Perspectives on the Consultant Nurse Role

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This report is dedicated to the memory of Chris Baker
(1955-2004)

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Introduction and background

The new role of nurse, midwife and health visitor consultant was established within the National Health Service (NHS) in 2000. The purpose of creating this role was to provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity with a view to retaining experienced and expert nurses, midwifes and health visitors in practice (NHS Executive 1999). The role was to contain four key elements:

- An expert function;
- A leadership function;
- An education and development function;
- A research and evaluation function.

Literature review

Since these posts were implemented, much anecdotal material has been made available but few empirical studies have been published. There is a need to provide descriptive accounts of new roles and their impact on practice along with a basis for recommendations and guidance for the future development of these roles. The aim of this study was to gather evidence to help address some of these issues by involving stakeholders in the evaluation of a number of local consultant nurse roles; in mental health at Dorset Healthcare Trust and in pain management at Poole Hospital NHS Trust.

Methods

A participatory research design was used. One of the central parts of the evaluation was the active role each consultant nurse would play in the production of their own case study. Drawing on the strategy of participatory research, the evaluation used multiple sources of evidence to explore the local impact of the consultant nurse role.

Following favourable ethical review, six consultant nurses volunteered to take part in the evaluation: five from a mental health Trust and one from a district general hospital Trust. There was an equal gender split. Each consultant nurse was asked to nominate up to six key informants to contribute to their case studies, including at least one manager from their practice institution, one clinical colleague, one colleague from the University, one student, and one senior academic from the University.

There were three discrete phases that contributed to the development of the final categories. Face-to-face semi-structured interviews were carried out with key informants, based on questions about the consultant nurses' practice and leadership, and their practice development, educational and research activities. Analysis of these was followed by the construction of

individual case studies. The second phase involved meeting individual consultant nurses, sharing their case study with them and inviting their feedback. The third phase occurred when all the individual analyses were considered together. A matrix analysis was undertaken to identify any further categories across cases.

Findings

Phase one: case studies

Following thematic analysis, four categories emerged from the data: evolution, about the person, the work and resolving issues.

Evolution includes codes that describe the informants' understanding of the historical emergence of consultant nurses; aspects of the role that are developing, changing or evolving; and critical comments in relation to how the roles had been set up, referring particularly to the immature infrastructures within the Trusts to support them.

About the person are the codes that describe the attributes expected of a consultant nurse, either observed or deemed desirable in an applicant. The ability to act as a role model and to have clinical credibility, leadership and intellectual reasoning skills were highlighted, as were the political complexity of the role and the expectations of others.

The work describes a range of codes that reflect the nature of the role, such as consultancy, working with staff, working across boundaries, professions and agendas. The nature of practice development undertaken by the consultant nurses was clearly at a level that crossed professions and agencies and reflected a wider national or international perspective. Much of the work by the consultant nurses was seen as 'pioneering' and respondents mentioned that the consultant nurses took the work or service 'to another level'.

Resolving issues brings together aspects of the role that present challenges, for example the lack of a supportive infrastructure such as administrative support and office space. They also include difficulties with managing time, conflict and expectations, and with gaining clinical credibility and trust from staff.

Phase two: the consultant nurse perspective

A number of participants referred to the difficulty in balancing the need to be 'the voice for nursing' with the need to attend to the clinical demands of their speciality. Some commented that the role was still in its infancy and that any authority they had in the eyes of their colleagues rested in them as a person, rather than in the role. There were comments in relation to the lack of a continuous clinical career structure. Related

comments referred to a lack of clarity about the way their role fitted into the organisational structure. Some of them did not feel part of a team, but were members of a number of different teams only for the duration of their particular clinical input. A small number referred to a 'paradox of impact' in that they felt their work was highly regarded nationally or internationally, but found it difficult to implement best practice locally.

Nearly all participants commented that being active in all four dimensions of their role at the same time was challenging if not impossible to achieve. The majority felt strongest in their clinical practice area and weakest in their ability to conduct and supervise research.

All participants raised the issue of the lack of administrative support for their post, which had a direct impact on their ability to perform their role effectively.

Phase three: matrix analysis

The concept of *'leadership'* enabled the research team to capture an activity that crossed each of the four categories. As leaders, consultant nurses needed support and sought out emerging infrastructures to help them. Skilled leadership enabled them to negotiate the often problematic processes of working across boundaries and professional groups. It touched on many facets of their working life.

The category of *'national work'* was an integral activity for each of the four themes as shown by the consultant nurses' national profile, which provided a forum for presenting their work as well as bringing knowledge and new insights back to the Trust. The data showed that consultant nurses were active in national forums, which was seen as an important aspect of the role by both clinical and academic colleagues.

Conclusions

The evidence gathered through this project points to an extensive and diverse portfolio of activities relating to expert practice, and educational and practice development; a more limited portfolio in relation to leadership, which has not yet been fully developed; and very little activity in relation to research. This may reflect appointment panels' concern with ensuring that consultant nurses bring with them evidence of advanced as well as safe practice, whereas well-developed leadership and research skills may not have attracted the same level of scrutiny at the beginning of the implementation phase.

There is an urgent requirement to support consultant nurses in developing their leadership potential and their skills in researching practice if what has been envisaged at the national level is to be

achieved locally. Explicating how consultant nurses achieve their goals is paramount if we are to ensure succession planning for future clinical leaders. This study provides the building blocks for the educational preparation of future leaders as well as contemporary consultant nurses who want support and development in their role. The opportunity to articulate and share this knowledge is exciting. Strategic vision to develop nursing and its contribution to health care requires nurses who are confident and competent in bringing this to fruition through effective leadership.

Introduction

National Context

The new role of nurse, midwife and health visitor consultant was established within the British National Health Service (NHS) in 2000. The purpose of creating the role was to

> '…help to provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwifes and health visitors in practice' (NHS Executive 1999).

The role was to contain four key elements:

- An expert function;
- A leadership function;
- An education and development function;
- A research and evaluation function.

The role had first been envisaged as long ago as 1989 when the Department of Health '*Strategy for Nursing'* predicted that

> '…new patterns of treatment and care will stimulate changes in professional practice in both hospital and community settings. Carefully evaluated innovations to change traditional boundaries of clinical and professional practice need to be encouraged. New nursing concepts are being tested and evaluated; they include the primary nurse, the nurse practitioner and the nurse consultant' (Department of Health 1989, p13).

It took ten years for the role to become a reality. The Prime Minister announced the creation of the nurse consultant posts, which were to be subject to further consultation and discussion in the Department of Health strategy paper '*Making a Difference'* (Department of Health 1999). A detailed implementation plan was set out in the Health Service Circular 1999/217 (NHS Executive 1999) which also insisted on specific criteria for appointments and their regional coordination.

Regional Context

In Dorset and Somerset, the implementation of the consultant role has spurred much debate and discussion in relation to its impact on patient care and service development, concerns about the lack of role

preparation and succession planning, and confusion around lines of authority, accountability and links with higher education. One of the insights that this evaluative study provides is that some fundamental issues need to be answered before further posts are created.

The participants in the study and the wider group of consultant nurses who work in the South West acknowledge the job satisfaction that they achieve, but recognise that their role is often perceived as being outside the main organisational structures of the NHS, with no real anchor to Trust boards or specific nursing groups. They often express the view that they are 'cuckoos in the nest'. Therefore, the various bodies, such as Strategic Health Authorities/Workforce Development Departments, NHS Trusts, Primary Care Trusts and universities, need to work together to form a robust infrastructure, akin to '*Modernising Medical Careers'* (Department of Health 2004), to ensure that the enthusiasm and commitment these expert nurses bring to their work are translated into better patient care and service development. The key issues such an infrastructure should address are:

- The provision of personal professional development planning for the post holder;
- The provision of a 'senior registrar' grade for nursing;
- The linking of professional development to academic credit and service development;
- Formalised academic/service positions – as part of a university clinical faculty;
- The awarding of the title of professor or senior lecturer;
- The clarification of lines of authority and accountabilities to nurse directors and chief executives;
- The provision of dedicated resources to support the role e.g. administrative support, office space and car parking;
- The formalisation of their position within the nursing structures;
- The allocation of clinical nurse specialists, staff nurses and nursing students to their service;
- The clarification of the consultant's role not just in terms of their specialist function, but as a consultant for nursing, caring and health for the health community as a whole;
- The clarification that the post holder should work within networks, not just NHS Trust boundaries;
- The freedom to re-shape their role and job according to patient need and workload management;
- The need to be registered/recorded as an advanced practice nurse in order to be seen as nurses in advanced care provision, akin to the registration of nurse teachers, which should identify the educational level of admission to the register.

The consultants in this evaluation and the wider group of consultants in Dorset and Somerset acknowledge the need to come together and help the wider health and public community understand their role. Within Dorset and Somerset, the group continues to meet at Bournemouth University every month. They intend to meet the Strategic Health Authority's lead nurse and the Chief Nursing Officer for England once a year. They meet the Professor of Nursing Development for coaching and professional development as a group and as individuals. They accept the responsibility that their role conveys as stated in the Health Service Circular 1999/217 (NHS Executive 1999). The question is whether the health community acknowledges this acceptance, and whether it will grant the post holders the autonomy to lead and develop services.

Local Context

Over the last eight years, the Institute of Health and Community Studies (IHCS) at Bournemouth University has developed a collaborative model with local providers of health care. The model supports separate administration for the University departments and service organisations. The two organisations are autonomous institutions but function interactively through a medium of joint appointments in education, practice and research. Lecturer practitioners and consultant nurses are a cornerstone of this clinical faculty. The experience being developed at Bournemouth University is acknowledged nationally, and colleagues are learning from this model. This research project seeks to build on the findings of a pilot project (Redwood et al. 2002) that evaluated the lecturer practitioner role from the post holders' perspective. This led to the inception of an evaluation project to capture the stakeholders' perspectives of the roles of lecturer practitioners and consultant nurses. Shaw (1999) suggests that stakeholder participation offers a wide range of interested parties the opportunity to influence policy decisions, it facilitates a range of views to be used to inform collection and interpretation of findings, and it increases the likelihood of the findings being used.

This report presents the consultant nurse study arm of the project which took place in 2003-2004.

Literature Review

A literature search was undertaken using the terms ‘consultant’, ‘leadership’ and ‘nurse’, restricted to the English language. The databases used were CINAHL, British Nursing Index, Medline, OVID and Social Sciences Citation Index. The ‘grey literature’ was searched using internet search engines. Of the papers identified, few were empirical; several offered a scholarly contribution to the development, but the vast majority contained descriptive accounts of personal experience.

Historical Evolution

When the Labour Government was elected in 1997, its members expressed their commitment to modernising the National Health Service. During 1998, an extensive consultation took place to examine nurse, midwife and health visitor roles. The consultation suggested that existing career structures were failing to improve recruitment and retention because many experienced practitioners were forced to leave practice-based positions if they wanted to advance their careers and improve their earnings and status. The strategy document *Making a Difference* (Department of Health 1999) highlighted that the public valued nurses, midwives and health visitors. However, despite the changing patterns of health care delivery leading to increasing nurse, midwife and health visitor activity in many new areas, the government still viewed them as an under-used resource for the health service and announced their strategy to strengthen their contribution.

The first wave of consultant posts was announced in January 2000, with the second wave proposed in June of the same year to take the number up to around 200 posts (Department of Health 2000a). By March 2001, 510 posts had been approved (Moore 2001). *The NHS Plan* (Department of Health 2000b, p86) promised that the NHS would employ ‘around one thousand nurse consultants’ by 2004, a figure that has been criticised as being insufficient given the size of the nursing workforce (Finlayson et al. 2002). In reality, the numbers appear to have been far less.

The opportunity for experienced practitioners to continue to be influential in practice areas, while being available to teach and act as a role model for learners, was believed to be central to achieving the modernisation agenda. The creation of consultant posts claimed to offer nurses, midwives and health visitors clinical career pathways that would enable them to continue to work in practice areas while advancing their careers. However, policy documents only provide details for the role at the

pinnacle of the clinical career pathway, the consultant role, but give little indication of the pathway leading to it. Instead, consultant nurses are represented as the pioneers of new ways of working and innovators in the organisation and delivery of health care. Appended to the circular, the role is described under the following major headings from the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) higher level practice pilot project (UKCC 1999):

- Practitioners working at a higher level;
- Improving quality and health outcomes;
- Evaluation and research;
- Leading and developing practice;
- Innovation and changing practice;
- Developing self and others;
- Working across professional and organisational boundaries.

These dimensions of consultants' practice are important for a role which is expected to respond to the changing needs and demands of the health community. However, the developmental process from newly qualified staff nurse to consultant in relation to these dimensions has been given scant attention. It could be argued, therefore, that the current nursing workforce is unlikely to produce the number of individuals needed to deliver these high expectations.

Definitions

The title of 'nurse consultant' is not a new concept in the nursing discipline. It has previously appeared in the United States, Australia and Britain. In the UK, the nursing development units (NDU) of the 1980s used the terms 'nurse consultant' and 'advanced practitioner' interchangeably (Wright et al. 1991; Manley 1997; Elcock 1998). In the United States during the 1980s, nurse consultants were a largely independent nurse practitioner group. They usually provided expert knowledge and leadership for innovative projects and were employed for fixed time periods (Lareau 1980; Berragan 1998). These roles were designed in response to rapid changes in the US health care system and were used in part as cost saving measures (Partlow & Graham 2000).

Lareau (1980) describes a consultant as a person who is consulted for professional advice, 'an individual with special knowledge and skill', and suggests that the title explicitly denotes an expert in their field (Lareau 1980). Benner (1984) describes the expert nurse as a person

> '…with an enormous background of experience, [who] has an intuitive grasp of each situation and zeroes in on the accurate

> region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions' (p32).

In Australia, the nurse consultant roles appear to have been created in response to medical and nursing staff shortages. Australian nurse consultants were usually involved in developing services for distinct patient groups, for example people living with diabetes, and the condition and its management were at the focus of their practice (O'Brien & Spry 1995). The factors that gave rise to the development of consultant roles in the US and specialist roles in Australia were similar to those that brought about the development of these and other roles in the UK. Staff shortages, the reduction in junior doctors' working hours, recruitment and retention difficulties, structural changes in primary care, demands of the implementation of National Service Frameworks and government targets have all been implicated in the development of the nurse consultant role (Daly & Carnwell 2003). While political pressures might have provided the impetus to develop the nurse consultant role, there was no doubt that the expectations of these roles, as envisaged in *Making a Difference* (Department of Health 1999), were quite different to previous visions.

Development of the Consultant Nurse

The role

Manley (1997) is credited with influencing UK policy in the development of consultant nurse, midwife and health visitor roles (Parish 2000). A three-year action research project conducted in an NDU sought to provide a conceptual framework for advanced practice. Key features for successful advanced nursing practice were found to be appropriate leadership, creating and sustaining a transformational culture within the work area, and nurturing a culture that facilitates growth and change.

> 'However much practical and theoretical expertise an advanced practitioner/consultant nurse possesses, this on its own is of little value. The context has to be conducive and the basic ingredients need to exist, namely shared values and a non-hierarchical, open management style.' (Manley 1997, p187)

All posts were to be firmly based in nursing, midwifery or health visiting practice and involve working directly with patients, clients or communities for at least 50% of the time available (ibid.). In practice, the catalyst for developing these roles was often unique to the local situation. Some developed from specialist roles (Da Costa 2002; Mulholland 2003) and others were newly created to fulfil NHS hospital Trusts' visions of the role (Armstrong 2003; Robinson 2003; Smy 2003). Appointments included candidates both from within and outside the recruiting organisations

(Pottle 2002; Coady 2003). The latter group appear to have been appointed on merit, with education, experience and service development records that were congruent with the Department of Health guidelines (Guest et al. 2001). Da Costa (2002) and Pottle (2002) describe the value of post holders' extensive consultation with key stakeholders to identify needs and expectations before working out strategies for their roles.

Difficulties for both practitioners and organisations may have had their origin in a failure to imagine a new role for nurses. Traditional perspectives and stereotypes that have restricted the contributions of nurses, midwives and health visitors in the past, persist (O'Dowd 2000; Guest et al. 2001; Lipley 2001; Moore 2001; Da Costa 2002) and prevent the potential contribution of nursing to health communities from being realised. Consultant nurses have also reported difficulty in acquiring guidance on how to develop their roles (Beacock 2002). The need for consultants to develop new ideas for role clarity was supported by the findings from a study undertaken by Guest et al. (2001). Most consultants were found to be active across the four main functions of the role (expert, leadership, education and development, and research and evaluation), with varying degrees of engagement in those areas. The authors linked greater role clarity with higher levels of achievement. Success seems to have been most readily achieved by those who were able to develop a clear vision, were confident about their position and had developed good relationships with key stakeholders.

Expert practice

While there has been a flexible approach to the interpretation of consultant roles, and therefore considerable variation in how the four main functions are achieved (Guest et al. 2001), the issue of expert practice is central to consultant nurse activity. The term expert practice implies that it is carried out at an advanced level and that it is likely to be applied in a specialist sense. With regard to advanced practice, there has been a proliferation of interpretations in many countries. In an attempt to facilitate a common understanding and promote consensus among nursing policy bodies globally, the International Council of Nurses (2002) defined the scope of practice of advanced practice nurses and nurse practitioners. The definition includes the following characteristics associated with the nature of advanced practice and is closely related to UK policy on the consultant role:

- Integrates research, education and practice;
- High degree of professional autonomy and independent practice;
- Case management/own caseload;
- Advanced health assessment skills, decision-making skills and diagnostic reasoning skills;
- Recognised advanced clinical competencies;

- Provision of consultant services to health providers;
- Plans, implements and evaluates programmes;
- Recognised first point of contact for clients.

In their document on the definition of nursing, the Royal College of Nursing (2003) points out that specialist practice could be seen as problematic because of a concern that specialisation may lead to fragmented care and the loss of holism. The document's authors also suggest that the development of specialisation in nursing tends to follow medical specialities rather than use its own conceptual frameworks. The literature in relation to the consultant nurse role certainly points to consultant appointments in specialist areas following medical specialities. As far as definitions of specialist practice are concerned, the UKCC (2001) explicitly characterises it as a level of practice:

> 'Specialist practice is the exercising of higher levels of judgement, discretion and decision-making in clinical care. Such practice will demonstrate higher levels of clinical decision-making and so enable the monitoring and improving of standards of care through supervision of practice; clinical audit; development of practice through research; teaching and the support of professional colleagues and skilled professional leadership…Specialist practice will require the exercising of higher levels of judgement, discretion and decision-making, focusing on four broad areas:
>
> - Clinical practice;
> - Care and programme management;
> - Clinical practice development;
> - Clinical practice leadership.
>
> This higher level of practice can be exercised in any area of healthcare delivery.' (p24)

With regard to practice, the UKCC (2002) explains the expert practice element of a higher level of practice in relation to knowledge, understanding and expertise that goes beyond the clinical dimension of care delivery and organisation:

> 'Practitioners who are working at a higher level of practice use their knowledge and skills as a basis from which to further develop practice. They understand the implications of the social, economic and political context of health care. Their wisdom, expertise, maturity, experience and critical judgement are demonstrated through a broadening and deepening of their practice and knowledge. Patients, clients and fellow

> professionals acknowledge their expertise in areas such as therapeutics, the biological, social and epidemiological sciences, the use and effects of drugs, and their enhanced skills in areas such as empowerment, communication and consultation.
>
> Practitioners working at a higher level of practice use complex reasoning, critical thinking, reflection and analysis to inform their health assessments, clinical judgements and decisions.' (p8)

Professional leadership and consultancy

Manley (1997) highlighted the need for appropriate leadership in practice areas to establish a culture where all practitioners can grow in their knowledge and expertise. Leadership is also seen as the cornerstone of developing and modernising the NHS. As part of *The NHS Plan* (Department of Health 2000b), the NHS Leadership Centre was established in 2001. It forms an integral part of the Modernisation Agency to promote leadership development across the service. In their review of the leadership literature, Hartly and Hinksman (2003) highlight a number of important aspects of leadership in relation to the NHS: leadership focuses on creating opportunities for working towards a future that is better than the past or the present. To achieve this, the leader cannot lead in an individualised, 'out in front' manner, but needs to build effective relationships with others, to manage change and to develop political skills such as negotiating and influencing. This does not necessarily depend on an individual's charisma, but may take different forms.

Furthermore, leadership should operate at all levels in an organisation; the content and scope of leadership activity will vary, but leadership qualities and processes will remain the same. Irving and Klenke (2004) propose that effective leadership is mediated by personal meaning:

> 'Given the tumultuous pace of change, competitive pressures and changing corporate purposes, employees are seeking work that brings meaning and enrichment to their lives. If leaders do not have an interpretive frame of reference which includes context and history to give the discrete activities of their lives and work meaning and significance, they will be seen as shallow, lacking conviction, principles and values.' (p19)

As part of their leadership function, consultants are also seen to have responsibility for providing expert advice to other healthcare practitioners, not only within their own organisation, but to other healthcare providers and organisations. The leadership function of the consultant role is also described in the 2002 UKCC report:

> ‘Practitioners working at a higher level act as leaders for change with individuals, groups and communities. They cross professional and agency boundaries to achieve this. They network locally, regionally, nationally and internationally, and recognise the ethical, legal and professional constraints on practice. They assess and manage risk…
>
> ‘…Practitioners working at a higher level of practice are engaged in flexible, cross-boundary partnership working. They are actively involved in facilitating communication and understanding between individuals, groups, professions and managers.
>
> ‘Practitioners working at a higher level of practice have the capacity to bring about change and development within their own and others’ practice and within the services in which they work.’ (UKCC 2002, p8)

Education, training and development

The guidance documentation on the implementation of the role (NHS Executive 1999) envisaged consultants taking an active part in the education of others through helping to integrate theory and practice, and sustaining productive relationships with higher education. The literature suggests that consultants are involved in formal and informal education, training and development. Some developed special education courses for patients and families (Alderman 2002; Mulholland 2003) and nursing and medical staff (Pottle 2002), as well as disseminating their work at major conferences (Hughes 2002; Armstrong 2003). Others have extended this role and established professional forums where important issues are discussed and improvements explored (Packham 2003) thereby creating platforms where none existed before and giving them a chance to influence policy decisions.

The original documents outlining the role and expectations for consultant posts suggested that consultant nurses should have:

> ‘…a track record of scholarship and the appraisal and application of research in practice; and in many cases formal research expertise. The nature of consultant practitioner posts will demand a portfolio of career-long learning, experience and formal education’ (NHS Executive 1999).

In several studies, the educational preparation for consultants has been discussed. Payne (1999) advocates that consultants should be educated to at least Masters level. Adkins and Forester (2000) found that 65% of

consultant nurses had a higher degree, although they do not say how many are qualified to Masters level and how many have a Doctorate. They also state that a further 25% have a Bachelors degree. This would, however, seem to suggest that some consultants have not studied at degree level, although many have other relevant qualifications and diplomas. Guest et al. (2001) conducted a preliminary analysis of the new role of the nurse, midwife and health visitor consultants. Of the questionnaires sent out, 147 returned them and a further 32 consultants participated in telephone interviews. While the educational qualifications reflected a well-prepared sample, with 65% having an MSc or PhD, the actual numbers are not given. Adkins and Forester (2000) go on to suggest that the education standards of these posts must be addressed to make them more enduring.

The UKCC pilot project (UKCC 2002) does not suggest minimum educational achievements for practitioners practising at a higher level, but looks at education as a facilitative tool:

> 'Those working at a higher level of practice have aspects of education, research and management included within their role but the main focus, purpose and impact of their work are individuals (patients and clients) and groups (including carers) or communities. They can identify their own and others' personal development needs and take effective action to address them.
>
> 'Practitioners working at a higher level of practice are likely to have made best use of the wide range of educational and development opportunities available to them, learning not only through formal educational programmes but also from their own practice and from the individuals with whom they work. Such practitioners will have a track record of practice and innovative service development, including taking a lead in the implementation of policy, national frameworks and quality improvement.' (p8)

Practice and service development, research and evaluation

As proposed by the guidance documentation (NHS Executive 1999), the literature indicates that consultant nurses are involved in practice and service development, audit and evaluation, which are realised through team and interprofessional working (Pottle 2002; Coady 2003; Robinson 2003). They are also involved in re-organising and developing services, integrating health and social care services (Packham 2003), and influencing nursing and medical practice. In rural areas, consultant nurses coordinate services so that care is more streamlined (Bryan 2002)

with similar approaches in acute settings (Armstrong 2003). Research does not feature as a separate activity except as shown in Smy (2003) who reports on an academic partnership that aims to achieve sustainable change and improvements to the patient experience. Crouch (2003) suggests that significant changes in the NHS over the past ten years have shifted the emphasis from the care of patients to the management agenda and economic issues. He proposes that consultant nurses have been charged with shifting the focus back to patient care and patient experience.

Challenges

In the literature, there appear to be three important challenges threatening the development and sustainability of these posts: lack of resources, inadequate support and a lack of national parity in relation to the local implementation of the role and levels of academic achievement on appointment to the role. While the importance of 'adequate resources' was evident in the original outlines for these roles, the reality, for some, has been considerably different. Lipley (2001) and Moore (2001) refer to Guest et al. (2001) and findings showing that only a quarter of consultants have adequate resources. Similarly, higher levels of support were linked with lower levels of 'role overload, conflict and ambiguity' and only a quarter of consultants felt adequately supported by management (Guest et al. 2001).

Summary

The introduction of the nurse consultant posts was intended to help provide better outcomes for patients by improving services and quality, by strengthening clinical leadership and by providing new career opportunities for expert practitioners. Since these posts were implemented, much anecdotal material has been published. However, there is very little in the way of research evidence, partly because of the difficulty in carrying out empirical inquiry in this rapidly changing field, and partly because of the problematic nature of evaluating new roles. It is hard to measure the direct impact that new roles have on the quality of patient care and on the learning environment because the roles often contribute indirectly to outcome measures. However, there is a need to provide both descriptive accounts of new roles and their impact on practice, and a basis for recommendations and guidance for their future development (Guest et al. 2001).

Such guidance should include issues such as whether particular types of role offer particular benefits and whether the way the roles have been

designed influences their chances of providing effective care, what types of organisational contexts are conducive to embedding new roles into existing structures, and what the impact of the roles has been on patient care and on those who work with or alongside them. The aim of this study was to go some way towards addressing these needs by involving stakeholders in the evaluation of some of the local consultant nurse roles, in mental health at Dorset Healthcare Trust and in pain management at Poole Hospital NHS Trust.

This project describes consultant nurse roles within their spheres of practice and education from the perspective of key informants. These key informants included employers, clinical and academic colleagues and students. Using case study methodology, the informants were able to critically examine and describe the consultant nurse roles from their experience of working with them.

Methodology

Introduction

The aim of the evaluation was to draw on multiple sources of evidence to explore the local impact of the consultant nurse role. Bournemouth University provided a facilitated learning set for all locally employed consultant nurses to give them space for reflection and support. Through their involvement in the learning set, the consultant nurses, in collaboration with researchers, developed the methodology for the evaluation of their own roles. This was based on the '360 degree feedback process' that Ward (1997) defines as

> '…the systematic collection and feedback of performance data on an individual or group, derived from a number of stakeholders in their performance' (p4).

A key part of the evaluation was the active role that each consultant nurse would have in selecting a number of individuals from their area of practice, students, clinical and academic colleagues, managers and others, who would be interviewed by members of the evaluation team. The justification for adopting this approach to the evaluation was its collaborative nature, its flexibility and the potential to generate insights into how the consultant nurses had developed their roles and their relationships in the different organisational contexts in which they operate.

Study Design

Central to the evaluation was the active role each consultant nurse would play in the production of their own case study. This strategy of participatory research understands

> 'practice as having both objective (externally given) and subjective (internally understood and interpreted) aspects, both of which are necessary to understand how any practice is really practised, how it is constituted historically and socially, and how it can be transformed' (Kemmis & McTaggart 2003, p354).

The value of such a study of practice lies in its potential to make explicit connections across both 'objective' and 'subjective' dimensions, usually seen as mutually exclusive. The focus is both on the individual and the social, on the aspects of structure and agency, and on the connection

between the past and the future (ibid p356). Adopting an approach of participation, collaboration and integration enabled the research team to explore some of these relationships and connections.

In collaboration with the consultant nurses, the evaluation was designed to use case study methodology by inviting stakeholders or key informants to provide information on their work with the consultant nurses. Shaw (1999) suggests that stakeholder participation in evaluation offers a wide range of interested parties the opportunity to influence policy decisions, facilitates a range of views to be used to inform collection and interpretation of findings, and increases the likelihood of the findings being used. A key strength of case study design is its flexibility, and it has been used to generate theory in the exploration of roles and relationships (Robson 2002).

Six consultant nurses who participated in the facilitated learning set volunteered to take part in the evaluation (for consultant nurse information sheet, see Appendix 1). Each was asked to select six key informants, including at least one manager from their practice institution, one clinical colleague, one colleague from the University, one student, and one senior academic from the University. A decision was made not to include service users at this early stage of the consultant nurses' development because their inclusion would pose a number of ethical and practical challenges.

The consultant nurses agreed to find out if their key informants were able to contribute to the evaluation and if they were willing to be contacted by a member of the evaluation team. The key informants were then invited by letter to take part in a face-to-face or telephone interview with a member of the evaluation team, who would arrange and carry out a loosely-structured interview based on a number of key questions about consultant nurses' practice and leadership, and their practice development, educational and research activities (Appendices 2 and 3).

Following the collection of all the interviews for one consultant nurse, the evaluation team would carry out a thematic content analysis (Miles & Huberman 1994) and generate an individual draft case study report to be shared with the consultant nurse prior to a meeting with a member of the evaluation team. At this final meeting, the consultant nurse would have the opportunity to negotiate the content of the final case study report. This report would remain confidential. However, key themes and patterns would be identified and analysed across all six case studies and would be written up to produce the evaluation report. Inclusion of case study material in the evaluation report that could not be anonymised would be

negotiated with the individual consultant nurses. For a graphic illustration of the study design, see Table 1.

Ethical Concerns

There were a number of issues that the research team anticipated, particularly in relation to privacy and confidentiality. Participating consultant nurses may have felt very exposed by the process of constructing their case study. However, their participation in the evaluation design and the confirmation that case studies were confidential to them and the research team would have ameliorated those concerns. Similarly, key informants may have felt uneasy in making critical comments about the consultant nurses and their work. However, key informants would be anonymised in the case studies and contextual information removed as much as possible. The evaluation team also planned to represent critical comments in a sensitive and constructive manner by avoiding personal judgements.

In the event, it was the participatory nature of the study design that led to criticisms of bias by the Local Research Ethics Committee. Furthermore, the design challenged the traditional role of the research evaluation team; we would not be cast as the detached, third-person observers using methods that would enable us to grasp the 'truth' of the nurse consultants' practice, their effectiveness and the quality of their practice (Elliot 1988). Our project was not about capturing the objective nature of their work, but one of gaining and communicating an understanding of diverse perspectives and relationships. Such a role demands a concern for the consultant nurse participants and those they select as key informants by respecting the trust on which our access to information is predicated. Flinders (1992) suggests that such a stance of relational concern has practical implications for the researcher insofar as we would become 'fully engaged as co-members of the participants' immediate community' (p107) and would need to accept that dialogue must be openly negotiated and would not be within our unilateral control.

The nature of our role as researchers/evaluators and the active participation of the consultant nurses in the selection of their key informants led to the deferral of the proposal. It was further pointed out that, because public money had been made available to evaluate the role, the evaluation team had a duty to ensure that the findings were useful and generalisable. Suggestions to address this major flaw in the design included the drawing up of clear selection criteria for key informants, which would enable us to exert some control over who was to provide information for the study. We would therefore reduce

unnecessary bias and lend some degree of authority and trustworthiness to the findings. Subsequently, the design was amended to indicate that the sample for the case studies would be based on the following criteria: participant's manager; senior University link; Trust-based educational colleague; clinical colleague (nursing, medical or allied health professional); student (within the last two years). One year's working experience and regular contact with the consultant nurse became the minimum requirements for key informant selection.

The Sample

Participants and key informants

Six consultant nurses agreed to take part in the study: five from a mental health Trust and one from a district general hospital Trust. There was an equal gender split. Each consultant nurse was asked to nominate and contact up to six key informants to contribute to their case studies.

Data Collection

Each consultant nurse informed the research team after they completed the nomination process and had gained their informants' consent to be contacted by a member of the research team (see Appendix 3 for the information sheet sent to each key informant). A meeting to conduct the interview between the key informant and a member of the research team was subsequently arranged. Although key informants were offered the option of a telephone interview, none chose to do so and all interviews were carried out face-to-face (see Appendix 4 for the interview schedule sent to the key informants prior to the interview). Written consent was given by the participants to take part in the study, to have their interview tape-recorded and transcribed by an administrative assistant at the IHCS Research department, and to have it entered for analysis. The interviews were carried out at the key informants' place of work by SR and two research assistants.

Data Analysis

Thematic analysis of the interviews was undertaken in keeping with case study research (Wolcott 1994; Creswell 2003, p191). The analysis of the data obtained about the consultant nurses at the mental health Trust was carried out by EC who did not personally know either the consultant nurses or their key informants. The analysis of the data for the remaining consultant nurse was carried out by SR – although she knew the participant, she was not in a direct working or management relationship with them. The analysis had three discrete phases, as described below.

Phase 1: Generation of the individual case study report

In the first instance, each set of transcripts for each consultant nurse was analysed, and key informant interview transcripts were separated into data sets for the individual nurses. Where key informant interview transcripts were shared by more than one participant, parts of the interview relating to the individual participant were grouped together and added to their dataset. Comments relating to the consultant nurse role in general were included in the data sets for all participants who had selected that particular key informant.

Each interview transcription was read three times. Codes were ascribed to key phrases or words within the narrative, and were then grouped together according to themes (Miles & Huberman 1994, p56). Qualitative coding was then carried out as a way of interacting with and thinking about the data (Coffey & Atkinson 1996). The analytic framework proposed by Streubert & Carpenter (1995) informed the draft case study report. They suggest that the report should include the following: the original research problem; a description of the context and setting for the study; a description of key participants, their interactions and how they influence the phenomena under study; a discussion of emerging categories; their importance and inter-relationship; and a discussion of the implications of the findings. An example of a report presented to one of the participants is given in Appendix 5.

Phase 2: Feedback process

Following the analysis and preparation of an individual case study report, the participant was contacted and a mutually agreed meeting arranged. One of the researchers (SR) sent each participant their own draft case study report several days before the meeting to give the participants time to read it and make notes of any issues they wanted to raise. The purpose of this meeting was three-fold. First, in line with participatory research strategies, it was agreed that the participants should have access to their own draft case study report and be given the opportunity to comment on it, clarify misrepresentations, and raise any concerns (Mays & Pope 2000). In the event, none of the consultant nurses requested any changes to be made.

Second, the trustworthiness of the evaluation was enhanced by the feedback process and by the analysis being carried out by a researcher who either did not know the participants or key informants, or was not involved in a direct working or management relationship with them (Lincoln & Guba 1985; Horsburgh 2003).

Third, the feedback process helped to develop clarity and understanding of the consultant nurse's role and practice, both for the individual concerned and the research team.

Phase 3: Final analysis

Following the meeting, the finalised case studies and thematic analyses were grouped together to generate a composite analysis. The data were then organised in a table, with the codes clustered in similar topics beneath each of the main themes to generate a matrix (Miles & Huberman 1994; Wendler 2001). This helped to develop themes across cases.

Findings

Introduction

Each consultant nurse was asked to identify between four and six informants who were subsequently asked to participate in the study and to be interviewed. Six consultant nurses nominated at least one clinical/line manager and at least two or three clinical and academic colleagues. Some senior managers were nominated by more than one consultant nurse. However, they were only interviewed once in relation to the consultant nurses who nominated them. Although five consultant nurses identified students or former students, only two students decided to take part in the study when contacted by the research team. One former student could not be traced.

Table 1: Profile of participants' informants

	Academic colleague	**Director of nursing**	**Clinical colleague**	**Line manager**	**Student**
Consultant nurse (A)	1	1	2	1	1
Consultant nurse (B)	1	1	1	1	1
Consultant nurse (C)	1	1	2	1	0
Consultant nurse (D)	1	1	2	1	0
Consultant nurse (E)	0	1	1	2	0
Consultant nurse (F)	2	0	4	0	0

Case Study Analysis

Drawing on the work of Yin (2003), Irving and Klenke (2004) suggest that a case study approach is appropriate when the researcher

> 'has little control over events being studied, when the object of study is a contemporary phenomenon in a real life context, when boundaries between the phenomenon and the context are not clear, and when it is desirable to use multiple sources of evidence' (p21).

Given the nature of the consultant nurse role and the research team's preference for a participatory design for the evaluation, a case study approach was adopted, producing an individual report for each consultant nurse. One of the researchers presented each participant with their report following the analysis of their informants' interviews. A framework offered by Streubert and Carpenter (1995) informed the production of this case study report. They suggest that the report should include the following: the original research problem; a description of the context and setting for the study; a description of key participants, their interactions and how they influence the phenomena under study; a discussion about the emerging categories; their importance and inter-relationship; and a discussion about the implications of the findings. It was not possible to include all components because the overall analysis had not taken place (for an example of a case study report, see Appendix 5). Participants were encouraged to comment on the case study and give feedback. This process is described in more detail further on.

Development of Categories

There were three distinct phases that contributed to the development of the final categories. The first phase was an individual analysis of the interviews for each consultant nurse and the generation of their own case study report (see Appendix 5). The second phase involved meeting individual consultant nurses and sharing the case report and their feedback from this. The third phase involved considering all the individual analyses together. A matrix analysis was undertaken to identify any further categories across cases. The findings from each of these phases are now described in more detail.

Phase 1: Generation of the individual case study report

Each interview transcription was read three times. Following thematic analysis, four categories emerged from the data: evolution, about the person, the work and resolving issues. **Evolution** includes codes to describe informants' understanding of the emergence of consultant nurses. It also includes aspects of the role reflecting components that are developing, changing or evolving. **About the person** are the codes that describe the attributes expected of a consultant nurse. These might be observed or deemed desirable in an applicant. They set the scene. **The work** describes a huge array of codes to reflect the nature of the role. This theme is closely related to 'About the person'. **Resolving issues** brings together aspects of the role that present challenges. It also helps identify areas for future development or research.

Phase 2: Feedback process

Following the analysis and preparation of the individual case study report, the participant was contacted and a mutually agreed meeting was arranged. One of the researchers (SR) sent each participant their own draft case study report several days before the meeting to give the participants time to read it and make notes of any issues they wanted to raise during the meeting. The purpose of this meeting was three-fold. First, congruent with participatory research strategies, it was agreed that consultant nurse participants should have access to their own draft case study report and be given the opportunity to comment on it, clarify misrepresentations and raise any concerns (Mays & Pope 2000). In the event, none of the consultant nurses requested any changes to be made. Second, the trustworthiness of the evaluation was enhanced by the feedback process in conjunction with the analysis being carried out by the researcher who either did not know the participants or key informants, or was not involved in a direct working or management relationship with them (Lincoln & Guba 1985; Horsburgh 2003). Third, the feedback process helped to develop clarity and understanding of the consultant nurse's role and practice, both for the individual concerned and the research team.

Participatory research frequently mentions the need to feedback findings to participants and yet how this occurs and the mechanisms for incorporating their voices are not made explicit (Lindsey & McGuiness 1998; Lindsey et al. 1999). Giving participants the opportunity to select individuals who have an inside knowledge of their practice as key informants, and sharing the draft case study reports with them prior to further analysis, are two mechanisms that contributed to the value of this evaluation.

Phase 3: Final analysis

After the participants received the case study reports (as described above) and had the opportunity to comment on the themes and categories, the data were then organised in a matrix display where all themes were considered across data (see Figure 1). This allows for the identification of further themes and categories across the data sets (Miles & Huberman 1994; Wendler 2001). Two further conceptual categories emerged which encapsulated the core aspects of the consultant nurse role: 'leadership' and 'national work' (see Figure 2). These concepts are briefly presented at the end of this chapter and are developed further in the discussion.

Themes from the Data

Evolution

This theme describes the history and the development of the consultant nurse posts according to the respondents' perspectives. The genesis of the posts was not clear to all respondents. However, some saw the role as emerging from practice development to address a specific project or patient/client need, while others recognised that the role was created as a result of a national policy drive to capitalise on the potential of nursing to expand their repertoire of skills and capabilities and to lead services. Some comments related to suggestions that the role had been created to fulfil regulations on junior doctors' working hours. The role was generally welcomed as an opportunity to develop a credible career pathway for ambitious and able individuals while maintaining their presence in clinical practice. Informants commented that while these individuals may have had to consider career opportunities in management, education or the private sector in the past, career progression and promotion was now possible within the clinical practice area. They are therefore not lost as a resource to junior staff, students and patients.

> *I think they* [consultant nurses] *have impacted positively* [at this Trust]. *What it is providing is a clear structure and career path for nurses. There isn't that decision of, do I want to stay a clinician or do I become a manager? It's taking away from that choice, which when I was at that decision-making process, there wasn't any choice really, you either stayed at the grade you were at, or you went into management.* (Clinical colleague A)

The excerpts below are typical of the responses in this category:

> *One of the biggest gaps in service in mental health has been identified as how we help people with personality disorders, and there has been a big push from the government to do this.* (Clinical colleague C)

> *The real clinical need came out of unmet need that was being recognised, that clients often moved between mental health and addiction services and were falling down a gap. That's what prompted the start of the development of services.* (Director of nursing, general comment)

> *The then chief nurse for England had been active in trying to create this role. The exciting thing was the major difference between this role and other types of advanced practice nurses, was that this person was supposed to straddle the academy and the service.* (Academic colleague A)

Setting up the role

There were a number of critical comments in relation to how the roles had been set up, referring particularly to the lack of supporting infrastructures within the NHS Trusts when post holders were expected to perform at a high level. Comments referred to the lack of suitable accommodation, equipment and administrative services. Furthermore, although defined criteria regarding role functions had been prescribed centrally (i.e. expert practice; professional leadership and consultancy; education, training and development; and practice and service development, including research and evaluation), it was not always clear at the planning stage for the posts how the roles fitted into the NHS Trust organisation. However, some time into the posts, a degree of clarity was beginning to emerge as the excerpt below illustrates:

> *…and what they are doing is more robust in terms of the Trust structures, around clinical governance, around research, clinical effectiveness, clinical audit and those kinds of things and what roles they have. Again as the roles develop and as we think about structures, it will be clearer.* (Line manager C)

About the person

The qualities and skills for a consultant nurse included having a high profile; an ability to demonstrate leadership and to systematically problem-solve; being innovative and skilled in communication within different contexts; and an ability to bring analytical processes to bear on practice situations. Some of these comments relate to the consultant nurse in post, whereas others speak of an expectation that the post holder should demonstrate these attributes and skills. The following excerpt is typical of key informants' descriptions of post holders' interpersonal and communication skills:

> [Name] *works independently but then links with the addiction team, the CMHT* [community mental health team] *or in-patient unit, so she steps in and out of a whole range of teams. Rivalries-wise, I am sure there is the same as with any profession, I think it comes down to personality really, it's about how to actually communicate. I think* [name] *does an excellent job, she is very professional, and she is very able to deal with any situation that she goes into. She has managed herself very well and got good outcomes in some very difficult situations of conflict of clinical opinion or the way that somebody should be managed. She's actively had to challenge practice at different times, not around the clinical interventions, but structures, referral processes, systems and things like that. She has done very well in doing what she can; I'm not saying that she has*

> *always succeeded 100%, but she's certainly done excellently in being able to work with people at all different levels and to try and find a way through the difficulties.* (Clinical colleague C)

Credibility in practice

The need for the consultant nurse to have credibility in clinical practice was emphasised by all informants. The following excerpts illustrate the key informants' contributions that led to the identification of this theme:

> *I think her contribution has been principally her enthusiasm. She is a very enthusiastic person and that motivates others.* (Clinical colleague F)

> *They* [consultant nurses] *have actually got be quite special to be able to the job because it is the top job for nursing.* (Clinical colleague D)

> *She came over as a consultant, as a person who has got authority and knowledge and she's very convincing in that role.* (Clinical colleague F)

> *Being a consultant nurse is about having very expert skills in a very specific area. I think to be credible and for people to respond to you and respect your knowledge and skills, that's absolutely essential and so, yes, that's important.* (Academic colleague B)

> *It's about somebody who has the ability to work across professional and organisational boundaries…Somebody who has a very professional approach, is able to be in the spotlight and is happy with that, who is able to work in a quite high profile way and to sell themselves. Some consultant nurse posts are quite new, depending on what area they are in, they need to be able to sell it and to carry things forward, to make a noise about things. They need to have excellent clinical skills in their area of expertise particularly, they need to be able to try and develop other people, they need to be able to conduct research and interview with a systematic approach. But mainly being able to work with a whole range of people, in a whole range of ways and to maintain their professionalism across that.* (Clinical colleague D)

> *It is somebody who could be self-motivated, enthusiastic, a dynamic sort of driven person who can work alone, have a*

> *vision and be able to motivate other people to bring that to fruition. That's the kind of person I think.* (Clinical colleague D)

Leadership qualities

Personal leadership qualities, like giving direction, responding to challenges and being politically astute, are described below:

> *They need to have vision and be able to focus and to know where they are going to go and to lead the area and like* [name] *does with acute pain so she is seen as the leader for the hospital in that area and new developments…So she needs to have behind her the education, research, evidence of practice and extremely good communication skills to be able to take forward change and manage that change. To have a vision for where the service needs to go and obviously to be open and receptive to others along the way as that change is taking place.* (Clinical colleague F)

> *So being able to argue their corner from a position of knowledge and strength. Being aware of how to interpret data found in both medical and non-medical journals or publications. Being prepared for people undermining you academically is a risk, so you need to have quite an exemplary level of education and training in order not to be beaten by getting in those kind of arguments.* (Clinical colleague F)

> *Well I think* [name] *has utilised my knowledge as an executive member of the PCT* [Primary Care Trust] *to advise her about who to contact within the PCT and what sort of approach to take so any letters, like the letters that we wrote to* [name] *who is the Director of Service Development at the PCT. We wrote it together so that she could put her angle onto it and I could temper what she wanted to do in terms of what might be realistically obtainable. So on the political side we have worked together and I think she's found it quite useful that I am an executive member so that I know a bit about the way the PCT works and the ways to maybe think about accessing funding.* (Clinical colleague F)

The ability to act as a role model was also highlighted:

> *It is good to have a top level nurse who uses models of care rather than the medical model and she acts as a role model for nurses as well.* (Clinical colleague F)

There was sometimes an expectation that the consultant nurse would continue to carry a caseload:

> *All the people with whom* [name] *works would have the most complex needs otherwise they could be worked by the CMHT* [community mental health teams], *or the community mental health teams working jointly with the addiction locality team. Those that would be asked to be seen by* [name] *are usually those with more complex needs.* (Line manager A)

Political complexity and role expectations

The political complexity of the role and the expectations were captured by the following comments:

> *Consultant nurses will have a much broader overview* [compared with the lecturer practitioner role]. *They will look at the environment within which the service operates, the other agencies which need to be involved, the effectiveness of interventions…their role is more analytical, more questioning, but both roles will be involved in training of course. But I think consultant nurses will be functioning at a higher, broader organisational level.* (Academic colleague B)

> *I think they have to be very strategic in their thinking. They have to have the ability to take an overview, because the politics are amazing at this level. They will get involved in national initiatives and so on, so I think to be able to be strategic is very important. They need to be able to manage managers. They need to be able to keep communications going, particularly when you may have strong feelings about things that are going on in the service. I think that's people skill stuff at fairly high level. How to manage the managers who are pretty skilled in managing people and getting what they want anyway. So a sort of cross between Montgomery and a snake charmer. There's an image!* (Clinical colleague D)

The national guidelines suggested that consultant nurses would have at least a Masters degree and preferably a Doctorate, or would be working towards one. Some respondents touched on the academic expectations for such highly skilled roles:

> *I think there's got to be some minimum, because clearly in that kind of senior position you've got to have an understanding of the literature and the research. But I don't think it should be set too high. It shouldn't be a PhD or something.* (Line manager E)

> *I am not sure that the academic educational level is something I would particularly set out. My personal view is that it's about the skills, abilities, knowledge and personality of the individual. I am sure there is a cut off point, but I wouldn't say somebody must have a Masters before you should consider them for consultant nurse or something on that level.* (Student B)

The work

The codes and categories making up this theme describe the different aspects of the role and areas of practice, which were identified as clinical practice, service development across traditional boundaries, education and research. The extended excerpts below illustrate, from the key informants' perspective, how consultant nurses are working across these aspects:

> *The* [medical] *consultants are very aware of* [name]*'s presence and quite a few of them contact her via e-mail, telephone or pop into the office just to ask for suggestions on patient management and it is good to see that happening as well. So she is used as a consultant for the nursing staff, for the medical staff, at the University for course curricula. She has been able to support things there as well.* (Clinical colleague F)

> *At the moment I would imagine that* [name] *has a caseload of about five clients. Her contact time, I think varies. One of the things with the dual diagnosis client is that they can take up a lot or a little time, they may need to be seen weekly, then somebody will have crisis and she'll be seeing them every day or something. So it can vary quite a lot depending on their clinical need. Her contact can take the form of assessment, so she offers specialist assessment to all of the CMHTs* [community mental health teams] *and addiction services, anyone can refer and say undertake a dual diagnosis assessment. The outcome of that would be that she may just write back and advise the team on the treatment models and needs, or whatever. She may actually go and do joint work with the CPA* [care programme approach] *key worker, the care coordinator in the community and joint worker in helping to draw up the treatment plan, reviewing and possibly with some interventions. Or she may actually take more of a leading role, although there would still be the CPA care coordinator, she may actually take on the clinical work herself, be the lead person in interventions and liaise with the care coordinators…Those* [patients] *that would be asked to be seen by* [name] *are usually those with more complex needs.* (Clinical colleague A)

I suppose the thing that [name] *and I have collaborated on since then, and which is an ongoing project, is that out of the original contact there grew a common interest in actually thinking about developing some sort of pain service in primary care that district nurses and GPs could refer into for people who have got long-term chronic pain which they're not managing properly, to see if we can improve their quality of life and help them to manage their pain so that they're putting less pressure on the therapy services. Because of my involvement at* [unit name] *and the intermediate care team we thought we'd look into first of all proposing that we develop some sort of pain service to the PCT and we had a pharmaceutical representative who was keen to fund the training of this.* (Clinical colleague F)

I think when I first arrived there was a big push to start developing the community side of eating disorder work, as opposed to the in-patient side. It was the outpatient bit that needed developing. [Name] *was very involved in developing that, so he was liaising with various senior people, Primary Care Trust people from other parts of Dorset, going to meetings and out and about to find out what their needs would be, then coming and talking with the management here. It is not just a question of having people working out there, they need to be working within the remit of what we are offering, they have to be supervised, they have to be managed and so on. That was the first thing that I was aware of happening when I first arrived. So that's the service development side of it, making sure that you have got people with the right skills, personality and attributes to be able to go out there and do the job. It is very much a PR job as well, if you are going out there and setting up a new service.* (Clinical colleague D)

Obviously that was a big education thing through the hospital that we could use more 'Oramorph', and [name] *then has managed to support the staff…The doctors were writing and prescribing that the patient is discharged on 'Oramorph'. Following the audit study follow-up of these patients like hernia type patients, whereas previously they would go home and have five days of antibiotics or codeine-based drugs, they now go home with a supply of 'Oramorph' and returning back to work and reporting less pain after five days and have less complications.* (Clinical colleague F)

> *He encouraged us to bring the scenarios, real life scenarios. Things perhaps that we were stuck on which happened during the week. So…usually sort of in the afternoon we would have a whole afternoon of having that supervision and role play and he would encourage us all to bring our own real life scenarios and we'd take that in turns and we might do two or three different role plays of problems or scenarios that had occurred the week before at family work. So that was really good because it was more real. If we had got stuck he would always, you know, have ample amounts of scenarios from his vast experience, you know.* (Student B)

> *This is his thing really, but he is very keen to encourage other people. I mean this body image thing, it has to be set up in a way which will mean that you could actually research it and write it up, ensuring that it's valid. He is very hot on that.* (Clinical colleague D)

Achieving goals

This theme also reflects the component parts of the role and the methods used by the consultant nurses to achieve their goals. One informant captured, as they saw it, the 'real' work of the consultant nurse:

> *But what nurse consultants do is probably reinforced by what is the essence of nursing, how their contribution, their unique contribution of nursing, how that is expressed in what they do*. (Clinical colleague D)

The nature of practice development, undertaken by consultant nurses, was clearly at a level that crossed professions and agencies and reflected a wider perspective. Much of the work by the consultant nurses is seen as 'pioneering' and respondents mentioned that the consultant nurses took the work or service 'to another level':

> *It's about being innovative, advanced practice, working across different professions and boundaries, things like that, so it was to take that to another level really, as I understood it.* (Director of nursing, general comment)

> *…with his work, because it is highly specialised, the advice and support he gives about early detection of the disorders and the cultures that prevail for that, will again be an example of how it is working across the different boundaries of primary/secondary care, social services and other groups.* (Director of nursing, comment about B)

The nurse consultants do as well obviously because they are within their speciality, but I think there is a larger expectation about taking that wider overview and you know representing the Trust and not thinking about one area only, but thinking how that would work, you know, ideas that would work across services. (Academic colleague B)

There were quite a lot of philosophical shifts in thinking. It was a very big meaty project and there was much interest nationally in what was happening here, because of this drive to be working with this very difficult client group, where there were no real practice pathways in place in this country. This has meant that we have been at the forefront of development on a national level…We didn't even know it was so novel, we just thought here is a new thing! We have managed to convince our management that we want the full training in this because it could be useful…What we didn't realise was that there was no-one, we were the only people who were using it, so there were all these extra responsibilities that we had in terms of dissemination, research and that kind of thing. It turned into a much bigger thing than we thought it would do, so it's quite fortuitous that we had somebody like [name] *around with experience to steer us through that minefield really.* (Clinical colleague C)

Their work went further than an individual Trust as they were recognised as contributing to national work and networking. If you look at the group of nurse consultants, they are very active both regionally and nationally, they deliver a lot of papers, bring a lot of kudos to the Trust, but also encourage other services to develop and again that fits with the culture of the Trust. (Director of nursing, general comment)

He comes with a lot of contacts that he already had so he is a well-connected person and he's very good at making sure that we in the hospital are tapped into what's going on in the outside world, if you like. (Clinical colleague D)

Resolving issues

Key informants were able to articulate some of the issues that were problematic for the individual post holders. An issue that was highlighted was the lack of a supportive infrastructure. A comparison was made by some key informants regarding the calculation of set-up costs for a medical consultant, which include office space, administrative help, clinical resources in terms of other people's time, pharmacy costs, etc.

None of these additional costs and resources were included when the consultant nurse's post was set up, although the Trust's expectations in terms of outcomes for the post were high.

Settling in

Settling into the role and gaining clinical credibility and staff confidence was a challenge, as the following excerpt illustrates:

> *Well I think it was quite difficult for* [name], *because he'd moved into a new area, into a new role. I think that locally it wasn't very clearly thought out what the expectations of this role were, so he has had to define the role as he went along. He has come across a bunch of clinicians who are really quite enthusiastic, motivated, they have very clear ideas of what they wanted to do, but a lot of what he had to do was on a kind of interpersonal level first of all. There was a lot of energy and heated debate about what we were doing, so I think he had to manage things…to help kind of get heads together in a way that moved things forward effectively. So that was his first thing really. Then I think he had to convince us that he was somebody worth doing business with. Why do we need this chap? Is he going to steal all of our thunder? This was an issue to begin with. Was this somebody that actually wanted to come and steal all the research that we'd done, done all the donkey work and used up all the energy that we have had to use up and just take some of the glory for it? Or is this going to be a chap that's actually going to be part of our team? I think we weighed that up really, I am aware that at first we were wary about just how much we wanted this chap involved. He had to gain our trust; he had to work quite hard at that. He certainly has achieved it, but it has taken all of his two years to get there. I certainly very much trust* [name] *now, but I wasn't quite sure to begin with. That's partly because the role was new and partly on an interpersonal level, I needed to work this guy out, to be honest.* (Clinical colleague C)

Lack of understanding

Another issue concerned a lack of understanding about the role by clinical staff and that much of the consultant nurse's work takes place 'behind the scenes':

> *I think she's not supported at the Trust. As I say, people can't always see what her job entails and I think even when you're told what the job entails, you still don't fully understand it.*
> (Clinical colleague F)

> *Some nurse consultants have got a very high profile, present at national conferences, they teach courses, they lead. I think the difficulty is that some, particularly the in-patient areas, perhaps there is quite a few problems with recruitment and retention. With a lot of very new staff, I think there is a danger really to widen the gap between the people that provide everyday care, that's perhaps the E and F grades, and the difficulty is that often nurse consultants are tied up and involved in lots of events and not actually improving things in their clinical areas, because they are preoccupied with promoting the aims of the Trust, teaching or presenting at conferences, or involved in research. So I think if that's the case the average nurse wouldn't really perceive their role as very valuable at all.* (Clinical colleague D)

Conflict

This category also reflected many aspects of the nurse consultant role where conflict was evident. Often this had been resolved, but sometimes issues continued to be problematic. For instance, while recognising the benefits of expertise afforded by national networks, there was criticism about the amount of information that actually 'filtered' through to practitioner level in the clinical environment:

> *He is well into those networks, but how much comes back into the hospital I feel less confident about.* (Line manager C)

Delivering new services

As the consultant nurses moved into new roles, and developed and delivered new services that traditionally may have been led by another professional group, one manager recognised the need to frame such work carefully:

> *If you view it as nurses doing the appropriate intervention that they've trained in school to do, to the appropriate type of patient, then that's fine and nurses are happy with that, then the medics are happy with that. If you say we haven't got enough medics, therefore x, y and z is now going to be done by a nurse, that's not satisfactory to anybody.* (Line manager E)

Negotiation skills

There was evidence that the skilled consultant nurses had the ability to negotiate their way through difficult situations:

> *We held a meeting yesterday about the big development issues that are going on and it got quite emotional and quite heated,*

> *but in actual fact we resolved a lot of stuff. I gave feedback to* [name] *afterwards, how particularly skilful I thought he'd been in that meeting, perhaps the most skilful that I had actually seen him.* (Line manager C)

Lack of power

A common issue mentioned by respondents relates to the lack of power held by the consultant nurses and their managerial role.

> *I think the advisory role hasn't been as effective as I would have hoped and I think that's not just* [name], *but all the nurse consultants within the Trust, it seems to me, don't have enough influence on management.* (Line manager E)

Maintaining a balance

It was recognised that the work had many demands and that maintaining a balance was important.

> *I think there is a bit of a balance there because, well, I think it is important but they are also there for the clinical perspective and about not losing that and putting too much into education. So I think it's about getting that right.* (Clinical colleague F)

> *I do think they need to be strong in all of those areas and that is one of my criticisms, that in a lot of nurse consultant appointments generally, people have been strong in one or two areas and very weak in others.* (Academic colleague, general comment)

> *Whilst some nurses might be a lone voice in the Trust, others are able to join with similar colleagues for support. But the overall picture suggests a lack of national cohesion.* (Academic colleague, general comment)

> *In many situations across the South West and I guess nationally, many don't see themselves as part of a structural web. They don't know where they fit within an organisation.* (Academic colleague, general comment)

Understanding about the role

There was evidence of variable understanding about the consultants' role, especially their roles within the NHS Trust or University.

> *I think from the outside, people are not sure whether they are clinically-based or whether they are university-based.* (Clinical colleague D)

> *I mean I know she is a consultant nurse in mental health, but what she does on a day-to-day basis as part of her role, I really don't know.* (Academic colleague A)

Academic expectations were mentioned as part of 'the person' and yet tensions existed between the hopes and reality. A clinical colleague held the expectation that consultant nurses would be educated to Masters level but the reality was different:

> *But I think working towards those things and at the beginning of that they would obviously have to be academically, professionally qualified to at least Masters level. That was the expectation. I think that was overestimating what depth there is in nursing on the ground to fill those posts*. (Clinical colleague D)

> *We're actually asking our consultant nurses to undertake, or to already have, a Masters*. (Clinical manager B)

> *I think as a natural development some people will move towards sort of Doctorate level. There's a danger that we will move people out of clinical practice if they go that far.* (Clinical manager E)

With regard to the consultant nurse role in general, the following excerpt illustrates how the 'nurse' in consultant nurse has been subsumed under the specialist expertise of the individual at the expense of championing the profession:

> *The other thing that I found interesting during the learning set was that it was the first time that many of them had actually thought about nursing. Nursing was something they left behind. Nursing was personal care stuff on wards and, working with them, what they began to realise was that nursing was more than doing personal tasks to somebody. It was a way of understanding health need and devising health plans to meet those needs. So they had retreated from nursing because that was unsavoury and not very sexy or glamorous or important and they could do it anyway and they had retreated into their 'specialisms', so they were a pain specialist or they were an eating disorder specialist or something and that was an end to*

> *itself. They were not a nurse so the learning set work made them start to realise that nursing is a discipline. It has to be studied, and what does nursing do with regard to health? And what are you doing about your health planning and meeting health need? I think that has been a powerful reorientation because that then tells them that they are advanced practice nurses leading research and education in nursing and also other professional groups. They have a corporate leadership role.* (Academic colleague, general comment)

However, another key informant commented that the consultant nurses who had been appointed across the organisation were beginning to work as a group, thus becoming a force for change:

> *I think that the work* [of consultant nurses] *now is starting to bear fruit for the Trust. I think, the thing for me, and I'm glad that we've got so many, is when they get together. They may be a bit weedy on their own, and weedy in the sense of trying to define their own role, but you put them together and that's not the case. The more they get together, and they do, the more things they do together, and they do, and the more people stop and think. So I think if they were isolated…it would be really hard for them but because they're actually a good cohesive group…it works. I think they're a potpourri, I mean even looking at them in terms of their personalities because of the way, you know, someone like* [name] *on the one hand and like* [name] *on the other, you know and everybody else, like the dippy one, the sensible one, the very academic one, the able one. They've actually got a really good group I think and they're a formidable force. I think that's good and that's what will make the difference to nurses.* (Clinical colleague E)

Participant Feedback

The participant feedback process facilitated communication between the research team and the consultant nurse participants following the compilation of the individual case study reports. This stage was built into the research process to increase the participants' control over what information about them and their role was to be released into the public domain, and to increase the study's trustworthiness through what could be understood as a 'member checking' process (Lincoln & Guba 1985; Horsburgh 2003).

The nurse consultants took a considerable personal risk by taking part in the evaluation because they did not participate in any interviews and did not have access to the data collected from their key informants. The participation feedback phase was a way of redressing this balance.

However, this process could have led to distortion because participants were given the opportunity to influence the data analysis and the representation of the findings. Although this was a potential risk, it was important to collaborate with the participants to gain access to the key informants. In the event, none of the consultant nurses requested any changes, deletions or additions. They commented that the draft case study reports were balanced, containing both positive and critical views on their roles and practice.

In terms of useful outcomes as a result of participating in this evaluation, some of the consultant nurses welcomed the opportunity to have feedback on their role and their performance from a range of perspectives. They hope to use their case study report as part of their professional portfolio or as a basis for their management appraisals. Others commented that they had participated in a number of national evaluations since their appointment, but had not received feedback or the opportunity to comment on any report prior to being published, which had left them feeling disempowered. Therefore, they appreciated having detailed feedback from this evaluation.

Participatory research frequently mentions the need to feedback the findings to participants, but how this should occur and the mechanisms for incorporating their voices are not made explicit (Lindsey & McGuiness 1998; Lindsey et al. 1999). Giving participants the opportunity to select individuals with an inside knowledge of their practice as key informants, and sharing the draft case study reports with them prior to further analysis, are two mechanisms that contributed to the value of this evaluation.

Key informant issues

The interviews with the consultant nurses raised a number of interesting issues in relation to their understanding of their role personally and as a group of senior nurses engaged in advanced practice. However, we as the researchers were unsure of the status of this information. Was this ‘data’ in the same way that the interviews with the key informants were? Could we use it only to clarify our understanding of their case studies? In what way could we represent their contributions? We decided to summarise the issues they raised separately from the key informants’ data to make it clear to the reader that these points were identified by them specifically:

- A number of participants referred to the difficulty in balancing the need to be 'the voice for nursing' in the organisation (through attendance at Trust board meetings, and nurse recruitment and public relations events) while attending to the clinical demands of their speciality. These demands were often in tension with each other and the post holder usually felt compelled to focus on clinical rather than organisational issues. This sometimes created conflicts with those who saw them as neglecting their organisational responsibilities.
- Some commented that the role was still in its infancy and that any authority they had in the eyes of their colleagues rested in them as a person, rather than in the role.
- There were comments about the lack of a continuous clinical career structure leading to the consultant nurse role to facilitate succession planning and the delegation of specific pieces of work to more junior nurses. Related comments referred to a lack of clarity about the way their role fitted into the organisational structure.
- Although the participants saw team working as an essential part of their work, some of them did not feel part of a team but were members of a number of different teams only for the duration of their particular clinical input. This depended on the organisational structure of their speciality and how the post had been set up. Of course, some were clearly part of, or leading, a particular clinical team while others' clinical input was only required when existing team members' resources had been exhausted.
- A small number referred to a 'paradox of impact' in that they felt their work was highly regarded nationally or internationally, with frequent enquiries about particular therapies or treatment interventions and invitations to run workshops or give conference presentations, yet they found it difficult to implement best practice locally.
- Nearly all participants commented that being active in all four dimensions of their role at the same time was challenging, if not impossible to achieve. Furthermore, they felt that they were not equally strong in all four areas. The majority felt strongest in their clinical practice area and weakest in their ability to carry out and supervise research.
- All participants raised the issue about the lack of administrative support for their post being particularly problematic because it had a direct impact on the efficacy of their role. This lack of a supportive administrative infrastructure means that post holders spend time booking rooms and making appointments for meetings, taking minutes and writing letters on a regular basis. Some participants mentioned that much of this work takes place outside working hours.

Secondary Matrix Analysis

Leadership

The concept of 'leadership' enabled the research team to capture an activity that crossed each of the four categories. As leaders, consultant nurses needed support and sought out emerging infrastructures to help them. Skilled leadership enabled them to negotiate the often tortuous process of working across boundaries and professional groups. It touched on many aspects of their working life.

National work

The category of 'national work' was an integral activity within each of the four themes, as shown by the consultant nurses' national profile which provided a forum for presenting their work and bringing knowledge and new insights back to the Trust. The data provided examples of how consultant nurses were active in national forums. This activity was seen to be an important aspect of the role by both clinical and academic colleagues.

Limitations of the Study

The data collection for this study was carried out in the second year of most of the consultant nurse appointments. This was a relatively early stage to evaluate a role that was so radically different to other new roles in relation to authority, status and remuneration (although at this stage many of the salaries were pitched at the lower end of the pay scale). At the time, it was also the only role for which there had been detailed guidance and criteria from the Department of Health for employers and employees on the implementation of the role. The same strategy was used later to implement the modern matron role.

Bias

Methodologically, the participatory nature of the study could be viewed as producing 'biased' findings, thus reducing their capacity to be transferred to other settings or even to be generalised. However, it was our aim to explore local roles in their contexts and produce an evaluation informed by those who were working alongside these individuals. It is therefore a necessarily partial perspective on the consultant nurse, but one that may generate insight and a more differentiated and detailed understanding of the role.

Consistency

There were a number of practical issues that may have had an impact on the research process. There were three interviewers – the lead researcher (SR) undertook the majority of the interviews while DW and CH interviewed five key informants in total. Both received training and

supervision prior to conducting interviews. The semi-structured interview schedule provided a coherent framework and ensured that similar information was collected. The quality of the data from the interviews was of a consistent standard across all three interviewers.

Objectivity

Some informants' interviews were used for more than one consultant nurse participant. This meant that informants weren't always able to offer specific comments about the individual who had selected them in relation to all the aspects under investigation.

There was some risk that, because the informants were 'selected' by the consultant nurses, the interviews might be uncritical and overly positive. This risk was emphasised by the Local Research Ethics Committee whose members reviewed the proposal. However, the research team found that informants were candid in their observations and were able to offer critical as well as supportive comments about their experience of working with the participating consultant nurses.

Discussion

Background

The findings were organised around four key categories which expressed the concerns of stakeholders. These were the ‘evolution of the consultant nurse role’, ‘about the person’, ‘the work’ and ‘resolving issues’. A secondary matrix analysis revealed two further categories, namely, ‘leadership’ and ‘national work’. Leadership appeared as the cornerstone of their work and captured what key informants viewed as an essential ability to successfully inhabit the role of consultant nurse. National work appears in each of the four main themes. It reflects an important aspect of their work and involved them moving and thinking beyond the boundaries of their own organisation.

Key Categories

Evolution

A critical issue in the evolution of the role was the interpretation and implementation of a national policy initiative at local level. The consultant nurse role was designed to focus on the development of nursing leadership and practice rather than on management. From the perspective of the key informants in this study, this leadership and practice development function is clearly visible and valued.

Implicit, and sometimes explicit, in some key informants’ interviews was the notion of ‘expert’ or ‘advanced’ nursing practice and its relationship with medical practice. Key informants alluded to the debate that has developed along two directions. One direction is that some see advanced practice as the interface between nursing and medical practice in which senior nurses develop skills associated with medicine. These include skills related to diagnosis, treatment and technical expertise at a time when patient demands are increasing while recruitment and retention in the medical workforce is becoming more problematic. Furthermore, the move to reduce junior doctors’ working hours has led to a vacuum that ‘advanced’ nursing practice is purported to fill (Daly & Carnwell 2003). This line of reasoning has been employed in relation to other nursing roles, for example nurse practitioner, clinical nurse specialist and advanced practitioner. The other line of argument relates to the development of advanced or expert nursing practice as an integration of the domains of clinical practice, education, practice development, research and consultancy as a way of strengthening the nursing contribution at the strategic and policy levels of health care.

It was the latter interpretation of expert function that most key informants identified in relation to the consultant nurse. In the examples they gave to illustrate their views, key informants talked about consultant nurses designing services for those clients who traditionally have not been served or have been poorly served by mainstream services, for example 'dual diagnosis' patients or people suffering from non-specific low back pain. Their accounts resonated with Daly and Carnwell's (2003) explanations of 'role development':

> 'The outcome of such roles is that the fundamental nature of service provision and scope of nursing practice within that specific role may be changed. Although this may often involve the acquisition of knowledge and skills, associated with, for example the medical domain, these should be used in a manner *that enriches the holistic quality of nursing practice, patients' health care experience and health care provision generally*' [emphasis added]. (p160-161)

This perspective of expert or advanced practice was reinforced through action learning groups, which were successfully used with a cohort of consultant nurses to help them deconstruct their mental model of themselves to form a new model of nurse consultant (Graham & Wallace 2005).

Key informants talked about consultant nurse roles in a way that went beyond the debates about what aspects of medical work were being undertaken. Instead, they described new or re-configured services for patient and client groups who are difficult to engage with or whose needs are inadequately addressed within the traditional medical model. Some roles had emerged from previous 'new' roles in nursing, for example the clinical nurse specialist and lecturer practitioner. However, what many key informants identified was that the scope of the consultant nurse role went beyond local clinical practice and local clinical learning environments. They highlighted how post holders worked as much outside the organisation as within it to develop communications and processes between agencies or service sectors. Their role was described as one that seeks to bring coherence and continuity to the patient experience.

One of the tensions that emerged from the interviews with key informants – and was confirmed by the participants in the feedback process – was the issue of power in relation to how it was incorporated in the policy documents for creating the role on the one hand, and their experience of effecting change in their organisation on the other. Although the role was

invested with power, the reality of working within their organisation and with colleagues was sometimes characterised by frustration, because their power to make decisions in terms of management and budget was limited. Another frustration that the key informants identified – and which was again confirmed by the participants – was the narrow and sometimes restricted understanding of their role by some colleagues. These colleagues valued direct patient contact and high presence and visibility of the consultant nurse in the clinical area over their strategic and collaborative work with other agencies, from which they could not see an immediate benefit. Blindness to long-term goals on behalf of colleagues and the organisation was a source of dissatisfaction for consultant nurses. However, from a management perspective, the importance of a balance of short-, medium- and long-term goals to measure consultant nurse performance was highlighted.

About the person

The categories within this aspect of the consultant nurse role related to the skills and attributes that key informants believed to be essential for the credibility and success of the role. The consultant nurses who participated in this study were seen as ‘champions’ for a particular service and the client group they served. Key informants appeared to take the consultant nurses’ expert practice and specialist knowledge for granted, as if they were prerequisites of the role. From their perspective, the critical aspect of their practice is the ability to lead, promote and develop the service for both clients and staff. ‘Beating our drum’, ‘putting us on the map’ and ‘raising our profile’ are examples of how key informants expressed this idea. References to their ‘energy’, ‘motivation’, ‘enthusiasm’ and ‘passion’ were frequent. It was this strategic aspect that differentiated consultant nurses from other specialist nursing roles, in conjunction with their personal effectiveness, political acumen and their ability to influence people and policy. As a result, the post holders’ interpersonal and communication skills were singled out by key informants as critical in any change and achievement that consultant nurses brought about.

These skills were closely related to the educational dimension of their role, which was described as direct (when consultant nurses were involved in curriculum planning and delivery at the University, and in-house teaching programmes) and indirect (when they acted as role-models or acted in a facilitative capacity). Furthermore, key informants highlighted their ability to diagnose and analyse practice problems, to critically evaluate evidence (usually from research or best practice guidelines derived from consultant nurse networks) and to synthesise that information to formulate and explain improvements or innovations in practice. Their ability to articulate and defend their position was valued,

particularly in relation to medical consultant staff who were sometimes seen as rivals.

Although Department of Health guidance on the implementation of the role had been produced (a strategy later used to introduce and implement the modern matron initiative), there was no consensus on academic and professional requirements for the role (Hayes & Harrison 2004). Wilson-Barnett (in Guest et al. 2001) reports that

> '…previously few new post holders have had planned education or tailor-made experience to prepare them for this role. They then also experience problems with continued professional development opportunities. Consensus exists that education for these posts should be pitched at Masters level (or beyond). However there is less agreement about the content and balance of such preparation for these new roles' (p31).

Of those consultant nurses who participated in this study, half were educated to Masters level at appointment, the other half were near completion of their Masters awards at the time of the interview. At that point, none of the participants were engaged in Doctorate level study.

The then Dorset & South Wiltshire Education Purchasing Consortium funded the Institute of Health and Community Studies to develop and run an action learning group to support consultant nurses for a three-year period from 2001-2003. This development emerged from work done by the Regional Nurse and the Chair of Nursing Development at the Institute of Health and Community Studies at Bournemouth University.

The work

This theme contained the largest amount of codes and categories and also had the greatest amount of diversity between these codes and categories for each participant. 'The work' was divided into four sub-themes; namely, clinical practice, service development across traditional boundaries, education and research. With regard to clinical practice, the descriptions provided by key informants most closely resemble 'role development' in the framework of practice levels offered by Daly and Carnwell (2003). According to these authors, 'role development' (the highest level of practice following 'role extension' and 'role expansion')

> '…involves higher levels of clinical autonomy brought about by new demands and perceived shortcomings in the quality of patient care and health care resources. The outcome of such roles is that the fundamental nature and scope of nursing practice within that specific role may be changed' (p162).

Some of the critical issues relating to the nature of advanced and expert practice have been discussed under the theme of ‘evolution’. However, some specific examples of consultant nurse work in the findings chapter serve to illustrate the complex clinical practice element of their work.

The emotional context of the work is rarely reflected in empirical work (Benner 2000; Dingwall & Allen 2001; Tarlier 2004) and yet this was an important aspect of this study. In the literature relating to the role of the consultant nurse, passion and enthusiasm are more often captured in the anecdotal reports of the work undertaken by the individuals themselves. However, many of the key informants raised the importance of post holders’ ethical and emotional engagement with their work and expressed the value of that engagement in relation to their leadership skills. Inspiring and motivating others, being seen to be successful at managing difficult situations and interpersonal conflicts, as well as ‘living’ their vision of patient care and nursing practice, were cited as important attributes of the post holder. They were considered to be equally important to cognitive abilities such as analytical thinking, applying knowledge to specific situations and problem solving.

Resolving issues

The introduction of the consultant nurse posts was intended to help provide better outcomes for patients by improving services and quality, by strengthening clinical leadership and by providing new career opportunities for expert practitioners. There was evidence in this study to suggest that the consultant nurses who participated had been able to address all three issues, although some issues continue to be problematic. In this context it was interesting to note that the problematic issues raised during the participant feedback phase were similar to those identified by the key informants and reported in the ‘resolving issues’ theme of the findings. This may suggest that there is consensus about what aspects of their work constitute tensions and challenges to be resolved. What is important to emphasise is that local difficulties may not be the result of individuals’ shortcomings, but may involve wider issues of organisational culture and structures beyond their influence and control. For example, the challenge of managing other people’s multiple expectations and unrealistic views of what one person can accomplish continues for some consultant nurses who are struggling to meet different priorities. However, from various responses by key informants, there appear to be signs of learning on behalf of the organisations and the consultant nurses themselves about how the role can function to support better health outcomes and quality of care. Also, there are signs of deliberate and careful joint planning across professions to make the role work for patients and clients, as well as for colleagues.

Role or work overload was a problem for consultant nurses that was raised by a number of key informants. Guest et al. (2001) and Bryant-Lukosius and Dicenso (2004) suggest that, rather than the issue being that the multidimensional nature of the advanced nursing practitioner is too broad, the problem lies with insufficient attention being given to defining and communicating role priorities. Perhaps a lack of priority also contributed to a general lack of research activity. This finding is also endorsed by Bryant-Lukosius & Dicenso (2004, p525).

One of the key informants observed that consultant nurses had not grasped the opportunity to lead nursing as a discipline, and nor had they recognised the potential for the considerable political influence they could exert as a group. Reasons were offered, including the lack a 'critical mass' of post holders regionally and nationally and the lack of investment in the academic development of the profession to Doctorate or Masters level, which led to consultant nurses' posts not being filled or appointments being made when the post holder had not achieved the academic level expected. Another reason concerned the lack of a coherent strategy for workforce development in relation to consultant nurses and their role in the delivery of services and in the structures of the organisations for which they work.

Categories from the Secondary Matrix Analysis

Leadership and national work were the two categories emerging from the secondary matrix analysis. They crossed all the themes generated from the first analysis and provide examples of work epitomising the consultant nurses in this study.

Leadership

Effective leadership has been identified as one of the major driving forces behind the process of modernising the NHS and of improving services (Edmonstone & Western 2002). It was therefore unsurprising that leadership was singled out as the core component of the nurse consultant role (NHS Executive 1999; UKCC 1999). Drawing on the themes generated from the interviews, we can begin to understand the nature of the leadership exhibited by the consultant nurses. This section describes the findings in terms of the wider context and draws on published work in the field of leadership.

Transformational leadership

Consultant nurses are expected to demonstrate leadership. However, their appointment at NHS Trust level sometimes leaves them without the necessary power or authority, including the ability to make financial decisions. The post holders are often responsible for a service or

patient/client group that spans several departments, rather than being the head of a department or unit. As a result, a large component of the work they do involves 'working across' different boundaries, forming a core feature of their professional lives.

To be successful in this work, they have to influence to change practice. The leadership model that most resembles the style of working of the consultant nurse participants is that of transformational leadership. Effective leadership from this perspective can be described as bringing about a change of culture to enable others to shift their perspective from self interest to a commitment to achieve the collective mission (Schein 1985; House & Shamir 1993).

Furthermore, transformational leadership is associated with creating a context and culture that facilitates the integration of evidence into practice, which emerged as an important aspect of the consultant nurse role. Individual post holders were seen to achieve this by setting high standards for their own practice, thereby role modelling behaviours such as searching and evaluating evidence and integrating it with patient preferences. The role is one of facilitation, which in turn consists of activities such as helping and enabling as opposed to telling or persuading (Rycroft-Malone et al. 2002).

Influence

The study of leadership and influence are closely intertwined, and some authors claim that influence is the essence of leadership (Yukl 1998). The most popular classification of this appears to be based on the extensive work of Yukl et al. (1996) and the tactics typically include:

- Rational persuasion (use of logical arguments, information, factual evidence);
- Inspirational appeals (arousing enthusiasm);
- Consultation;
- Ingratiation;
- Personal appeals;
- Exchange;
- Coalition (seeking or claiming support from superiors or peers);
- Legitimating tactics;
- Pressure or assertiveness.

The consistent use of hard tactics, such as assertive and forceful attempts to influence, can result in increased job tension and can ultimately be less successful than 'soft tactics'. For instance, the use of rationality, inspirational appeals and consultative tactics are more likely to lead to effective outcomes (Van Kippenberg & Van Kippenberg 2003). Many of these attributes were described by the key informants.

The Performance and Innovations Unit published a report calling for the strengthening of leadership in the public sector (Cabinet Office, Performance and Innovations Unit 2001). In their executive summary they suggest that having a shared understanding of what works when delivering public services is fundamental for effective leadership to be built upon. Sharing the expertise of clinical nurse leaders and their leadership style provides understanding that can inform future leaders. Cook & Leathard (2004) suggest that preparation for clinical leaders is currently inadequate and they call for interprofessional programmes to enhance their knowledge of 'soft tactics' that cultivate the development of creativity and influence. The strength of their influence was frequently reflected in the national activities that the consultant nurses were involved in.

National work

This category captures the work that is shared with others outside the organisation, is scrutinised and is open to peer review. It is seen as the pinnacle of success and a sign that the work has reached maturity. Implied in this category is recognition of the contribution the consultant nurses make to the development of national policies and infrastructures, for example the setting up of national forums, the establishment of clinical career pathways and succession planning. Participation in activities within a national context sets the consultant nurses apart from many of their colleagues in that they can attend forums where they can influence peers, policy and service development.

Networking and participating in national initiatives provided the consultant nurses with insights into the work of consultant nurses across the country, which often revealed a lack of national parity. Fundamental differences in, for example, the qualifications required for the role have already been alluded to (Higgins 2003; Redfern 2003), as shown in the variation in educational qualifications of the participants in this study. The vision that these nurses would participate in research is not reflected in the findings from this study. Those working in Trusts rarely mentioned education unless specifically prompted, and it was not generally viewed as an integral part of the role.

Summary & Conclusion

The findings of this evaluative study provide some evidence of how national policy has been implemented locally and how the consultant nurse role is perceived by those who have a close working relationship with the post holders. The evidence points to an extensive and diverse portfolio of activities relating to expert practice, and educational and practice development; a more limited portfolio in relation to leadership which has not yet been fully developed; and very little activity in relation to research. This may reflect appointment panels' concern with ensuring that consultant nurses bring with them evidence of advanced as well as safe practice, in an attempt to enhance the quality of care given to patients and clients.

Well-developed leadership and research skills may not have attracted the same level of scrutiny at the point of recruitment in the early stages of implementation. However, as the role matures, these abilities will grow in importance. Therefore, there is an urgent requirement to support consultant nurses in developing their leadership potential and their skills in researching practice if what has been envisaged at a national level is to be achieved at a local level.

The development of a flexible career pathway for nursing, with clear opportunities to develop clinical, leadership and research skills, along with developmental posts to support consultant nurses, are equally important in underpinning the role.

Many of the issues generated by this study can be found in published literature in key areas. Exploring how consultant nurses will achieve their goals is paramount if there is to be effective succession planning for future clinical leaders. This study has brought together a rich perspective from a range of colleagues working closely with six consultant nurses. Through their eyes, we have seen examples of their practice. These provide us with building blocks that can be used in the educational preparation of future leaders as well as contemporary consultant nurses who want support and development in their role. The opportunity to articulate and share this knowledge is exciting. The strategic vision to develop nursing and its contribution to health care requires nurses who are confident and competent in bringing this to fruition through effective leadership.

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Figures

Figure 1. Synthesis of the case study analyses: categories and themes

Evolution	The person	The work	Resolving conflict
• Government requirement • Finding clinical supervision; Support • Integrating activity with Trust structures • Evolving role; Early days • Evolving from service; Develop from need • Role transition	• Autonomous • Self-motivating • Champions • Enthusiastic; Dynamic; Motivate others • Leadership; Clinical leadership • New models of care • A wider view; Visionary • Strategic expert • Valuing supervision • Masters educated; Aspire to doctoral education	• Corporate responsibility; Representing the Trust; Recruitment and retention • Working with people; Engaging people; Part of team; Working across services; Working across agencies; Working across boundaries; Interprofessional work **Consultancy** **Taking it forward** • Clinical change agent; Practice development; Celebrate excellence in nursing **Research** • Practice-based research; Personal research; Local research • Contributing to national guidelines; Conference presentations: national/international; External exposure; Putting us on map; Raising the profile; Networks; Bringing back information **Informing practice** • Provide clinical supervision • Realistic expectations • Inform training; Skills into practice; Education; Links to HE • Strategic direction; Creating a culture for quality improvement • Practice development; Making it happen • Representing the profession of nursing; Provides credibility to nursing • Nurse-led service	• Managing potential conflict • Issues around management • Still attracting clinicians into management • Confidence for doctoral education? • Are nurse consultants a luxury? • Balance • Lack of organisational infrastructure at Trust, university and national levels

Figure 2. Matrix analysis[1-2]

	EVOLUTION	ABOUT THE PERSON	THE WORK	RESOLVING ISSUES
LEADERSHIP	Organic: *Developed from unmet need* *Gap between services* *Natural growth* *Unplanned* Finding support: *Clinical supervision* Immature infrastructures: *Integrating with Trust structures* *Clinical career pathway*	High profile: *Being seen* *Champion* Clinical expertise: *Specialist* Credibility Intellectual reasoning: *Analytical* *Systematic problem-solving*	Consultancy: *Advisory* *Complexity* *Caseload* Working with others: *Supporting staff* *Developing others* *Motivating* Working across: *Professions* *Services* *Agencies* *Boundaries* Taking it forward: *Clinical change agent* *Pioneering*	Lacking: *Organisational infrastructure* *Admin support* *Feedback mechanisms* Managing: *Conflict* *Time* *Expectations*
NATIONAL WORK		Leadership: *Autonomous* *Visionary* *Strategic expert* Masters education: *Doctoral aspirations*	Working nationally: *Guidelines* *Conferences* *Research active* Bringing it back: *Informing practice* *Influencing recruitment/retention*	National context: *Isolation* *Lack of national parity* *No platform*

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Appendix 1

Consultant Nurse Participant Information Sheet

Consultant Nurse Evaluation Project

Consultant Nurse Participant Information Sheet

The Institute of Health and Community Studies has been commissioned to carry out a joint research project with Northumbria University to evaluate the impact of the Lecturer Practitioner and Nurse Consultant roles. This project aims to establish the impact of these roles from the perspective of key informants selected by the Lecturer Practitioner and Nurse Consultants themselves.

If you are Lecturer Practitioner / Nurse Consultant we would like to invite you to take part in this study. If you decide to participate, a member of the project team (please see names and contact details overleaf) will arrange a meeting between yourself and your manager with the aim of identifying six key informants who are in a position to comment on the impact of your role. You may choose to nominate managers, senior staff within your organisation, clinical and academic colleagues, students, representatives of the workforce confederation and senior academic staff at the University. We would ask you to contact your key informants before the project team member sends them an information sheet and interview schedule (please see attached).

Once the project team member has collected the interviews with your key informants, the information will be analysed so that an individual case study report can be generated. The project team member will contact you when a draft version has been written, send you a copy for your comments and arrange a meeting with you in order to produce your final case study report. At this meeting you will have the opportunity to negotiate the content of the report. When all the participants' case study reports have been drawn up, we will analyse them to identify key themes, differences and common issues. These will be shared with the project team at Northumbria University and compared with their findings, before drawing up a draft report. We will send you a copy of that draft report and arrange another meeting with you and your manager to generate recommendations and conclusions for the final report which will be published and widely disseminated. We will send you a copy of the final report.

Thank you for your time. Please do not hesitate to contact any of the project team (see below) if you have any queries.

Project Director:	Professor Kathleen Galvin - Head of Research	01202 504167
Project Lead:	Sabi Redwood - Senior Lecturer	01202 504173
Researchers:	Eleanor Jack	01202 504171
	Christine Partlow	01202 504177

The Institute of Health and Community Studies is based at:
Bournemouth University
Royal London House
Christchurch Rd.
Bournemouth
BH1 3LT

Members of the project team are available on the 1st Floor of Royal London House, Room 111

Appendix 2

Letter to Research Participants

Address

Date

Dear …..

RE: CONSULTANT NURSE EVALUATION PROJECT

I understand that you are aware that Consultant Nurse X has nominated you as key informant regarding his role at the Trust for the above study. As part of this study, I would like to arrange an interview with you in the near future of about an hour's duration at your place of work, or if you prefer, at the University. I wonder if any of the following would be convenient to you:

I would be grateful if you could contact me by telephone, email or by letter to the address at the bottom of this letter.

I enclose an information leaflet about the study and the proposed interview schedule.

Kind regards

Sabi Redwood
Senior Lecturer in Research

Tel 01202 504173
Email: sredwood@bournemouth.ac.uk

Appendix 3

‘Key Informant’ Information Sheet

Consultant Nurse Evaluation Project

‘Key Informant’ Information Sheet

Version Two

The Institute of Health and Community Studies has been commissioned to carry out a joint research project with Northumbria University to evaluate the impact of the Lecturer Practitioner and Nurse Consultant roles. This project aims to establish the impact of these roles from the perspective of key informants selected by the Lecturer Practitioner and Nurse Consultants themselves. You have been selected as one of these key informants and as such we invite you to take part in an interview with one of our researchers. Other informants may include managers, clinical colleagues, lecturers at the University, representatives of the workforce confederation and representatives of the senior academic staff at the University.

The interview, which will be recorded with your permission, is expected to last approximately 1 hour or less. You are free to withdraw at any time. We will discuss confidentiality with you as issues raised in the interview may need to be made widely known. Your anonymity will be protected in any published material. Please note that should issues of a sensitive nature be raised during the interview (for example, acts of malpractice or negligence) this information will not be disclosed. The researcher will not take any action but will remind you of your responsibility to manage these issues. The information generated by the interview will be transcribed and then written up by the researcher who will then send it straight back to you so that information can be checked, erased or amended by you at this point. Once you have approved the interview data, it will be collated with all the other interview data and analysed. The information you give us will only be used for the purposes of this study, and audio tapes will be destroyed at the end of the study.

The findings of the study will be published and widely disseminated. We will send you a copy of the final report.

Thank you for your time. Please do not hesitate to contact any of the project team if you have any queries.

Version two, 30 January 2003

Appendix 4

Interview Schedule (Version 2)

1. Can you please let me know what your current job title is?
2. In what capacity do you know the LP/NC?
3. How long have you known the LP/NC in their role?
4. Were you involved in the design of the LP/NC role?
    - What level of involvement did you have?
    - Who else was involved in the design?
    - Do you feel anyone else should have been involved?
    - Did the LP/NC (once in post) contribute and perhaps further define their own role?
5. What were your expectations of the role before the person came into post? Did you think the role would be about:
    - Education
    - Research (bridging the theory-practice gap)
    - Management
    - Leadership
    - Specialist nurse – clinical area
    - Change agent
    - Would you like to add anything else about your expectation of the role?
6. How did you see the role of LP/NC impacting on the:
    - Trust
    - University
    - Nursing profession
    - Specific department/unit
7. What personal skills do you feel are important to the LP/NC role?
    - Why do you feel these are important?
    - How do you think these personal skills contribute to the role?
8. Currently, what do you feel is the purpose of the LP/NC within the organisation?
9. Currently, what do you see as the key responsibilities of the LP/NC?
    - Education
    - Research (bridging the theory-practice gap)
    - Management
    - Leadership
    - Specialist nurse – clinical area
    - Change agent
    - Anything else
10. In your opinion, is the role achieving/not achieving what it set out to achieve?
    - Can you give specific examples of this?

11. How has the LP/NC contributed to their role?
    - Can you give specific examples of this?
    - What skills did the individual bring to the role?
    - How have they influenced the relationship between different organisations i.e. Trust and University?
12. What kind of support has been provided for the LP/NC?
    - Do they receive clinical supervision?
    - Who provides them with support?
    - Are there opportunities for professional and personal development?
    - In your opinion do they need any additional support?
13. Does the LP/NC provide clinical supervision for other nursing staff?
14. Who is the LP/NC accountable to?
    - FOR LPs ONLY – What are the advantages/disadvantages for the LP in serving two organisations?
15. How do you see the career pathways for these posts?
    - Should the LP/NC post be a long-term position?
16. In what way do you feel the role has developed or is developing?
    - Has the role exceeded/not exceeded your initial expectations?
    - Have you been surprised by the way the role has developed?
    - Have there been any developments which you think are not helpful?
    - Is there any aspect of the current role you feel the LP/NC should/should not be undertaking?
    - How would you like the role to be developed further?
17. Any other comments?

Appendix 5

Case Study Analysis

Case Study Analysis

Consultant Nurse

[name]

Introduction

A framework offered by Streubert & Carpenter (1995) has informed the production of this case study report. They suggest that the report should include the following: the original research problem; a description of the context and setting for the study; a description of key the participants; their interactions; how they influence the phenomena under study; a discussion of emerging categories; their importance and inter-relationship; a discussion of the implications of the findings.

For the purposes of this case study I have included only the preliminary analysis from the interviews. In this respect, the final report is incomplete, although a picture of [name] role should be clear. [name] identified 6 key informants to provide a 360 degree perspective of her role; two clinical colleagues, a manager and colleague, senior academic manager and a further manager. These interviews took place March-May 2003 and were undertaken by Sabi Redwood and David Wood.

Emerging categories

Each interview transcription was read three times. Codes were ascribed to key phrases or words within the narrative. These codes were then grouped together according to themes. Four themes emerged from the data. Evolution includes codes that described informants understanding of the emergence of consultant nurses. It also includes aspects of the role that reflects components that are growing, changing or evolving. For example, supportive infrastructures. About the person are the codes that describe the attributes expected of a consultant nurse. These might be those observed or deemed desirable in an applicant. They set the scene. The work describes a huge array of codes that reflect the nature of the role. It is obvious that these two themes are closely related. Resolving issues bring together aspects of the role which present challenges. They also identify areas for future development or research possibly. The term ‘essence’ has been included as a possible link of two themes which are closely related and might inform the development of broader categories, at a later date. Here, the meaning of the term essence is ‘the essential part’.

Implications of the findings

The final section of this case study gives exemplars from the narratives to illustrate each of the main themes. The purpose was to highlight key issues which might inform the discussion.

Reference

Streubert H J & Carpenter D R (1995) *Qualitative Research in Nursing.* J B Lippincott Company: Philadelphia.

CASE STUDY ANALYSIS

	The essence	The essence	
EVOLUTION	**ABOUT THE PERSON**	**THE WORK**	**RESOLVING ISSUES**
Original project Inception Natural growth Evolution Developing a career pathway Clinical career pathway Identity for nurses Develop nursing Developed from unmet need Complex needs A different service The gaps between services Shifting power base Moving clinical responsibility Corporate role Developing critical mass Political acumen Supportive forums Organisational support Supportive infrastructure Improving recruitment	High profile Having a profile Raising the profile Being seen Increased recognition Leadership Credibility Clinical expertise Specialist Systematic problem-solving Intellectual reasoning Analytical Masters education Skilled communicators Networking Respect Confidence Personal attributes Openness/accessible Facilitative Clinical expertise Competence Expertise & complexity Networking	Authority Pioneering Taking it another level Taking forward Agent for change Dissemination Showcase/champion Innovative Inter-agency Across boundaries Challenge organisation Strategic lead Multiprofessional work Local partnerships Developing clinical services Catalyst Developmental Develop others Clinical supervision Supporting junior staff Work with staff Inspirational Enthusiasm Key resource ‘facts & figures’ Informative Advisory Consultation Integrating theory/practice Improving practice/patient care Carrying a caseload Extending and advancing practice In-depth assessment Dealing with complexity High standards Conduct research Participate in research Research based practice Research active Written skills Education (local, national international) Education and training University teaching Link to Gov groups National policies Taking forward policies Clinical governance	Need to review/feedback Meeting expectations Balancing Realistic relationships Navigate difficulties Hidden conflicts Team memberships Loose membership Fluid membership Challenge traditional work patterns Variable understanding of role Staff resources vs cost NC Academic achievement (variable attainment of MSc) Low expectations for research Lack of research skills Independent vs dependent researcher Lone voice National disillusion Lack national parity Lack of national platform Accountability All singing, all dancing

Evolution

This theme describes the history that most respondents gave of the development of the nurse consultant. Some saw the role emerging from practice development for a specific project and others recognised the role as an outcome of a national policy. It was seen as the opportunity to develop a credible clinical career pathway.

What actually happened, was that [name]*'s role as CN was developed from that project, so she became CN a couple of years ago, directly as an extension from that project really. [F45]*

The then Chief Nurse for England had been active in trying to create this role. The exciting thing was the major difference between this role and other types of advance practice nurses, was that this person was supposed to straddle the academy and the service. [B16]

It appears that a key issue in the development of these posts relates to the identification of 'unmet need' where a consultant nurse had seen an opportunity to develop a service.

But very damaged, very demanding, very difficult, a difficult to engage client group that presents an awful lot of challenges to the traditionally configured mental health service. [D168]

Generally people aren't recognising that they have got an addiction, or that the substances are causing problems, they also don't have a recognition they have got mental health problems either. [E114]

The real clinical need came out of unmet need that was being recognised, that clients often moved between mental health and addiction services and were falling down a gap. That's what prompted the start of the development of services. [F314]

About the person

The essence of these roles was often invested in the person appointed.

The particular one that comes to mind is as much about their personality, as well as their skills. It's about somebody who has the ability to work across professional organisational boundaries that sort of thing. Somebody who has a very professional approach, is able to be in the spotlight and happy with that, who is able to work in a quite high profile way and to sell themselves. [F130]

The attributes for a NC included having a high profile, being innovative, the ability to demonstrate leadership, skilled communication, the ability to systematically problem-solve and apply analytical processes. Some of the comments relate to the NC in post and others to an expectation of the role. The need to have credibility in clinical practice couldn't be endorsed enough.

I think you can develop in education, you can develop in research, but if you haven't got good, strong and RECENT experience in practice, I think it is very hard to find that again. [C91]

They need to have excellent clinical skills in their area of expertise particularly. [F37]

The ability to carry a caseload and continue to practice clinically is central to the role of the NC. The level of practice is advanced and requires a skilled clinician.

All the people with whom [name] works would have the most complex needs otherwise they could be worked by CMHTs, or CMHTs working jointly with the addiction locality team. Those that would be asked to be seen by [name], are usually those with more complex needs. [F394]

The role encompasses many attributes including being a resource:

She is the resource to go to, when people don't know what else to try. She is a great source of information, backed up by research. She has spent a long time researching things, manages to remember it all and she is fairly clear with her answers as well. [E49]

The work

This theme reflects the component parts of the role and the methods used by the NC to achieve their goals. Changing practice was very much in evidence but the NC did more than this. Much of the work by the NC is seen as 'pioneering' and respondents mentioned that the NC took the work or service 'to another level'.

It's about being innovative, advanced practice, working across different professions and boundaries, things like that, so it was to take that to another level really, as I understood it. [F54]

The work was seen as an exemplar of innovative practice, the way to do things and could be presented at conferences as a 'showcase' of good practice:

I used to go to conferences, sometimes with [name] *or without her and Dorset was held up as being a good example. [E302]*

The work frequently takes place in a complex clinical arena which crosses traditional boundaries. The approach to managing change would frequently involve 'working alongside'. The skilled level of working is reflected in the following comment:

She's actually managed to say "well, actually this is what you can do and it works", and it worked. Not purely because of her in this area, but a lot to do with her, her work and how she's managed to work alongside people is that there's no great mystic to it, "this is what you can do, I'll give you some advice". She's always at the end of a phone, she's always managed the openness. [D87]

The consultant nurse was expected to work across traditional boundaries, agencies and services. The work was expected to be strategic.

Resolving issues

Whilst some nurses might be a lone voice in the Trust, others are able to join with similar colleagues for support. But the overall picture suggests a lack of national cohesion.

In many situations across the South West and I guess nationally, many don't see themselves as part of a structural web. They don't know where they fit within an organisation. [B95]

There was evidence of variable understanding of the role, especially their roles within the Trust or University.

I think from the outside, people are not sure whether they are clinically-based or whether they are university-based. [E53 Clinical colleague]

I mean I know she is a consultant nurse in mental health, but what she does on a day-to-day basis as part of her role, I really don't know. [C27 Academic colleague]

Achieving a balance to the work was often seen as challenging. It was recognised that a fine balance was needed between practice, research and education.

I do think they need to be strong in ALL of those areas and that is one of my criticisms, that in a lot of consultant nurse appointments generally, people have been strong in one or two areas and very weak in others. [C78]

…. but how they carve up the role will change from week to week, month to month. [C77]

The academic achievements for the consultant nurse were variable and it became apparent that there were differing expectations. A manager and colleague felt that Masters preparation was not essential:

I am not sure that the academic educational level is something I would particularly set out. My personal view is that it's about the skills, abilities, knowledge and personality of the individual. I am sure there is a cut-off point, but I wouldn't say somebody must have a Masters before you should consider them for CN or something on that level. [F145]

A clinical colleague held the expectation that consultant nurses would be educated to Masters level but the reality was different:

But I think working towards those things and at the beginning of that they would obviously have to be academically, professionally qualified to at least Masters level. That was the expectation. I think that was overestimating what depth there is in nursing on the ground to fill those posts. [D40]

We're actually asking our consultant nurses to undertake, or to already have, a Masters. [A226]

Yet moving the consultant nurse towards a Doctorate was perceived as a threat to their clinical focus. This might reflect the traditional view of doctoral education and the research PhD, rather than a professional Doctorate with a strong emphasis on clinical scholarship.

I think as a natural development some people will move towards sort of Doctorate level. There's a danger that we will move people out of clinical practice if they go that far. [A231]

There was an expectation that the consultant nurse would be able to influence the national political agenda and contribute to policies in health care. There was disillusionment in the role the consultant nurse might take:

Nursing, I think, is still very politically weak, so it's how you make your voice heard where this voice was never heard before. [D93]