Title Page: Partnership between Nurse Navigators and adult persons living with complex chronic disease – an exploratory study

Running title: Partnership with Nurse Navigators

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Title: Partnership between Nurse Navigators and adult persons living with complex chronic disease – an exploratory study

Abstract

Aims. The aim of this study was to explore Nurse Navigators and consumers' experience of partnership.

Background. The Nurse Navigator has recently emerged as an advanced practice role in the care of persons with complex and chronic disease states. Self-care is an important principle in chronic disease models of care, requiring health care practitioners to partner with clients in their care. How Nurse Navigators and consumers [clients and family] experience partnership has not been explored.

Design. An interpretive exploratory qualitative approach was used. Semi-structured interviews were conducted with seven Nurse Navigators working with adults with complex disease states and eleven of their clients. Interviews were analysed using descriptive content analysis. (COREQ checklist Supplementary File 1)

Results. Five themes about partnership emerged. Three themes from Nurse Navigators were: establishing and sustaining relationships, nurse-led planning and aligning care with clients' needs. The two consumer themes were: regular contact means access to the health system and nurse presence is valued. The secondary analysis revealed two themes about partnership between the nurse and consumer: establishing relationships require nursing effort to be established and partnerships are person-focused and nurse-led.

Conclusions. Partnership begins with a relationship, largely driven by the Nurse Navigator through regular communication and personal contact that was valued by consumers. The nurse-led partnership reduced opportunities for consumers to learn to manage their treatments, particularly how and when to access services, meaning that self-care may not be fully achieved. Client navigation occurs over long periods, which could lead to the navigators being overwhelmed, raising an issue of sustainability.

Relevance to clinical practice. Nurse Navigators establish a client relationship as a foundation for partnership. This partnership needs a focus on promoting client self-care, self-management of treatment, including when and how to access available services, to ensure the sustainability of the Nurse Navigator model of care.

Keywords: Nurse Navigators, Advanced Nurse Practitioners, chronic disease, client partnership, self-management of care

Impact statement

What does this paper contribute to the wider global clinical community?'

- Extending Nurse Navigation from cancer services to chronic disease management has the potential to address the challenges of complexity of both client care needs and a fragmented system.
- Assumptions about Nurse Navigation in cancer such as transition to survivorship or palliative care may not apply in chronic diseases, which have quite different and often much longer, illness trajectories.
- Further investigation into the meaning of partnership and how Nurse Navigators can use partnership to transition people living with chronic disease to self-care is required to ensure a sustainable service.

Title: Partnership between Nurse Navigators and adult persons living with complex chronic disease – an exploratory study

Introduction

Internationally, governments are advancing policy to integrate primary and tertiary health services in order to meet the complex and long-term healthcare requirements of an ageing population living with multiple chronic diseases. The growing number of people with more than one diagnosed chronic disease has become an international concern (WHO, 2018), with three in five global deaths attributed to four major chronic diseases – cardiovascular disease, cancer, chronic lung disease and diabetes (GBD Mortality Causes of Death, 2016).

Chronic disease is increasing in prevalence. For example, in Australia, approximately 23% of the population has more than one chronic disease (Australian Institute of Health and Welfare, 2018). In a dynamic microsimulation model focused on population ageing in the UK, researchers found that multi-morbidity prevalence was expected to increase, with the proportion of people living with four or more chronic diseases expected to double by 2035 (Kingston et al., 2018). Given that people living with chronic disease are often higher users of services from multiple health providers (Australian Institute of Health and Welfare, 2018), research into how health services are utilised is urgent. In an editorial for the *New England Journal of Medicine*, Blumenthal and colleagues (2016) argued that people with multiple chronic conditions, often complicated by a limited ability to care for themselves independently and with complex social needs, require special attention.

Navigating the multiple health and social services available is challenging for people unfamiliar with those services. Patient navigation has evolved from a coordination service for people living with cancer in Harlem New York in 2001 (Freeman & Rodriguez, 2011) to a recognised advanced practice nursing position, Nurse Navigator, in cancer nursing (Doerfler-Evans, 2016). Patient navigation aims to integrate a fragmented health system for the individual patient (Freeman & Rodriguez, 2011). While early Nurse Navigator models were focused on improved access to health services, health literacy, and timely interventions (Freeman & Rodriguez, 2011), more recent models in chronic disease management have been developed to ensure integration of social care services with health and medical services (Wodchis et al., 2015). As with cancer care, chronic disease management requires coordination of services and those integrated care programs with a single point of care assessment and planning, usually by a Nurse Navigator or similar role, were most successful (Wodchis et al., 2015).

While health service coordination and navigation are important, people living with chronic diseases must also enact self-care while making day-to-day decisions. In a systematic review of qualitative research into the challenges that reduce people's capacity to enact self-care, mobilisation of available resources was only one element of capacity (Boehmer et al., 2016). Other considerations included making their lives meaningful in the face of the chronic conditions, accomplishing self-care tasks, sustaining social connections, and encountering empathy in the development of a feasible treatment plan (Boehmer et al., 2016). For clinicians, critically thinking about a patient's capacity to self-care presents a unique opportunity to partner in developing a feasible treatment plan (Boehmer et al., 2016).

Partnership can be defined as the interactions between consumers and clinicians during care provision, that supports and encourages consumers in their own care and self-management (Australian Commission on Safety and Quality in Health Care, 2011). In a Swedish study, partnership in person-centred care was found to be an informal relationship between the person with chronic diseases and the health professional, with a close connection that builds patient confidence while often deferring to expert opinions of health professionals (Wolf et al., 2017). In an English research study of patients with chronic back pain, a good patient-professional partnership has been found to have a positive effect on patient self-care abilities (Fu et al., 2016). Ideally, a self-care partnership supports the person with the chronic disease, and their families, to accrue the knowledge, confidence and skills to manage their condition (Bodenheimer et al., 2002; Whitehead et al., 2018).

In one Australian jurisdiction, the Nurse Navigator role was introduced to a range of chronic disease management programs. Understanding how partnership between Nurse Navigators and people living with chronic disease is enacted can enhance patient confidence in self-care.

Background

The Nurse Navigator role was introduced in the cancer field in the early 21st century (Freeman & Rodriguez, 2011). The Nurse Navigator has become a widely recognised role in integrated health care systems, working with people living with chronic disease to help them understand their disease and care (McMurray & Cooper, 2017), which in turn is expected to improve the person's ability to self-care and therefore avoid hospitalisation (Grealish et al., 2017). The Nurse Navigator is a pivotal point of contact to identify and link the person to the health and social services across the tertiary and primary sectors (Douglas et al., 2018; Spooner et al., 2018).

In some countries, such as Australia, the Nurse Navigator role has been more recently established. In a role analysis, the Nurse Navigator role has been characterised as providing integration of diverse health services for individual consumers, reducing service duplication and tailored to individual and family needs (McMurray & Cooper, 2017). The Nurse Navigator role is guided by primary health principles and focused on transitions through the health system, continuity of care, and health literacy for self-management (McMurray & Cooper, 2017). The challenge associated with the emergence of the Nurse Navigator role is differentiating the role from other existing advanced nursing practice roles such as care coordinator or case manager.

McMurray and Cooper (2017) differentiate the Nurse Navigator from care coordinator as using a population approach, rather than an individual approach, recognising the importance of optimising limited health services in navigation. They also differentiate the Nurse Navigator from a case manager, which is limited to patient-centred management of a condition (McMurray & Cooper, 2017). Nonetheless, an analysis of the activities of Nurse Navigators, conducted in Australia, suggests that Nurse Navigators primarily provide direct comprehensive care, in addition to support of systems and health education (Spooner et al., 2018). While the overlap between roles remains problematic, the Nurse Navigators focus on effective use of limited resources, continuity of care and health literacy for self-management of chronic disease is considered fundamental (McMurray & Cooper, 2017; Spooner et al., 2018).

Partnership between the person living with chronic disease, their family, and the Nurse Navigator is considered the best way to tailor support, reduce hospitalisations, improve health literacy and provide early intervention (McMurray & Cooper, 2017; Spooner et al., 2018). For the purpose of this study, the term ‘consumer’ is adopted to describe the person living with chronic disease and their family unit, consistent with other family research (Coyne et al., 2019).

Rather than continue the debate about role clarification, this research focused on the concept of partnership between consumers and Nurse Navigators in order to contribute to developing models Nurse Navigation and tailor nursing education programs for this role.

Aim

The aim of this project was to explore the experiences of partnership for Nurse Navigators and adult persons with complex chronic disease.

Method

An interpretive exploratory qualitative approach (Kim et al., 2017) was used to explore how Nurse Navigators and consumers experience partnership in health care. This approach allowed for understanding of the unique perspectives of both the Nurse Navigator and consumer, as well as juxtaposing the perspectives to draw conclusions about the nature of the partnership.

The research questions guiding the study were:

1. What is the experience of partnership from the Nurse Navigator perspective?
2. What is the experience of partnership from the consumer perspective?
3. What is the nature of partnership between consumers living with complex chronic disease and Nurse Navigators?

Setting

The study was conducted in a tertiary level health service in southeast Queensland. The health services are publicly funded and inclusive of inpatient and community services where Nurse Navigators work with clients. In this jurisdiction, there is a range of providers of home-based supportive or social care, day programs, and housekeeping services. Some of these services are subsidised by government but all require some type of consumer contribution.

This service appointed 50 new Nurse Navigator positions across multiple disease streams involving multiple clinical and operational teams. The Nurse Navigator positions were funded by new government funding, necessitating a relatively quick recruitment and complemented an existing and modest Nurse Navigator program in complex and integrated care. The role of the Nurse Navigators in this health service is consistent with the published accounts (Spooner et al., 2018): to facilitate client centred healthcare across the lifespan and work closely with the client, their support persons or informal carers, and health and community service providers to improve their healthcare experience and their quality of life. Nurse Navigator role appointments are reflective of specialist medical care (e.g. paediatric Nurse Navigator) or generalist (e.g. complex care Nurse Navigator) clinician to support their healthcare. Nurse Navigators are hospital-based, work closely within their specialist medical teams, and liaise with other hospital and community-based services.

Clients are usually allocated to Nurse Navigators in this service when they re-present to the Emergency Department within 28 days of hospital discharge. Nurse Navigator client caseloads are guided by the cumulative acuity of needs of their clients, not defined by a limited number of clients. The Nurse Navigator role aims to understand the unique needs of the client that arise due to complexity associated with their unique combination of diseases

and social circumstance. Through this assessment, a holistic nursing care plan is developed. Through negotiation, the care plan is actioned and amended accordingly and the relationship continues until the client is self-sufficient, ceases to engage or there is a transfer of care, such as to an aged care facility. Nurse Navigators partner with the client to assist with coordination of health appointments, negotiate access to social services, and liaise with health professionals in inpatient and outpatient settings.

Sample

This study included only Nurse Navigators working with adult clients with chronic disease on the grounds that the research team was interested in partnership with people living with chronic diseases. Nurse Navigators working with mental health or paediatric and maternity caseloads were therefore excluded. We aimed to achieve a convenience sample of 10 Nurse Navigators drawn from the 19 working in chronic disease areas within the service. Interview transcripts were reviewed as the project progressed and Nurse Navigators were recruited until data saturation was achieved.

The consumer participants were adult persons living with complex chronic disease (i.e. two or more diagnosed chronic diseases) and their family members who were receiving Nurse Navigator services from the health service. A convenience sampling method was used for this group again. We aimed to secure at least ten consumer participants.

Data collection

Nurse Navigators were contacted via an email from their line manager. The email provided information about the study and the option to contact the researcher [EC] for a personal telephone interview. Informed consent was secured before the interview.

Consumer participants were recruited by the Nurse Navigators. The Nurse Navigators provided information about the research to their clients and their family members. When the consumers expressed interest in the study, the researchers contacted them and secured informed consent.

The telephone interviews were conducted by four experienced nurse researchers who used the same interview guide [EC, WH, JC, AA]. Each interview started with an explanation of the research and the researcher's personal connection with the research. The interviews were approximately 20 to 40 minutes in length. The research questions were built from baseline questions, which explored the expectations and experience of partnering with a Nurse Navigator and the benefits and challenges of the partnership relationship (see Table 1 for questions). Field notes were taken during each interview to allow the researchers to discuss the interviews and ensure consistency across interviews. Following an interview

guide, taking field notes and discussion between interviews during the qualitative research process promotes rigor and validity of the findings (Graneheim & Lundman, 2004).

Qualitative reporting was completed using the COREQ checklist. See Supplementary File 1.

Interviews were digitally recorded and professionally transcribed. All participants were offered the opportunity to review their interview transcripts but no one took up this opportunity. To describe the sample for the purpose of reproducibility, demographic data were collected from the Nurse Navigators including qualifications and length of time working in the role. Demographic data on the consumers included age, gender, employment status, and diagnosed chronic diseases. No follow-up interviews were completed due to time constraints.

The study was approved by Human Research Ethics Committee at the hospital [HREC/QGC/44286] and university [2018/863] and was conducted consistent with the requirements of *National Statement on Ethical Conduct in Human Research 2007* (Updated 2018). To ensure anonymity of participants, numbers were used for individual excerpts and all identifying information removed.

Analysis

A two-stage analysis process was conducted to triangulate the data. In the first stage, the transcripts from each participant group (Nurse Navigator and consumer) were analysed separately. A descriptive content analysis (Silverman, 2003) was completed. The analysis was conducted independently by two members of the research team (EC/LG). The steps of analysis included reading the data for understanding, highlighting data which linked to the research questions or aspects within the data which became patterned responses, consistent with the processes for content analysis (Silverman, 2003). The table of themes was shared with the Nurse Navigators for their input to verify the themes. Mutual agreement of the themes was established to enhance qualitative rigor (Polit, 2010). Verification was not able to be conducted with the consumer group.

In the second stage, data from the two groups were compared, a form of data triangulation. Data triangulation is the combination of different data sources that are examined at different times (Flick, 2018). Triangulation of two data sources, consumers and Nurse Navigators, adds breadth and depth to the analysis (Flick, 2018). In this case, considering ‘partnership’ from the perspectives of each of the ‘partners’ provides a richer description of partnership between consumers and Nurse Navigators. In this process, two researchers (EC, LG) used interpretive analysis to review the themes of each data set, looking for areas of convergence and difference, and noting comparative absences in the data for each

group. Once these content themes were agreed, analysis across themes was conducted to identify shared concepts between the Nurse Navigators and the consumers.

Results

A total of 19 Nurse Navigators were invited to participate, with six declining, 'Personal time concerns' and no response from six. After six interviews with Nurse Navigators, data saturation was achieved and a seventh confirmatory interview was conducted. The Nurse Navigators had worked on average 23 years as a registered nurse, all nurses had a Master's degree, at least three years in their speciality and at least two years as a Nurse Navigator. One Nurse Navigator was male. The Nurse Navigators worked with clients whose complexity stemmed from renal, liver, respiratory, cardiac and neurological disease. See Table 2 for Nurse Navigator demographic characteristics. A total of 14 consumers were invited with three declining with the response of 'Not interested'. Eleven consumers, clients and family members were interviewed, with a median age of 72 years (SD 11). The employment status of the consumers was mainly retired. See Table 3 for consumer demographics.

Across the Nurse Navigators transcripts there was three themes identified; *establishing and sustaining relationships, nurse-led planning and aligning care with clients' needs*. Across the consumer transcripts, two themes emerged; *regular contact means access to health system* and *nurse presence is valued*. The secondary analysis of combined transcripts identified two themes; *establishing relationships* and *person-focused and nurse-led partnerships*.

The theme, *establishing and sustaining relationships*, reflected the Nurse Navigators' valuing of relationship and trust with the client. For Nurse Navigators, the relationship builds over time and therefore reduces the need for the client to keep explaining their needs.

'so that every time I speak to this person, we don't need to go through the whole story again about what was it again, who was it, when did I see you, you know, all that's a given that I remember that and she knows that I remember that so there's that – it's a deeper professional relationship' [N3]

The Nurse Navigators invested a lot of effort in making the relationships happen, using openness during multiple visits that would always include some face-to-face time.

'open and honest conversation... involving the carer [is required]' [N2].

'It takes more than one visit to build a relationship with a patient' [N5]

‘really good to have a face to face interaction with our consumers and I think that it is essential that you have a relationship with the consumers’ [N6].

As the relationship developed, the Nurse Navigators completed the assessment and presented choice for care. **Nurse-led planning** reflects the Nurse Navigators’ commitment to solving problems for the consumer, rather than with the consumer,

‘We’re social workers, counsellors, you know, we can organise housing, we can organise furniture to be removed, we can organise your dog to be fed, because it’s so holistic.’ [N5].

‘So there’s one thing about partnering with consumers and supporting them and listening to them and working with them and getting their input into service, how you can plan care and provide a better service and all that sort of thing, but sometimes there are unrealistic expectations, sometimes they think that the public health service has an inexhaustible budget. So I think it’s just sometimes being the realist in the situation as well.’ [N7].

Nurse Navigators were committed to aligning health services for optimum client outcomes,

‘we work with the patients and all their support people, to try and optimise their health and give them some quality of life’ [N5]

However, the Nurse Navigators’ perspective was revealed in statements that suggested, at times, that the values and beliefs of the consumer were problematic to achieving nurse-led plans and operational expectations of the health service,

‘some of the challenges are that patients don’t want to change and so, that could be a bit of a barrier to meeting organisational and role outcomes’ [N5].

‘I think the level of dependence needs to be carefully managed. I think that from a sustainability point of view...they’re all ringing you could potentially be quite fatiguing’ [N5].

While the Nurse Navigators valued consumer as experts, *‘recognising them [consumer] as experts in their care’ [N7]*, there were no examples raised in the interviews to suggest that consumers were leading the care.

The Nurse Navigator theme, **aligning care with clients’ needs**, highlights the complexity of the health service and the difficulty of navigating the health system for people living with complex chronic diseases. The Nurse Navigator shared how they would assess the

client [health literacy and physical] and then become their advocate to enable health visits to be aligned, help them work through priorities of care for improved clients outcomes:

“Working with him and his wife as his advocate to access those things that he would have otherwise been unfamiliar with” [N5].

There was a sense from the Nurse Navigators of simplifying the health system,

“it’s easier to clear things up with them [client] or at least alleviate some of their concerns or tell them priorities of what the current situation is ...breaking things down and simplifying, understanding’ [N1].

Connecting the health service with the client’s needs was part of the Nurse Navigator role,

‘I’m happy to be a conduit between them and the medical staff if that’s what they need but it’s also about trying to line up – if I know that the discharge plan is going to include a few things, then I can try and coordinate them, so maybe they will happen on the same day or try and reduce – can they come to those appointments? [N5]

The consumer theme, **regular contact means access to health system**, related to the benefits of the Nurse Navigator ability to access the right services within the complex health system.

The clients shared how the Nurse Navigator helped them to liaise with service providers,

‘Having the Nurse Navigator as your go-between’ [C7].

‘the Nurse Navigator calls and explains everything- just makes it so much easier. If not able to answer- she calls back’ [C11].

‘Partnership with Nurse Navigator is valued and you feel reassured and not alone’ [C4].

Beyond the liaison work, all consumers **valued the presence** of the Nurse Navigator, often expressed as gratitude that the Nurse Navigator was there to help them.

‘Tremendous help- Nurse Navigator comes to my specialist appointments: helps talking to doctors’ [C3].

‘When we’ve been waiting for the car to come and pick us up, she’s come downstairs where you wait to pick up’ [C5].

‘Having Nurse Navigator in our life has really made a massive difference- doesn’t matter how big or small the hurdle is, we have someone that we can go to’ [C8].

The presence may have been in person or via the phone but Nurse Navigator initiation of contact was valued,

'She gives me a ring every now and again to see how I am going' [C10].

'because there's so much information to take on board, and NN was like a filter; explain it, like break it down from medical jargon to plain English' [C11].

'We no longer feel alone' [C8].

In the secondary analysis of the Nurse Navigator and consumer generated themes, partnership was produced through **establishing relationships**. Relationships were two-way, with regular contact, initiated by the nurse at first and as trust built, initiated by the consumer as well. Relationships were built and enhanced through multiple contacts, both face-to-face and by telephone. Over time, the Nurse Navigator learned more about the consumers' needs and increasingly provided advocacy and direct liaison with health and social service providers on their behalf. Consumers valued the support, particularly the assistance with service liaison.

Related to establishing relationships, the theme, **partnerships are person-focused and nurse-led**, reflects the sense from both the Nurse Navigators and consumers about the value of working together, and the importance of the nurse exercising expertise in leading the partnership. However, the nurse-led nature of the partnership appeared to render the consumers increasingly dependent on the Nurse Navigator, at times overwhelming navigator capacity to manage their workload. Whilst the Nurse Navigator was employing skills in assessment and health education, the way that they did navigation, by liaising on behalf of clients rather than coaching clients to liaise directly with health and social services, appeared to contribute to their increasing workload. As time progressed, and more people with chronic disease were identified for their services, the Nurse Navigators were unable to reduce the contact with existing clients due to the increasing dependency, thereby increasing their workload.

Discussion

This qualitative study sought to explore the experiences of partnership for Nurse Navigators and consumers in their care. The partnership was developed over time and with Nurse Navigator presence and regular contact. This support was strongly valued by the consumer. However, the nurse-led nature of the emerging partnership may threaten the

sustainability of the Nurse Navigator role and undermine opportunities for consumers to learn to access services to manage their disease.

Nurse Navigators experienced partnership positively. Through multiple contacts and the process of assessment, Nurse Navigators developed relationships with consumers. While the multiple contacts and assessment processes necessary to establish the relationship required effort, Nurse Navigators valued establishing the relationship and acknowledged that consumers particularly valued not retelling the story. The Nurse Navigators in this study emphasised the importance of advocacy, aligning available services to optimise client outcomes. This experience of partnership resonates with the original role in cancer care (Freeman & Rodriguez, 2011) and is consistent with more recent definitions of the role (Douglas et al., 2018; Spooner et al., 2018). The extension of the Nurse Navigator from the cancer field into other chronic disease specialties clearly has the potential to address the complex needs of the consumer within a fragmented health care system.

Consumers experienced improved access to the health system. Consumers were grateful for assistance and welcomed the Nurse Navigator's advocacy and coordinating upon their behalf. While this was a relief for many consumer participants, there is a risk of disempowering consumers by 'doing for' in partnerships (Henderson et al., 2014; Henderson, 2003), and requiring navigation for the long trajectory of illness associated with chronic disease.

In this study, partnership was person-focused and nurse-led. This is consistent with the role of Nurse Navigators in the oncology field. Nurse Navigators in cancer care are evaluating and reframing the provision of care and expectations in a move to a survivorship model (Panozzo et al., 2019). The advanced practitioner within cancer care has developed innovative ways to support and empower the family thus enabling the transfer of care to local general practitioner with the provision of information and follow up support for their client (Finley, 2018).

Because the illness trajectory in chronic disease is often longer, with no option for 'cure' (survivorship), there is a risk of Nurse Navigators becoming overwhelmed by service demand. With the proportion of people living with four or more chronic diseases expected to double by 2035 (Kingston et al., 2018), how to close partnerships between consumers and Nurse Navigators must be investigated. Closure would require consideration of how to shift from nurse-led to a consumer-led partnership, where the consumer is leading through self-care, affirmed by the Nurse Navigator, to appropriately access health and community-based services.

Limitations

There are several limitations to this study. Using a convenience sample means that the findings are susceptible to recruitment bias. However, the exploratory nature of this study has been met in that new insights into how partnership may be enacted in Nurse Navigation emerged. The sample size was relatively small and from only one jurisdiction in Australia. As the Nurse Navigation role extends in integrating health and social services outside of cancer care, opportunities for larger and more detailed studies are expected. The findings from this study provides an initial framework for understanding the strengths and limitations of partnership in this relatively new role in chronic disease management.

Conclusion

As health service leaders work to improve the efficient and effective alignment of services with consumer need, a nurse-led integrated model of care, such as the Nurse Navigator role, presents a solution. The main aspect of integrated care is enabling the client to have a voice and be active in learning, which can lead to self-care and management of service utilisation. In this study, partnership had a clear beginning through establishing relationship and this necessarily is nurse-led. However, there was little evidence of working with consumers to establish independence in service utilisation. If this role is to be sustainable, and available for the expected rise in people living with chronic illness, further investigation into how partnership is enacted, and specifically how partnerships can be closed, is critical for sustainability of the Nurse Navigator role in chronic disease.

Practice points

- Extending Nurse Navigation from cancer services to chronic disease management has the potential to address the challenges of complexity of both client care needs and a fragmented system.
- Given the expected rise in demand for navigation in chronic disease management, Nurse Navigators must work to shift their services from nurse-led to consumer-led, with a plan for closure of the partnership.

Relevance to clinical practice

- Nurse Navigators can reflect upon how they can enhance client independence, and support learning about how and when to access diverse services;
- Nurse Navigators and service managers must work collaboratively with consumer representatives to identify strategies for closure of partnerships to enable Nurse Navigators to assist new clients.

- Nurse Navigators could consider collaboration with nurse researchers to explore their practice more carefully, focusing on how partnerships can become more person-led.

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Table 1 Stem of the research questions tailored for each participant group

<p>What are your expectations of this healthcare partnership?</p> <p>How would you describe 'partnering in healthcare'?</p> <p>What has been your experience of partnering?</p> <p>What benefits do you see to have come from partnering?</p> <p>What challenges do you see in the partnership relationship?</p> <p>What suggestions do you have for ways to improve partnering?</p>
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Table 2 Nurse Navigator demographics

Participant number	Highest Qualification	Time in speciality area
NN1	Nurse practitioner^	20 years
NN2	Masters in nursing	3 years
NN3	Nurse practitioner^	8 years
NN4	Masters in public health	5 years
NN5	Masters in nursing	3 years
NN6	Nurse practitioner^	3 years
NN7	Masters in nursing	5 years

^equivalent to Masters in nursing

Table 3 Consumer demographics

Consumer	Participant number	Age (years)	Gender	Time with NN
Client	C1	82	Female	2.5 years
Family	C2	79	Male	2.5 years
Client	C3	53	Female	1 year
Family	C4	67	Male	1 year
Client	C5	88	Female	2 years
Family	C6	91	Male	2 years
Family	C7	67	Female	1 year
Family	C8	64	Female	2 years
Client	C9	60	Male	6 months
Client	C10	50	Female	6 months
Family	C11	54	Female	6 months