EVALUATING THE PERCEIVED IMPACT OF THE NURSE CONSULTANT ROLE USING A 360 DEGREE APPROACH: THE FINDINGS FROM A COLLABORATIVE STUDY IN THE UNITED KINGDOM (UK)

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Evaluating the perceived impact of the nurse consultant role using a 360 degree approach: the findings from a collaborative study in the United Kingdom (UK)

Abstract

This multi-site evaluative study is the result of work commissioned by a number of National Health Service (NHS) Trusts to evaluate the impact of the nurse consultant role. It explored the views of both stakeholders and nurse consultants and was conducted by Northumbria, Teesside and Bournemouth Universities and a number of their affiliated NHS Trusts. The evaluation was based on the '360 degree feedback process' and used case study methodology, inviting stakeholders or key informants, including clinical and academic colleagues, students and managers, to provide information on their work with the nurse consultants. The findings are discussed around the themes of (1) role aspirations and lived reality, (2) challenging boundaries, (3) impact and outcomes and (4) leadership. The findings concur with previous studies demonstrating a series of common themes associated with leadership, clinical expertise, research and educational activity. Importantly, these findings articulate the ways in which nurse consultants are working to develop unique services to meet patient needs.

Background

Nurse consultant posts were established in England in 1999 to provide better outcomes for patients by developing practice and improving the quality of health services, strengthening nursing leadership and improving recruitment and retention through the provision of additional clinical career opportunities. The posts are focused around four core functions: expert practice; leadership and consultancy; education and training; practice/service development and research (NHS Executive 1999). The multifaceted nature and strategic role of the nurse consultant makes the post both exciting and challenging for the individual, for the service and for the profession (McSherry & Johnson, 2005). While workforce statistics (DH 2004) demonstrate a progressive rise in nurse consultant numbers working in the NHS which are estimated to be around 600, this number is far lower than the 1000 posts proposed by 2004 in the NHS Plan (DH 2000) which, given the size of the nursing workforce, had already been criticised as being inadequate (Finlayson et al 2002). This shortfall in predicted nurse consultant posts raises some doubts about the commitment in the NHS to invest in the role and to raise the strategic contribution of nursing in the provision of health services. However, there continues to be great interest in the progress and impact of nurse consultant roles to establish their effectiveness and secure future role investment.

The role has attracted much attention since its introduction, and there is wide debate about its nature and impact. For example, Coady (2003) argues that it is because of the diverse and complex nature of these evolving posts that confusion and conflicts of interest have arisen between and within the healthcare professions. Graham & Wallace (2005) suggest that the confusion and ambiguity associated with the role can be resolved by ensuring the nurse consultant and the organisation are aware of the scope and parameters of the role. However, Dawson & Benson's (1997) study indicates that the multifaceted nature of the role and variety of specialist settings have contributed to the uniqueness of the role. Taking Graham & Wallace (2005) and Dawson & Benson (1997) arguments into account, the reality of achieving a common set of role attributes and responsibilities for the nurse consultant role seem difficult to achieve. Based on the work of Coady (2003), Hayes & Harrison (2004) and Harker (2001) this approach could be used to define the nurse consultant roles to enable individuals to design the role to best suit them, their clients and the organisation.

Existing evidence includes a preliminary evaluation of nurse consultant posts by Guest et al in 2001 and a more substantive evaluation in 2004 (Guest et al 2004). Guest et al (2004) point out that assessing the impact of nurse consultants on patient care directly is problematic firstly

because post holders tend to work through others to improve processes and systems, and secondly because no two posts are the same. More recently, Woodward et al's (2005) study examined nurse consultant characteristics and role achievements. These studies have added to the empirical evidence available to evaluate the impact and value of the role. Both of these studies have focused on the perspective of the post holders themselves although some data from informants were collected.

This multi-site study is the result of work commissioned by a number of NHS Trusts to evaluate the impact of the nurse consultant role. It explored the views of both stakeholders and post holders and was conducted by Northumbria, Teesside and Bournemouth Universities and their affiliated NHS Trusts.

Methodology

The evaluation was based on the '360 degree feedback process' that Ward (1997 p.4) defines as "…the systematic collection and feedback of performance data on an individual or group, derived from a number of stakeholders in their performance." Qualitative 360 degree feedback is a method advocated by Manley et al (2005) and Dewing et al (2004) to obtain information about nursing roles from colleagues and users. As a research approach, 360 degree research evaluation captures self and observer evaluation about the impact of an action, intervention or programme. Also referred to as a collateral approach (Sobell & Sobell 1980), it offers a level of robustness that is absent in self-report designs (Bowles 2000).

A key part of the evaluation was the active role that each nurse consultant would have in selecting a number of individuals from their area of practice 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 nurse consultants have developed their roles and their relationships in the different organisational contexts in which they operate. The evaluation was designed to use case study methodology by inviting stakeholders or key informants to provide information on their work with the nurse consultants. The methods used reflected the literature, which suggests that between 5 and 11 participants should be included in order to ensure reliability of the findings and anonymity of the participants (Ramsey et al 1993, Fletcher 1999). Ramsey *et al* (1993) suggest that the method of selecting colleagues and the relationship between the person doing the rating and the person being rated do not substantially bias results. Furthermore, King (2002) proposes that it makes little difference to the findings if participants are selected by the post holder or by the researcher.

Sample

A combined total of 14 nurse consultants participated in the study. The nature of their posts spanned secondary care and included nurse consultants from acute (n=9) and mental health care (n=5). They had been invited to take part in the evaluation by letter and encouraged to contact a member of the research team to discuss the implications of their potential participation. If they wanted to go ahead they were asked to nominate up to ten key informants who could be clinical and academic colleagues, students, or managers. A decision was made not to include service users at this early stage of the nurses consultants' development. Their vulnerability as well as the lack of opportunity to reach their full impact on patients at this stage were the main reasons for this. It was agreed that the inclusion of patients would be more appropriate to a second stage study.

Methods

Each nurse consultant who had elected to participate in the study 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. A meeting to conduct the interview between the key informant and a member of the research team was subsequently arranged. Written consent was given by the informants to take part in the study, to have their interview tape-recorded and transcribed by an administrative assistant, and to have it entered for analysis.

The interviews focused around the following topics: the informants' perspective on the performance and achievements of their nurse consultant colleague, their expectations before they came into post, their relationships within and beyond the team or service the consultant was working in, their impact on patient care and suggestions for development. The processes of data collection and analysis were parallel and interviews conducted later in the study explore themes emerging from earlier interviews.

Local Research Ethics Committees and NHS Trust Research & Development Committees reviewed each of the three study proposals. Trust board members also supported the study at each site. For a detailed discussion of the ethical issues please see Redwood (2005).

Data Analysis

Following completion of the interviews, the researchers undertook a thematic content analysis (Miles & Huberman 1994) and generated an individual draft report, which was shared with and verified by each nurse consultant. Key themes and patterns were identified and analysed, and a full research report for each site was generated. The findings presented here are composite findings from the three sites. They resulted from collaborative analysis between researchers from all three sites. This involved researchers analysing each sites research report, engaging in collaborative discussion and reaching consensus about common findings. While different names were given to conceptual categories at each site, there was a strong sense of congruence in the three sets of findings. The congruent findings will be reported under the headings of the common themes (1) role aspiration and lived reality (2) challenging boundaries and (3) impact and outcomes and (4) leadership.

Findings & discussion

(1) Role aspirations and lived reality

The informants provided a diverse set of views about the nurse consultant role. These perceptions tended to be associated with their personal attributes and the parameters of the post. Expert practice and specialist knowledge were viewed as prerequisites for the role. Essential aspects of their practice include the ability to lead, and to promote and develop services for both patients and staff. Colleagues expressed this as 'beating our drum', 'putting us on the map' and 'raising our profile'. There was reference to their 'energy', 'motivation', 'enthusiasm' and 'passion'. They were: 'clinical leader', 'expert', 'change agent', 'credible leader', 'confident', 'dynamic', 'forward thinking', 'dedicated' and 'pro-active'. The strategic aspect of their role distinguished them from other specialist nursing roles, as did expectations for their personal effectiveness, political acumen and ability to influence people and policy. One informant commented:

> *'I think they [nurse consultants] have impacted positively [at this Trust]. What they are 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 that dilemma, which when I was at that stage, there wasn't any choice really. You either stayed at the grade you were at, or you went into management'.*

Another informant captured, as they saw it, the 'real' work of the consultant:

> *'But what they 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.'*

Another informant commented on the strategic and national importance of the role and their contribution to the nursing profession:

> *'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.'*

Critical views were also expressed. For example, some informants were sceptical about the introduction of the role, and cautious about what the role would achieve and about its impact on their workload. The following excerpt illustrates this point:

> *'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 were, so he has had to define the role as he went along. … 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'.*

Some colleagues were unsure of what the role was meant to achieve and thought that the consultant would be fulfilling a management or education function. Some spoke of potential difficulties as a result of the lack of a managerial role. Despite the initial challenges faced by the consultants in terms of effecting change, most were well respected and seen as credible and were valued. Good working relationships and effective communication were achieved by most with nursing, medical and managerial colleagues. These were seen as central to the success of the role, in particular in order to bridge the gap between nursing and medical staff. The role of the nurse consultant is exceptional in that the expectation was that they would constantly be challenging practice and pushing boundaries.

(2) Challenging boundaries

The nature of practice development undertaken by the nurse consultants was clearly at a level that crossed professions and agencies and reflected a wider national or international perspective, as the following excerpt suggests:

> *'There were barriers to be broken down, bridges to cross and she's gone out there and done it by, not going in as an authoritarian, saying this is going to happen, but working alongside people, getting to know them and breaking down those barriers and it's been very effective I think.'*

Much of their work was seen as 'pioneering', and respondents mentioned that the consultant took the work or service 'to another level'.

> *'The roles between nurses and doctors are becoming a little bit blurred in that there are a lot of areas which in the past you saw as being specifically a medical role, you*

can now see that nurses are getting more involved and really it is the nurse consultant who has developed nursing in the direction of taking on more clinical responsibility.'

The way in which the role was introduced had implications for expectations of the role. This led to confusion about role and role boundaries between other nurses and junior medical staff. Role or work overload was a problem for some consultants which was an issue raised by a number of key informants.

(3) Impact and outcomes

Significant changes and improvements to service delivery, which were specifically attributed to the nurse consultant appointments, were identified. This was a major feature of their work. Examples of this included the development of a thrombolysis service, a walk-in centre, a dual diagnosis service and a community-based pain management service. Key informants talked about consultant roles in a way that went beyond the debates about what aspects of medical work were being undertaken. They described new or re-configured services for patient and client groups whose needs are poorly addressed within the health care system. 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 role went beyond local clinical practice. They observed post holders working as much outside the organisation as within it to develop communications and processes between agencies or service sectors. An interview excerpt illustrates this particular theme clearly:

'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 … got good outcomes in some very difficult situations of conflict of clinical opinion. 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 …; 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'.

Research was identified as that of least activity. Post holders expressed a desire to develop further in this area. The nurse consultants in this study have focused principally on the clinical aspect of their role and, by demonstrating their own expertise, have proven themselves as credible practitioners and have become clinical leaders. Research has a history of being the poor relation in nursing. "Heavy workloads, possibly a lack of priority and a lack of research skills may have contributed to this finding" (Bryant-Lukosius & Dicenso 2004, p525). Interestingly many of the consultants held a masters degree indicating that a lack of research skills may not have been the main reason.

(4) Leadership

The concept of 'leadership' was a core component of their work. Skilled leadership enabled the nurse consultants to negotiate the often complicated process of working across boundaries and professional groups. In particular, their attributes reflected an 'emotional intelligence' which was seen as an essential ingredient of good leadership (Goleman, 2000). Many post holders were creating new services to meet discrete patient or community needs, and leadership skills were needed to cross into this new territory. One of the informants commented:

'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 her service. So she is seen as the leader for the hospital in that area…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'.

Cook & Leathard (2004) suggest that effective clinical leaders adopt transformational leadership styles but require an environment that is supportive. Some of the difficulties identified in this quest were organisational barriers that inadvertently hindered their leadership endeavours. Traditional structures and heavy workloads have been recognised as obstacles to establishing new specialist services (Mills et al 2002). As leaders, nurse consultants need new support mechanisms and organisational infrastructures help them in their task.

Limitations of the study

Data collection was carried out in the second and third years of most of the nurse consultant 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. 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. Methodologically, the participatory nature of the study could be viewed as producing 'biased' findings, thus reducing their capacity to be transferred to other settings. While the anonymity of informants was protected, it is possible that they may not have given honest feedback if they feared that their responses could be identified or if they were unclear about how they would be used. Furthermore, the need to protect the informants' anonymity resulted in some of the data being omitted from the findings to protect their identity. Part of the reason for a collaborative report was to enable some of these data to be included without the threat of revealing informants' identity. If further studies of this type are to be conducted, the researchers would advise the use of a larger sample to avoid some of these issues.

However, the aim was to explore local roles in context and produce evaluations informed by those who were working alongside these individuals. It is a method that generated detailed insight and understanding of the role.

There was some risk that, because the informants were 'selected' by the nurse consultants, the interviews might be uncritical and overly positive. This risk was emphasised by one of the Local Research Ethics Committee whose members reviewed the proposal. However, the research teams 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 nurse consultants. Finally, it could be argued that the findings are limited because the 360-degree approach did not involve patients and carers in the evaluative process.

Conclusion

The nurse consultant is, undoubtedly, an important role contributing to the modernisation agenda of the NHS and the future career pathways, and professional maturity of nursing. Using a 360-degree collaborative stakeholder approach revealed a detailed perspective of the role and its perceived impact, as seen through the eyes of those who work alongside the nurse consultant. The findings concur with previous studies demonstrating a series of common themes associated with leadership, clinical expertise, research and educational activity. Importantly, these findings articulate the ways in which nurse consultants are working to develop unique services to meet patient needs. There is now the opportunity to develop education, based on these findings that can support and facilitate new leaders in nursing.

Stepping up the view from local to national and international arenas requires further work and support to make best use of these pioneers in nursing.

Implications for practice

The findings of this evaluative study articulate the ways in which nurse consultants are working to develop unique services to meet patient needs.

The essential aspects of nurse consultants' practice are their ability to lead, promote and develop services for both patients and staff.. Expert leadership enables the nurse consultants to negotiate the often complicated process of working across boundaries and professional groups.

The nature of practice development undertaken by the nurse consultants is carried out at a level that crosses professions and agencies and reflects a wider national or international perspective.

A major feature of the nurse consultants' work is the significant change and improvement to service delivery.

References

Bryant-Lukosius D & Dicenso A (2004) A framework for the introduction and evaluation of advanced practice nursing roles. Journal of Advanced Nursing 48, 5, 530-540.

Coady E (2003) Role models. Nursing Management 10, 2, 18-21.

Cook MJ & Leathard H (2004) Learning for clinical leadership. Journal of Nursing Management.,12:436-444

Dawson J & Benson S (1997) Clinical Nurse Consultants: Defining the role Clinical Nurse Specialist. 11, 6, 250-254.

Department of Health (2000) The NHS Plan: A Plan for Investment, a Plan for Reform. HMSO, London.

Department of Health (2004) NHS Hospital and Community Health Service Non-Medical Workforce Census England. 30 September 2004. HMSO, London.

Dewing J, Hancock S, Brooks J, Pedder L, Adams L, Riddaway L, Uglow J and O'Connor P (2004) An account of 360 degree review as part of a practice development strategy. *Practice Development in Health Care,* 3 (4) 193-209.

Finlayson B, Dixon J, Meadows S & Blair, G (2002) Mind the gap: the policy response to the NHS nursing shortage. British Medical Journal 325, 541-544.

Fletcher L (1999) 360 Degree Self Awareness. How Feedback Develops Successful Careers http://www.getfeedback.net/article.php?NewsId=18

Graham I & Wallace S (2005) Supporting the role of the nurse consultant- an exercise in leadership development via an interactive learning opportunity Nurse Education Today. 25, 87-94.

Goleman D (2000) Leadership That Gets Results. Harvard Business Review, March-April:78-90.

Guest D, Redfern S, Wilson-Barnett J & Dewe P (2001) A Preliminary Evaluation Of The Establishment Of Nurse, Midwife And Health Visitor Consultants. (Report To The Department Of Health) Kings College London: University Of London.

Guest D, Peccei R, Rosenthal P, Redfern S, Wilson-Barnett J, Dewe P, Coster S, Evans A, Sudbury A (2004) An evaluation of the impact of nurse, midwife and health visitor consultants. Management Centre, King's College London.

Harker J (2001) Role of the nurse consultant in tissue viability. Nursing Standard. 15, 49, 39-42.

Hayes J & Harrison A (2004) Consultant nurses in mental health: a discussion of the historical and policy context of the role. Journal of Psychiatric and Mental health Nursing.11, 185-188.

King, J. (2002) 360° Appraisal BMJ 324 (7352):195.

Manley K, Hardy S, Titchen A, Garbett R McCormack B (2005) Changing patients'worlds through nursing practice expertise *Exploring nursing practice expertise through emancipatory action research and fourth generation evaluation* .A Royal College of Nursing Research Report, 1998 – 2004

McSherry R & Johnson S (2005) Demystifying the Nurse/Therapist Consultant A Foundation Text. Nelson Thornes Publishers, Cheltenham.

Miles M & Huberman A (1994). Qualitative data analysis. An expanded source book. Sage , Thousand Oaks, California

Mills N, Campbell R & Bachmann M (2002) Professional and organizational obstacles to establishing a new specialist service in primary care: case study of an epilepsy specialist nurse. Journal of Advanced Nursing; 37 , 1, 43-51.

NHS Executive (1999) Health Service Circular 1999/217: Nurse, midwife and health visitor consultants. Leeds: NHS Executive.

Ramsey, P.G., Wenrich, M.D., CarlineJ.D., Inui, T.S., Larson, E.B. & LoGerfo, J.P. (1993) Use Of Peer Ratings To Evaluate Physician Performance JAMA 269(13)pp.1655-1660

Redwood, S, Carr, E & Graham, I (2005) Perspectives on the consultant nurse role. Qualitative research in health and social care at IHCS series. Bournemouth University report.

Redwood, S. (2005) Colliding discourse: deconstructing the process of ethical approval for a participatory evaluation project. Journal of Research in Nursing. 10, 2, 217-230.

Shaw, I (1999) Qualitative Evaluation. London: Sage.

Sobell L & Sobell M. (1980) Convergent validity: An approach to increasing confidence in treatment outcome conclusions with alcohol and drug abusers. In: Sobell L, Sobell M & Ward

E (eds.) Evaluating Alcohol and Drug Abuse Treatment Effectiveness: Recent Advances New York Pergamon pp. 177-183.

Ward, P (1997) 360 Degree Feedback. London: Institute of Personnel and Development.

Wendler M (2001) Triangulation using meta-matrix. Journal of Advanced Nursing, 35, 4, 521-525.

Woodward V, Webb C & Prowse M (2005) Nurse consultants: their characteristics and achievement. Journal of Clinical Nursing. 14, 7, 845-54.