Paper 1: Conceptualizing the transition from advanced to consultant practitioner: career promotion or significant life event?

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Paper 1: Conceptualizing the Transition from Advanced to Consultant Practitioner: Career Promotion or Significant Life Event?

ABSTRACT

Background: The diversification of nursing and allied health profession (AHP) roles has seen unprecedented growth as organizations have sought to optimize limited health care resources. Within the UK health care system, the non-medical consultant is viewed as the pinnacle of the clinical career ladder. Yet, nearly 15 years after their introduction, recruitment to these positions remains slow. Criticisms of non-medical consultant practice include a lack of role clarity, a failure to work across the four domains of consultant practice, a lack of suitable applicants, and poor preparedness of new appointments. Although there is evidence exploring the nature and effectiveness of established consultant roles, little research addresses the development phase of aspiring consultants.

Objectives: To explore the transitional journey experienced by trainee consultant radiographers as they move from advanced to consultant practitioner within a locally devised consultant development programme.

Design: Longitudinal qualitative enquiry.

Methods and Settings: Five trainee consultant radiographers were recruited to a locally devised consultant practice development program within a single UK hospital trust. Semi-structured interviews were undertaken at 1, 6, and 12 months with the trainees.

Results: A challenging journey was recounted involving five key emotional stages that occurred in a consistent and predictable order (ie, elation, denial, doubt, crisis, and recovery). The identified stages had close parallels with Hopson's Life Events model, suggesting that transition to consultant practice is a significant life event rather than a straightforward job promotion.

Conclusions: Current emphasis on the four domains of practice, although providing a clear framework for expected external role outcomes, overlooks the importance of the internal or subjective career development on the perceived success or failure of the role. Employers, educators, and professional bodies have a responsibility to facilitate aspirational consultants to explore and enhance their internal career development, offering more time to define themselves and their role with support to guide them through the transition journey.

Paper 1: Conceptualising the transition from advanced to consultant practitioner: career promotion or significant life event?

Introduction

Nursing and allied health profession (AHP) roles have seen unprecedented growth over the last decade as healthcare organisations have sought to optimise limited resources [1]. In the United Kingdom (UK), the implementation of the national career framework for nurses and AHP's [2-4] has formalised support for advanced practice roles. The pinnacle of this career framework, often referred to as the 4 tier model (see Figure 1), is the (non-medical) consultant practitioner, a role which is delineated from advanced/specialist roles by virtue of the breadth of responsibilities held. In particular, in addition to being expert clinicians, consultant practitioners are expected to lead strategic clinical developments and advance clinical practice and service quality through education, research and evaluation. However, limited access to strategic development opportunities to support the smooth transition from advanced/specialist practice to consultant practitioner are a concern [5]. As a result, lack of candidate preparedness has been cited as a reason for consultant practitioner roles not being as widely implemented as initially intended [6-8].

Figure1: The 4-Tier Model [9: radiography skills mix)

Assistant Practitioner
An assistant practitioner performs protocol-limited clinical tasks under the direction and supervision of a State registered practitioner.

Practitioner (State registered*)
A practitioner autonomously performs a wide ranging and complex clinical role; is accountable for his or her own actions and for the actions of those they direct.

Advanced practitioner (State registered*)
An advanced practitioner is autonomous in clinical practice, defines the scope of practice of others and continuously develops clinical practice in a defined field.
(Sometimes referred to as specialist practitioner)

Consultant practitioner (State registered*)
A consultant practitioner provides clinical leadership within a specialism, bringing strategic direction, innovation and influence through practice, research and education.

** A professional regulated by the various Acts and Orders which ensure the public have access to, and are treated by, health professionals who are qualified and competent.*

Previous research exploring non-medical consultant practice has focussed predominantly on individual case studies and experiential evaluations of consultant practitioners in post [10-12]. Little understanding exists as to the generic experiences of health professionals moving from advanced/specialist practitioner roles, where the scope of practice is often clearly-defined, to consultant roles where operational boundaries are fluid and external scrutiny high. Further, no identified study has overtly considered the transitional journey experienced by newly appointed or aspirant consultant practitioners and the impact this may have on the acquisition of desired skills and attributes. This study aims to fill this gap and whilst it is based on UK practice, the accelerating international interest in advancing non-medical roles means the findings will be of interest to a global multidisciplinary audience engaged in service development and redefining traditional professional roles.

Background

In 1999, the UK government announced the introduction of nurse consultants to the National Health Service (NHS) workforce within the publication *Making a Difference* [2]. The following year, the implementation of consultant roles was extended to the AHP workforce, including radiographers (Medical Radiation Technologists/Radiologic Technologists) [3], further emphasising the UK governments' commitment to modernising health service delivery [4] through embracing new ways of working [13]. However, despite clear employment targets being set, recruitment to consultant positions has not been as rapid as anticipated. Some authors have suggested that this is because healthcare organisations have struggled to clearly define the role of a non-medical consultant, or differentiate it sufficiently from other advanced/specialist roles [14, 15]. Others have argued that the generic expectations of consultant practice are clearly defined but local expectations of the role are inconsistent and that this, combined with the inherent role variability that exists due to professional or practice speciality, that has prohibited the production of standardised role descriptors [6, 7, 16]. The lack of role clarity, both from the perspective of the organisation and individual practitioner, is reported to be a cause of anxiety and an important factor in the perceived success or failure of the consultant practitioner role [17, 18]. Local expectations of consultant practice may emphasise clinical expertise and delegation of medical responsibilities without appreciating the importance of the wider aspects of consultant practice. Indeed, evidence suggests that many consultant practitioners are not working fully across the four domains of consultant practice (Figure 2) [10, 18-20]. Further, the lack of role clarity and limited developmental opportunities has meant that newly appointed non-medical consultants are often ill-prepared for

working at consultant level [6-8] and this may explain the extended time period (2-5 years) reported as necessary for consultant practitioners to become established in their role [21].

Figure 2. The Four Domains of Consultant Practice [22]

- Expert clinical practice
- Professional leadership & consultancy
- Practice & service development, research & evaluation
- Education & professional development

This lack of preparedness is not unique to any one professional group or specialism [19, 20, 23]. Within radiography, the 'expert practice' domain is generally well-developed [10], probably as a consequence of the clearly demarcated clinical expectations of advanced practice roles which have specific task components and tangible measures of success. Postgraduate radiography qualifications may also inadvertently promote this with emphasis being predominantly on task driven advancements and achievement of practical skills and expertise rather than the development of critical, strategic and analytical thinking expected of consultant practitioners.

Although no educational pre-requisites for nursing or AHP consultant practitioners currently exist in the UK, Master's or Doctoral level study is recommended [24-26]. However, the lack of consistency in educational expectation across posts, organisations and professional groups has led some nursing consultants to advocate national training and accreditation for consultant practitioners similar to the United States [23] calling, in some cases, for a medical model of education similar to

registrar training [27]. While this would provide a recognisable, and medically acceptable, structure to consultant practice development [28], the content, delivery and time frame for such a developmental programme has not been defined, nor how the variation in existing skills and attributes may influence career transition. Importantly, the transitional or developmental phase in becoming a consultant practitioner has not been explored beyond individual case review. Consequently, while we can postulate that the transition from advanced to consultant practice is a complex adaptive journey for both of the employing organisation and appointee, rather than a single step on the promotional ladder [29, 30], no identified research has considered this explicitly.

Study aim and design

The aim of this longitudinal study was to describe the transition journey experienced by the TCRs through a series of qualitative interviews as they moved from advanced to consultant practitioner status. It was anticipated that the individuals may struggle to move from a highly managed, clearly defined advanced practice role to a self-defined, self-managed and essentially boundary-less consultant career [30]. The data are drawn from a larger study exploring the attainments and experiences of 5 aspiring (trainee) consultant radiographers (TCRs) employed within a single UK hospital Trust and seconded to a locally devised 12 month consultant development programme. The study took place over a 3 year period from 2009 to 2011 with trainees being recruited at different points within this time frame. This paper is the first of 2 papers exploring the concept of transition to consultant practitioner.

Methods

Five radiographers from a single UK hospital Trust were seconded to a 12 month trainee consultant post as part of a locally devised consultant development programme implemented as part of a service development initiative. Each participant identified and agreed personal objectives related to the 'four pillars' of consultant practice (Figure 2) and were supported to develop the attitudes, attributes and behaviours appropriate to consultant practice. The researchers (MH & JN) were invited to independently evaluate the programme and monitor the progress of participants, exploring the meaning and significance of their experiences via a longitudinal qualitative approach over an eighteen month period from recruitment.

Qualitative research is an inductive approach of human interactions and the research reported here was sensitive to the underlying traditions of phenomenology, which may be defined as the investigation of phenomena , seeking to understand the 'essence' of experiences related to the phenomenon [31]. The main focus of phenomenology is with reflective experiences and feelings [32] and was thus ideal for investigating the personal beliefs, values and attitudes of participants engaged in a career development pathway.

The project was considered by the study organisation to be service evaluation and did not require ethical approval [33]. Research, service evaluation, audit, and surveillance are strictly defined with the UK healthcare system. It is an expected that healthcare practitioners will audit and evaluate service change and innovation as part of quality assurance. As such, ethical review is only required for studies considered by the sponsoring organisation to be research [34]. However, the standard ethical principles for the conduct of qualitative studies were followed as part

of this evaluation including seeking informed consent and assurances of confidentiality.

Research team

To preserve objectivity, the research team comprised two female researchers (MH & JN) employed in an academic setting out with the study hospital Trust. Both researchers possess doctoral level qualifications, are registered with the UK Health Care Professions Council (HCPC) as diagnostic radiographers, and have a strong academic interest in advanced and consultant practice, education and research. One of the researchers (JN) resided outside the study region and conducted all data collection as both participants and study setting were unfamiliar to her. Both researchers collaborated on study design, data analysis and dissemination.

Participants

A purposive sample of five TCRs were recruited to a consultant development programme between 2009 and 2010. All participants consented to take part in the external monitoring and reporting of their developmental progress. Four TCRs were existing employees of the hospital Trust and one was recruited from an external healthcare organisation. All of the TCRs had previously established themselves as advanced practitioners/clinical specialists with a wide range of clinical skills and competencies. Two of the TCRs had also previously held a management position with responsibility for workforce and service organisation in addition to maintaining clinical expertise and two had been employed within the hospital organisation for more than 10 years.

Data collection

Individual semi-structured interviews were undertaken in a quiet setting at the study hospital at the beginning (month 1), mid-point (month 6) and end (month 12) of the development period. The interview schedules encouraged exploration of the participants' progress towards their goals, related to the four pillars of consultant practice, at each of the three interview stages. The interview topic areas for each interview stage can be seen in Appendix 1. Each interview lasted approximately 45 minutes but continued until both interviewer and participant felt that all aspects had been explored thoroughly. The interviews were digitally audio-recorded and later transcribed verbatim with names removed. Participants were invited to check the transcripts although no substantial changes were suggested by participants. While not initially planned, a final focus group was organised at the end of the study period to explore participant experiences of the process and validate the findings.

Data analysis

A staged approach to data interpretation and analysis was adopted; transcribed interviews and associated field memos were analysed by JN shortly after each set of interviews. This provided an insight into the broad content that was emerging from individual TCR accounts and perspectives, enabling adaptation of subsequent interview schedules if required. Thematic content analysis of each transcript was undertaken following a widely used method originally described by Burnard [35] which aims to identify the themes and categories emerging from each interview. These themes were documented and used as probes in subsequent interviews to

encourage the TCRs to reflect on previous responses and explore progress. The second researcher (MH) did not participate directly in data collection but reviewed the transcripts to validate the emerging themes and categories. Once all interviews had been completed, the transcripts for each participant were read in sequence (interview 1-3) to enable any longitudinal patterns and changes to emerge. The transcripts were coded using reported incidents, behaviours and emotional reflections and these were compared and contrasted within and between interviews. Finally, codes were grouped into related themes and subthemes for reporting.

Rigour and quality

This study adopted a range of strategies outlined by Murphy and Yielder [36] to ensure a high standard of rigour and credibility (Table 1). The preliminary findings of the study were reflected back to the participants during a focus group interview lasting approximately 90 minutes. This enabled the findings to be validated by the participants and where necessary further explored. At the time of the focus group all participants were at least 15 months from the commencement of the development period. The analysis process was documented carefully to make all coding and theme development decisions transparent and direct quotations have been used to illustrate the themes identified and permit external scrutiny of interpretations.

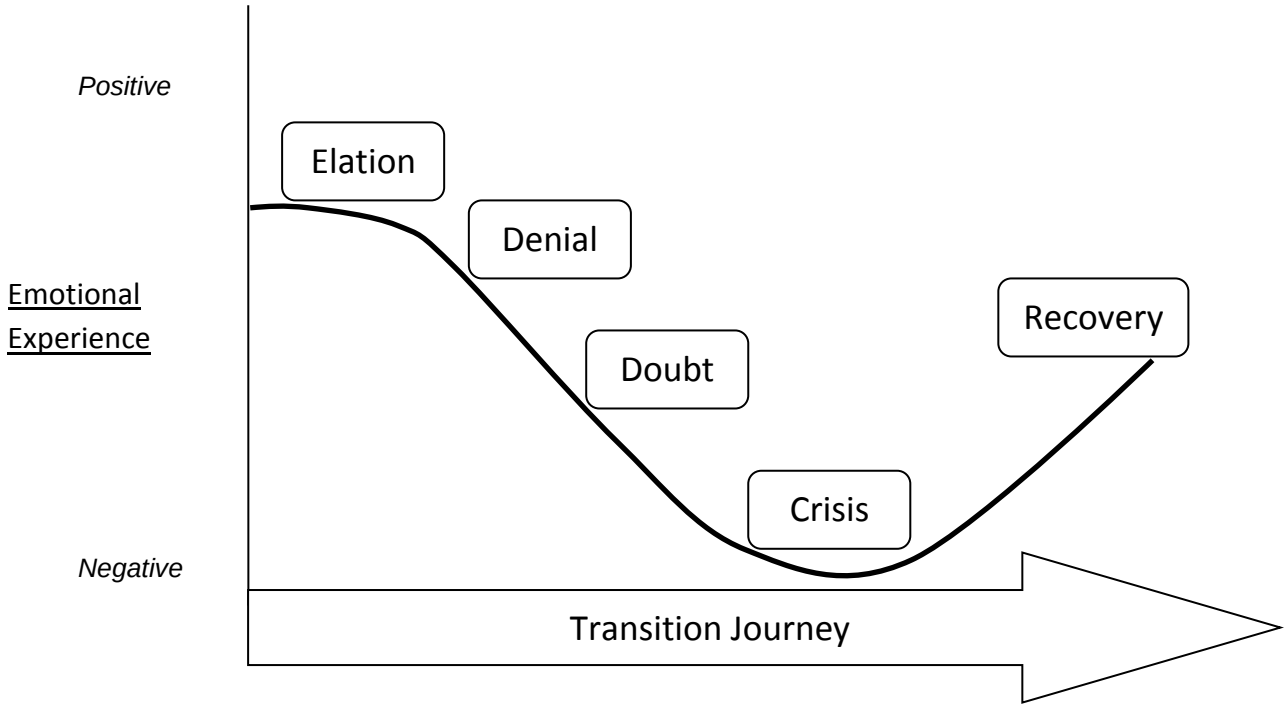
Table 1: Strategies employed to increase rigour in this study

Quality Assessment	Strategies employed
1. Internal validity / Credibility	1.1. 'Member checks' - participants invited to validate their own transcripts 1.2. Researcher peer engagement and debriefing, both during and after each set of interviews 1.3. Prolonged engagement of the researcher with the participants 1.4. Participant validation via researcher presentation of findings at focus group 1.5. Triangulation of data: different researchers / published literature 1.6. Complete interview transcripts retained to contextualise findings
2. External validity / Transferability	2.1. Original context described clearly so that readers can make their own judgements about transferability of the findings to their own setting 2.2. With small numbers interviewed, it is difficult to generalise widely, but findings showed parallels with nursing literature suggesting some degree of transferability
3. Reliability / Dependability:	3.1. Use of a clearly defined and rigorous method of analysis [31], set within a wider phenomenological approach 3.2. Use of a clearly defined audit trail, including field memos, marginal transcript notes, and documented decision making during analysis
4. Objectivity / Confirmability:	4.1. Clearly defined audit trail offers evidence of researcher neutrality. 4.2. Interview schedule, while flexible, includes a set of literature-determined topics that need to be explored, thus reducing the potential for researcher bias. 4.3. Use of reflective field diary / memos to identify any worries and concerns (limitations and researcher bias) which arise during data collection. 4.4. Reading transcripts alongside digital audio recordings picks up any suggestions of bias in the interviewer's tone of speech or affirmation 4.5. Use of additional independent researcher in data analysis 4.6. Retaining transcript identifier codes alongside quotations identifies over-reliance on any one transcript or quotation

Findings

The transition journey from advanced/specialist practitioner to consultant practitioner for each participant was similar but not identical. Emotional experiences described by participants ranged from positive to negative with key emotional stages in the journey (elation, denial, doubt, crisis, recovery) occurring in a consistent and predictable order (Figure 3).

Figure 3: Representation of the transition journey identified from interviews



Emotional Experiences

Elation

Feelings of excitement, joy and pride in personal achievement were expressed at the start of the consultant development programme. All participants formally applied to the development programme and were recruited through interview selection. Two

consultant radiographers were already in established posts within the hospital Trust and the success of these roles had inspired the introduction of the development initiative to enhance and support future workforce sustainability at this clinically elite level.

> *"I'm excited...as it's an opportunity to do what I enjoy doing."*
> *[Participant C, Interview 1]*

> *"This was the automatic next step and what I've always wanted...I feel exceptionally lucky." [Participant A, Interview 1]*

Denial

Denial in the context of this study relates to the feeling that *nothing has changed* from previous role to current role. For some TCRs, this was focussed solely on how they felt others perceived them in their new role, with the denial phase perceived as an external event associated with personal disappointment that role changes were not visible.

> *"...there have been a couple of comments where they [colleagues] have said 'what is the difference between what you are doing now and what you were doing before?', and because they can't actually see any difference...they don't think I [am] doing anything more." [Participant B, Interview 1]*

“I don’t think they [colleagues] make a distinction...they see me as being their clinical lead person and the person they come to with the rota...I don’t think they make a distinction.” [Participant E, Interview 1]

“...because I was the manager of the service before, they’re [colleagues] still looking at me to do the running of the day to day service which is a bit of a blow really.” [Participant C, Interview 1]

For other TCRs, comments from colleagues appeared to affirm their personal beliefs of similarity between previous and current roles and this was particularly evident where the TCR was established in their previous role within the organisation. For these participants, the period of denial persisted longer as external perceptions appeared to support an internal belief that nothing was different in their new role.

“I think people have seen me in this role for such a long time...when I was going around saying I’m going to a trainee consultant post, half a dozen people said ‘I thought you already were a consultant’...and once I started the trainee consultant post, not much changed in my working day.” [Participant D, Interview 1]

“...they [colleagues] don’t see anything different, and most of the time we don’t see anything different within our job either, it’s just continuation of what we’ve

always been doing. I think the only difference is now we've got this uniform with consultant written on it." [Participant D, Interview 2]

Doubt

The theme of doubt reflects a period of self-questioning. Negative emotions and experiences were reported and feelings of self-doubt were associated with changes in the way that they were being perceived, and indeed perceived themselves. Participants also reported being increasingly aware of the differing expectations of a consultant role compared to that of an advanced/specialist practitioner and that managing the different expectations was causing anxiety. For some, "letting go" of previous roles and relationships was also creating additional pressure.

"I got really upset last week...I've gone from X years [good] relationships with some people to hostility which I haven't encountered before and I am really struggling with that." [Participant A, Interview 2]

"I think a lot of it is self-inflicted, and I keep being told get yourself out of the department, you'd get a lot more done if you were somewhere else, but I also feel guilt associated with that. I want to be that person. I want to be there when they want me and I find it very, very difficult not to be there....so how do I deal with that, I don't know! That's caused me a lot of angst certainly in the last month or so!" [Participant A, Interview 2]

"All your career you've been directed and now I've got to direct and I found that quite difficult." [Participant E, Interview 3]

"You think you know what you're going to have to do and you come in [to this role] and you think 'oh my gosh!' " [Participant E, Interview 3]

Crisis

The theme of crisis represents a turning point in the transition journey. By this point the participants had experienced a number of changes in their clinical roles and relationships and felt under a lot of pressure to meet the expectations of the development programme/organisation. Previous relationships with colleagues as part of supportive networks were no longer viewed to be working and external scrutiny and perceived criticism was causing anxiety.

"There was that pressure that if I don't fulfil what I'm doing I'm going to look slightly stupid, so right at the beginning I felt completely out of my depth, it felt quite pressured, stressful and there was a point when I thought do I really want to do this?" [Participant B, Interview 3]

"I know I need to be liked and I know I need people to be telling me I'm doing things right, and I lost that along the way and I felt I was being criticised a lot." [Participant A, Interview 3]

"On more than one occasion I've gone home and either burst into tears thinking I can't do things or had a strop [colloquial phrase: tantrum]." [Participant C, Interview 3]

Recovery

Recovery represents improvement in emotional well-being towards the end of the development period. Practical changes in working patterns and responsibilities as well as achievement of programme objectives and improvement in working relationships all contributed to the increase in reported confidence in the role.

"I would definitely recommend that this [trainee period] is a good way of...the transition from advanced practitioner to the next stage [because] there is such a gap...I look back at what I've learned, I've learned so much that I think that if I'd just gone straight into a [consultant] position, I would not necessarily have had the time to learn something and digest it...the Trust probably wouldn't have got somebody that's as suitable for the position, but now I feel that I have the qualities." [Participant B, Interview 3]

"I've become a lot more confident in my area of expertise and I feel that a lot of other people have started to...to really value my role and I've been asked to get involved in something that...obviously because they thought I was at that level that I should be included, which was really nice." [Participant D, Interview 3]

Discussion

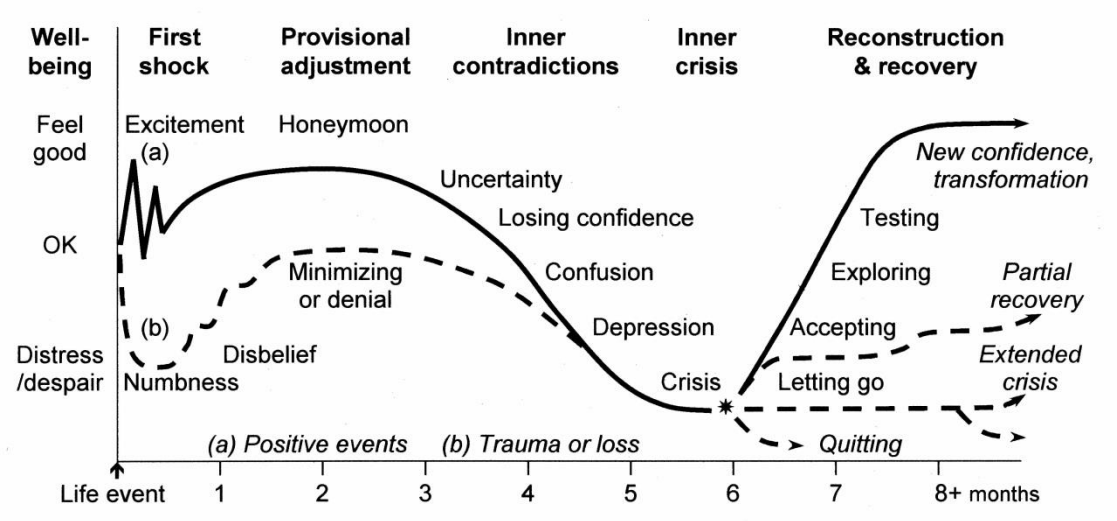
It is clear from the findings of this study that the transition from advanced to consultant practice is not purely a job promotion, defined as advancement in a person's rank within an organization [30]. Instead, the expectations at the personal, professional and organisational level are such that the experience becomes a significant life event associated with a high level of emotion. As a result, the transition journey is clearly aligned to career development, considered by Hoekstra [30] to be the interactive combination of internal career identity formation alongside growth of external career significance, fed by results and reputation. Implicit within this are the subjective (internal) and objective (external) elements crucial to defining a career pathway. Stephens [37] describes these career pathway elements:

"*The objective career refers to the externally defined reality of the career, the visible, observable activities, behaviours, or events that comprise a person's work history. The subjective career is typified in the attitudes, orientations, and perceptions about the career that are held by an individual*." [37]

While the external career as described above is easily observable, and therefore easily researched, the internal subjective career has rarely been scrutinised yet has

the potential to significantly affect the successful progression of any individual career pathway. If we consider this within the context of non-medical consultants, they are often ‘launched’ into a new role without consideration of the potential challenges likely to be experienced as part of the transition process [6, 23]. Graham and Wallace [6] identified the enormous personal challenges facing consultant nurses following their initial appointment, but exploration of the transition journey of TCRs suggests that the experiences described by Graham and Wallace are not unique to nursing and perhaps represent the realities of consultant level practice across a wide range of non-medical professions. However, while previous studies have described consultant practitioner experiences through cross sectional descriptive study designs, this current study has demonstrated clearly that the experiences reported are not isolated events. Instead, they represent a sequential, longitudinal transition with a clear and predictable pattern of emotional responses. As a result, whilst previous studies using single investigative approaches may have identified important issues within the transition process, they have not captured fully the tumult of emotional and professional development, or successfully mapped the transition journey, from advanced to consultant practice. Importantly, the pattern of emotions experienced in this study align clearly with the life events transition cycle [38, 39] (Figure 4) and role transition models reported in nursing literature [40-42] adding validity to the findings and reinforcing the suggestion that movement from advanced to consultant practitioner is a developmental (life) event and not purely a job promotion.

Figure 4: Phases and features of the transition cycle (re-produced with permission) [37]



While the findings of this study are important in recognising the impact that the transition from advanced to consultant practitioner has on emotional wellbeing, it is in the application of these findings to the appointment and preparation of new non-medical consultants that this study may have the biggest influence. No evidence exists to suggest that aspirant consultants or healthcare organisations take into account the emotional journey likely to be experienced. If we add to this the varying clinical and professional expectations placed on consultant practitioners, who are often employed without a peer group of similar practitioners with whom to share their experiences, then a new understanding as to why these posts may have been difficult to appoint to, experienced considerable attrition, and viewed as unsuccessful becomes apparent.

Organisations often view the implementation of non-medical consultant roles as a means to address an immediate service delivery need. However, if outcome targets and measures are applied too ambitiously and in too short a time frame, the full potential of the appointment of a non-medical consultant is unlikely to be reached. Organisations would be better advised to support newly appointed consultant practitioners during the first year of appointment by providing developmental opportunities to ensure that they are both professionally and emotionally able to rise to the challenges ahead and meet organisational expectations.

Conclusion

Transition from advanced or specialist practice, where roles are clearly defined, to consultant practice, where greater professional autonomy exists, should not be considered purely a job promotion. The expectations at the personal, professional and organisational level are such that the transition is associated with high level emotions and experiences. In this study, participants recounted an intense sequential transition associated with a clear and predictable pattern of emotional responses, with defined episodes of elation, denial, doubt, crisis and recovery.

Current emphasis on the four domains of consultant practice in the UK, while providing a clear framework for expected external role outcomes, overlooks the importance of the internal or subjective career development on the perceived success or failure of the role. In the push to promote consultant practice it can be argued that we have failed to recognise the impact that emotional wellbeing has on professional success. The findings from this longitudinal study suggest that employers, educators and professional bodies have a responsibility to facilitate aspirational consultant practitioners to explore and enhance their internal career

development and emotional resilience, offering more time to define themselves, and their role, with support and mentorship to guide them through the transition journey.

References

1. Laurant M, Harmsen M, Faber M, Wollersheim H, Sibbald B, Grol R. *Revision of professional roles and quality improvement: a review of the evidence.* London: The Health Foundation; 2010.

2. Department of Health. *Making a difference: strengthening nursing, midwifery and health visiting contribution to health and healthcare*. London: DoH; 1999.

3. Department of Health. *Meeting the challenge: A strategy for the allied health professions*. London: DoH; 2000[a]

4. Department of Health. *NHS Plan: a plan for investment, a plan for reform.* London: DoH, 2000[b]

5. Hardy M, Snaith B. How to achieve consultant practitioner status: A discussion paper. *Radiography*. 2007; 13: 265-270.

6. Graham IW, Wallace S. Supporting the role of the nurse consultant – an exercise in leadership development via an interactive learning opportunity. *Nurse Educ Today.* 2005; 25: 87–94.

7. McSherry R, Mudd D, Campbell S. Evaluating the perceived role of the nurse consultant through the lived experience of healthcare professionals. *J Clin Nurs.* 2007; 16: 2066-2080.

8. Young S, Nixon E, Hinge D, McFadyen J, Wright V, Lambert P, et al. Action learning: a tool for the development of strategic skills for Nurse Consultants? *Journal of Nursing Management.* 2010; 18: 105–110.

9. Department of Health. Radiography skills mix: A report on the four-tier service delivery model. London: Department of Health; 2003

10. Ford P. The role of the consultant radiographer – experience of appointees. *Radiography*. 2010; 16:189-197.

11. Kelly J, Hogg P, Henwood S. The role of a consultant breast radiographer: a description and a reflection. *Radiography*. 2008; 14(Suppl 1): 2-10.

12. Stevenson K, Ryan S, Masterson A. Nurse and allied health professional consultants: perceptions and experiences of the role. *J Clin Nurs.* 2011; 20: 537-544.

13. McSherry R, Johnson SC. *Demystifying the nurse/therapist consultant: A foundation text*. Cheltenham : Nelson Thornes; 2005.

14. Daly WM, Carnwell R. Nursing roles and levels of practice: a framework for differentiating between elementary, specialist and advancing nursing practice. Journal of Clinical Nursing 12, 158-67. *J Clin Nurs.* 2003; 12: 158-167.

15. Maylor M. Differentiating between a consultant nurse and a clinical nurse specialist. *BJN.* 2005; 14: 463-468.

16. Guest DE, Peccei R, Rosenthal P, Redfern S, Wilson-Barnett J, Dewe P, et al. *An Evaluation of the Impact of Nurse, Midwife and Health Visitor Consultants*. London: King's College; 2004.

17. Lathlean J. Researching the implementation of pioneering roles in nursing and midwifery: Empirical insights about lecturer practitioners, consultant nurses and nurse registrars. *J Res Nurs*. 2007; 12: 29-39.

18. Woodward VA, Webb C, Prowse M. Nurse consultants: organizational influences on role achievement. *J Clin Nurs.* 2006; 15: 272-280.

19. Forsyth L, Maehle V. Consultant radiographers: Profile of the first generation. *Radiography*. 2010; 16: 279-285.

20. Woodward VA, Webb C, Prowse M. Nurse consultants: their characteristics and achievements. *J Clin Nurs.* 2005; 14: 845-854.

21. Mullen C, Gavin-Daley A. *Ten Years on – Evaluation of the Non-Medical Consultant Role in the North West*. NHS North West; 2010.

22. The College of Radiographers. *Implementing Radiography Career Progression: Guidance for Managers*. London: The College of Radiographers; 2005.

23. Charters S, Knight S, Currie J, Davies-Gray M, Ainsworth-Smith M, Smith S, et al. Learning from the past to inform the future – A survey of consultant nurses in emergency care. *Accid Emerg Nurs*. 2005; 13: 186–193.

24. Manning D, Bentley HB. The consultant radiographer and a Doctorate degree. *Radiography*. 2003; 9: 3-5.

25. NHS Career Planner for nurses (Career framework) http://nursingcareers.nhsemployers.org/ Published 2010. Accessed 4th March 2014.

26. The College of Radiographers. *A strategy for the education and professional development of radiographers.* London: The College of Radiographers; 2002.

27. Hoskins R. Should aspiring consultant nurses follow a medical training programme? *International Journal of Emergency Nursing*. 2008; 16: 29-34.

28. Graham IW. Consultant nurse – consultant physician: a new partnership for patient-centred care? *J Clin Nurs.* 2007; 16: 1809–1817.

29. Crouch JB, Douglas JB, Wheeler DS. Clinical career ladders: the Moses H. Cone Memorial Hospital. *Am J Hosp Pharm*. 1989; 46: 2272-2275.

30. Hoekstra HA. A career roles model of career development. *J Vocat Behav*. 2011; 78: 159-173.

31. Cresswell JW. Research Design. Thousand Oakes,California: Sage; 2009.

32. Ajjawi R, Higgs J. Using Hermeneutic Phenomenology to Investigate How Experienced Practitioners Learn to Communicate Clinical Reasoning. *The Qualitative Report* 2007; 12(4): 612-638.

33. Personal Correspondance from sponsoring organisation dated December 2009

34. Health Research Authority. Defining research http://www.hra.nhs.uk/documents/2013/09/defining-research.pdf published 2013. Accessed 15th August 2014

35. Burnard P. A method of analysing interview transcripts in qualitative research. *Nurse Educ Today.* 1991; 11: 461-466.

36. Murphy FJ, Yielder J. Establishing rigour in qualitative radiography. *Radiography.* 2010; 16: 62–67.

37. Stephens GK. Crossing Internal Career Boundaries: The State of Research on Subjective Career Transitions. *Journal of Management.* 1994; 2 :479-501.

38. Hopson B, Adams J. Transition – Understanding and managing personal change. London: Martin Robertson; 1976.

39. Williams D. Life events and career change: transition psychology in practice. http://www.eoslifework.co.uk/transprac.htm Published 1999. Accessed 4th March 2014

Interview Schedule	Topic Areas

40. Glen S, Waddington K. Role transition from staff nurse to clinical nurse specialist: a case study. *J Clin Nurs.* 1998; 7: 283 - 290.

41. Boychuk Duchscher J. A process of becoming: the stages of new nursing graduate professional role transition. *J Contin Educ Nurs.* 2008; 39: 441–450.

42. Boychuk Duchscher JE. Transition shock: the initial stage of role adaptation for newly graduated registered nurses. *J Adv Nurs.* 2009; 65: 1103–1113.

Appendix 1. Topic areas explored within each participant interview	
Interview 1	Explanation of research / informed consent Purpose of interview 1 Exploration of career history Exploration of perceived personal attributes and qualities Understanding of Consultant Practice and personal goals Vision for the new role and service External perspectives of this training period Closing Statements
Interview 2	On-going informed consent Purpose of interview 2 Changes to expectations and personal aspirations Progress towards goals (mapped to 4 pillars of consultant practice) Working relationships and support mechanisms Issues raised at interview 1 – e.g. work-life balance Closing statements
Interview 3	On-going informed consent Purpose of interview 3 Progress towards academic and research goals Progress towards audit and change management goals Progress towards leadership and business planning goals Reflection on goals (facilitators and barriers to achievement) Reflections on self (personal development) Closing statements