A socio-material approach seeks to understand knowledge production, recognising that it is complex, situated and local. This view challenges the assumption that learning needs can be specified in advance and delivered through a course (Hopwood et al 2016) and it has the potential to offer new insights into how practitioner roles are learned and shaped. A socio-material approach (Fenwick and Nerland 2014) would suggest that learning the role in the practice setting gives student practice teachers the opportunity to perform the new role whilst still in the process of becoming a practice teacher. They experience professional practice and the feelings associated with it and they physically practice the technical skills associated with the role in order to achieve a higher level of performance. Fenwick and Nerland (2014) describe a 'tangled web' of relations that can be brought in to play to facilitate learning and suggest that learning is influenced by

what those systems and people allow it to be. Fenwick et al (2012 p6) acknowledge that human knowledge and learning is embedded in material action and interaction and recognise the importance of considering how these tools, technologies and objects of practice are intertwined with human aspects. For practice teachers work life is entangled with clinical practice in a diverse range of settings, working in teams but often in isolation and this experience is significant in constructing and shaping their professional identity. In their dual role as clinicians they work within systems, and are governed by targets, guidelines and protocols which constrain clinical autonomy. They use a range of technologies to share knowledge, provide client care and interact with multi-disciplinary colleagues and this in turn informs the learning of their students. Material features of the practice teacher role are more difficult to identify and the role is not prescribed to the same extent as the clinical role in texts or protocols. This may be significant in understanding the subordinate or secondary status of the role and could also be a factor influencing how practice teachers learn and enact their role. This is explored in the analysis.

A socio-material approach facilitates examination of how things have come to be as they are taking account of historically developed rules and connections in addition to the cultural norms of the environment (Arnseth 2008). This study identified that a number of socio-material factors influenced how the role of the practice teacher was construed. Drawing on theories described in the literature review that examine the socio-material, the following section presents empirical illustrations grounded in interview data which provide insights into how the social and material environment assembles to enable or constrain practice teacher enactment of their roles and how they learn their roles.

4.5.1 The work context

As discussed in the literature review the NHS has increasingly become characterised by policies, procedures, protocols and targets which standardise work practices in order to maximise efficiency and contain costs. The context of this research and the data that has emerged can thus be usefully framed and analysed using literature on productive systems. Every work role occupies a place in a productive system, whether the output is a service or a product.

Productive systems differ in the way work is organised and the degree to which various work roles and practices are prescribed (Fuller et al 2006 and Felstead et al 2007). By prescribing and standardising a role organisations can better predict what the outcomes will be. Training supports this and enables the standardised provision of services or products. Felstead et al (2007 p.191), liken this training to 'working according to script' and suggest that it is the script writers that retain possession of the specialist knowledge. The overall aim of this is to maximise efficiency in order to be able to compete effectively in the open market. Research into productive systems (Fuller et al 2006 and Felstead et al 2007) has examined the impact of this and suggest that occupants of roles that are prescribed in more detail have less autonomy to make professional judgements for example in relation to planning their own work priorities and this was examined in the analysis.

Professional identity is not static but develops and redevelops throughout the individual's professional career, mediated by the socio-material features of their environment and these have consequences for their status (Johnson et al 2012). A significant factor referred to by the range of stakeholder groups in all three community nursing disciplines represented in this study was around how economic and political factors created instability and impinged upon how the practice teacher role was construed. Major financial constraints were an important factor influencing practitioner work roles during the period that this study took place. M1 stated '*I think some of the economic crisis has impacted a little bit on workloads and how people can juggle all those balls*' (M1). The NHS was tasked to make £20 billion of efficiency saving between 2010 and 2014 (Department of Health 2010a) and this led to changes in band 7 positions. Job cuts, increased workloads and staffing shortages together with a reluctance to train more practice teachers because of the financial implications were reported during this time (PT2 and PT1).

A number of practice teachers commented on how financial pressures impacted upon job security. Both PT3 and PT7 described changing roles and job cuts. PT7 described how they were re-interviewed for their practice teacher posts in order to reduce the number of practice teachers because of financial cutbacks and PT3 stated '*There were twenty one of us (practice teachers) ... I think*

we've got nine across the city now and the job was created as a leadership role'. PT2 and PT8 described feelings of insecurity 'I think there ... was the feeling that ... we were an expensive commodity' (PT2) and describing how there were 'less students coming through so the necessity for having us, you know, and do they need so many of us' (PT8). This would suggest that economic factors were creating role instability and putting pressure on employers to redefine roles.

This study provides evidence to suggest that declining workforce numbers, which were a consequence of economic and political constraints, have led to practice teachers carrying increasingly large caseloads. There was evidence that they juggled a number of competing demands in an environment with no protected time, for most, to undertake their practice teaching remit. In addition to caseload responsibilities and providing practice education for one or more students, practice teachers were often expected to take on operational management duties, leadership roles and other specialist roles. As noted in the literature review, these incompatible caring and efficiency demands challenge nurses to redefine their professional roles and identities (Kirpal 2004). PT9 states *'I know quite a few CPT's did projects in the past but I think because the health visiting service has been in such a crisis that the CPT's have fundamentally been trying to deliver the service as well as train up the students (PT9). PT6 laments 'I think we haven't been able to develop the role as we anticipated ... in school nursing ... we have such massive caseloads and we've had two students ... We've been pulled back into practice a 100% of the time and the practice teacher part is on top ... it was a management decision because staffing levels were low (PT6). PT1 described 'major financial cuts in our service..... our service (school nursing) used to be very wide and very varied... and now because capacity is at a level that it is we're very much focused on safeguarding issues rather than the public health agenda' (PT1).*

Managers also described how economic pressures were impacting upon health care services and practice teacher roles. M4 described how financial constraints had impacted on district nurse training over the years *'I've also previously experienced as possibly within district nursing now, not a complete moratorium on district nurse training but as a slowdown of the amount of*

numbers....I feel that certainly in district nursing it sort of has been a bit of a rollercoaster, ... in 1991... the need for newly qualified district nurses was possibly at that time at it's all time low due to the previous financial recession and the political field at the time ...but then that picked up again and more district nurses were required' (M4). In district nursing the number of students fluctuated as a consequence of economic constraints and therefore some district nurse practice teachers had only limited opportunity to enact their role. This data suggests that the practitioner roles were being severely constrained by political and economic pressures and this had consequences for how practitioner and practice teacher roles were construed. PT 9 however, indicated that *'over the last year obviously things are moving forward in the organisation and so the CPT's had been asked to do more'* (PT9). This related to the Health Visitor Implementation Plan (DH 2011) which required practice teachers to take responsibility for training a much larger number of health visiting students in order to expand the health visiting workforce as well as support the existing staff to deliver a new and enhanced model of service. Managers recognised the pressures on the workforce and the need to provide practice teachers with the time to teach however the evidence suggests that competing clinical priorities impinged upon this. M2 states *'I certainly think that in this organisation, you know, there's a commitment to providing practice teachers with the space that they need to practice teach, but you know that's always within the constraints of actually what then comes along and hits you'* (M2). M3's response identifies similar pressures *'We'd like to recognise that (excessive workload) but given the resources we have at the moment with hand on heart I can't say there is (any reduction in workload) because we just haven't got the resources to allow that'* (M3).

4.5.2 Practice teachers' own professional histories

The essential nature of an individual, their beliefs and their feelings form as they grow and are shaped by the society and culture in which they are immersed (Blunden 2007). As such, in addition to the social and material context, the historical context is significant for learning as activities are mediated by rules developed historically (Arnseth 2008). Cultural Historical Activity Theory (CHAT) proposes that cultural behaviours and associations are accumulated

and passed on over time (Arnseth 2008 and Blunden 2007). This study found that practice teachers used artefacts inherited from the past to develop insights into the role to shape their own work practices. Practice teachers described how their learning was built on their mentoring experience, *'even before (I was) a practice teacher when I worked as a ward sister, I used to teach the students then and the nurses on the ward. So I always had an interest in that side of nursing'* (PT5). More notably, however, the evidence suggests that historical role models were significant in terms of learning and enactment of their role and these predominantly related to role models drawn from their experiences of being a specialist community nursing student. In this study several practice teachers, representing all three of the disciplines included in the study (PT1, PT2, PT3, PT4, PT5, PT6), described drawing on a number of historical reference points to inform their learning and enactment of the practice teacher role. These experiences were both positive and negative and related to their skills, expertise and behaviours. PT1 described how she emulated her practice teacher *'I think I try to mirror the way that I am a practice teacher the way that my practice teacher was with me because she was really calm ... she let me go off and do my own thing but the support was there should I need it'*. Similarly PT3 described the influence of her practice teacher in shaping her own practice *'I suppose you tend to mirror your role models don't you and I had an excellent, excellent practice teacher and more than anything she gave me her time and she never made me feel stupid.....she was really on the ball and she was motivated in what she did' ... so I suppose I try to emulate her as much as possible*. PT2 also discussed the significance of her own experiences as a student in shaping her practice *'She was there with a deep passion to get me through that course and make it a good experience and I think that's what I try to do*. PT4 explained how her practice teacher had shaped the way she worked. *'She was enthusiastic, she was up to date, constantly reading new research and I think that got me in the mind set of 'This is the way we need to go' and learning from that ... she's set time aside no matter what was going on in the caseload'* (PT4). PT6 described how her aspirations for her role were driven by observing other practice teachers in addition to her own experiences of being a student.

Negative experiences of being a learner were also significant for practice teachers in shaping their roles, for example PT5 described how *'I didn't get very well supported and just left to get on with it and it just made me think 'I'm not going to do that to anyone else'* and PT2 explained how *'It's the negative one's that spring to mind to be honest... she left me in this corridor and I felt silly, I felt stupid.....and I think it's about learning from those things that you make sure that doesn't happen to a student'*.

Nurse educators' comments triangulated well with the above findings. They described how *'their (practice teacher students) experiences ... as a student probably influences (them) ... they learn through experience and reflecting on that ... it can be negative or positive ... it was like a baptism of fire ... but I remember thinking 'if I ever have a student will never do this to them'* (FG).

4.5.3 Formal education

Education is critical to nurses' professional identity, because it is through education that they can become professionals (Johnson et al 2012). In addition it provides symbolic attachment to the role. Practice teachers suggested that their formal education made an important contribution to preparing them for the role. Practice teachers valued the focus on teaching and learning theories and strategies and how they should assess students *'looking at theories of learning ... adult learning ... we did the assessment of the student...how to manage failing students ... all that was really good'* (PT9). PT3 explained how their assignments forced them to reflect on their practice and *'unpick some of the theory behind what I was doing'* (PT3). PT9 explained *'I think it (my educational preparation) prepared me quite well... it gave me a refreshed insight into supporting a student... and it deepened my knowledge of what makes a good teacher'* (PT9). PT6 commented positively about how the course inspired and challenged her. *'I think it was coming back into education (that prepared me)... I think because that inspires you, I think it challenges you ...when I come into University and I'm doing the course I certainly feel more inspired and like I have more knowledge'* (PT6). PT8 described how the course, in addition to her clinical expertise were important in preparing her for the role. *'I suppose I learnt on the course really... trying to help you see how you're meant to help your*

student to learn etc. of course all learning helps you develop yourself....so I think with the academic thing alongside with my idea that I'd finally realised 'yes I could do this'.... because I had so much practical knowledge... so I think the back up of the course to support me... and how to help this student'.

Nurse educators discussed the content of the practice teacher programmes at their respective institutions which were situated across England. The evidence revealed that programme content tended to focus on the practice teachers one to one role supporting their specialist community nursing student rather than including an additional focus which acknowledged the broader range of responsibilities often aligned to practice teacher roles. *'Well we obviously do teaching theory and we talk about different learning styles and we talk about responsibility and accountability as a practice teacher. We look at students with educational needs and requirements and we look at students, failing students ... how they would handle that'* (FG). Nurse educators described how *'The course, I'm sure we all think, prepares them quite well I think, it's that transference of knowledge, isn't it, to the student which is so important and that flexibility in being able to assess your student and what their learning needs are'* (FG). *'I mean they're all expert health visitors, mentors ... (the) difference is that the practice teacher has done the course ... to enable them to actually impart that knowledge to the students ... I think it's that extra knowledge that enables them to transfer their expertise successfully to the student ... that defines a mentor from a practice teacher'* (FG). This focus on the one to one teaching element of their role is likely to influence how practice teachers learn and enact their role but it also has the potential to create tensions where the reality of what is expected in practice differs from how they understand it.

A socio-material perspective (Fenwick et al 2012), contends that formal education processes, where learning is detached from the context of practice, are insufficient in preparing practitioners for the complexities of learning to be part of a network of people and systems in clinical practice. This reflects the perspectives of PT7 and PT3. *'Well I went to UniversityI enjoyed it but I actually feel that afterwards, what now, you know what am I supposed to do now with a student?'* (PT7). *It (the course) was very much about learning styles, you know, sort of theory and practice rather than 'Ok, what' it actually*

like when they're out there doing the job? (PT3). In addition nurse educators described how practice teacher students asked *'yes but what do I do when I've got my ... how do I do it in the first instance with a student, and you know, what exactly have I got to do with this student when they walk through the door ... they want a sort of handbook don't they? ... yes and I don't often think we are able to do that and I suppose as HEI's as well it's our role but it sometimes isn't one that's totally addressed* (FG). These comments suggest that whilst an education programme can provide the knowledge to underpin teaching and learning in clinical practice, student practice teachers feel unprepared for the realities of practice and need support in developing their professional identity. It is also of significance that all quotes relate to supporting a specialist community nursing student, with no mention of the additional responsibilities often aligned to the role by employers.

In common with Whitehead et al (2017) who examined findings of absence, this study found an absence of a material infrastructure in the practice area to support new practice teachers in preparing for the role. Several practice teachers described how they had felt inadequately prepared for the role as they had been required to support a student whilst learning to become a practice teacher themselves and studying the taught course. PT6, PT8 and PT9 discussed how preparatory work prior to taking a student and starting the practice teacher course would have been beneficial to them. Practice teachers described how some prior knowledge regarding what the role entailed and the study commitments would have been helpful for them as it was challenging to manage their own as well as their student's learning. *'I probably would have got a little bit more knowledge about it and I probably would have, in hindsight, when I started the course, prepared myself and been more structured'* (PT6). M3's comments concurred *'I think there's some preparatory work before you get the student, so maybe some work needs to start before the student arrives so you have some basics ... maybe attaching themselves for some time or a short time to another CPT (practice teacher)'* (M3). PT1 and PT9 also described how a lack of preparation time prior to their student starting was problematic. *'There wasn't a great deal of preparation time it was like this is what I'm doing and I needed to get on with it'* (PT1). This would suggest that insufficient forward

planning went into determining the number of practice teachers required in the organisation at any given time and determining what support needs new practice teachers might have. The evidence suggests that student practice teachers feel unprepared and find it challenging to support students when they themselves are learners however the data below indicates that it is highly significant for their own learning.

4.5.4 Interaction with students

An understanding of practice teaching would be incomplete without a focus on the relationship between the practice teacher and the student since the interrelationship between the two mediates activity (Arnseth 2008). Materialities, according to Mulcahy (2013), acknowledge the contribution of concrete physical practices in knowledge production. The student represents the material artefact (Arnseth 2008) and the purpose for which the role was designed and thus provides the opportunity for the practice teacher to try out her teaching skills. Interacting with a student through doing the job of a practice teacher whilst learning the role, was significant for practice teachers. *'It was a massive learning thing for me (having a student) because I at the time was doing my CPT course, but I sort of think we did ok'* (PT1). PT1 stated that *'although I found it tricky I think it probably is key that you need to have a student whilst you're undertaking the course'*. PT2 concurred, describing how undertaking the practice teacher role with her student was significant for learning. She stated *'I think the main thing to me really was ... putting it into practice ... having a student and being supported (by the course team) about having that student'*. When describing how she learned to be a practice teacher PT3 stated *'we only had three study days...we learnt on the job really I learnt with my student'*. PT5 described how she evaluated the effectiveness of her teaching through *'feedback from the student asking them how did they feel when they were in the patients home, what did they learn'*. PT2 described the importance of receiving feedback from her student following a learning experience where the student had been encouraged and supported to problem solve herself. *'She came and said, 'that was such a great learning experience and I'm glad you didn't answer it all for me because people have been doing that in the office for me recently'*. This would suggest that the feedback enabled

the practice teacher to evaluate the approach she had used to teaching the student and it is likely that this will impact upon her future enactment of the role.

Nurse educators too described how taking a student contributed to learning the role. *'practice teacher students have been really excited about really looking at the students learning needs, because they've got to examine that in their portfolio and we've had good feedback from the students about the fact that they're engaged in learning and learning how to support the student'* (FG).

It is likely that learning and enactment of the role is influenced by specialist community nursing student expectations. Understandably students' expectations were focused around meeting their specific learning needs for example ST2 described the importance of establishing a good relationship. *'The main thing is the fact that you're with the practice teacher for the whole placement ... so I think getting that relationship right and understanding each other is much more important.'* Students expected that their practice teacher should have maintained her clinical expertise and that she was up to date with the broader political context of health care, *'keeping up their skills and things but you know like policies'* (ST1), *'Keeping abreast of their own learning ... and being able to use that information then to guide the student'* (ST6). They expected that *'mentorship would be their primary role'* (ST6) and that *'they're there to teach students ... the practical side ... they're there to assess students and see where they're at in their training ...and also teach them everything from the background of their role to ...things that are changing currently in practice'* (ST3). Students expected that their practice teacher should have *'Knowledge of what the course is about'* (ST5) and *'what the students are learning academically'* (ST3). Students described their expectations of the support that they should receive from their practice teacher. *'You'd expect them to be supportive, ... if a student's suffering personally, if they've got personal issues, well they might be struggling academically as well, so they need the whole support, it's not just about the academic support'* (ST7).

Students observed, questioned and challenged their practice teachers. *'In clinic ... she had a really good way of diffusing situations and I would sort of look and quickly think 'well how's she handled...'* and would then go to her and say *'look,*

you know, I've just observed how you dealt with that. How come you were quite strict?' (ST2). ST8 describes 'I would go out and shadow her on visits, so she's showing me the best practice' and ST6 described modelling the observed behaviour of her practice teacher. Looking at what they do and do well ...I would model some of that behaviour (ST6). Being observed and acting as a role model for students influences how practice teachers enact their clinical role. For example PT1 described how 'being a practice teacher makes you a better practitioner because you have to be. Because you need to be current ... when somebody observes me I want to do a good job', and PT4 described how 'you're there to be an influence and it's practice what you preach, you know. You've to set a precedence for your team and you've to sort of instil that on your student as well you know. Lead by example and that's how I went with her'.

The interactions with their designated student were particularly significant for practice teachers and influenced how they learned and enacted the role. A number of practice teachers described how their clinical and teaching roles were advanced through learning from the student and requesting feedback from the student. PT4 described how her clinical expertise was advanced through her interactions with the student. *'I would look at what skills they need and then find a patient that would probably match and then go out and go through the assessment tool myself, then probably once we were back in the car, just sit and discuss that patient'. Would they have asked anything differently?... How did they feel about the situation? Was there anything that they noticed? ... because you know I can learn from the student (PT4).* PT9 described how having a student helped her keep up to date clinically. She states *'I'm always saying to the students 'if you learn anything new please tell me because I can't read everything' and when you're in practice sometimes it's hard to keep up to date and I think having a student helps you to do that (PT9).* PT5 stated *'it's two ways, you learn from students, different information different things'.* This would suggest that the practice teachers recognise that maintaining clinical expertise is key for supporting practice learning.

Students too commented on the bi-directional nature of the learning. *'I feel it's a bit more on a level... working with them ... they do teach me but ... we both sort of teach each other, she learns a lot from me you know' (ST1). 'they see it as a*

two way process as like a mature student, they learn from us as much as we learn (from them) ... and I think that's a good attitude to have, we've all got something to learn ... I ought to give them a medal really' (ST7).

PT1 described the advancement of her practice teaching skills, picking up on cues from the student *'it's about ... taking some hints from your student. I think if you were doing anything majorly wrong with them you would hope that you would pick up on it'*. PT6 describes seeking out feedback from her student *'we were learning together and for me that was very beneficial because I could actually say to her 'I am just learning so if it's not working or whatever, tell me because I don't know'*. These comments imply that the practice teacher is almost 'feeling her way' in her role and testing out her practice teaching skills through doing the job.

The attitude and motivations of the student also appeared to affect how practice teachers enacted their role. PT4 stated *'if they're (the student) motivated you're more motivated to teach them'*. PT4 stated *'they've (the student) got to know what they want to learn ... they may need to do a teaching so you'd plan to give them time to sort out what subject they need to know, help them find the resources for it and then set time aside with other team members, encouraging them to be part of it so they pass their learning on'*. Practice teachers described the intrinsic rewards of supporting a student. *'I don't think they (HV colleagues) realised how invigorating it was (to have a student in the office) (PT3). 'I think it's really fulfilling and rewarding when you see your student then go on to manage a team and they're successfully managing the team it's nice (PT4).*

The absence of opportunity to physically practice in the role was identified by some participants as having important implications for learning of the role, and this was particularly the case for district nurse practice teachers during the period of data collection. PT4 described how opportunities to enact the role were constrained by low student numbers, *'we've so many practice teachers now and not a lot of students coming through, they're rotating them'*. Not only does the absence of opportunity to physically practice in the role affect learning it also impinges upon identity development and as a consequence it is likely that they will continue to rely on their prior clinical or managerial identity (Pratt et al

2006). In this study some practice teachers describe their role in terms of their clinical and managerial responsibilities, failing to mention the practice teacher remit at all.

4.5.5 Interactions with peers

Practice teacher participants discussed the significance of peers in terms of influencing their learning and enactment of the practice teacher role. A relational materialist analysis (Mulcahy 2013) suggests that transfer and learning is ontologically variable and in this study it was evident that whilst for some practice teachers peer networks and peer supervision were successful, for others it was less so.

Peer networks were valued by a number of practice teachers (PT1, PT2, PT3 and PT7) for sharing ideas, seeking guidance and for one to one support. PT2 stated *'I see other practice teachers / practice educators sort of in their role and we do share ideas'*, and PT3 explained how, *'I had a couple of CPT's who were good around me who I drew on.... I can remember having quite a detailed conversation with one of my CPT's about 'how friendly are you towards the student?' What are your boundaries? What are your professional personal boundaries? Because that was quite tricky, I felt, and it wasn't covered on the course'*. PT1 explained *'In my own discipline I've got the person that supervised me whilst I was doing the course (she) is still there available for me should I need any one to one support'*.

All practice teachers engaged in some form of peer supervision. This varied from one-to-one supervision with an experienced practice teacher from the same specialist community nursing discipline, to uni-disciplinary and multi-disciplinary group supervision. The value placed upon the type of supervision differed for individual practice teacher participants. Several practice teachers valued the group mentoring and supervision processes that were in place to support them in learning and developing in their practice teacher role. Where these processes hadn't been in place some practice teachers described how they had set up these processes themselves. *'We organised them as practice educators (teachers)... we didn't have the opportunity (to) meet up as a group so we asked for that and then on the back of that came, can we have somebody*

there as well from... management to sort of lead us in that respect' (PT2). This describes an approach used by practice teachers that could be said to be developing a material feature of the role, in the form of a regular supervision meeting. This has the potential to increase the stability of their role and creating an opportunity to develop a shared identity and role boundaries.

Practice teachers described how their group supervision processes were used to network with other practice teachers from the same or different disciplines and also used to plan how they could work together to support organisational objectives which were discipline specific. PT2 described a uni-disciplinary supervision process. *'We meet on a monthly basis and part of that meeting is ... networking, we talk about our roles, reflect a bit ... and then the other side is a little bit more operational, so our manager comes to that part of it ... so for instance with the Health Visitor Implementation Plan it was about (how) we were going to get there, what we were going to do, what the expectations of the organisation was and what ideas. So it was looking at our ideas as sort of a joint support / focus group... and looking at what we could do and how we could achieve this ... it's not just a one way process it's about communicating this back to our teams as well'* (PT2). This would suggest that practice teachers in this organisation were perceived to have a leadership role and this was evidenced in their differing job title and job description, which is referred to elsewhere in this thesis. There is also evidence here of a degree of overlap in terms of the dual role and discipline specific discussion that was integrated into the supervision session. Ashforth et al (2000) discuss the extent to which roles are segmented or integrated and suggests that there are benefits and costs associated with maintaining role boundaries or enabling integration. In relation to multidisciplinary practice teacher supervision the costs associated with integration of the clinical and practice teacher roles are likely to be that discipline specific discussion will not be relevant to some group members and therefore the perceived value of supervision for some may be lost and this was identified in the data below.

PT1, PT5 and PT7 described the importance of multidisciplinary group supervision and how it gave them the opportunity to learn from each other explaining that *'otherwise you can feel very much on your own and don't know if*

you're doing it right (PT1). *'We (school nurse practice teachers) joined with the health visitors (practice teachers) and we've been having bi-monthly (supervision) meetings....we learn a lot from each other'* (PT1). *'When I look back what helped me to learn was talking and meeting with other practice teachers ... learning from each other and discussing how we managed different situations'* (PT5). *'I sort of link up with not just the district nurse practice teachers but I'm also friendly with the school nurse (and) health visitor (practice teacher), because even though their role is different I think there's quite a lot (of) commonalities ... we've made a meeting so we can all get together and see where we're at'* (PT7). These quotes suggest that practice teachers had been proactive in creating networks and supervision processes in order to access support. According to Ashforth et al (2000) specific settings or times provide a symbolic indicator of which identity to activate. Multidisciplinary group supervision provides a favourable context for more clearly segmenting the practice teacher role from the various clinical roles. This has the potential to benefit practice teachers since they are a relatively small occupational group and numbers in any one discipline and organisation may be small and geographically wide spread. The opportunity to learn from one another in a multidisciplinary context may enable practice teachers to access the support they need and strengthen their position and negotiate a more clearly defined shared identity.

Peer networks and supervision processes were less successful for some practice teachers. PT8 was critical of local networking processes *'I am obviously on the practice teacher forum.....but I've got to say it is very health visitor biased, very heavily... and it's a waste of time quite honestly for me'* (district nurse practice teacher). PT6 concurred *'well my (practice teacher) colleague (same discipline), she gives me quite a lot of support. I find it very challenging with the health visitor practice teachers, I feel they have their own agenda and the school nurse practice teachers are not included in that ... I find it quite difficult sometimes with them in meetings, they do quite dominate ... it's as though I'm not heard or I'm ignored and I find it a little bit disrespectful'*. For these two practice teachers the differing clinical roles affected the perceived value of the peer supervision. In the organisations represented in the study

health visitor practice teachers significantly outnumbered those in the other disciplines and these practice teachers appeared to feel marginalised by being in a minority. These practice teachers did not identify with practice teachers from different professional disciplines. The identity of the practice teacher appeared to be subsumed under the features of the more visible and dominant identity of the professional discipline. This was despite the context being focused on practice teaching.

Research examining group processes (Roccas and Brewer 2002) argues that most individuals are members of more than one social group at any one time and have multiple group identities. As discussed earlier practice teachers have a dual role and the practice teaching element is generally perceived as the secondary or subordinate role to the dominant clinical role. Roccas and Brewer (2002) suggest that individuals are sometimes evaluated by others in terms of their dominant identity, the secondary identity being ignored or inhibited. This may help explain why these practice teachers did not value multidisciplinary supervision to the same extent as some other participants. Roccas and Brewer (2002) contend that where the degree of overlap between social categories is only partial individuals may feel part of the 'in-group' on one dimension and an 'out-group' on the other. A district nurse practice teacher, therefore may perceive that she is a practice teacher on one dimension and so part of the 'in-group' at a practice teacher forum, however where this is dominated by health visitors she may perceive that she is an 'out-group' member on the other dimension. The lack of commonly understood and agreed practice teacher role descriptors and boundaries is likely to compound this perception as the practice teacher role has few distinctive features other than it's one to one role supporting a specialist community nursing student.

An absence of an infrastructure to support access to peer supervision was evident in the data and thus opportunities to interact with peers were problematic for some practice teachers. The geographically disparate nature of the practice teacher workforce and low numbers further compounded the difficulties. Other than a regulatory body requirement to attend an annual update (NMC 2008) which was monitored through a triennial review process there were no policies or protocols to prioritise support mechanisms for practice

teachers. Practice teachers are a relatively small occupational group in comparison to their specialist community nursing discipline and they often work geographically isolated from one another. One manager (M4) explained that *'currently I have been managing district nursing services ... I have one CPT practice teacher who currently hasn't got a student'*. Data from district nurse practice teachers concurred with this, *'(supervision) has been difficult ... because there are so few of us and because the people that I may be could access were busy.... my mentor is at (...) you can see how far away that is ... it's not practical ... so really it was telephone conversations... because you've still got to get on with the day job'* (PT8). A second district nurse practice teacher explained how she had struggled to access peer support *'I didn't really have any contact with any practice teachers from over here until I started the course ... I think I even struggled to get a practice teacher at the beginning to mentor me ... there was only three of them, three practice teachers and I think there was five practice teacher students, so it was quite hard at the time'* (PT4). PT2 (health visitor practice teacher) explained similar difficulties *'I didn't have a mentor and there weren't many practice teachers around at that particular point and we didn't meet up ... I didn't have any sort of preceptorship, and I didn't know really ... I was making up the rules as I went along'*. PT8 portrayed similar difficulties *'(I) had indirect contact really with some of the practice work teachers ... I don't think I had many role models to look to'*. PT4 described difficulties accessing face to face support. *'We had a practice teacher that had already been signed off for a number of years. The only problem ... was getting together. It was hard. We did a lot of talking over the phone because of me based here and the other practice teacher at ... it's the distance, and it was getting together'. It would have been better if there had been somebody over this side but I don't think there was that many practice teachers, so support was quite sparse ...a lot of telephone contact, but they were there to support us when we needed it.*

PT9 described how the nature of the role itself made it difficult to learn from peers. *'It's so kind of one to one that you don't really get an insight into how another practitioner teaches their student on a day to day basis'* (PT9). This would suggest that even where there was an opportunity to share the physical

environment with another practice teacher the opportunities to learn are constrained by the nature of the work itself. It is evident that the opportunity to access support from peers in their own clinical discipline was difficult for some due to time and geographical constraints, the nature of the work itself and low numbers of practice teachers in the workforce. These practice teachers were, however, proactive in learning and developing their own professional identity drawing on alternative environmental mediators.

Nurse educators (FG) who were based in universities across England discussed the importance of supervision for student practice teachers. They described a mixed picture of the availability and quality of supervision processes in their areas and these bore a close resemblance to what was portrayed by the other participants in the study. Despite supervision being materially mandated in regulatory body requirements (NMC 2008) for student practice teachers, nurse educators described the availability as being stretched and that these meetings were often the first to be cancelled when there were competing priorities. Nurse educators also suggested that supervision for qualified practice teachers ought to be more robust *'I think in some areas they have some very good practice teacher forums in other areas they're not as good'* (FG). Nurse educators also described the mixed availability of supervision for qualified practice teachers *'in some areas I work they do actually have specific supervision within their practice area' ... 'I think that's very limited, very limited' ... 'they should be having their own peers support within their organisation ... a few of them get clinical supervision but that's not across the board either, where they might be able to bring up issues'* (FG). *'Some of them go to their training lead (for supervision), if there's a training lead in their organisation'* (FG). The variable availability and quality of practice teaching supervisory processes would indicate that it plays less of a role in influencing in shaping individuals roles than clinical priorities. This may be a consequence of a lack of detail in the NMC (2008) standards indicating what supervision ought to look like and an absence of alternative standardised texts that organisations could refer to in order to determine local arrangements.

Actor network theory (Mulcahy 2013) proposes that knowledge is a social product and learning occurs through networks that can exist over multiple sites.

As such it provides a useful conceptual framework for considering the factors that are significant for learning through disparate networks such as those available to practice teachers. Nurse educators discussed how joint meetings with a group of practice teachers and students, together with a member of the academic team supported student practice teachers to learn the role. *'I like the bigger groups, a joint meeting ... because the experienced practice teachers bring up issues that the ones that are in training never thought of and it gives the ones that are in training an opportunity to ask questions and ask the practice teachers who have been trained for a long while how they have dealt with certain situations'* (FG). The quotation above indicates the value of the physical practice of working as a team and in addition to actor network theory (Mulcahy 2013) it can be examined using complexity theory (McMurty et al 2016) as a conceptual framework. In this quotation new collective knowledge is suggested to emerge through dynamic interactions which have the potential to exceed what could be achieved by individuals working in isolation. In terms of identity formation these networks and teams create a context for spatial separation from their clinical roles and this may support new and experienced practice teachers to more readily activate their practice teacher identity (Ashforth et al 2000).

In some organisations managers described ad hoc supervision and a lack of supervisory frameworks and processes to support student practice teachers learning the role and existing practice teachers enacting the role. M3 described how *'we leave it entirely up to them (student practice teachers) to organise that (support and supervision) ... at that level they should be able to be self-directed really'*. M3 stated that *'I think there is supervision and support (for practice teachers) but they have to get it themselves'*. The lack of a robust supervisory process was also evident in a second organisation. M1 stated *'I don't think we've got anything written down; it would be more as the support is needed really (for student practice teachers). 'That (supervision for existing practice teachers) would probably be through the CPT meeting and I'm not sure if that is robust enough ... because some people would never go'* (M1). M4 described a similar structure *'they err, have an organisational network, they have a forum ... to discuss issues of the day and changes to pathways, changes to the learning*

or the experience that the learning centre might be offering ... and the practice educator is invited by the learning centre to go and attend their updates'. This would suggest that supervisory support relates to student learning rather than a more broadly defined remit. M4 described how 'they probably do on the whole, what they've always done ... I think organisationally we have allowed the practice educator to operate within the function without having any organisational measures on that'. This manager stated that 'the measures have come from the learning centres, the universities'. This would suggest that managers have paid little attention to quality assuring practice learning and developing clear boundaries for the practice teacher role. By leaving it to the university to provide the texts and materialities to support the role this manager's perception appears to be that the practice teacher role is primarily about supporting students. This lack of attention to the practice teacher role in terms of the organisation developing and maintaining supervisory frameworks and processes may relate to financial constraints and a context of practice where the core business is about achieving health care outcomes. Indeed the nurse educators indicated that staff shortages were significant in terms of being able to access support. 'it's when there's a shortage of staff and preceptorship doesn't happen in their training here and afterwards for a year. I think then there are issues but when that isn't happening certainly in my experience they tend to draw on me (nurse educator), you know, they know they can get support from somewhere and that's usually me' (FG).

In contrast to the other three managers M2 described established supervisory processes for supporting the practice teacher role. *'I have set up uni-disciplinary groups ... they (practice teachers) get together as a group and they discuss areas of practice ... so we're kind of looking at how they're doing their practice teaching ... it's a member of the leadership team who's also a practice teacher who leads that group'. Ashforth et al (2000) contend that individuals are more likely to identify with a role if they understand what it entails and they feel valued. In this organisation work had taken place to clarify the boundaries of the practice teacher role in school nursing. For these practice teachers supervision processes were discipline specific and therefore boundary crossing did not create tensions in the group. Whilst this provides a favourable context*

for discussing the dual role, according to Ashforth et al (2000) the crossing of role boundaries can blur the roles and could lead to the dominant clinical role interrupting practice teacher supervision processes.

4.5.6 Interaction with peers through the university networks

Both actor network theory (ANT) (Mucahy 2013) and social identity theory (Tajfel and Turner's 1985) provide a lens through which to examine the value of peer networks. Practice teachers described the networks and peer support developed through participation in the university course. PT3 explained how *'it (the course) gave me a group of people....who I could call on... who were doing the course at the same time'*. PT4 similarly found that peer support networks were established through attending the course *'I was on the course with another district nurse that was working here so we supported each other as well as students'*. Practice teachers highly valued the interaction with multidisciplinary peers and academic staff *'it was good (my educational preparation) because I met colleagues from other areas ... you know there is a lot of other disciplines doing practice teaching...so it made for very interesting discussions and I think it's always good to have that bit of networking around so that you can see what's happening in other areas* (PT9). Whilst actor network theory (ANT) (Mucahy 2013) focuses on the significance of social, material and textual materialities important for knowledge transfer, in this case the course itself, Tajfel and Turner's (1985) work on social identity theory contends that individuals define themselves and others through connecting with other group members and using these opportunities to make intergroup comparisons. Individuals subsequently seek to engage in activities which are congruent with salient aspects of their group identity, though this of course depends upon there being some clearly defined parameters to the role. In the quotations above there is evidence of the high value placed on formalised networking opportunities created externally to the workplace and this may be partly attributed to the absence of, or limited opportunities elsewhere in the workplace to engage with their own occupational group. PT6 described how working with like minded people was helpful. She explained how *'you come out (of practice) and you come into university and you're with people who are doing the same as you and you're with lecturers and people with a lot of knowledge'* (PT6).

Ashforth et al (2000) contend that this spatial and temporal separation from their clinical roles, coming out of practice, provides a favourable context to activate their practice teacher identity and enable them to negotiate a collective identity which has the potential to strengthen role boundaries. This is further supported by the multidisciplinary context which constrains opportunities to cross role boundaries and discuss clinical issues.

Nurse educators also commented on the perceived value of peer networks developed through the university and these referred to qualified practice teachers attending study days in the University. *'on the study days ... we have to give them ever such long coffee breaks and lunch breaks because that seems to be more important than what we're actually trying to offer them because they just want to talk to each other about how they're getting on with their students'* (FG). This data suggests that practice teachers continue to seek out external networking opportunities post qualification and this may be reflective of the secondary or subordinate nature of the role which limits opportunities within the workplace to activate their practice teacher identity as clinical priorities take precedence.

Nurse educators suggested practice teachers actively sought out opportunities to network with peers and academic staff in the university setting as it was felt that their role was understood in this context and this made them feel valued. *'I think they like it (the university study days for all practice teachers). I remember we evaluated ours once, and in the old days we used to give them lunch and they loved it because they used to feel that it was about being valued as a practice teacher, going somewhere where they did feel valued ... we get good numbers every time'* (FG). Brun and Dugas (2008) contend that recognition is important for building and maintaining professional identity. Recognition from peers and teams being particularly important since they are best placed to judge the quality of the work performed and this recognition supports a sense of belonging to that community. Low workforce numbers of practice teachers and geographical isolation from one another inhibits local opportunities for some and this may help explain the value placed upon accessing external networks. In addition the secondary or subordinate nature of the practice teacher role may

limit the recognition that they receive in the workplace where rewards and recognition are focused on the achievement of health care outcomes.

4.5.7 Interaction with nurse educators

Nurse educator expectations of the practice teacher role are likely to influence how practice teachers learn and enact their role as they are responsible for designing and delivering practice teacher programmes that meet regulatory body requirements (NMC 2008). Nurse educators described the practice teacher role largely in relation to facilitating learning and assessing the specialist community nursing student. This may be reflective of their position in teaching specialist community nursing students and that they are not immersed in the practice environment and so not exposed to the pressures and additional responsibilities aligned to practice teacher roles. It may also be a consequence of the dominance of this aspect of the role in the regulatory body standards (NMC 2008) which provide the material text that underpins course design and the basis on which it is validated. Participants described how practice teachers *'are really responsible for the whole of the practice curriculum'* (FG), *'they translate theory into the practice demonstrating practice...and supervising them'* (FG). Nurse educators also articulated the practice teachers accountability for managing risk and managing failing students. *'A practice teacher has the ability to fail (a student) through assessment ...so manages the risk more effectively'* (FG). This may be reflective of their greater understanding of the role over other stakeholder groups as it relates to a nurse educators role in the same way. The quotations above provide additional evidence to explain why the role may be perceived to focus on the specific needs of individual students rather than the broader remit often aligned to practice teacher roles.

Conversely, whilst the nurse educators described the role primarily focusing on supporting the specialist community nursing student, one practice teacher described how she had been asked to do some teaching at the university. *'I've been asked by the university to talk to pre-reg students and I've actually quite enjoyed that'* (PT8). The opportunity to enact a broader teaching role and the recognition by nurse educators that her expertise was valued is likely to influence how this practice teacher understands her role. As this is not a

distinctive feature of all practice teacher roles, however, it may not be recognised or valued by other stakeholders.

4.5.8 Interaction with managers

Kirpal (2004 p276) described how the expectations of others influence the individual to behave as others would do in a similar social or professional context. The rewards for conforming to these expectations might include some form of recognition or acceptance by the group members and this supports the individual in building the dimensions of their own professional identity. For practice teachers the expectations of managers are likely to be highly influential in terms of how practice teachers learn and enact their role.

As noted in the literature review perceptions of what a good practice teacher 'looks' like may vary across the different participants interviewed in this study. Palmer (2004 p.8) sums up notions of both extrinsic and intrinsic goodness. He considers how we use the word 'good' and suggests that goodness always has reference to something outside of itself and is measured by the performance of an external task. As managers can influence the responsibilities aligned to the practice teacher role they are likely to be significant in shaping it in a way that captures their notions of 'goodness'.

All the managers indicated that clinical expertise was an important attribute for a good practice teacher. M4 described several years experience of managing community nursing services, mainly district nursing and rehabilitation services, and therapists. M4's understanding of the practice teacher role was developed through experience of being a practice teacher many years previously and further developed through experience of managing practice teachers and ensuring that they were available in sufficient numbers to support the development of the nurses that were required as part of the organisational workforce plan. M4 explained that *'An ideal practice educator is someone who has been a district nurse for at least 2 years and within that time shown and can articulate and demonstrate their abilities they need to be a reflective practitioner politically aware (and) they need to be clinically expert'*.

M1's perception of the practice teacher role derived from her experience, ten years previously, of being a student health visitor assigned to a practice teacher for the practice element of her course. This manager described having a large portfolio which included managing health visiting services and through this she had developed further insights into the practice teachers role. M1 described how she understood the role. *'The kind of person staff and students would look at to see how Practice should be happening ... I want to try to get that sort of culture where they are seen as the experts really and that people would go to them (M1). Somebody who's up to date with current legislation, what's happening politically, public health Someone who really had their finger on the pulse (M1). I think that's what the practice teacher role should be, as a leader and as somebody who's got clinical knowledge of what practice should be (M1).*

M2 described her role as managing school nursing services across the whole of a large provider organisation. She indicated that her role had changed in the last couple of years and that she had previously been managing children and family services which had included health visiting and school nursing teams. M2 had never been a practice teacher and described how her understanding of the practice teacher role developed through managing them. She explained that since the reorganisation of services she was now responsible for managing a much larger workforce but appreciated a model which enabled her to focus on just school nursing. M2 described how clinical credibility was essential for practice teachers and that they were vital in making sure that students had a good placement experience.

M3 explained that she had been a practice teacher in a previous role but that her role in managing them had made her more aware of their responsibilities and recognised that they had a leadership role and a key role in preparing safe autonomous practitioners. *'They need to keep up to date ... so that they're giving the appropriate steer and change in practice to their students'. 'they've got to ensure that their practice is up to par... we need to ensure they're attending mandatory training and compulsory training which directly relates to their role and the role the student will be doing'.*

The data above indicates that managers placed a high value on clinical expertise and this expertise was drawn upon by organisations in a number of different ways in order to role model expert practice to staff and students and to lead and develop practice. These practices were context specific and influenced by local priorities. Concrete physical practices (materialities) contribute to knowledge production (Mulcahy 2013) and identity formation and this may help explain why practice teacher roles have evolved differently since they are mediated and constrained by what the various social, material and textual materialities in their organisation allow them to be.

M2 described how workforce numbers of school nurses had recently been increased in her area and this had enabled practice teachers to focus more on their role, however at the same time student numbers had fallen and so there were fewer opportunities for practice teachers to work with school nursing students. M2 described how practice teachers had been drawn into the clinical governance structure and this enabled them to share their expertise, promote good practice and seek ways to improve and extend the school nurses role in relation to improving public health. She described how *'they contribute more than do the school nurses to things like reviewing of NICE (guidance) ... and being involved in the writing of standards, School Nurse Standards with the evidence base'* (M2). In this organisation a clearly embedded and broader practice teacher remit was established within the school nursing discipline and their clinical and education expertise was drawn upon by the employer to improve health care outcomes.

M1, M3 and M4 described their aspirations for the practice teacher role but these were not firmly embedded. M1 stated *'What (I) would be looking for in the CPT's is to show some leadership ... setting some example really of what I would expect for somebody at a senior grade'. 'leading more than in education'* (M1) ... *'I think we probably are looking at all CPT's (practice teachers) having some extra role like breast feeding (lead) or CONI (care of the next infant) (lead)'* (M1). These aspirations would suggest that the role is under review. A number of quotes by managers indicated that the role lacked stability and that the leadership role ought to be strengthened. Some organisations were creating new roles where practice teachers were expected to take on a clinical

leadership role whilst maintaining a clinical caseload in order to maintain the clinical skills required to teach a student. Managers suggested that the practice teacher role was changing and was being scrutinised with a view to aligning additional responsibilities. M1 described how the leadership role of practice teachers should be strengthened and that it ought to involve day to day service coordination as well as training the wider workforce, *'leading more than in education, I suppose leadership per say really, that they are sort of leaders of moving things forward'*.

Practice teachers sensed the differing expectations of managers upon their role. PT3, who held a more clearly defined leadership role and title, accepted that she *'should be delivering excellence and that's what we're doing'* (PT3). This may be reflective of the nature of the highly productive system and a need to maximise the contribution of all practitioners to achieving quality health care outcomes. PT6 described a broader remit to her practice teaching role and indicated how it was changing, enabling her to have greater influence despite carrying a full school nursing caseload. *'You seem to be expected to take on the role of teaching everyone and being a mentor to everyone'* (PT6). This included new starters, pre-registration students and school nursing students. PT8 also described a broader teaching remit *'they were having us deliver all the mandatory training which was a bit of a throw off really because that's not the thing that you sort of particularly (do)'*. This practice teacher sensed some tension in terms of her understanding of the role and the expectations of her managers. For two of these practice teachers additional responsibilities related to teaching activities and this could be seen as an attempt by managers to align workload priorities to those best equipped to respond to them. In addition mandatory training is audited and this is likely to be a factor influencing workload priorities. PT4, however, indicated that the requirement to undertake any additional educational remit beyond her role in supporting the specialist community nursing student was only required by the employer if no student was allocated to them *'if you've not got a student there's different expectations from you ... you need to carry on teaching ... they encourage you to go and do study days, you know deliver training'* (PT4). In PT4's organisation, which is a social enterprise, district nurse practice teachers were all team leaders and the

number of district nursing students was low. This might help explain why the practice teachers in this organisation were not expected to take on any additional teaching responsibilities other than their role with their specialist community nursing student.

Recognition by managers is likely to influence how practice teachers learn and enact their role. Brun and Dugas (2008) point to a large body of literature which suggest that recognition is an important factor in employee motivation, acting as a personal development agent. In addition employee recognition is a significant factor in reducing the risk factors associated with psychological distress in the workplace. Brun and Dugas (2008) suggest that recognition is a key element in managers' ability to handle difficult professional situations and is vital to the success and continuity of organisational change. The evidence in this study suggests that practice teachers were valued by their managers. Practice teachers were credited by managers with having an essential role in creating a good quality workforce and as being the biggest influence on the development of future practitioners. M1 described how her own practice teacher had *'a massive influence on how I practised in the future'*. She states *'If we're ever going to get a good quality workforce you need to have your practice teachers delivering quality to the students'* (M1). M3 concurred *'they are in a very important role, they are the mainstay of the training, and the reliability of the staff who actually comes out at the end of that training ... knowing they are safe practitioners'*. M3 described how becoming a manager had made her more aware of their responsibilities *'because we need ... to have autonomous practitioners who are self reliant'* (M3). M2's comments supported this *'they're certainly seen as vital to both the organisation, because we're providing and supporting, you know, nurses to go on and do a specialist practitioner course. So they're seen as crucial to making sure that the students are getting a good placement'*.

The above evidence is at variance with how practice teachers in this study perceived they were valued by their managers and also existing literature which indicates that practice teachers do not feel that their dual role is supported by the organisation (Carr and Gidman 2012). Practice teachers perceived job cuts, job insecurities and lack of career development opportunities as indicative of

their employers and managers not valuing the practice teacher role. PT7 described how *'the practice teacher role as far as they're (managers) concerned comes at the bottom of the list ... I don't think they value (us) the same as they used to do'*. PT5 explained how *'you've always got to push the fact that you're a practice teacher and put the emphasis on education because when there are any cutbacks or shortcomings in anything education's always at the bottom'*. PT4 described a lack of investment in the future practice teaching workforce and described how their status in the organisation had declined *'There's no recognition that you're a practice teacher... no encouragement ... I've not heard anything about anyone going on the practice teacher (course)'* and PT5 explained *'the practice teachers that we've got at the moment obviously know what banding they are on (band 6) and there's no promotion if you like for them unless one of us (practice educator on a Band 7) leaves'*. PT2, whilst valuing the recognition for her role provided by the practice educator title, indicated some discontent with how she felt the role was perceived by managers and suggested that the role was not valued by the organisation. This may be indicative of the context of practice where significant economic constraints were impacting upon the organisation, caseload demands were very high and not adjusted to accommodate a teaching remit, and most had no protected time to undertake the practice teacher role. In addition the absence of a material infrastructure, such as a common role descriptor and a system to monitor the quality of education outputs left practice teachers feeling invisible, undervalued and needing to defend the boundaries of their role when it was being encroached upon by clinical pressures. During the data collection period there was also the additional pressure to support higher numbers of health visiting students in order to meet government targets (DH 2011). The prioritisation of achieving clinical outcomes impinged upon practice teacher roles and this was interpreted by practice teachers as the organisation not valuing the educational aspect of their role. The quotations suggest that practice teacher roles were undermined in order to manage clinical pressures, maximise efficiency and reduce costs. In this context the highly productive system, with its dominant material features, directly influenced how practice teachers perceived that their role was valued by their managers.

4.5.9 Interaction with team members

Practice teachers described how support from colleagues was vital in enacting their role *'The support from colleagues really, you know, you can't do it on your own we're part of a team'* (PT9). PT3 concurred *'I think now you need a good team. I really need a good team around me... things have moved on from us being a one-handed practice. So I need good systems, I need good support staff, I need people who are willing to spend time with my students that I maybe can't, in data collection that kind of thing'*.

PT9 described how feedback from team members was important in terms of evaluating her own teaching skills. The perceptions of team members regarding the progress of the student was significant in this *'You know when they go out with other members of staff if other members of staff sort of feed back to me about what they're doing and what their perceptions are ... I think that kind of gives you an opportunity to see that you're not barking up the wrong tree, you know, if there was a major problem then somebody else might identify it but so far that hasn't happened'*.

The findings from this study reflect those found in existing literature (Carr and Gidman 2012, Haydock et al 2011) which suggest that practice teachers receive little support from team members. The data suggested that this might be because team members don't understand the role. PT2 described how strategies used by practice teachers to raise their profile had revealed that *'people didn't realise our role'*. PT6 concurred and stated *'I think people don't have an understanding really and because there are only a couple of us in School Nursing it makes it very difficult ... people don't see what we do, they don't see what we do with the students, they don't see what we do, you know, sort of developmentally within the Service ... I think they think it's just a title I've got that I don't do very much with and I do find that a little bit frustrating'*. Interview data from students triangulated well with practice teachers views. Students perceived that team members often had only a limited insight into the role. ST1 described her view *'I'd say it's very different to having a pre-reg student, I think sometimes they (colleagues) are not always really aware of how much work it is and what a challenge it actually can be and I think sometimes if*

they had a bit more of an understanding of that then it would help the practice teachers to be able to do their job a little better'. Managers also recognised that the practice teacher role was not always understood by team members. M2 described how they had addressed this issue as it was envisaged that greater recognition of what the role entailed would enable team members to make allowances in terms of time for them to undertake the role (M2). 'We did some work ... on roles and responsibilities of the skill mix team so the whole of the different disciplines including CPT's, so that clarified where there was a bit of uncertainty'. This organisation had been pro-active in more clearly defining a practice teacher role in their school nursing service and the structures that had been created have the potential to support practice teachers in developing and maintaining a clearer and more stable professional identity. This could be a model that could be drawn on elsewhere.

4.5.10 Interaction with patients and clients

Interaction with patients and clients was referred to a lesser extent than other groups in terms of learning the role and this was talked about mainly in relation to evaluating teaching and learning. PT4, for example, described how receiving affirmation that her student had provided effective care enabled her to evaluate the success of her teaching. This gave her confidence that the approach she had taken to teaching and learning had been successful, *'she got recognition from the family you know, thank you for all your help, and I think to myself yes I did something right there'* (PT4).

4.6 The influence of material features

Socio-material theory (Fenwick and Nerland 2014) acknowledges the real environment and its material features as significant in shaping learning. Student practice teachers learn their role in the practice setting and this gives them the opportunity to perform as if they were already practice teachers. Qualified practice teachers enact their role within the practice setting, influenced and constrained by the features of the individual context. The environment is real and not preconfigured for the purpose of learning. It cannot be standardised and so it is inevitable that it will be experienced in a diverse range of ways by different practice teachers and student practice teachers. A web of relations and interactions influence how the role is understood and enacted and learning is influenced and constrained by what those systems allow it to be.

As discussed earlier the nature of the productive system prioritises the achievement of health care outcomes over education outcomes through a range of socio-material influences including what Blundau (2014) describes as 'technologies of governmentality'. These include policies, guidelines, procedures, targets and physical practices which stipulate clinical roles and indicate the organisations intentions for the role. Fenwick and Nerland (2014) acknowledge the important contribution that these tools, technologies and objects of practice make to shaping practitioner roles when intertwined with social aspects.

The concept of governmentality was developed by Michel Foucault to help explain the ways in which individuals' behaviour in society is shaped and controlled (Blundau 2014). Its emergence was underpinned by a developing evidence base which was used to design a range of social policies, institutions and ideologies, replacing professional knowledge as the dominant power used to govern populations. Blundau (2014) suggests that the features of the institutional context play a significant role in shaping the professional identity of nurses. Technologies of governmentality, specifically hospital policies and protocols or the lack thereof, were significant in this. The evidence in this study revealed that the clinical and managerial elements of practice teachers dual roles were shaped by a plethora of material features including policies,

guidelines, targets, and contracts related to health care delivery within a pay structure that related to knowledge and skills (Knowledge and skills framework KSF). Conversely there was little material guidance available to influence and shape practice teaching work practices other than the NMC standards (NMC 2008), variable supervision processes and a limited range of tools in the form of texts to guide practice teachers in enacting the one to one role with their specialist community nursing student. PT4 states *'you just don't hear anything. There's nothing apart from being told to ... make sure you're up to date on your study days, there's no recognition that you're a practice teacher'*. A consequence of this has been that practice teacher roles have evolved differently and they subsequently do not share a group identity. Responsibilities aligned to the practice teacher role were found to differ according to the specific local environment and clinical work was prioritised over practice teaching.

Schatzki (2010) contends that human lives are connected in a complex web of material configurations and practice arrangements which inevitably overlap. The findings of this study suggest that whilst organisations use technologies of governmentality to directly influence the behaviour of their populace the picture is much more complex and, as Fenwick (2010) contends, these material artefacts mediate social interaction. This tangled web includes the interactions with colleagues which have been referred to earlier. The expectations of colleagues are influenced by the material features of the environment and these exert further pressure on practice teachers to conform to expectations.

Locally developed tools, technologies and artefacts, including job titles, job descriptions, pay grade and protected time as well as a range of national and local targets, protocols, frameworks and policies, some of which were discipline specific, were found to be influential in determining how the role was assembled and enacted and these are explored in the analysis below. The findings are presented in order of their perceived significance in terms of shaping practitioner work roles though it is acknowledged that there will be individual differences in terms of their influence.

4.6.1 Workload pressures

Financial constraints were a significant factor influencing work practices during the period of this study. There were examples of how the changing economic and political climate led to escalating workloads and an increased range of performance targets which resulted in clinical roles being reshaped and redefined to the detriment of the practice teaching role. M1 explained how *'the national and international financial state has impacted on everybody... and certainly the role of the district nurse has had to adapt'*. M1 described how *'In some areas practice teachers have had to become managers... so I think there's an awful lot happening ... in this current climate and it is geared around finance... and you know there's a review of specialist nurses within our organisation – so I think potentially there could be quite a lot of things happening'*.

Students from all three disciplines gave examples of how care provision was prioritised over practice teaching. ST4, a health visiting student, explained how *'she has her diary and I have mine and occasionally she'll block out some time to spend with me. Sometimes she'll ask me to bring my portfolio in but more often than not we don't actually get a chance to go through it because she generally gets like phone calls and things like that ... that take up her time'*. ST6, a school nursing student, described how she felt reluctant at times to approach her practice teacher for guidance because she could see that she was so busy with other responsibilities. *There were times when I felt she was spinning a lot of plates ... I might have been selective about when I needed to approach her ...I do feel she was under a lot of pressure and very busy'*. ST5, a district nursing student, stated *'She's even considered not having another student and that's no reflection on me, but just because with all the cuts that's going on nowadays she has found it extremely difficult at times to try and look at my development ...they're cutting down on district nurses and team leaders, there's less of them'*. This evidence would suggest that the financial cuts and the target driven context of clinical care impacted across all the disciplines represented in the study, though evidence presented elsewhere in the findings indicates that roles were reconfigured in different ways in response to this.

Practice teachers concurred explaining how clinical demands had to be prioritised over practice teaching. PT4, for example, explained how *'our (district nursing) roles have changed recently ... it's led to more management now ... we're doing less clinical time and more management time trying to manage the team of (district) nurses ... looking at all the targets we've got to meet ... we are being commissioned now for the services we provide, so we're looking at new services, how we can provide them, cost implications and reporting, making sure all our reports are up to date'* (PT4). This practice teacher did not refer to her practice teaching role at all and this would suggest that she identifies very little with this aspect of her role. PT4 only refers to the practice teaching element of her role later on when asked directly about it. PT7 concurred describing how the role was becoming much more pressurised *'because of all the additional things that they're wanting us to do for patients which is great but we don't get any extra additional staff and we don't have a lot of time to do it in and we work the clock round really sometimes ... and yes sometimes I feel that I can't always allocate as much time as I really would like to the students'*.

Nurse educators described how workload pressures impinged upon practice teachers ability to role model the breadth of professional practice and the time that they needed to undertake their role. One participant described feedback from a practice teacher *'I know I'm supposed to be teaching prevention and all the rest of it. I've got these three safeguarding cases, reports, case conferences that I've got to deal with so that's the crisis'* (FG). A second nurse educator described *'and the practice teacher will say to me ... There aren't enough of us so we just do the child protection so then students sort of end up going out with the nursery nurses to learn about the Healthy Child Programme'* (FG). The activities described here are controlled through policies and procedures and practitioners are professionally accountable, through their regulatory body requirements (NMC 2004, NMC 2015) for ensuring that these are managed safely and effectively. A third respondent explained that *'They're wanting everybody back in the work arena ...so it's like the crisis work overtakes and that itself is lack of time to get the broad experience'* (FG). *'It's that fact that there's a caseload there, that they are having to react to ...they might be seen as the most experienced person within that team ... I think it's a*

juggling act... whose needs they meet at which time' (FG). These three nurse educators are suggesting that workload pressures force practice teachers to prioritise specific care related activities such as safeguarding and this affects their capacity to teach and role model the breadth of professional practice that their student needs to engage in to develop their own competencies. This data suggests that practice teachers are working in pressurised clinical environments where work priorities are governed by policies, procedures and targets which prioritise care related activities in order to meet prescribed targets and this context is likely to impinge upon how student practice teachers learn the role.

4.6.2 Information technology and data collection

In the context of this study it is apparent that as a consequence of the introduction of the internal market and severe financial cuts, practitioner work roles have been redefined and become increasingly constrained. The target driven culture in the productive system relates to efficient care provision and as a corollary there are increased requirements for practitioners to provide data regarding this. M4 explained that as a care provider organisation they were required to achieve targets and provide information in relation to this explaining that *'there is a lot of activity around data collection, submitting data on a regular basis, which certainly a district nurse practice educator hasn't (in the past) really had to do'*. The technologies which record care related activities added to the workload of practitioners and influenced work priorities which disproportionately affected the practice teacher element of the dual role where no similar activity recording was required. Indeed nurse educators pointed out the bias towards the recording of care related activities as opposed to time spent teaching students. *'It doesn't show the time they spend with the student and so they've still got to reach those (clinical care) targets'* (FG). The failure to give recognition and record teaching related activities signifies its subordinate or secondary position in relation to care delivery and this contributes towards the difficulties in demonstrating education outcomes and creating clear boundaries for the role.

Practice teachers described how the requirement to provide performance related data impinged upon workloads and practice teaching roles. *'This*

organisation seems to want you to record things so they can pull reports off to make sure that we are getting the targets that we should do' (PT4) and 'because we have deadlines to have all reports in and sometimes they can be when your student's with you, you feel as though you're not giving them the time then and it's that fine balance' (PT4).

Practice teachers also described the additional demands on them of supporting health care staff to learn how to use the new technologies and input accurate activity data. *'We're all computerised now....which has been a huge learning curve for everybody.... so you're trying to balance a team that's struggling with that and having a student as well' (PT8).* This would suggest that during the data collection period team members needed additional time to learn how to use it the new technology. It is likely therefore that this further impinged upon workloads disproportionately affecting practice teaching roles.

PT4 spoke positively about the potential for technology to free up more time for teaching and patient care in the future. *'We're changing at the moment ... we're getting to work smarter ... I think once we know what our role is and how to report things on the system it'll make it a lot quicker so we should end up with more time ... for teaching and more time for patients'.* This would suggest recognition that the use of technology in health care practice had the potential to create space for practice teaching in the future.

Students also referred to the use of technology in relation to their own learning and practice. For example ST8 spoke about how the use of technology was now integrated into practice. *'We work with tough books ... my practice teacher does her records more or less in the visit or she'll do protected admin time at the end'.* This would suggest that the practice teacher had learned to integrate the use of technology into her practice and role modeled its' use with students. In the current context of practice the use of technology is a fundamental element of delivering health care services and it is therefore important that she can model expert use of it as part of her practice teacher role.

4.6.3 Reward and recognition

Hallam (2000 p.142) discusses the importance of status in the new market economy in terms of nurses' ability to continue to differentiate its services from those of other paramedical professional groups. This has resonance for practice teachers in terms of differentiating themselves from mentors. Pay differentials make it possible for employees to distinguish between each other in terms of status and it gives legitimacy to seniority. The Knowledge and Skills Framework (KSF) is used in the NHS in order to provide a framework to plan the personal and professional development of staff. In addition it informs and structures performance appraisal processes and is linked to pay progression at specific points in the pay bands. The KSF enables staff to be clear about the level of knowledge and skills required for a post and as such it supports practitioners in identifying the boundaries of their role. The framework is designed generically in order that it can be applied in a range of health care settings. Each post has a KSF outline and this describes the knowledge and skills required for their particular position. Pay band was significant in determining the way the practice teacher role was understood by the range of participants included in this study and managers indicated that additional responsibilities were aligned to practice teacher roles because of their higher pay banding (M1 and M3).

According to Lindemann (2007 p.66), status in the labour market influences people's opinion about their social position and her analysis demonstrated that people's opinion about their social position ascends when their level of education and income increases. Pay banding was referred to on a number of occasions by participants and particularly practice teachers. For practice teachers pay band appeared to be an important way of defining themselves and determining the responsibilities aligned to their role, though these responsibilities were context specific.

For district nurse practice teachers a band 7 was associated with management responsibilities. PT7 described how she was given additional responsibility because of her status as a band 7 but this was related to service manager duties rather than anything related to practice education *'I think they (managers)*

don't look at you as a practice teacher they look at you because of your band, because you are a manager' (PT7). PT4 also stated that her pay band related to management responsibilities. *'With myself being a band 7 (district nurse), I'm more management'*. This resonates with PT8's comments, though she also cites an additional education remit, *'I think management are very of the opinion of 'Oh well you've raised a Band now, so you can ... take the lead on this or do a lecture on that ... they were having us administer all the mandatory training which was a bit of a throw off really ... many a time it's a refresher for yourself isn't it and then suddenly you're having to present this sort of thing'* (PT8). PT8 had little alternative external guidance in determining what her practice teacher role ought to look like as she struggled to access peer supervision because of geography and workload pressures. For health visitor practice teachers a higher pay band was not normally associated with management responsibilities. PT9 described how a band 7 post in health visiting was aligned to additional responsibilities, but these related to producing highly skilled, well trained students, though recently practice teachers had been asked to do more. This related to the Health Visitor Implementation Plan which is discussed separately.

PT6 (a school nurse practice teacher) described attending strategic meetings related to quality assurance and policy development and referred to her work with service commissioners. *I've been working with her (someone in commissioning) really from a school nursing role but because I am a practice teacher and of the level that I'm at (band 7), we'll have some influence on the Service Specification'* (PT6). This would suggest that she perceives that her role title and pay band are important in terms of her professional identity and how she is perceived by others. Cultural-historical activity theory (CHAT) focuses on 'activity' as the unit of analysis (Fenwick 2010) and this quotation suggests that these material artefacts mediate her activity and social interactions, and thus contribute to her learning. There are similarities here to differing material factors referred to elsewhere in the findings which describe how in this particular organisation the practice teacher role had been renamed and redesigned and the evidence above suggests a clear leadership remit designing school nursing services.

ST2 stated *'I know that other practice teachers are on our standards group. They also sort of undertake clinical supervision ... and I think there is an expectation, because obviously they are a band 7, that they will undertake more ... development of newly qualified health visitors'* (ST2). This would suggest that within this organisation practice teachers in health visiting did have a more clearly defined clinical leadership and education remit which resonates with the competencies and outcomes defined by the NMC (2008) and this is in addition to their role in supporting the development of their health visiting student and managing a clinical caseload. There is also evidence here to suggest the significance of pay band in determining the responsibilities aligned to the role. Practice teachers in health visiting also had a higher profile during the Health Visitor Implementation Plan (DH 2011) and there was an expectation that they would support the development of newly qualified health visitors and this may have also influenced how the role was perceived by students at this time.

ST1 (a district nurse student) was aware of an additional education remit held by her practice teacher. *'They have a little bit smaller caseload and they take much more of a lead in the team. I think they're a band 7 where as a normal district nurse is band 6 and they, you like sort of things like 'off duty' and things like that but the sort of education of the team, not just their student, (that) they seem to have more responsibility for'*. This student recognised that her practice teacher has additional responsibilities, and she relates this to her band 7 status as well as her practice teaching role. It is again evident here that pay band is significant in terms of defining the responsibilities aligned to the role.

M4 suggested that the practice teacher role needed to change to involve a greater leadership function. *'Not only will they be a band 7 CPT they may also might have a leadership role to play within the service too'* (M4). This would suggest that managers perceived that pay grade was significant in terms of aligning responsibilities and that the role needed to be extended beyond supporting a student in order to merit band 7 pay.

Nurse educators described different problems associated with pay banding. They described how some practice teachers remained in post despite poor performance because they were being paid a band 7 and described how they

were *'bounced around different ... HEIs'* (FG). This seemed to suggest reluctance on the part of the employer to stop using a poor practice teacher because they were paying them a band 7 to undertake the role. A second nurse educator described a Trust merger that resulted in a number of existing band 7 health visitors being told *'they've got to be a practice teacher because they're a band 7 ... a lot of them actually don't want to do it'* (FG). The way in which these organisations made provision for practice learning appears to reflect its subordinate status in relation to clinical priorities. The variable and limited range of tools and texts in place to monitor the performance of practice teachers may mean that there is a greater likelihood that poor practice will go unnoticed to the detriment of learners entering the profession.

Managers described threats to the pay grade of practice teachers. Pay was seen as an important factor in recruiting practice teachers *'a lot of people use it as a career pathway so if we are not going to pay a Band 7 anymore then people may not want to do it'* (M3). Where there is no additional remuneration for undertaking the additional responsibilities of a practice teacher or there is a threat to remove the additional remuneration it seems possible that practice teachers might perceive no advancement in their social position or recognition for their role and status as an employee.

These findings indicate that employers use pay grade as a tool for aligning responsibilities to a role and giving recognition for that. The evidence suggests that pay band and its associated KSF descriptors were of greater significance than NMC (2008) standards or the title of 'practice teacher' in determining the responsibilities aligned to the role.

4.6.4 Job titles and job descriptions

The evidence in this study indicates that the title 'practice teacher' is most commonly understood to refer to the practice teacher's role supporting a specialist community nursing student. This is despite the regulatory body (NMC 2008) determining a broader leadership remit. Additional duties aligned to practice teacher roles vary and are more likely to be related to pay banding and the way different clinical and managerial roles are assembled rather than in relation to educational expertise, though this was apparent in some of the data.

Two organisations represented in this study had renamed and redesigned the practice teacher role. In these two organisations a more clearly defined clinical educational role had been set out in a job description which also incorporated a broader leadership remit.

PT2, PT5 and PT6 represented the 3 nursing disciplines included in this study. They were all employed in the same organisation and shared a common job title (practice educator rather than practice teacher). They clearly identified themselves as leaders and educators in clinical practice and referred to the dual aspects of their role in more equal terms than other practice teacher participants interviewed in this study. PT2 (health visitor) and PT6 (school nurse) also shared a common job description and this provided them with some role clarity and role boundaries. PT5's (district nurse) job description differed, incorporating protected time for the teaching aspect of her role. This organisation had reviewed the role and remit of practice teachers and it is possible that this was driven by other material factors including economic pressures and an acknowledgement that all of these participants were paid on a band 7. The participants appeared to value the recognition of the role provided by the employer in terms of giving the role what was perceived to be an elevated status by being described as practice educators and having a more clearly defined education remit. *I'm managing the education of a locality and I also attend an educational forum to have an overview of what education the staff might need within the organisation*' (PT5). This practice teacher defined the education remit of her role separately from her clinical role and this may be a consequence of her being given protected time to undertake it and this is discussed separately within the findings. PT2 and PT6 both described a more integrated role. *'I'm a school nurse by background and I'm also a practice teacher ... we're called practice educators'* (PT6). *'I'm a practice teacher...Practice Educator and also a health visitor* (PT2). *'I don't think you can separate the two roles (practice teacher and health visitor) ... I see it as a combined sort of role'* (PT2). This perception may be influenced by the job description which for health visitors and school nurses integrates the clinical and the teaching roles. PT2 stated that practice teaching was about *'supporting the student in the learning environment'* (PT2) whereas her practice educator

role encompassed a broader remit including '*supporting education within the community services*' (PT2) and gave examples of developing training to address learning needs identified in the wider workforce. This role resonates with that described by PT3 as clinical leadership in a different organisation, however it differs in that PT2 is given no protected time to undertake this element of her role. It is also of note that this participant, in a similar way to PT3, identifies the practice teacher role as one which is only focused around supporting the individual specialist community nursing student rather than the broader education remit set out by the NMC (2008).

PT3 described how the clinical leadership element of her role emerged through recognition by her employer that practice teaching was a leadership role. She described this aspect of her work as *supporting quality and looking at delivering good practice* (PT3). It is interesting to note however that the leadership element, though derived from her status as a practice teacher, is defined separately as clinical leadership rather than it being acknowledged as part of the practice teacher role.

It is problematic that the role title 'practice teacher' is commonly understood to relate only to the practice teacher's role supporting a specialist community nursing student. It is likely that this has affected the recognition that practice teachers have been afforded for their role and threatens the stability of the role. Work undertaken in the two organisations described above has the potential to strengthen the position of practice teachers and improve the stability of the role and could be considered as a potential model by other organisations for employing practice teachers.

4.6.5 Criteria for selection of practice teachers

Managers described a lack of any tools and texts that could be drawn upon to support the selection of new practice teachers, relying on practitioners themselves to self select. '*I don't think we've got any criteria that we actually look at and say you've met that*' (M3). A second manager stated '*I don't think in my experience there's any particular science or set of measures that we organisationally put on this sort of function (practice teacher role) really*' (M4). This would suggest that organisations do not have a clear idea about what

attributes are important and what the role ought to look like. The lack of clarity regarding the requirements of the role is likely to impact upon the professional identity formation of practice teachers and make role boundaries unclear.

Nurse educators questioned the selection processes for those entering a practice teacher role. *'I think that the student CPT's should be more carefully selected than they seem to be. I think they're just sent to do the course without careful selection and I think they can be sent when they don't want to do it ... they've looked around the team managers and thought 'we need two more so you've been here a long time you should go' (FG). Nurse educators suggested 'those who are motivated to do it and talented as well' (FG) ought to be the ones selected to become practice teachers.*

Both of the examples above indicate that organisations have not prioritised the development of tools or texts to support the selection of practice teachers and this again signifies the subordinate position of the practice teacher role in relation to their clinical role.

4.6.6 Protected time / no protected time

Several practice teacher participants described having insufficient time for their role. PT7 stated that *'I wanted to sort of improve my knowledge about being a practice teacher and I don't always think you have that time, that quality time, to do it' (PT7)*. A lack of protected time is likely to be a consequence of financial constraints and the prioritisation of meeting health care targets. Evidence presented throughout the findings indicated the significant pressures on health care providers to maximise efficiency and reduce costs and this has affected practice teachers ability to enact their role fully and establish a more stable professional identity. PT1) stated *'the thing I would change is some protected time ... you don't have any caseload taken away from you, the caseload responsibility is still there'*. Protected time was identified as important for practice teachers to facilitate the creation of visible boundaries for the 2 roles and to validate the role itself. For practice teachers it was indicative of an employer's commitment to supporting the role. PT2 described how protected time would be helpful in influencing team member's expectations. *'One of the things that would help us at the moment is the recognition ... because we were*

recognised as doing 50% clinical, 50% practice educator ... we're purely clinical now (100%), but there is a big expectation that we do deliver on certain things and that's not recognised.....I found it much easier when it was recognised as 50% that the expectations of both team and management were very different to what they are now (PT2) ... if they don't put a figure on it then that supports not going to be there, certainly (PT2). PT9 explained how *'We get the same workload as if we weren't CPT's'*. This evidence suggests that the allocation of equal workloads for those with and without additional practice teaching responsibilities creates pressures from team members on practice teachers to make an equal contribution to achieving caseload and management priorities. The costs associated with this are likely to impact upon the enactment of the practice teacher role rather than the system.

In PT2, PT5 and PT6's organisation time was allocated to the educator part of the role in just one of the three specialist community nursing disciplines represented in this study (district nursing). The participant in this position (PT5) described her role differently to other participants with the same job title but from a different specialist community nursing discipline. *I'm a district nurse caseload manager for 18.75 hours and the other 18.75 hours as a practice educator. I manage the caseload ...I'm also responsible for ensuring the staff are updated within the team (PT5).* Those from the other disciplines (health visiting and school nursing) did not have allocated time for the education element of their role. In this organisation roles had been realigned further in the district nursing discipline. This practice educator (teacher) was expected to oversee the work of others defined locally as practice teachers, who were paid a band 6. These band 6 practice teachers were not expected to take on any further responsibilities in relation to education other than their role in supporting the specialist community nursing student and managing their clinical caseload. Practice educators were however described as having a broader education remit in terms of addressing the education needs of the wider district nursing workforce and overseeing district nurse practice education. This role is similar to a suggested model for practice teaching published by the HEE (2014) in relation to health visiting practice teachers. The band 6 practice teacher role described here relates well to the specialist practice mentor role proposed by

HEE (2014). The data here suggests that despite investment in more clearly defining a practice teacher (educator) role in this organisation, the discipline specific health care and management priorities have led to the practice teacher (educator) role being enacted differently. This provides further evidence of the significant pressures in the NHS as a productive system to prioritise the achievement of health care outcomes

PT3, a health visitor with clinical leadership responsibilities, was the only other practice teacher given protected time to undertake her dual role. PT3 had experienced a recent change to her role as a consequence of scrutiny by management of the practice teacher role. This practice teacher now had a more clearly defined role together with protected time and a new title, that of Clinical Lead. She described how the role *'should be about leading practice ... we're looking at being involved in developing pathways and we're there to see how that impacts on practice ... it should be about supporting quality and looking at delivering good practice'* (PT3). She described holding a clinical leadership role for half of her week and health visiting caseload responsibilities for the remaining half. Her role in supporting her designated student, however, was fulfilled during her caseload hours. PT3 described how time constraints impinged on her role *'it's easy to say time because you know I make sure I allocate time to my student and I do it and will do that before anything else, though it's just a reallocation of time really and the pressure of time ... it was the one thing that was important that my CPT gave me'*. This practice teacher created her own boundaries in order to prioritise meeting her student's needs within her caseload responsibilities, accepting that it would create time pressures elsewhere. These boundaries were reinforced by historical reference points which influenced how she enacted her role. For PT3 the allocation of protected time by the employer was in order to provide clinical leadership relating to improving health care outcomes and therefore of greater significance than education per se in the productive system.

Nurse educators also recognised that practice teachers were managing competing priorities. *'I think one of the biggest issues is that they don't get reduced caseloads and that they're very aware that they're going to have to do*

this job as well as what they're already doing and I think that really can be something that puts them off taking the role' (FG).

Students also observed that their practice teacher was juggling competing priorities. ST7 commented ... *'when you're so short staffed, most of the CPT's are team leaders so they have a heavy caseload as well and it's juggling everything. So it's not the ideal really (ST7).* This suggests that her practice teacher role was constrained by competing clinical and management demands. ST8 described how her practice teacher managed her competing priorities. *'My practice teacher tries to do maybe a visit less when she's got a student out with her but it just depends on time, so that you've got time to discuss things, but they're just doing ... a normal role, obviously on top of that being a practice teacher' (ST8).* This student is suggesting that the practice teacher attempts to manage the dual roles and make space for student learning, however the evidence suggests that it is her clinical work that takes priority when there are caseload pressures.

4.6.7 Physical environment

Some participants described how the material features of the physical environment constrained enactment of the practice teacher role. This related to a lack of private space to work with the student. Nurse educators explained how *'it's (reflection) quite difficult to do, in a car as well, which is quite a regular occurrence in London, it's very difficult to reflect on a noisy bus or in a busy street. It's something that the student is complaining about constantly that they haven't had any time with their CPT on his or her role. When I say you can bring this up in your reflective time they pull faces ... and say 'that's not happening' (FG).*

PT9 explained *'I suppose the biggest factor really is the hot desking and the sharing. I don't like that because there's nowhere really quiet and private that you can go and do work on a one to one basis with the student at that level ... The offices I've worked in have been very loud and very busy and I think it would be good in each area perhaps to have an office set up with a computer that you could just book.....to do some one to one work with a student' (PT9).*

This lack of private space is another consequence of an efficiency driven healthcare system with many organisations saving money by reducing office space and increasing the use of mobile technologies.

4.6.8 National policy

The impact of the Health Visitor Implementation Plan (DH 2011) was significant for participants in the health visiting discipline at the time of the data collection. There was political pressure and close scrutiny at the time by government to ensure that organisations were achieving targets to increase the health visiting workforce numbers and deliver a new and enhanced model of service. PT9 described how additional responsibilities were aligned to the practice teacher role in relation to this. *'I'm currently involved with the Implementation Plan (DH 2011) ... We have to get involved with the leadership, strategic changes that are taking place at the moment ... trying to improve the delivery of the health visiting services. The focus of what I was doing as a CPT was ... training the students but over this last year things are moving forward in the organisation and so the CPT's have been asked to do more'* (PT9). During this period health visitor practice teachers had new opportunities to lead service developments and were challenged with supporting an increased number of students. This raised the profile of health visitor practice teachers and the evidence suggests that there was enhanced recognition of their role at this time. PT2 comments, *'the turnabout was the Health Visitor Implementation Plan was certainly, in my mind it created a lot more recognition of our worth and our role' ... and on a personal level ... making me feel we are worth our money and that we are needed...and that certainly the expectation is that we take more students* (PT2). Abbott (2005) contends that professions can *"proact and react by seizing openings and reinforcing or casting off their earlier jurisdictions"* (p246). The Health Visitor Implementation Plan (DH2011) raised the profile of health visitor practice teachers during the data collection period and there was evidence to suggest that it provided an opportunity that was seized by some to reinforce and redefine their position.

4.6.9 Regulatory body framework (NMC 2008)

The NMC is nursing and midwifery's regulatory body and is the organisation tasked with protecting the public. Part of this role requires setting standards for education, training, conduct, performance and ethics. The NMC (2008) Standards to Support Learning and Assessment in Practice describe a developmental framework of knowledge and skills and determine the outcome requirements for mentors, practice teachers and teachers. NMC1 described how the NMC engaged with a range of stakeholders including Trusts, practitioners and higher education institutions in order to develop the Standards (NMC 2008) and states that everything that is required in the standards is what the NMC expects practice teachers to be doing.

Practice teacher courses are required to meet regulatory body (NMC 2008) requirements and it is therefore likely that they will influence practice teachers understanding of what the role ought to look like. Indeed PT1 suggested that her understanding of what practice teachers need to learn is derived from the NMC (2008) standards. The NMC (2008) determine that the practice teacher role should be ... *'supported by practice development activity, to provide an evidence base for teaching'* (NMC 2008 p29). This would indicate that practice teachers should be experts in their specialist area of practice. The NMC (2008) requires that practice teachers access an NMC approved course to qualify as a practice teacher, attend annual updates and demonstrate through triennial review that they have maintained and developed their clinical expertise and teaching practice. In addition they are required to support a minimum of one specialist community nursing student within the three year period. This is monitored to ensure that organisations comply.

The evidence in this study suggests that regulatory body (NMC 2008) requirements facilitate access to practice teacher courses and preferential access to continuing professional development. M4 described how practice teachers were supported by the organisation to access refresher days and time out of work to keep abreast of their role as a practice teacher (M4). PT9 concurred, describing how her role improved her access to training courses and enabled her to maintain links with the University. Students also observed that

practice teachers were encouraged to maintain their expertise. ST7 stated *'I think they get encouraged to keep up to date with their training ... and I know there was a day for students and CPT's ... that was about getting them together and about the course really'*. Whilst preferential access to professional development could be described as a form of symbolic recognition and support of the role it is more likely that the context of practice, where they are bounded by the requirements of the regulatory body, is influencing access to professional development opportunities. PT4 explained that this was the only recognition she received for her practice teacher role. *'There's nothing (in terms of recognition), apart from you being told to go on your ...make sure you're up to date on your study days. There's no recognition that you're a practice teacher...there's no encouragement'*.

The competencies and outcomes for practice teachers (NMC 2008) are a range of descriptors indicating the requirements of the role. A significant proportion of these directly relate to the practice teachers role in creating an appropriate learning environment and teaching and assessing specialist community nursing students and others. In addition to this, however, the NMC (2008) indicate that practice teachers have a duty to engage in advancing their own expertise through research and to disseminate this research in order to develop and enhance practice. They also determine that practice teachers have a responsibility to provide practice leadership and lead education in practice. NMC1 explained that a good practice teacher would be one who met all the standards (NMC 2008) *'so that ultimately we safeguard ... the health and wellbeing of the public (NMC1)*. This would suggest that the main priority for the NMC is about making safe and valid assessment decisions regarding individual students rather than determining a clearly defined role for practice teachers. A consequence of this is that though the NMC define a broader educational leadership role this is interpreted in different ways by organisations and the NMC does not concern itself with monitoring this, leaving it to be locally determined (NMC1).

The only role boundaries defined by the NMC that appear to have been maintained are those which are monitored or have some disciplinary distinctiveness. For practice teachers this relates to their one to one role

supporting a specialist community nursing student, access to professional development and participation in triennial review. The clinical and financial pressures within the productive system have constrained aspects of the role for some practice teachers and led to different responsibilities being aligned to the role.

4.6.10 Documentation

Practice teachers and nurse educators referred to course documentation provided for both the practice teacher student and the specialist community nursing student. These documents, supplied by the Higher Education Institution (HEI) gave some direction to practice teachers in enacting their one to one role with their student. PT4, for example, stated *'It's ensuring that the clinical side matches what they're taught in University ... they come out with their portfolio, we'll look at what aspects they're learning in university what they need to learn out in community and match it up that way' ... look at their learning contracts, make sure the contracts reflect what they are supposed to be learning in the community and what they are learning at university'*.

Nurse educators described the use of a tool for planning, sequencing, implementing and evaluating students experiences of teaching and learning *'one of the things that I do sometimes ... is I go and talk to the (practice teacher) students about using a portfolio and using something like Steinaker and Bell ...and they find that really helpful to have something practical so that they can get their head around what they should be doing on a practical level sitting down with their student in reflective sessions and thinking'* (FG).

Nurse educators (FG) described how their practice teacher students used a portfolio to support their own learning. *'our practice teacher (students) have to keep a portfolio rather like the (specialist community nursing) student portfolio and they have to write learning contracts and they have to evidence them and they have to use critical incidents or a reflective piece or a literature review and reflect and critique and so I think that helps them when they have a student because they've done it themselves'*.

The examples described above all support qualified and student practice teachers developing their skills in supporting practice learning on a one to one basis with their specialist community nursing student. This may be because this is a commonly understood and key aspect of the role, indeed for nurse educators their primary concern is likely to be that student practice teachers are effectively prepared to support specialist community nursing students.

Support and guidance for practice teachers in learning their role in the practice setting was much more difficult to identify. PT4 explained *'When I first started out as a practice teacher student there was not guidelines it was just 'oh this is your mentor and you'll get together and sort it out between you', whereas I think you need some guidelines so that your mentor and your student knows where you stand'*. PT2 stated *'I didn't have a mentor and there weren't many practice teachers around at that particular point (when learning the role) and we didn't meet up ... I felt that my support came from the university and it wasn't in practice and I would have liked more support in practice.....I was making up the rules as I went along'*. The evidence suggests that a lack of guidance left practice teachers feeling unsure about the requirements of the role and this lends further support to evidence presented elsewhere in the findings that practice teachers do not have a clear role identity.

Chapter 5: Conclusion

I sought to address an important gap in the literature by illuminating the broader socio-material determinants that influence how practice teachers learn and enact their role and develop their professional identity. It is of importance since practitioners are being prepared to work in health care settings where professional roles are influenced and constrained by the unique combination of features present in their specific context of practice. My review of the field enabled me to develop focused aims in relation to the identity development and role of practice teachers. The literature review offered a partial explanation in terms of understanding the nature of professional learning (Schön 1991) and socio-cultural theory (Hodkinson et al 2004). What was missing, however, was an exploration of the broader range of factors influencing practice teacher roles and professional learning. By interviewing a broader range of stakeholders and approaching the analysis with a socio-material sensibility I was able to develop new empirical insights into the networks, relationships, work practices, tools and technologies that shape practice teachers learning and enactment of their role. Attuning my sensitivities to the mundane material and immaterial features of the environment I was able to expose less visible features of the social and material world that they inhabit. Drawing upon the literature that examines identity I was able to blend the two theoretical perspectives and present new and original insights into practice teachers roles and their capacity for self determination.

The aims of this study were:

1. To critically explore the context for the preparation of practice teachers
2. To examine the perceived role and professional identity of the practice teacher from the perspectives of different stakeholders.
3. To critically examine the socio-material factors that influence how practice teachers learn and enact their role
4. To discuss the implications of the study's findings for institutions.

5.1 The context for the preparation of practice teachers

Practice teachers have a dual role that is embedded in a productive system which concentrates on achieving health care related identifiable outputs. Considering the NHS as a productive system provided a framework for understanding how the reproductive nature of the practice teacher role can be marginalised. The literature review highlighted frequent re-organisations in the NHS and a move towards a market based system characterised by policies, procedures, protocols and targets that sought to improve efficiency and contain costs. The findings revealed that economic and political factors together with major financial constraints were important factors creating instability and influencing practice teacher roles during the period that this study took place.

Practice teachers are located within individual local contexts where a unique combination of factors, including the discipline specific context and differing clinical priorities, assemble to impinge upon and influence the role. As a consequence practice teacher roles are enacted differently, even within the same organisation where they share a common job description. By attending to the different socio-material configurations I was able to illuminate how the different versions of the practice teacher role were enacted in practice. The findings revealed that a range of socio-material factors such as protocols and targets, influenced and shaped clinical roles prioritising the achievement of health care outcomes. In contrast there was an absence of networks, tools, technologies and protocols to support the practice teacher role and this led to their status being socially and structurally ambiguous.

5.2 The perceived role and professional identity of practice teachers

Professional identity does not emerge from regulatory systems and structures, but rather it is influenced and shaped by the context of practice. Practice teachers occupy a dual role where the practice teacher role is subordinate or secondary to a clinical role which is often aligned to additional leadership and management responsibilities. Clinical work was found to be a significant factor influencing when and to what extent the practice teacher role was enacted as they juggled with the competing demands on their time. Practice teachers were found to experience role ambiguity and instability, occupying a liminal socio-

cultural space where they struggled to gain a sense of the role and how it ought to be enacted. They faced continued uncertainty regarding their role and were thus compelled to compose and recompose their work identities to reflect changing organisational priorities. The only elements of the role that appeared to be stable were those which were monitored or had some disciplinary distinctiveness. This related to their one to one role supporting a community nursing student, access to professional development and participation in triennial review, as required by the regulatory body (NMC).

The title 'practice teacher' was most commonly understood to refer to the practice teacher's role supporting a community nursing student and as a consequence this was a relatively stable aspect of their role. Other duties aligned to the role were less stable and appeared to be prone to being enhanced or diminished depending upon a range of socio material factors and the political and economic climate. Variation in roles within and across organisations and disciplines created difficulties for practice teachers in establishing an unambiguous professional identity and clear role boundaries. This has contributed to the role being understood in differing ways by different stakeholders and this is despite the regulatory body (NMC 2008) determining a broader remit. It is possible that this has affected the recognition that practice teachers have been afforded for their role and it threatens the stability of the role. In district nursing and school nursing practice, for example, team leader responsibilities were commonly aligned to the practice teacher role but this was less common in health visiting.

There was evidence that managers were dissatisfied with how roles were assembled and there were suggestions that the leadership role ought to be strengthened to include training the wider workforce and coordinating service delivery. The findings indicated that managers believed that practice teachers were essential in creating a good quality workforce and they valued their clinical expertise, drawing on it to role model expert practice to staff and students and to lead and develop practice. These practices were context specific and influenced by local priorities.

Professional identity is influenced and mediated by the environment although it is clear that practice teachers have a capacity for self determination. Those entering and occupying practice teacher roles have attempted to develop a role identity but this has not been a shared group identity. The data in this study revealed that practice teachers perceived their roles differently within and across organisations and disciplines using historical role models, particularly their own practice teachers to shape their own work practices. For some practice teachers their practice teacher identity was embedded within their clinical identity and as a consequence they only identified with others who were also from the same professional discipline. For these practice teachers their perceived 'in-group' was very small and this affected the external guidance that they could draw upon to develop their practice teacher identity. Other practice teachers recognised their dual and overlapping identities. These practice teachers made efforts to create a shared group identity with practice teachers from different community nursing disciplines by forming networks and seeking to establish working relationships, for example through shared supervision processes and practice teacher forums. For these practice teachers their 'in-group' was larger and this increased opportunities to learn from one another and secure a more stable identity.

5.3 The socio-material factors influencing how the role is learned and enacted

Tracing the mundane, material and immaterial revealed the extent to which a diverse range of factors influenced practice teacher learning, role enactment and identity development within the highly productive system of the NHS. Mulcahy (2013) described how learning and knowledge circulate in relationships. The processes of knowing described in the findings show practice teachers materially engaging with the setting, for example struggling to manage the competing priorities of their clinical and teaching practice, and interacting across a range of complex networks. For practice teachers learning is distributed in social, material and textual networks. Contexts are localised and this has led to a range of differing responsibilities being aligned to the practice teacher role. Practice teacher roles have been influenced by what the different features of their specific productive system have allowed them to be.

They therefore do not share a common role identity despite being categorised as such.

Clinical and managerial elements of practice teachers dual roles were shaped by a plethora of material features including policies, guidelines, targets, and contracts related to health care delivery within a pay structure that related to knowledge and skills. Conversely there were few resources available to influence and shape practice teaching work practices other than the NMC standards (NMC 2008), variable supervision processes and a limited range of tools in the form of texts to guide practice teachers in enacting the one to one role with their community nursing student. Thus their role was vulnerable to being undermined.

5.4 Absence of technology

The use of technology is a fundamental element of commissioning and delivering health care services and is increasingly used to monitor and record clinical activity. A corollary to this is an increased requirement for practitioners to provide data. Practice teachers had learned to integrate the use of technology into their practice, role model its use with students and support health care staff to learn how to input activity data accurately. Technology has made clinical activity more visible and therefore measurable but equally it has fostered invisibility of the practice teacher role. The practice teacher role is influenced to a lesser extent by technologies of governmentality than the clinical and managerial roles that it is commonly subordinate or secondary to. The technology used to monitor and record clinical activities was not used to record teaching activities, and as a consequence practice teachers' work was rendered indiscernible. In addition the requirement to record care related activities was found to add to the overall workload of practitioners impinging upon other responsibilities. This disproportionately affected the practice teacher element of the dual role as no similar recording activity was required.

5.5 Absence of protected time

A consequence of financial constraints and the prioritisation of meeting health care targets was a lack of protected time. Evidence presented throughout the

findings indicated the significant pressures on health care providers to maximise efficiency and reduce costs and this affected practice teachers' abilities to enact their role fully and establish a more stable professional identity. Practice teachers often had to balance competing organisational and professional priorities with no protected time for most to undertake their teaching role. The time taken to support the student was allocated to the individual practice teacher and it was taken for granted by the organisation that this would be accommodated. Practice teachers learned to manage this by sometimes integrating the roles and at other times segmenting them, using temporal and spatial techniques.

5.6 Absence of / limited text related to the practice teacher role

Formal education and the associated texts made an important contribution to preparing practice teachers for the role. Programme content however, tended to focus on the practice teachers' one to one role supporting their community nursing student and this mediated how practice teachers understood the role, creating tensions when the reality of what was expected in practice differed from how they understood it. Learning in and through practice was essential to learning the role, giving student practice teachers the opportunity to perform the new role whilst still in the process of becoming a practice teacher. Despite this however, practice teachers described feeling inadequately prepared for the realities of practice and needed support in developing their professional identity.

There was little external guidance available to support practice teachers in learning their role and creating a shared group identity. The NMC (2008) make reference to a broader remit but its main focus is on the one to one role supporting the community nursing student and on protecting the public. Whilst the NMC (2008) standards inform practice learning and roles, they are not monitored and measured in the same way as performance targets related to clinical care. Though this has left potential for greater autonomy in terms of determining priorities for teaching practice, the broader context in which the role is situated, as part of a prescribed clinical role, has constrained these opportunities and enabled different stakeholders to influence the duties and responsibilities aligned to the role

Documentation was found to be available to support qualified and student practice teachers to develop their skills in supporting practice learning on a one to one basis with their community nursing student. Support and guidance for practice teachers in learning their role in the practice setting was much more difficult to identify. A lack of guidance left practice teachers feeling unsure about the requirements of the role and this lends further support to evidence presented elsewhere in the findings that practice teachers do not have a clear role identity.

Despite attempts in some organisations to more clearly define practice teacher roles, the discipline specific context and differing clinical priorities have led to the practice teacher role being enacted differently, even within the same organisation where they share a common job description. This would suggest that the socio-material factors which shape clinical roles prioritise the achievement of health care outcomes and these are more influential in shaping practice than those surrounding the practice teacher role. These factors have impinged upon the way practice teachers learn and enact their role.

Job descriptions and role descriptors are markers of recognition in health care. It was evident that organisations did not have a consistent idea about what attributes were important and what the role ought to look like. No priority had been given to the development of tools or texts to support the selection of practice teachers and this provided insights into the subordinate position of the role. This lack of clarity regarding the requirements of the role is likely to impact upon professional identity formation.

In the absence of a job description or role descriptors participants sought out alternative texts to inform their understanding of the role. Pay scales, defined in the Knowledge and Skills Framework (KSF), were significant in determining the way the practice teacher role was understood by the range of participants included in this study. Managers indicated that additional responsibilities were aligned to practice teacher roles because of their higher pay banding and practice teachers used their pay band together with their job title as a way of underpinning their status and professional identity.

5.7 Opportunities for social interactions with practice teachers

Insights have been afforded into the value placed on networking opportunities by practice teachers. Tajfel and Turner's (1985) work on social identity theory contends that individuals define themselves and others through connecting with other group members and using these opportunities to make intergroup comparisons. Individuals subsequently seek to engage in activities which are congruent with salient aspects of their group identity. Ad hoc supervision and a lack of supervisory frameworks and processes to support student practice teachers learning the role and existing practice teachers enacting the role were a common problem. Where processes hadn't been in place some practice teachers described how they had set them up themselves and undertaken work to clarify the boundaries of their role. This may be reflective of the invisibility of the role in the clinical area and facilitate access to a context where the role is valued and understood. Opportunities for learning in a socio-cultural context were constrained however, by time, geography, the nature of their clinical work and the low numbers of practice teachers in the workforce.

Most practice teachers valued the group mentoring and supervision processes that were in place to support them in learning and developing in their role, particularly valuing opportunities for sharing ideas and seeking guidance. Practice teachers described how supervision processes were used to network with other practice teachers from the same or different disciplines and also used to plan how they could work together to support organisational objectives which were discipline specific. There were, however, differences in the perceived value of multidisciplinary versus unidisciplinary supervision processes, there being both costs and benefits associated with each. Where discipline specific discussion filtered into multidisciplinary supervision it affected the perceived value of peer supervision for some and thus some of the benefits were lost. For others the multidisciplinary context provided a favourable environment for more clearly segmenting their practice teacher roles from the various clinical roles. Practice teachers described benefitting from this since it broadened their opportunities to learn from another.

5.8 Opportunities for interactions with students

Interacting with a student through enacting the practice teacher role was significant in terms of their own learning. Clinical expertise was advanced through interactions with the student, and being observed and acting as a role model had a positive influence on how they performed their clinical role. Practice teachers learned from their students and benefitted from the feedback that they received in terms of evaluating their teaching practice. In addition practice teachers were influenced by their student's expectations, motivations and attitude since all are unique and bring their own specific needs to the context of practice. The material features of the physical environment, however, constrained opportunities for some to learn through practice. This related to the increased use of mobile technology and the reduced availability of office space to work privately with their students. The limited availability of students was also a problem for some, constraining enactment of the practice teacher role.

5.9 Summary

Following interviews with a range of stakeholders I concluded that a complex entanglement of socio-material factors have influenced learning and enactment of the practice teacher role. All stakeholders viewed practice teachers through their own disciplinary lens, seeing a part of the whole whilst believing that they were seeing the whole. A socio-material sensibility illuminated the extent to which a diverse range of factors have influenced how practice teachers learn and enact their role and develop their professional identity and how their ambivalent status as both clinician and clinical teacher has rendered it difficult for them to achieve recognition for their teaching role in terms of status.

6. The policy implications for institutions

The following recommendations emerge from an evaluation of the ways in which the socio-material categories identified earlier could be utilised to improve practice learning for those entering and occupying practice teacher roles. As identified in the findings, clinical and managerial roles have distinctive features, social networks and boundaries which are reinforced by a range of tools, texts and technologies. Common distinctive features of the practice teacher role however are less well defined, other than their one to one role supporting students. Fewer processes, texts and frameworks exist to support practice teachers in creating and maintaining boundaries for their role and where these do exist they are more permeable. Practice teachers undertake a dual role where the clinical and managerial aspects dominate the education remit and consequently practice teachers receive varying degrees of recognition and reward for their role. In an organisational culture that is driven by targets a more stable role and identity might be secured through the development of supervision processes, protected time, co-teaching strategies, structured support from colleagues and appropriate resources for learning. Thus the recommendations of this thesis are:

1. Recruitment and pre-course preparation processes

In order for applicants to appreciate the requirements of the role and be in a stronger position to manage the role transition and the dual role, robust recruitment processes need to be established. These should be based on a set of role descriptors which are common to all practice teachers and form the basis of their job description, including a requirement to be an expert practitioner.

The evidence in this study suggests that student practice teachers initially feel unprepared for their role and would benefit from additional support at the beginning of their course and prior to their student arriving in the practice placement. Organisations need to consider developing structured processes to support the role transition of their student practice teachers and this should include providing insights into how the dual role is managed. These processes should begin prior to commencing in the role and should be facilitated by an experienced practice teacher colleague.

2. Educational preparation

Education makes an important contribution to the construction of professional identity and the cultural context and environment in which this takes place is significant. Nurse educators have a significant role in shaping the curriculum in order to influence professional identity development (Johnson et al 2012). This study found that practice teacher preparation programmes made an important contribution towards understanding how the role was learned and enacted, but that learning in and through practice was an essential addition to this. This study found that the taught component of programmes tended to focus on the one to one role with their specialist community nursing student. As indicated in the findings a range of differing additional responsibilities are aligned to practice teacher roles. Education programmes will need to make reference to these and incorporate strategies that practice teachers can draw upon to influence stakeholders and shape work processes and structures to create a more coherent professional identity. Practice teacher preparation programmes might also need to include a discourse that acknowledges the psychological stress of coping with a dual professional identity and offer techniques to support the development of strategies to manage this.

Managers and practice teachers themselves recognised that there was the potential to develop the educational leadership role in practice teaching much further, for example supporting the development of the wider workforce. If educational preparation is to be successful in preparing practice teachers for the challenges of contemporary health care practice then programme leaders will need to work with key stakeholders to develop a curriculum which supports practice teachers in developing a professional identity which reflects service needs.

3 Strengthen and securely embed socio-material artefacts that enable practice teachers to work together

The evidence in this study indicates that practice teachers are a small occupational group who often learn and enact their role geographically isolated from one another with limited opportunities to network with other practice teachers. This study found that supervision processes were ad hoc for some

and organised in differing ways across organisations and disciplines resulting in mixed perceived benefits and outcomes. Authors such as Mulcahy (2013) contend that networks have the potential to create knowledge as a social product. The findings from this study indicate that organisations should develop robust multidisciplinary supervision processes in order to provide a context in which new and existing practice teachers can support one another and work towards creating a more shared professional identity. Structured shadowing and mentoring processes could also be established to increase opportunities for linguistic interaction and to observe the practice of other practice teachers.

4 Develop output measures that enable the performance of practice teachers to be measured

Organisations should develop output measures that could be used to monitor the performance of practice teachers thus quality assuring practice learning opportunities for students. Such a system has the potential to improve the performance of practice teachers and thus indirectly contribute to improving health care standards.

5. Common job descriptions

Job descriptions and role descriptors provide markers of recognition. Locally designed job descriptions which integrate differing clinical, managerial and teaching roles for practice teachers according to local priorities have contributed towards the lack of distinctiveness in terms of determining what the role ought to look like. The evidence in this study points towards a need to determine a clearer role identity which gives practice teachers the opportunity to enact their role more fully, and draw on their educational expertise. As identified in the findings, practice teachers were described as clinical experts who were politically aware and who understood the broader context in which they were situated. They were described as needing to possess leadership skills in order to effectively advance clinical practice. All the managers that were interviewed acknowledged that practice teachers made a vital contribution to practice learning but recognised that the role needed to be reviewed in order to more effectively draw on their leadership skills in practice learning more broadly. This provides a favourable context for reviewing practice teacher job descriptions

more widely with a view to determining more distinctive role descriptors and a more stable education remit. Stakeholders need to work together to identify common core role descriptors which could be used to inform local discipline specific job descriptions. In a productive system a more clearly defined practice teaching role which includes an educational leadership remit has the potential to create greater stability and more distinctive work practices which draw on the expertise of practice teachers.

Subsequent to the data collection period of this study Devlin et al (2014) published a national competency framework and a suggested job description for health visiting practice teachers in order to strengthen and more clearly define their role. This document, which I co-authored, may provide insights and a starting point for stakeholder work, though it needs to be acknowledged that these were developed for the health visiting practice teacher workforce and as such do not take account of the differing disciplines priorities and work structures.

6. Reward and recognition

Health care practice is prescribed, monitored and measured and these material features give recognition to the clinical and managerial roles. In a financially constrained health care system focused upon achieving quality health care outcomes it is not difficult to appreciate how practice teacher roles have been marginalised. Organisations need to consider developing texts which state the organisations intentions for the practice teacher role and systems which capture the contribution that they make to the education of the workforce and the subsequent impact this has on improving the quality of health care. This has the potential to secure them a more stable role and enable them to develop a clearer professional identity.

The evidence that emerged from this study suggests that practice teachers require recognition to be exemplified in a way that supports effective clinical and educational practice. Roles that are valued and that receive greater social affirmation are more likely to be internalised and the individual is more likely to identify with that role (Ashforth et al 2000). Practice teacher participants in this study described differing degrees of social affirmation that they received for

their role, describing role instability and threats to their pay and conditions. This may explain why the role was perceived as subordinate to their clinical and managerial roles and may also provide insights into why they tended to only partly identify themselves as such. In order to support identity development and facilitate effective clinical and educational practice, secure employment conditions are required.

The humanistic and existential view of recognition (Brun and Dugas 2008) suggests that employees will approach their work more positively if they are provided with proper working conditions. For practice teachers this might mean having an indication that others acknowledged their existence and had taken their needs into account. It was acknowledged by some participants that the role was not universally well understood, nor was it understood in the same way by different stakeholders, and this impacted upon the recognition that practice teachers received for their role and the expectations made of them. Work needs to take place in teams to develop a shared understanding of the practice teacher role. Practice teachers need to use a range of approaches to raise awareness of their role with their colleagues in order to enhance role recognition and create an environment where time for the teaching element of their role is understood and valued.

For practice teachers time seemed to be an important symbol of recognition. In the current economic climate, however, it seems unrealistic to propose that practice teachers are given protected time to undertake their role, though clearly this would be advantageous in terms of opportunities for role development. Strengthening the professional identity of practice teachers through agreeing common core role descriptors and developing a shared understanding of the remit amongst colleagues and the wider workforce may create a context where the role is more widely understood and valued and therefore more readily integrated into the clinical workload of the team.

7. Investigate how technology can support practice teachers in learning and enacting their role

Practice teachers are a small occupational group who are often geographically isolated from one another and this creates a physical barrier to learning. Opportunities for informal learning have become increasingly constrained by the reduced access to office space and increased use of mobile technology to communicate in regard to patient care. The use of technology is securely embedded in the provision of health care but its use could also be developed to create further opportunities to share knowledge and develop practice. Organisations need to consider investing in technology and social media that could provide a new material infrastructure to facilitate learning and networking with peers.

7. Limitations of the study

Historical period

The data collection for this study took place during 2011/12, a period of severe financial constraints and, for health visitors, an unprecedented demand for increasing workforce numbers. It is therefore possible that the socio-material factors thought to be influencing practice teacher roles, identified in the findings were unique to the time and may not represent the current context of practice.

Transferability

An inductive approach was drawn upon to capture the perspectives of a relatively small number of participants from each stakeholder group, mainly in one geographical region of England about the role of the practice teacher and their learning needs. Whilst this study sought some degree of transferability, it must be acknowledged that the findings cannot be generalised to a wider population (Bowling 2002 p.188). The nature of the limitations imposed by conducting research in one geographical region were illuminated in chapter three, revealing disparities in terms of how the role was learned and enacted even within the region where this study was conducted. It is therefore acknowledged that the findings may not be transferable to other settings since it is possible that there may be a differing range of socio material factors present in other settings influencing the responsibilities aligned to the role.

Credibility, dependability and trustworthiness

As interviews with practice teachers, managers and students took place in the same region as the author's host institution it was inevitable that some participants were known to me. I had worked as a health visitor in three different organisations in the region over eleven years and subsequently taught community nursing students and practice teacher students at the host institution. To identify participants unknown to me would have required travelling some distance beyond the local region, seeking additional ethical approval and relevant permissions and would have incurred additional time and resources which were not feasible within the timeframe of the study. Whilst steps were taken to confirm my position in the study, acknowledge my

professional background and assure confidentiality it must be acknowledged that my professional position may have affected participant responses.

It was not feasible to find someone to separately analyse the transcripts and consequently the trustworthiness and dependability of the findings has not been tested. Steps were taken however, to ensure consistency, credibility and dependability. In order to add credibility to my findings and overcome the limitations presented above I presented the outcomes of my study to a group of thirty practice teachers. This group included some of the practice teacher participants included in the study. Feedback from the group suggested that the findings were closely aligned to their perceptions of the factors influencing how the role was learned and enacted. In addition the outcomes of this study have been presented at four international research conferences (see appendix 7). Audience feedback indicated that health care academics, clinicians and researchers with expertise in the socio-material identified with the study's findings, recognising also its broader relevance to clinical teaching roles in other settings.

Theoretical framework

Socio-material theory (Fenwick and Nerland 2014) provided a theoretical framework that influenced the way in which the data was analysed and presented. Whilst a focus on the socio-material was valuable in drawing attention to the mundane material and immaterial features of the context of practice it is possible that as a consequence I may have inadvertently ignored other important factors affecting learning and practitioner roles.

What I did or did not ask

It was evident in the data that there was a lack of common understanding across the different stakeholder groups around the practice teacher role and this influenced the way it was learned and enacted. Team members were found to be significant in terms of their expectations of practice teachers and how they envisaged that they should contribute to fulfilling workload priorities. In hindsight it would have been advantageous to interview team members in order

to elicit their views of the practice teacher role and also to seek insights into the extent of their support for the practice teacher role.

The liminal status of those learning the role was a significant finding of this study. In retrospect I could have examined this further had I included student practice teachers in my sample. Incorporating the views of those currently experiencing a role transition would have been preferable to relying on the recall of qualified practice teachers.

8. Areas for further research:

Despite the limitations acknowledged by undertaking this research in one geographical region this research does break new ground and leaves the potential for further research which could strengthen the evidence base.

1. Research into productive systems (Fuller et al 2006 and Felstead et al 2007) suggests that occupants of roles that are prescribed in more detail have less autonomy to make professional judgements for example in relation to planning their own work priorities and according to Fenwick et al (2012) this may lead to deskilling over time. Further research could examine the extent to which practice learning and professional expertise may be undermined by the context of health care practice.
2. Action research could be employed to test out new ways of using social media and technology to support the creation of networks and facilitate learning in community nursing practice.
3. An investigation into the perspectives of a broader range of stakeholders in differing geographical regions, has the potential to provide a richer insight into the context for learning in contemporary health care settings.

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Appendix 1

Consent form Version 2



Research Informed Consent Form

Please initial

box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without it having a direct impact on me as a student / practitioner

3. I understand that the information I provide will not be shared with anyone who is not directly involved with the research.

4. I understand that the final study outputs might contain anonymous quotations and will be available at the end of the study in the form of a thesis, journal and conference publications

5. I consent to the audio-recording of the research interview

6. I agree to take part in the above study

Participant name Date Signature

Researcher Date Signature

Contact: Karen Adams, University of Huddersfield, Queensgate, HD1 3DH.
K.L.Adams@hud.ac.uk Tel 01484 472195

Appendix 2
Participant information sheets



Information sheet for participants

Dear Course leader

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

The purpose of this study is to examine the perceived role of the Practice Teacher from the perspectives of different stakeholders. It seeks the views of different stakeholders regarding the knowledge, skills and attributes required of a good Practice Teacher and their views on how Practice Teachers should be educationally prepared and supported to undertake their role. The aim is to provide a sound evidence base to inform the educational preparation of Practice Teachers.

This research study is being undertaken in order to fulfil the requirements for the Doctor of Education in the School of Education and Professional development and is supported and funded by The University of Huddersfield. It has received ethical approval through the School of Education and Professional Development and has been reviewed by the Leeds Central Research Ethics Committee.

Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer a course leader's perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 5

course leaders and 25 additional key stakeholders will be interviewed as part of this study

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you decide to take part you will be asked to participate in a single focus group interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by group members.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit to course leaders as it aims to contribute towards developing a body of knowledge which will inform and underpin the educational preparation of Practice Teacher students.

Participation in this study has the potential to provide you with a valuable reflective opportunity and this could lead to improvements in practice based teaching and learning.

There is the potential risk of inconvenience to you due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Counseling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

This study is being conducted in order to fulfill the requirements for the Doctor of Education. As such the researcher (Karen Adams), the supervisor (Dr Ros Ollin) and possibly the external examiner will have access to your personal data.

Confidentiality will be maintained and participants will have a right to withdraw from the study at any time. Pseudonyms will be used when interviews are transcribed and no identifying information will be included. Interview recordings and transcripts will be kept securely and anonymously to preserve confidentiality. Any quotes that are used will be anonymised. All data will be combined and therefore it will not be possible to identify individuals in published work.

If, however, you were to disclose information which indicated a serious case of misconduct then there would be an obligation to inform an appropriate authority.

Who to contact regarding your rights as a participant

This research project is being supervised by Dr Ros Ollin at The University of Huddersfield who is happy to be contacted if required to provide you with further information regarding your rights as a participant. She can be contacted on 01484 478262 or email r.e.ollin@hud.ac.uk.

How will the findings be used?

An opportunity to share the outcomes of the research with all participants will be provided. In addition the findings will be shared in conference papers and journal publications. The findings from this study will contribute towards my thesis for Doctor of Education. The completed thesis will be available electronically via the University of Huddersfield repository.

If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

University of Huddersfield

Room 2/29 Harold Wilson Building

Queensgate

Huddersfield

HD1 3DH

Tel: 01484 472195

E.mail: K.L.Adams@hud.ac.uk

✂.....

Please return this reply slip to: (details provided)

or ring / email me on: Tel 01484 472195 / K.L.Adams@hud.ac.uk

I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....

Information sheet for participants

Dear manager

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

The purpose of this study is to examine the perceived role of the Practice Teacher from the perspectives of different stakeholders. It seeks the views of different stakeholders regarding the knowledge, skills and attributes required of a good Practice Teacher and their views on how Practice Teachers should be educationally prepared and supported to undertake their role. The aim is to provide a sound evidence base to inform the educational preparation of Practice Teachers.

This research study is being undertaken in order to fulfil the requirements for the Doctor of Education in the School of Education and Professional development and is supported and funded by The University of Huddersfield. It has received ethical approval through the School of Education and Professional Development and has been reviewed by the Leeds Central Research Ethics Committee.

Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer a manager's perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 5 managers and 25 additional key stakeholders will be interviewed as part of this study

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you

decide to take part you will be asked to participate in a single interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by you.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit to managers as it aims to inform the educational preparation of student Practice Teachers and therefore potentially improve the professional development of members of the workforce, the learning environment and the educational opportunities available to students in clinical practice.

Participation in this study has the potential to provide you with a valuable reflective opportunity and this could lead to improvements in practice based teaching and learning.

There is the potential risk of inconvenience to you due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Counselling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

This study is being conducted in order to fulfill the requirements for the Doctor of Education. As such the researcher (Karen Adams), the supervisor (Dr Ros Ollin) and possibly the external examiner will have access to your personal data.

Confidentiality will be maintained and participants will have a right to withdraw from the study at any time. Pseudonyms will be used when interviews are transcribed and no identifying information will be included. Interview recordings and transcripts will be kept securely and anonymously to preserve confidentiality. Any quotes that are used will be anonymised. All data will be combined and therefore it will not be possible to identify individuals in published work.

If, however, you were to disclose information which indicated a serious case of misconduct then there would be an obligation to inform an appropriate authority.

Who to contact regarding your rights as a participant

This research project is being supervised by Dr Ros Ollin at The University of Huddersfield who is happy to be contacted if required to provide you with further

information regarding your rights as a participant. She can be contacted on 01484 478262 or email r.e.ollin@hud.ac.uk.

How will the findings be used?

An opportunity to share the outcomes of the research with all participants will be provided. In addition the findings will be shared in conference papers and journal publications. The findings from this study will contribute towards my thesis for Doctor of Education. The completed thesis will be available electronically via the University of Huddersfield repository.

If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

University of Huddersfield

Room 2/29 Harold Wilson Building

Queensgate

Huddersfield

HD1 3DH

Tel: 01484 472195

E.mail: K.L.Adams@hud.ac.uk

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I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....



Information sheet for participants

Dear NMC representative

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

The purpose of this study is to examine the perceived role of the Practice Teacher from the perspectives of different stakeholders. It seeks the views of different stakeholders regarding the knowledge, skills and attributes required of a good Practice Teacher and their views on how Practice Teachers should be educationally prepared and supported to undertake their role. The aim is to provide a sound evidence base to inform the educational preparation of Practice Teachers.

This research study is being undertaken in order to fulfil the requirements for the Doctor of Education in the School of Education and Professional development and is supported and funded by The University of Huddersfield. It has received ethical approval through the School of Education and Professional Development and has been reviewed by the Leeds Central Research Ethics Committee.

Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer the Professional body's (NMC) perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 30 key stakeholders will be interviewed as part of this study

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you decide to take part you will be asked to participate in a single interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by you.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit as it aims to contribute towards developing a body of knowledge which will inform and underpin the educational preparation of Practice Teacher students and may provide evidence to inform future revisions to the Standards for Practice Teachers (NMC 2008).

Participation in this study has the potential to provide you with a valuable reflective opportunity and this could lead to improvements in practice based teaching and learning.

There is the potential risk of inconvenience to you due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Counseling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

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Who to contact regarding your rights as a participant

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How will the findings be used?

An opportunity to share the outcomes of the research with all participants will be provided. In addition the findings will be shared in conference papers and journal publications. The findings from this study will contribute towards my thesis for Doctor of Education. The completed thesis will be available electronically via the University of Huddersfield repository.

If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

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I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....

Dear Practice Teacher

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

The purpose of this study is to examine the perceived role of the Practice Teacher from the perspectives of different stakeholders. It seeks the views of different stakeholders regarding the knowledge, skills and attributes required of a good Practice Teacher and their views on how Practice Teachers should be educationally prepared and supported to undertake their role. The aim is to provide a sound evidence base to inform the educational preparation of Practice Teachers.

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Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer a Practice Teacher's perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 10 Practice Teachers and 20 additional key stakeholders will be interviewed as part of this study

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you

decide to take part you will be asked to participate in a single interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by you.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit to Practice Teachers as it aims to inform the educational preparation of student Practice Teachers and therefore potentially improve the professional development of the future Practice Teaching workforce and the educational opportunities available to community nursing students.

Participation in this study has the potential to provide you with a valuable reflective opportunity and this could lead to improvements in practice based teaching and learning.

There is the potential risk of inconvenience to you due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress, for example through reflecting on your own attributes as a Practice Teacher. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Counseling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

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How will the findings be used?

An opportunity to share the outcomes of the research with all participants will be provided. In addition the findings will be shared in conference papers and journal publications. The findings from this study will contribute towards my thesis for Doctor of Education. The completed thesis will be available electronically via the University of Huddersfield repository.

If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

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I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....



University of
HUDDERSFIELD

Inspiring tomorrow's professionals

Information sheet for participants

Dear student

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

The purpose of this study is to examine the perceived role of the Practice Teacher from the perspectives of different stakeholders. It seeks the views of different stakeholders regarding the knowledge, skills and attributes required of a good Practice Teacher and their views on how Practice Teachers should be educationally prepared and supported to undertake their role. The aim is to provide a sound evidence base to inform the educational preparation of Practice Teachers.

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Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer a student's perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 10 students and 20 additional key stakeholders will be interviewed as part of this study

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you

decide to take part you will be asked to participate in a single interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by you.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit to community nursing students as it aims to inform the educational preparation of student Practice Teachers and therefore potentially improve the learning environment and educational opportunities available to students in clinical practice.

There is the potential risk of inconvenience to participants due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress, for example through reflecting on your experiences as a student. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Students may access counseling services at The University of Huddersfield
- Counseling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

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How will the findings be used?

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If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

University of Huddersfield

Room 2/29 Harold Wilson Building

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I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....

To enable me to select a diverse student sample it would be helpful if you could provide me with the following information

Are you a Health Visiting, School Nursing or District Nursing student?.....

Are you a full time or part time student route

Are you in your 1st, 2nd or 3rd year of study?.....

What is your professional background (previous or current role)?.....

How many years is it since you last undertook any academic study?.....

Dear UKSC chair

You are being invited to take part in a research study. Your participation in this research is voluntary and will not affect your job whatever your decision. You may withdraw from the study at any time without giving a reason. Before you decide, it is important for you to understand why the research is being done and what it will involve. This information sheet explains the purpose and potential value of the study and how you may be able to contribute. If anything is unclear or you would like further information then please contact me on the details provided at the end of this sheet. Please take time to read through this information and decide whether or not you wish to take part.

What is the purpose of this research study?

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Why have I been chosen?

There is a large body of literature relating to mentor education but relatively little which focuses on the specific education needs of Practice Teachers. You have been selected as someone who will be able to offer the UKSC's perspective on the knowledge, skills and attributes required of a good Practice Teacher. Approximately 30 stakeholders will be interviewed as part of this study.

What will happen if I take part?

It is up to you to decide whether or not to take part. Participating in this study is entirely voluntary and you are free to withdraw from the study at any time. If you choose not to participate you will not be disadvantaged in any way. If you decide to take part you will be asked to participate in a single interview during 2011/12 which will last approximately one hour and will be conducted at a place of convenience selected by you.

The interview will take the form of an informed participant discussion. It will be recorded electronically and written notes will additionally be taken. I will ask you for a few personal details relating to your professional background and will ask questions to elicit your views regarding the knowledge, skills and attributes required of a good Practice Teacher.

What are the risks and benefits of taking part?

This study will be of benefit as it aims to contribute towards developing a body of knowledge which will inform and underpin the educational preparation of Practice Teacher students. It therefore has the potential to improve the learning environment and educational opportunities available to community nursing students in clinical practice.

Participation in this study has the potential to provide you with a valuable reflective opportunity and this could lead to improvements in practice based teaching and learning.

There is the potential risk of inconvenience to you due to the time involved in participating in the interview process. Additionally, there is a slight risk that the interview process might cause you some emotional distress. Should this occur the following options will be available to you:

- Debriefing/s with me following the interview.
- Counseling / supervision as appropriate / available through your employer

Will my taking part in this study be kept confidential?

This study is being conducted in order to fulfill the requirements for the Doctor of Education. As such the researcher (Karen Adams), the supervisor (Dr Ros Ollin) and possibly the external examiner will have access to your personal data.

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If you wish to discuss any aspects of the study please feel free to contact me.

Your participation in the interview process along with a written consent form will be accepted as consent to participate in the study.

If you are willing to take part then please respond by email or telephone or return the reply slip attached. I will then contact you to arrange a convenient time, date and venue for the interview.

Thank you in anticipation of your response.

Karen Adams

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I am willing to be interviewed as part of the proposed research project.

Name (print).....

Contact details to arrange an interview date.

Telephone.....

Email.....

Appendix 3

Interview guides



Specialist Community Nursing students

Interview guide (version 2)

Have you got any questions before we start?

Why

What

How

Can you give me an example

Can you explain what you mean by....

Background

1. Could you tell me about your professional background and level of experience?
2. Where did you work prior to commencing your specialist practice course?

What Practice Teachers do

3. How would you describe what Practice Teachers do?

Could you give me some examples?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

What is your knowledge based on?

4. Are you aware of any additional responsibilities assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

Your experience as a student and as a mentor

5. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

Could you tell me about the relationships that you have / have had with mentors / PT's?

How did these factors impact on your learning?

Where did your learning occur?

6. When did you commence your course?

7. As a student on your current course have you always had the same Practice Teacher?

If you have moved – was there a particular reason?

8. In what way/s is your role as a specialist practice student different from that of a pre-registration student?

9. Could you tell me about what you perceive to be your responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what way do your responsibilities differ from that of a preregistration student?

Can you give me some examples?

10. Could you give me an example of a good learning experience with a Practice Teacher in clinical practice?

What made it a good experience for you?

How did you learn?

How did your PT help you learn?

Have you had any bad experiences?

11. Have you any experience of being a mentor? How has this experience influenced your perception of what makes a good Practice Teacher?

Can you give me an example?

12. What qualities do you think a practice teacher needs to possess?

Why do you think this?

What are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor

13. Are there any aspects of your Practice Teachers practice that you admire?

Are there any aspects that you would change?

Why?

14. In what way does being a student affect your perspective in relation to what makes a good practice teacher?

Preparing & supporting Practice Teachers

15. If you were to plan the education programme for student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What are your ideas based upon?

16. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

17. What constraints are there on developing good Practice Teachers?

18. What do you think the main constraints will be in the future in creating new Practice Teachers

19. Have you got any comments to make regarding how my approach to this research could have been more helpful?

Practice Teachers

Interview guide (version 1)

Have you got any questions before we start?

1. Could you tell me about your role in the organisation?
2. How long have you worked in this organisation and in what capacity?
3. Where did you work previously?
4. How is this organisation different from where you came from?
5. Has anything impacted upon your role causing it to change in any way?
6. Could you tell me about your role as a practice teacher?
7. How long have you been employed as a practice teacher?
8. Has the job of a practice teacher changed in any way over the past 2 years?
9. What factors have influenced the responsibilities assigned to the role?
10. What do you think makes a good practice teacher? What knowledge, skills and attributes do you need?
11. Why do you think this – what are your ideas based upon?
12. Do you think that being a practice teacher yourself affects your perspective in any way?
13. How should practice teachers be educationally prepared and supported to undertake their role?
14. Why do you think this? What are your ideas based upon?

Practice Teachers

Interview guide (version 2)

Have you got any questions before we start?

Why

What

How

Can you give me an example

Can you explain what you mean by....

Background

1. Could you tell me about your role in the organisation?
2. How long have you worked in this organisation and in what capacity?
3. How long have you been employed as a Practice Teacher?
4. Where did you work previously?
5. How is this organisation different from where you came from?

What Practice Teachers do

6. How would you describe what Practice Teachers do?

Could you give me some examples of what practice teachers do & their responsibilities?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

Can you give me an example of how you teach / assess?

In what ways is it different from how mentors teach / assess?

What is your knowledge based on?

7. Has anything impacted upon your role causing it to change in any way over the last 2 years?

8. What additional responsibilities are assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

What factors led to the addition of these responsibilities?

Practice teaching itself

9. Could you tell me about your experiences of being a practice teacher?
What are your responsibilities?

10. How many students have you supported in your role as a Practice Teacher?

11. How has your practice teaching experience shaped your perception about what makes a good Practice Teacher?

12. What do you think makes a good practice teacher? What knowledge, skills and attributes do you need?
Why do you think this – what are your ideas based upon?

13. What qualities do you think a practice teacher needs to possess?

Why do you think this?

What are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor

14. Could you give me an example of a good teaching experience with a student in clinical practice?

What made it a good experience for you?

How did your student learn?

How did you help her / him learn?

How did you know that your teaching had been effective?

Have you had any bad experiences?

15. In what way/s is being a practice teacher different from being a mentor?

16. Could you tell me about what you perceive to be the students responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what ways does this responsibility differ from that of a preregistration student?

Can you give me some examples?

17. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

Preparing & supporting Practice Teachers

18. Could you tell me about the preparation that you undertook for your role as a Practice Teacher?

In what ways did it prepare you for the role?

Were any aspects of the role unexpected to you?

What was good about the preparation?

What would you have changed about your preparation?

How were you supported in practice?

19. If you were to plan the education programme for student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What are your ideas based upon?

20. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

21. What factors impinge on your role as a Practice Teacher?

How could these issues be addressed / overcome?

22. What constraints are there on developing good Practice Teachers?

23. What do you think the main constraints will be in the future in creating new Practice Teachers

24. Have you got any comments to make regarding how my approach to this research could have been more helpful?

Practice Teachers

Interview guide (version 3)

Have you got any questions before we start?

Why

What

How

Can you give me an example

Can you explain what you mean by....

Background

1. Could you tell me about your role in the organisation?
2. How long have you worked in this organisation and in what capacity?
3. How long have you been employed as a Practice Teacher?
4. Where did you work previously?
5. How is this organisation different from where you came from?

What Practice Teachers do

6. How would you describe what Practice Teachers do?

Could you give me some examples of what practice teachers do & their responsibilities?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

Can you give me an example of how you teach / assess?

In what ways is it different from how mentors teach / assess?

What is your knowledge based on?

7. Has anything impacted upon your role causing it to change in any way over the last 2 years?

8. What additional responsibilities are assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

What factors led to the addition of these responsibilities?

Practice teaching itself

9. Could you tell me about how you made your decision to become a Practice Teacher?

10. Could you tell me about how your views on what practice teaching is may have changed since becoming a practice teacher?

11. Could you tell me about the practice teacher that you are today?

What most contributed to this change / continuity?

What are your responsibilities?

How do these factors impact upon student learning?

12. Could you tell me about the status of practice teachers in your organisation?
Has the status of the role changed in any way over the past 2 years?
- Why do you feel that this is so?*
- What recognition do you get for your role (employer / student / team / elsewhere)*
13. How many students have you supported in your role as a Practice Teacher?
Could you tell me about the particular attributes of your students?
- How do these differing attributes impact upon student learning?*
14. Could you tell me about the relationship that you have with your student
15. How has your practice teaching experience shaped your perception about what makes a good Practice Teacher?
16. What do you think makes a good practice teacher? What knowledge, skills and attributes do you need?
Why do you think this – what are your ideas based upon?
17. What qualities do you think a practice teacher needs to possess?
- Why do you think this?*
- What are your ideas based upon?*
- Could you explain why these are important?*
- In what ways are they different from what makes a good mentor*
18. Could you give me an example of a good teaching experience with a student in clinical practice?
- What made it a good experience for you?*
- How did your student learn?*
- How did you help her / him learn?*
- How did you know that your teaching had been effective?*
- Have you had any bad experiences?*

19. In what way/s is being a practice teacher different from being a mentor?

20. Could you tell me about what you perceive to be the students responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what ways does this responsibility differ from that of a preregistration student?

Can you give me some examples?

21. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

Preparing & supporting Practice Teachers

22. How did you learn your role as a Practice Teacher?

What factors stand out as the most important factors influencing your learning?

Were any aspects of the role unexpected to you?

Could you tell me about your educational preparation?

In what ways did it prepare you for the role?

What would you have changed about your preparation?

How were you supported in practice?

Tell me about your relationship with other Practice Teachers – in what ways does this contribute or not to your learning?

What other factors contributed towards your learning to become a PT?

What advice would you give someone who was about to take on the role of PT?

23. If you were to plan the preparation of student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What are your ideas based upon?

24. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

25. What factors impinge on your role as a Practice Teacher?

How could these issues be addressed / overcome?

26. What constraints are there on developing good Practice Teachers?

27. What do you think the main constraints will be in the future in creating new Practice Teachers

28. Have you got any comments to make regarding how my approach to this research could have been more helpful?

Managers

Interview guide (version 2)

Have you got any questions before we start?

Why

What

How

Can you give me an example

Can you explain what you mean by....

Background

1. Could you tell me about your role in the organisation?
2. Has anything impacted upon your role causing it to change in any way over the past 2 years?
3. Could you tell me about your role in relation to your responsibilities for managing practice teachers?
4. How long have you worked in this organisation and in what capacity?
5. How long have you been employed as a manager?
6. Where did you work previously?
7. How is this organisation different from where you came from?

What Practice Teachers do

8. How would you describe what Practice Teachers do in your organisation?

Could you give me some examples of what practice teachers do & their responsibilities?

What factors have influenced the responsibilities assigned to the role?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

What is your knowledge based on?

Do you think that being a manager affects your perspective in any way?

9. Could you tell me about the status of practice teachers in your organisation?

Has the status of the role changed in any way over the past 2 years?

Why do you feel that this is so?

What recognition do they get for their role? (employer / student / team / elsewhere)

10. Has anything impacted upon the role of the Practice Teacher causing it to change in any way over the last 2 years?

11. What additional responsibilities are assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

What factors led to the addition of these responsibilities?

Practice teaching itself

12. What do you think makes a good practice teacher? What knowledge, skills / attributes / qualities do you need?

Why do you think this – what are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor?

13. Could you tell me about how your views on what practice teachers do may have changed since becoming a manager of practice teachers?

14. Tell me about your experiences of being a mentor or Practice Teacher?

In what ways has this experienced shaped your perception about what makes a good Practice Teacher?

15. In what way/s is being a practice teacher different from being a mentor?

16. Could you tell me about what you perceive to be the students responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what ways does this responsibility differ from that of a preregistration student?

Can you give me some examples?

17. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

Preparing & supporting Practice Teachers

18. How are potential Practice Teachers selected for the role?

What are you looking for when you select an individual to take on the role of a PT

In what way is their learning supported in clinical practice?

19. If you were to plan the educational preparation of student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What other factors are important in learning to become a PT?

What are your ideas based upon?

20. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

21. What factors impinge on the role of a Practice Teacher?

How could these issues be addressed / overcome?

22. What constraints are there on developing good Practice Teachers?

23. What do you think the main constraints will be in the future in creating new Practice Teachers

24. Have you got any comments to make regarding how my approach to this research could have been more helpful?

NMC representative

Interview guide (version 1)

Have you got any questions before we start?

Background

1. Could you tell me about your professional background
2. Could you tell me about your role in the organisation?
3. Where did you work previously?
4. How is this organisation different from where you came from?
5. Could you tell me about the NMC's role in relation to setting the Practice Teacher Standards as defined in 'Standards to Support Learning and Assessment in Practice' (NMC 2008)?
6. How were the standards developed?
7. Who was involved?

What Practice Teachers do

8. How would you describe what Practice Teachers do?

Could you give me some examples of what practice teachers do & their responsibilities?

What factors have influenced the responsibilities assigned to the role?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

What is your knowledge based on?

9. Could you tell me about the status that is ascribed to practice teachers?
Has the status of the role changed in any way over the past 2 years?
Why do you feel that this is so?

10. Has anything impacted upon the role of the Practice Teacher causing it to change in any way over the last 2 years?

11. What additional responsibilities are assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

What factors led to the addition of these responsibilities?

Practice teaching itself

12. What do you think makes a good practice teacher? What knowledge, skills / attributes / qualities do you need?
Why do you think this – what are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor?

13. Could you tell me about how your views on what practice teachers do may have changed since working for the NMC?

14. Tell me about your experiences of being a mentor or Practice Teacher?

In what ways has this experienced shaped your perception about what makes a good Practice Teacher?

15. In what way/s is being a practice teacher different from being a mentor?
16. Could you tell me about what you perceive to be the students responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what ways does this responsibility differ from that of a preregistration student?

Can you give me some examples?

17. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

Preparing & supporting Practice Teachers

18. How should Practice Teachers learn their role?
19. If you were to plan the educational preparation of student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What are your ideas based upon?

What other factors are important in learning to become a PT?

20. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

21. What constraints are there on developing good Practice Teachers?

22. What do you think the main constraints will be in the future in creating new Practice Teachers

23. Have you got any comments to make regarding how my approach to this research could have been more helpful?



UKSC Chair

Interview guide (version 1)

Have you got any questions before we start?

Why

What

How

Can you give me an example

Can you explain what you mean by....

Background

1. Could you tell me about your role as Chair of the UKSC?
2. How long have you been a member of this organisation?
3. What is the purpose of this organisation?
4. How has the role of the organisation changed over the past 2 years?
5. Why did you become a member of this organisation?
6. Could you tell me about the UKSC's interest / involvement in Practice Teaching?

What Practice Teachers do

7. How would you describe what Practice Teachers do?
What is your knowledge based on?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

8. How has the job of a practice teacher changed in the past 2 years?

Could you tell me about the factors that have influenced the changes to what practice teachers do?

9. Are you aware of any additional responsibilities assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

Your experience as a student & as a mentor / PT

10. Can you tell me about your experiences of being a student with an assigned mentor / PT for your clinical practice?

How have these experiences shaped your perception about what makes a good Practice Teacher?

11. Could you give me an example of a good learning experience with a Practice Teacher in clinical practice?

What made it a good experience for you?

How did you learn?

How did your PT help you learn?

Have you had any bad experiences?

12. Have you any experience of being a mentor or PT? How has this experience influenced your perception of what makes a good Practice Teacher?
Can you give me an example?

13. What qualities do you think a practice teacher needs to possess?

Why do you think this?

What are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor

14. In what way does being the Chair of UKSC affect your perspective?

Preparing & supporting Practice Teachers

15. If you were to plan the education programme for student Practice Teachers what would it look like?

What would you include?

How would it be delivered?

Who would be involved?

Why do you think this?

What are your ideas based upon?

16. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

17. What constraints are there on developing good Practice Teachers?

18. What do you think the main constraints will be in the future in creating new Practice Teachers

19. Have you got any comments to make regarding how my approach to this research could have been more helpful?

Nurse educators

Focus group guide (version 2)

Have you got any questions before we start?

Gather information from each participant in a short questionnaire before commencing the focus group.

1. What is your role in the HEI?
2. How long have you worked in higher education?
3. How long have you been involved with the educational programmes leading to Practice Teaching & Specialist Practice qualifications?
4. Where did you work previously?

What Practice Teachers do

1. How would you describe what Practice Teachers do?

Could you give me some examples of what practice teachers do & their responsibilities?

Could you give me an example of what a Practice Teacher's day might look like?

In what way/s is this different from what a mentor's day might be like?

Can you give me an example of how PT's teach / assess?

In what ways is it different from how mentors teach / assess?

What is your knowledge based on?

2. What factors have impacted upon the role of Practice Teachers over the last 2 years?

3. What additional responsibilities are assigned to Practice Teachers that extend beyond their direct involvement with their assigned student?

Could you give me some examples of these additional responsibilities?

What factors led to the addition of these responsibilities?

Practice teaching itself

4. Could you tell me about how your views on what practice teaching is may have changed since becoming an academic?

5. Could you tell me about the status of practice teachers locally?
Has the status of the role changed in any way over the past 2 years?

Why do you feel that this is so?

What recognition do Practice Teachers get (employer / student / team / elsewhere)

6. What do you think makes a good practice teacher? What knowledge, skills and attributes do you need?
Why do you think this – what are your ideas based upon?

7. What qualities do you think a practice teacher needs to possess?

Why do you think this?

What are your ideas based upon?

Could you explain why these are important?

In what ways are they different from what makes a good mentor

8. In what way/s is being a practice teacher different from being a mentor?

9. Could you tell me about what you perceive to be the students responsibilities as a learner / student in clinical practice on a specialist practice course (HV/SN/DN/OH/CCN)?

In what ways does this responsibility differ from that of a preregistration student?

Can you give me some examples?

Preparing & supporting Practice Teachers

10. Could you tell me about the preparation programme for Practice Teachers in your HEI's?

How are candidates selected?

What do you include?

How do you deliver it?

In what ways do you develop the knowledge requirements?

In what ways do you develop the skills requirements?

In what ways do you develop the attitudes / behaviour requirements?

Who is involved?

How was it written?

In what ways does it prepare Practice Teachers for the role?

Would you change anything about this preparation?

11. Please could you look at the list of needs identified by Practice Teachers in my earlier interviews (see below)

To what extent do current programmes address these needs?

To what extent do you agree that these needs should be addressed in a PT programme

12. How do Practice Teachers learn their role?

What factors stand out as the most important factors influencing learning?

How are student Practice Teachers supported in practice?

In what ways do other Practice Teachers contribute or not to learning?

What other factors contribute towards learning to become a PT?

What advice would you give someone who was about to take on the role of PT?

13. What supervision and support is available to Practice Teachers?

Could you give me an example of what this looks like?

Who is involved?

Do you see a need for anything in addition to this?

What might this look like?

14. What factors impinge on the role of a Practice Teacher?

How could these issues be addressed / overcome?

15. What constraints are there on developing good Practice Teachers?

16. What do you think the main constraints will be in the future in creating new Practice Teachers

17. Have you got any comments to make regarding how my approach to this research could have been more helpful?

Appendix 4

Focus group interview prompts – relates to question 11 of the nurse educators interview guide

- Creating an appropriate learning environment / planning learning experiences
- Creating a learning culture in the placement
- Identifying the training needs of students
- Supporting students in the transition from one role to another
- Professional boundaries
- Relationship with the student
- What it's like to be a PT
- Role of PT
- Being a role model
- Skills based training
- Relate theory to practice
- Hands on experience - Having a specialist practice student whilst undertaking the course is key
- How to interact with the student
- How to impart knowledge
- Active listening / motivational interviewing, asking open questions, communication skills
- Skills to do role play
- Learning contracts
- Portfolios
- Teaching skills
- Learning styles
- Coping with challenge
- Giving feedback
- Assess the 'way' the student does things, how they interact
- Managing failing students

- Legal & ethical aspects / accountability
- Setting standards for practice
- Organisational skills
- Managing competing demands of student & caseload
- Course administration
- Opportunity for supervision with PT colleagues & academic team eg to discuss how to manage a student that is not progressing as planned / failing
- Opportunity to share experiences with other PT's
- Contact time with university teaching team valued
- Course delivered by a teaching team with expertise in relevant specialist practice disciplines
- Prior knowledge regarding what their specialist student is trying to achieve & the rate at which they are expected to progress

Appendix 5

Participants

Student participants

Students Interview guide version	Type of student	code	Date of interview	Professional background / previous role	Venue	Years since last HEI education
Version 2	DN Year 1 FT	ST1	15 March 2011	2 yrs exp as band 5 in DN team Organisation 1	Uni	1
Version 2	HV year 3 PT	ST2	23 March 2011	Experience as a Band 5 in a HV team Organisation 2	Uni	3
Version 2	HV year 2 PT	ST3	24 March 2011	No Band 5 exp. Entered SCPHN prog direct from qualifying as RN (child) Organisation 3	home	Straight from pre reg prog
Version 2	HV year 2 PT	ST4	19 May 2011	Experience as a Band 5 in a HV team Organisation 4	Uni	9 months
Version 2	DN Year 1 FT?	ST5	5 April 2011	6 yrs exp as band 5 in DN team Organisation 3	Uni	1
Version 2	SN PT yr3	ST6	6 April 2011	Nursing sister in primary care Organisation 5	home	13
Version 2	SN Year 2 PT	ST7	22 June 2011	Experience as a Band 6 School Nurse Organisation 3	Uni	1
Version 2	HV Year 1 PT	ST8	3 May 2011	Paediatric nurse Organisation 3	Uni	1

Practice teacher participants

PT's Interview guide version	Role		Date of interview			Level of experience as a PT
Version 2	SN PT & TL Grade 7	PT1	27 June 2011	Organisation 3	clinic	2
Version 2	HV PT & Practice educator Grade 7	PT2	20 September 2011	Organisation 4	clinic	6 students in 4 yrs as pt
Version 2	HV PT & TL Grade 7	PT3	11 July 2011	Organisation 5	clinic	6
Version 3	DN PT & TL Grade 7	PT4	9 January 2012	Organisation 3	clinic	1
Version 3	DN PT & PE Grade 7	PT5	16 November 2011	Organisation 4	clinic	several
Version 3	SN PT & TL Grade 7	PT6	15 December 2011	Organisation 4	clinic	4
Version 3	DN PT & TL Grade 7	PT7	20 January 2012	Organisation 2	clinic	7
Version 3	DN PT Grade 7	PT8	27 February 2012	Organisation 6	clinic	2
Version 3	HV PT Grade 7	PT9	5 March 2012	Organisation 3	clinic	3
Version 1 (pilot)	HV PT & PLF Grade 7	PT10	28 January 2011	Organisation 3	Uni	several

Manager, NMC and UKSC participants

Manager interview guide version	Background		Date of interview		
Version 2	HV	M1	28 October 2011	Organisation 6	University
Version 2	SN	M2	19 th Dec 2011	Organisation 2	clinic
Version 2	SN	M3	8 March 2012	Organisation 3	clinic
Version 2	DN	M4	1 June 2012	Organisation 2	clinic
NMC rep	Role		Date of interview		
1	Education advisor NMC	NMC1	21 November 2011	NMC	telephone
UKSC rep	Role		Date of interview		
1	Chair of national body representing nurse educators	UKSC 1	18 March 2011		Meeting room

Nurse educator participants

Nurse educators Focus group			
1	FG	March 2012	East Anglia
2	FG	March 2012	South east England
3	FG	March 2012	Yorkshire
4	FG	March 2012	Yorkshire
5	FG	March 2012	West Midlands
6	FG	March 2012	East Anglia

Appendix 6

Example code book

Initial code	Learning the role	
Subcategory 1	Learning through interaction with students	
Coding categories	Definition:	Sample quotes
Student expectations	Examples of what students expected from their practice teacher	<i>'The main thing is the fact that you're with the practice teacher for the whole placement ... so I think getting that relationship right and understanding each other is much more important.'</i> (ST2)
		<i>'Keeping abreast of their own learning ... and being able to use that information then to guide the student'</i> (ST6)
		<i>they're there to teach students ... the practical side ... they're there to assess students and see where they're at in their training ...and also teach them everything from the background of their role to ...things that are changing currently in practice'</i> (ST3)
Working with a student	Doing the job	<i>'I think the main thing to me really was ... putting it into practice ... having a student and being supported (by the course team) about having that student'</i> (PT2)
		<i>'In clinic ... she had a really good way of diffusing situations and I would sort of look and quickly think 'well how's she handled...'' and would then go to her and say 'look, you know, I've just observed how you dealt with that. How come you were quite strict?'</i> (ST3)
Restricted opportunities to learn through working with a student	Not having sufficient opportunity to do the job	<i>'we've so many practice teachers now and not a lot of students coming through, they're rotating them'</i> (PT6)
Learning from the student	Practice teachers draw on student knowledge to keep clinically up to date	<i>'it's two ways, you learn from students, different information different things'</i> (PT5)
		<i>'I feel it's a bit more on a level... working with them ... they do teach me but ... we both sort of teach each other, she learns a lot from me you know'</i> (ST1)
		<i>'I'm always saying to the students 'if you learn anything new please tell me because I can't read everything' and when you're in practice sometimes it's hard to keep up to date and I think having a student helps you to do that'</i> (PT9)
Feedback from students	Types of feedback from students that practice teachers draw on	<i>'it's about ... taking some hints from your student. I think if you were doing anything majorly wrong with them you would hope that you would pick up on it'. (PT1)</i>
		<i>'that was such a great learning experience and I'm glad you didn't answer it all for me because people have been doing that in the office for me recently'. (PT2)</i>
		<i>'we were learning together and for me that was very beneficial because I could actually say to her 'I am just learning so if it's not working or whatever, tell me because I don't know'.(PT6)</i>
Motivations to do the job	Intrinsic rewards facilitate /	<i>'I don't think they (HV colleagues) realised how invigorating it was (to have a student in the office) (PT3).</i>

	motivate practice teacher learning	
		<i>'I think it's really fulfilling and rewarding when you see your student then go on to manage a team and they're successfully managing the team it's nice (PT4).</i>
		<i>'if they're (the student) motivated you're more motivated to teach them' (PT4).</i>
Subcategory 2	Learning through interaction with peers	
Coding categories	Definition:	Sample quotes
Informal support	Ad hoc support	<i>'I see other practice teachers / practice educators sort of in their role and we do share ideas' (PT2)</i>
		<i>'I had a couple of CPT's who were good around me who I drew on.... I can remember having quite a detailed conversation with one of my CPT's about 'how friendly are you towards the student?' What are your boundaries? What are your professional personal boundaries? Because that was quite tricky, I felt, and it wasn't covered on the course' (PT3).</i>
		<i>'In my own discipline I've got the person that supervised me whilst I was doing the course (she) is still there available for me should I need any one to one support' (PT1).</i>
Uni-disciplinary Peer supervision	Learning the role with peers who are from the same clinical background	<i>'We meet on a monthly basis and part of that meeting is ... networking, we talk about our roles, reflect a bit ... and then the other side is a little bit more operational, so our manager comes to that part of it ... so for instance with the Health Visitor Implementation Plan it was about (how) we were going to get there, what we were going to do, what the expectations of the organisation was and what ideas. So it was looking at our ideas as sort of a joint support / focus group... and looking at what we could do and how we could achieve this ... it's not just a one way process it's about communicating this back to our teams as well' (PT2).</i>
Multi-disciplinary peer supervision positive experience for learning	Learning the role with peers who are from differing clinical backgrounds – positive experiences	<i>'We (school nurse practice teachers) joined with the health visitors (practice teachers) and we've been having bi-monthly (supervision) meetings....we learn a lot from each other' (PT1).</i>
		<i>'When I look back what helped me to learn was talking and meeting with other practice teachers ... learning from each other and discussing how we managed different situations' (PT5).</i>
		<i>'I sort of link up with not just the district nurse practice teachers but I'm also friendly with the school nurse (and) health visitor (practice teacher), because even though their role is different I think there's quite a lot (of) commonalities ... we've made a meeting so we can all get together and see where we're at' (PT7).</i>
Multi-disciplinary peer supervision negative experience for learning	Learning the role with peers who are from differing clinical backgrounds – negative experiences	<i>'I am obviously on the practice teacher forum.....but I've got to say it is very health visitor biased, very heavily... and it's a waste of time quite honestly for me' (district nurse practice teacher) (PT8).</i>
		<i>'well my (practice teacher) colleague (same discipline), she gives me quite a lot of support. I find it very challenging with the health visitor practice teachers, I feel they have their own</i>

		<i>agenda and the school nurse practice teachers are not included in that ... I find it quite difficult sometimes with them in meetings, they do quite dominate ... it's as though I'm not heard or I'm ignored and I find it a little bit disrespectful'. (PT6)</i>
Difficulties accessing support / supervision	Factors influencing access to support / supervision	<i>'(supervision) has been difficult ... because there are so few of us and because the people that I may be could access were busy.... my mentor is at (...) you can see how far away that is ... it's not practical ... so really it was telephone conversations... because you've still got to get on with the day job' (PT8).</i>
		<i>'I didn't really have any contact with any practice teachers from over here until I started the course ... I think I even struggled to get a practice teacher at the beginning to mentor me ... there was only three of them, three practice teachers and I think there was five practice teacher students, so it was quite hard at the time' (PT4).</i>
		<i>'I didn't have a mentor and there weren't many practice teachers around at that particular point and we didn't meet up ... I didn't have any sort of preceptorship, and I didn't know really ... I was making up the rules as I went along' (PT2)</i>
		<i>'(I) had indirect contact really with some of the practice work teachers ... I don't think I had many role models to look to'. (PT8)</i>
		<i>'We had a practice teacher that had already been signed off for a number of years. The only problem ... was getting together. It was hard. We did a lot of talking over the phone because of me based here and the other practice teacher at ... it's the distance, and it was getting together'. It would have been better if there had been somebody over this side but I don't think there was that many practice teachers, so support was quite sparse ...a lot of telephone contact, but they were there to support us when we needed it (PT4)</i>
		<i>'in some areas I work they do actually have specific supervision within their practice area' ... 'I think that's very limited, very limited' ...'they should be having their own peers support within their organisation ... a few of them get clinical supervision but that's not across the board either, where they might be able to bring up issues' (FG).</i>
Absence of frameworks to support supervision	No formal organisational structures to support practice teachers	<i>'we leave it entirely up to them (student practice teachers) to organise that (support and supervision) ... at that level they should be able to be self-directed really' (M3)</i>
		<i>'I don't think we've got anything written down; it would be more as the support is needed really (for student practice teachers) (M1).</i>
		<i>I think organisationally we have allowed the practice educator to operate within the function without having any organisational measures on that' (M4)</i>

Appendix 7

Example of coding an interview transcript

So can you tell me more about the education preparation, you know, in what way has it prepared you for the role?

I think it was **coming back into education**. I think because that inspires you, I think it challenges you. I certainly feel when I **come in to University and I'm doing the course, I certainly feel more inspired** and like I have more knowledge for some reason. I think because **you work then with like minded people**, where as **when you're in your job doing your job day in day out, you've got all the, you know, constraints of what's happening in the Trust, lack of money blah, blah, blah** and so all of that is in your head all of the time. You come out and you come into University and **you're with people who are doing the same as you** and your with Lecturers and people with a lot of knowledge, I think it's really inspirational and I think it just helps you up the anti really, **makes you want to do better**, makes you want to do more back out in Practice.

Is there anything that you would change about your preparation to become a Practice Teacher?

Erm I probably would have got **a little bit more knowledge about it** and I probably would have, in hindsight, when I started the course, **prepared myself** and been more structured had I known that there was going to be that length of time where we sort of had not direct

Spatial separation from clinical role
Feels valued

Spatial separation prevents clinical role encroaching and supports PT identity development

Constraints of managing a dual role in a productive system

Spatial separation creates an environment to developing a shared identity

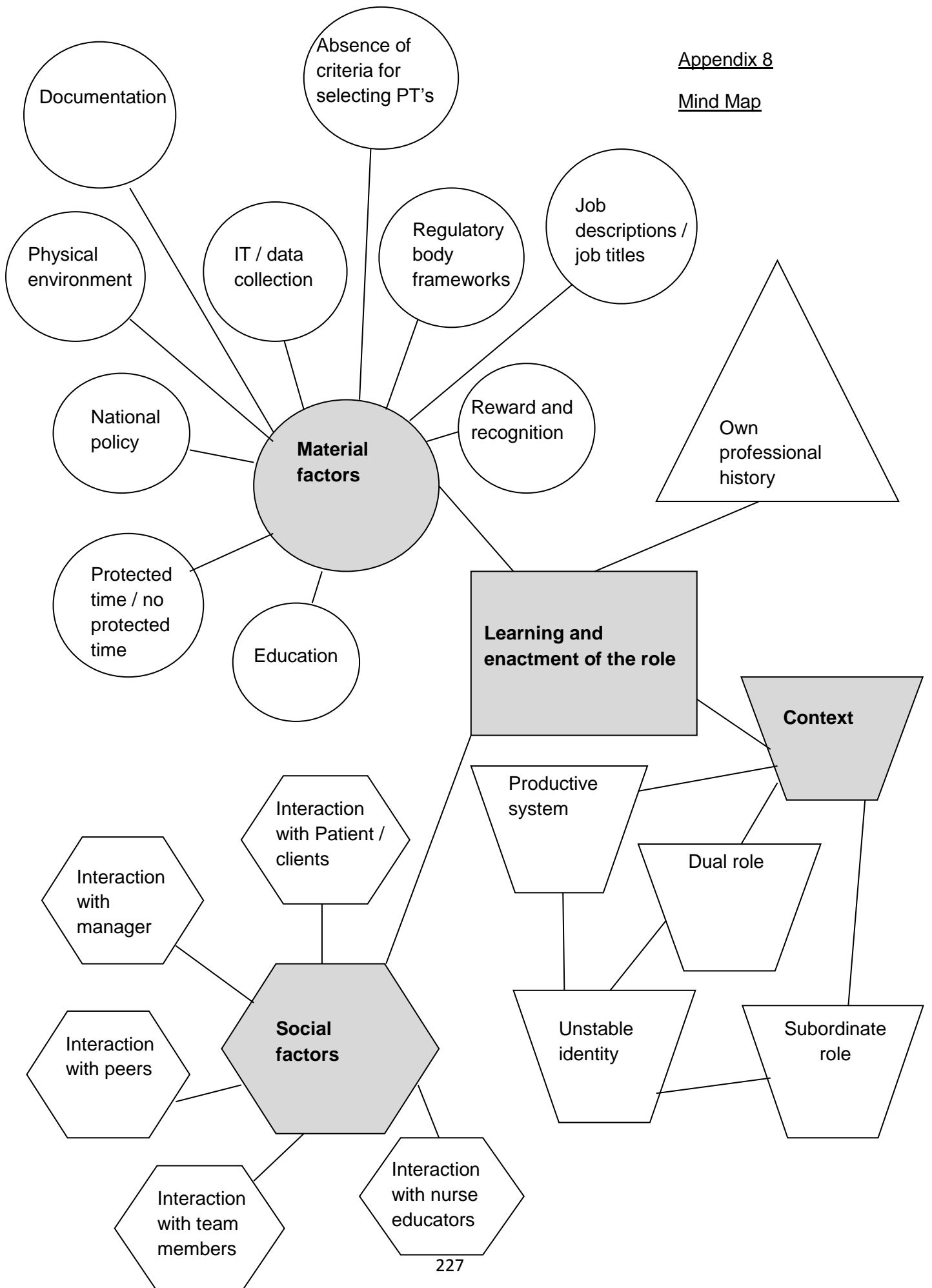
Supportive and motivating

Feeling unprepared

Should have planned better

<p>contact in University. I didn't really sort of think that far ahead I don't think so maybe plan a bit better and structure my time better.</p>	<p>Fluctuating status</p>
<p>K: How are your supported in Practice in terms of your Practice Teaching role?</p>	
<p>: I think we've had a period of time where we haven't been supported and that co-incided with being brought back into Practice 100% of the time. We no longer went to Senior Team Meetings; we weren't included in any of that. But there's been a turn around, change in Management and that all seems to be sort of resolving and so we now have someone who meet with month by monthly and that feels more supportive. They want to know, you know, if we've any issues, what we're doing, where we're going, what's happening, you know, is there anything that we need to access, so that feels really more supportive than it has done probably for about 18 months 2 years. So that's really good and so I do think there is that level of support now whereas before, like I said, we were demoted and we weren't included in that. And I also feel that people don't give us the recognition at the Band that we're at, we should be able to have more influence and I'm hoping now with this change in Management that that will come again and we will be influential. But I also, within that, it becomes quite difficult because there are only 2 of us in</p>	<p>Clinical pressures prioritised over education remit</p> <p>Diminished status / unstable role</p> <p>Fluctuating status and recognition for role</p> <p>Structured support makes PT feel valued</p> <p>Fluctuating status</p> <p>Pay grade significant in determining status</p> <p>PT keen to be proactive in shaping role</p> <p>Small PT workforce</p>

<p>School Nursing, so where as there are sort of 4 in Health Visiting, Practice Educators, and there are 4 of them to share things out, there's only 2 of us in School Nursing which means we come away with twice as much to do as the Health Visiting colleagues and that can be quite hard bearing in mind the caseloads, the fact that we've had 2 students, you know, for several years, it has been really quite hard to manage. But I do feel like we're getting more support now which is positive.</p>	<p>Challenging to manage workload / dual role</p>
<p>Ok. Tell me about your relationship with other Practice Teachers and how that contributes or not to your learning?</p>	
<p>Well my colleague, she gives me quite a lot of support and I've got another colleague who's done the Practice Teacher course but she's not actually a Practice Educator, we have a good relationship and we do meet and we do discuss the students. Obviously our students are in the same Cohort and they're at so we do discuss them together and any issues that we may or may not have. I find it very challenging with the Health Visitor Practice Educators, I feel that they have their own agenda and the School Nursing Practice Educators are not included</p>	<p>Informal support from PT colleagues</p> <p>Feel excluded from wider PT community of practice. Differing clinical roles creates a barrier to developing a shared PT identity</p>



Appendix 9

Outputs related to this study

Conference presentations:

1. QNIS / ICCHNR International Conference – *Transforming Community Health: The Nursing Impact, Edinburgh (2013).*
The Education Needs of Practice Teachers
2. 15th Health Care interdisciplinary research conference in Dublin (2014)
The Education Needs of Practice Teachers
3. Nurse Education Today Conference Cambridge (2015)
Practice Education in a Productive System
4. 3rd International ProPel Conference Linkoping Sweden (2017)
The Practice and Identity of Liminal Professionals: exploring the social and the material context for practice teachers in the health service, and learning mentors in schools in the UK (with co-presenter: Pete Sanderson)

Publications:

1. Adams, K (2013) '[Practice teaching: professional identity and role recognition](#)' *Community Practitioner*, 86 (10), pp. 20-23. ISSN 1462-2815
2. Devlin, A., Adams, K., Hall, L. and Watts, P. (2014) [Educating Practice Teachers and Specialist Practice Mentors for their new role: Ensuring high quality Practice Learning](#). Health Education England
3. Sanderson P, Adams K, Bishop J (2017) *The Practice and Identity of Liminal Professionals: exploring the social and the material context for practice teachers in the health service, and learning mentors in schools in the UK* (draft paper)

Appendix 10

Approval forms and letters

The University of Huddersfield
School of Education and Professional Development

Minutes of the School Graduate Education Group

21 April 2010

Reviewers: Dr P Sanderson (Chair), Professor J Avis, Professor M Halstead,
Dr A Harris, Dr C Jarvis, Dr P Oliver

Secretary: S Brown

Following the receipt of urgent business, the Director of Graduate Education requested that this meeting was conducted 'virtually' with reviewers comments provided via email.

SEPD-SGEG-21Apr10-M1 FORM 2 APPLICATION FOR APPROVAL

1.1 Karen Adams – EdD

Main Supervisor: *Dr Ros Ollin*

Title: *A critical investigation to determine the education needs of Practice Teachers*

1.2 In preparation for the first annual progress report, SGEG members reviewed the proposal and provided their advisory feedback.

1.2.1 This proposal is thorough, well informed and well organised, and the

ethical issues involved are thoroughly discussed and accounted for.

Professor King in HSS has offered to support Karen in the process of
IRAS

approval, and the Group recommend that she accepts this offer.

This plan augurs well for progression at the end of the first year.

1.2.7 Action: Provide the student with the reviewers feedback

S Brown

SEPD-SGEG-21Apr10-M2 ANY OTHER BUSINESS

2.1 There was no other business.

SEPD-SGEG-21Apr10-M3 NEXT MEETING

DATE, TIME AND PLACE OF

3.1 To be advised.

Suzanne Brown

Research and Quality Assistant

Date: 29 April 2010



National Research Ethics Service

Leeds (Central) Research Ethics Committee

Yorkshire and Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Telephone: 0113 3050127

10 March 2011

Ms Karen Adams
Senior lecturer Primary Care & Public Health
University of Huddersfield
Room 2/29 Harold Wilson Building
Queensgate
Hudderssfield
HD1 3DH

Dear Ms Adams

Study Title: A critical investigation to determine the education needs of Practice Teachers
REC reference number: 11/H1313/4
Protocol number: N/A

Thank you for your letter of 25 February 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		06 December 2010
Letter from Sponsor		22 November 2010
Evidence of insurance or indemnity		22 November 2010
Investigator CV		22 November 2010
Response to Request for Further Information		25 February 2011
Participant Information Sheet: UKSC Chair information sheet	2	25 February 2011
CV Supervisor - Ros Ollin		22 November 2010
Protocol	1	16 November 2010
Participant Information Sheet: Student Information Sheet	2	25 February 2011
Participant Information Sheet: Course Leader information sheet	2	25 February 2011
REC application		06 December 2010
Participant Information Sheet: Practice Teacher information sheet	2	25 February 2011
Participant Information Sheet: NMC Representative information sheet	2	25 February 2011
Participant Information Sheet: Manager information sheet	2	25 February 2011
Participant Consent Form	2	25 February 2011
Interview Schedules/Topic Guides	1	06 December 2010
Interview Schedules/Topic Guides	1	06 December 2010
Interview Schedules/Topic Guides	1	06 December 2010
Interview Schedules/Topic Guides	1	06 December 2010
Interview Schedules/Topic Guides	1	06 December 2010
Interview Schedules/Topic Guides	1	06 December 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research

Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H1313/4

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Dr Margaret L Faull
Chair

Email: nicola.mallender-ward@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Nigel King (Professor), University of Huddersfield

