Nottinghamshire Healthcare NHS Trust

A Review of the Nurse Consultant Role

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EXECUTIVE SUMMARY

Background

This paper reports the results of a review of the Nurse Consultant role at Nottinghamshire Healthcare NHS Trust the aim of which was to provide a clear picture of the current role remit and impact of each Nurse Consultant to inform recommendations for [any] required revision and ensure that Nurse Consultant's roles and responsibilities are aligned to the evidence on best practice, reflect the Trusts business priorities, and that there is a well understood model in operation.

Methods

Using multiple methods of data collection, we investigated perceptions of the impact of Nurse Consultants among general managers and clinical directors, service users and carers, and selected other colleagues using semi-structured interviews and a focus group, as well as exploring with Nurse Consultants their view of the impact of their role via semi-structured interviews. In addition, we evaluated the leadership skills of Nurse Consultants using a 360 degree evaluation. Finally, we examined the activities of Nurse Consultants by analysing their diaries during a three month period.

Results

Nurse Consultants spend 38% of their activity on expert practice, 26% on professional leadership and practice, 19% on education, training and supervision and 15% on practice development, research and evaluation; 2% is spent on other activities. On the 360 degree evaluations, Nurse Consultants scored highest on enabling others (median 52/60), followed by modelling, encouraging and inspiring others (51/60). They scored lowest on challenging others (47/60). General Managers and Clinical Directors reported the positive impact Nurse Consultants have on clinical leadership and their contribution to improving clinical strategies and service developments. Service users and carers reported that they value the role, but were critical of the absence of Nurse Consultants in acute mental health wards.

Conclusions

The practices of Nurse Consultants at Nottinghamshire Healthcare Trust reflect the suggested domains of the role, but they fall short of national expectations of the percentage time NC should spend on expert clinical practice. There is widespread recognition of the positive impact of the role on service development and evidence of the positive impact of Nurse Consultants on practice. In general, colleagues recognise that Nurse Consultants are positive role models, who inspire, challenge, encourage and enable others. There is a widespread belief in the untapped potential for Nurse Consultants to play a more strategic leadership role in the Trust. Recommendations are made for the future development of the Nurse Consultant role.

ACKOWLEDGEMENTS

The authors acknowledge the contribution and cooperation of the following to the successful completion of this review:

The respondents: Nurse Consultants, General Managers and Clinical Directors, Service Users, Carers, those who participated in the 360 degree evaluation and the external Nurse Consultants: John Cathey, Tracy Flanagan and Chris Holley.

Liz Walker from the INVOLVEMENT team

Julian Eve, Acting Head of Education, Tim Constable and Michelle Persaud, Associate Director of Nursing

Claire Stagg, Executive Assistant to the Chief Executive

Dan Barley, Finance Department

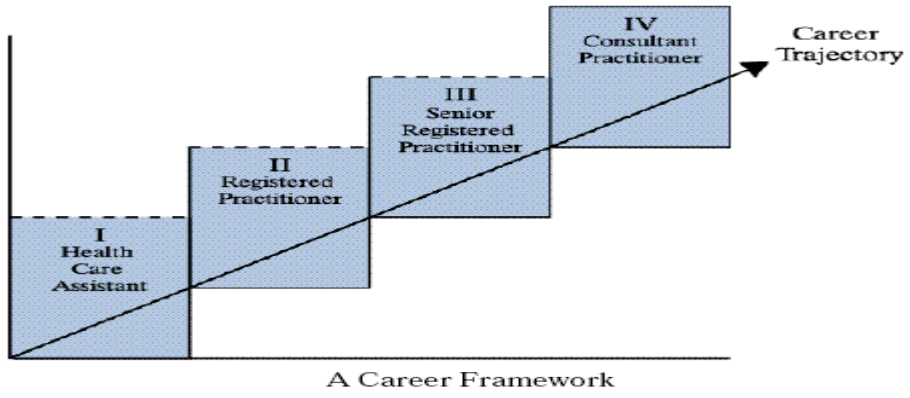
1. INTRODUCTION

Prior to the arrival of nurse consultants (NC) there were few opportunities for nurses working in the UK who wished to progress their careers, to remain in practice. As a result, expert clinical nurses seeking promotion found themselves in management, education or research, roles which invariably removed them from practice, lessened their chances to influence the quality of care, and retain their clinical capability. The arrival of NC in the year 2000 in Trusts throughout the UK sought to change this picture. Since the introduction of NC, there have been several studies in which researchers have attempted to evaluate the impact of NC, but these have produced largely descriptive results. As a result, there is little empirical evidence as to the impact of NC, beyond the largely impressionistic accounts reported by NC and others with whom they interact. This paper is a report of the results of a review of the NC role within Nottinghamshire Healthcare NHS Trust conducted between October and December 2008.

2. BACKGROUND AND POLICY CONTEXT

Following the publication of *Making a Difference: Strengthening The Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* (Department of Health [DH], 1999a), the UK Government identified the need for an alternative career pathway for expert clinical nurses, midwives and health visitors. Figure 1 shows how this pathway would look.

Figure 1: Proposed career pathway for nurses, midwives and health visitors (DH, 1999a)



The aim of the proposed NC role was to [1] Provide better outcomes for patients by improving the service and quality of care; [2] Strengthen clinical leadership; [3] Retain expert nurses, midwives and health visitors in practice; and [4] Provide clinically credible nurses, midwives and health visitors with the opportunity to specialize, and remain clinically active (DH, 1999a).

The Nurse, Midwife and Health Visitor Circular (NHS Executive, 1999b) expanded upon the ideas outlined in *Making a Difference*. The circular contained guidance about establishing NC posts, making appointments, post structure, role definition and functions, noting that these should be seen as a whole rather than separate. It also detailed how the new position would encapsulate the four main competencies of the advanced practice/consultant nurse role that Manley's work (1997) had suggested. These are shown in Box 1.

Box 1: The four domains of the NC role (Manley, 1997)

Expert Clinical Practice
Direct and indirect practice, i.e. working directly with clients and their significant others, whilst indirectly influencing clinical work through supervising and providing guidance to others, developing practice protocols and exploring practice issues.

Professional Leadership and Consultancy
Providing professional leadership and direct evidence based, client-centred recommendations to those stakeholders involved in delivering care, at macro and micro levels. It was envisaged this would involve, for example, strategically planning service development initiatives, helping nurses to develop assessment skills, responding to requests for advice about challenging circumstances and/or working through prevailing ethical dilemmas. An important departure for nurses working at a senior level was there was no managerial component attached to the job: indeed, the circular stipulated that nurse consultants should not be managers.

Education, training and development
Facilitating other clinicians to develop their roles, gain new knowledge and skills, either by strategically planning educational initiatives; advising on higher education routes or through promoting positive learning environments in clinical settings.

Practice service development, research and evaluation
This involves the development of evidenced based protocols, highlighting research questions and exploring the implications of research upon service delivery. This was expected to further involve NC in promoting a culture where research activity is ongoing and recognized as an integrated part of clinical practice and development.

3. LITERATURE REVIEW – THE IMPACT OF NC ON PRACTICE

In this section, using a rapid appraisal of key papers, we examine published, empirical studies that have attempted to evaluate the impact of NC on practice. Our starting point is the systematic and meta-synthesis review assessing the effectiveness of the impact of nurse, midwife and health visitor consultants, published by Humphreys et al (2007). Of their original 107 studies, 14 met the inclusion criteria. The authors report that few NC appeared to be engaged in all four domains of practice, with most appearing to be involved in expert practice and leadership, usually working on service developments. Several studies focus on perceived impact of NC as viewed by NC and others, of these, most reported positive benefits from the role and achievements in being able to meet the requirements of the post, but there were no studies measuring the actual benefit of NC.

The focus of the review Humphreys et al report was on NC in general, few have reported on the role of NC in mental health with the exception of the survey of NC reported by Brooker et al (2004), the action research of Jinks & Chalder (2007) and the focus groups with NC and others reported by Gamble et al (2008). These studies show variance in the percentage of time spent on the different domains of the role, with most delivering expert practice - mostly using CBT interventions - and leadership, struggles in meeting the education and research requirements of the role, diversity in working in the different specialities of mental health and variation in the support NC received from their line managers.

The results from this rapid appraisal of the key literature on the impact of the NC also show:

- There has been widespread introduction of NC in the UK since the year 2000 – in some this has been haphazard – and they work in many areas of specialist practice;
- Most NC are delivering expert practice and leadership, whilst they are also active in education and research, many are struggling to deliver on these elements of their role;
- There is uncertainty among NC and colleagues about the role;
- There have been no economic evaluations of the role;

- There is evidence from NC and others of the *perceived* benefits of NC; there is no published evidence showing the *actual* benefits.

4. THE CURRENT REVIEW

This review was commissioned by Rachel Munton, Executive Director of Nursing and Allied Health Professionals.

The Aims of the Review

1. Provide a clear picture of the current role remit and impact of each Nurse Consultant to inform recommendations for [any] required revision;
2. Ensure that Nurse Consultant's roles and responsibilities are aligned to the evidence on best practice, reflect the Trusts business priorities, and that there is a well understood model in operation.

Methods

We used multi-methods of data collection as follows:

Network analysis

A network analysis of the views and perceptions of the NC role from Nurse Consultants (n=10) by questionnaire (see appendix 1) and semi-structured interviews, General Managers, and Clinical Directors by questionnaire (see appendix 2), Service Users and Carers (n=4) purposefully selected from the INVOLVE team, using a focus group, the Chair of Standing Nursing and Allied Health Professionals Advisory Group (SNAAC), the Trust's Project Officer and an Associate Director of Nursing using semi-structured interviews. In addition, we interviewed three external Nurse Consultants, their data is not included in the review, but their responses have been used to promote objective data analysis.

360 Degree Appraisal

In addition to the network analysis, we used a 360 degree appraisal to elicit the views of two people who work closely with each NC. These were selected at random by PC from a list of colleagues nominated by the NC.

Activity review

We also conducted an analysis of the activities of NC over a typical three month period during 2008, i.e. not in months when NC had leave, using data the researchers collected from their diaries retrospectively. We benchmarked these results against the four domains of the NC role.

Results

The Local Context: NC in Nottinghamshire Healthcare NHS Trust

Appendix 1 shows details of the NC in post at the Trust. The demographic characteristics of NC at Nottinghamshire Healthcare NHS Trust, compared with data from a national survey of NC in the UK[1], are shown in Table 1.

Table 1: Demographic characteristics of NC working in Nottinghamshire Healthcare NHS Trust compared with a national sample of mental health NC

Criterion	Nottm Healthcare NHS Trust	National sample of all NC
Number	11	419
Mean Age	46 yrs	Range =29-59
Gender	45% male; 55% female	22% male; 78% female
Registration	Mental Health = 7 Learning Disabilities = 4	11% MH, inc LD
Post Registered Qualifications	Postgraduate Diploma = 1 Masters degree = 10 Ph.D = 1	65%
Years in post	Mean = Range = 2 - 8 years	Mean = 2yrs
Years qualified	Mean = Range = 25 - 34 years	Mean = 22yrs
Banding, grade point and Salary	Median = 8b GP = 6 Salary = £53,432, Range = £44,527-£53,432	NA NA

Activities of NC

During the semi-structured interviews NC were asked to describe how they met the role domains and state what percentage of their time they spent on each.

[1] Guest et al (2004)

Expert Practice: Descriptions ranged from running specific therapeutic groups, seeing clients individually to assessing and report writing. Two respondents included their supervision activity.

Professional Leadership and Consultancy: Examples ranged from providing expert advice, being involved in setting up other services in the UK, supporting the development of Department of Health policies and guidance. Chairing meetings and modelling leadership skills in clinical review meetings

Education, Training and Development: The majority (56%) described this as working closely with link tutors, teaching in universities, setting up post graduate programmes, developing training packages and strategies, whilst the remaining (44%) summarised the activity as variable and wasn't always undertaken in the Trust.

Practice Development, research and evaluation: examples varied from recently securing evaluation grants; to presenting at conferences, but not publishing; being shaped by their own motivation rather than being part of an overall strategic direction; undertaking a lot of audits to trying to get one day per fortnight but it's just not possible within work time and/or the activity was pushed out of the role at the moment.

Quantitative responses were then compared with the figures taken from the diary analysis. Figure 2 shows these results.

Figure 2: NC activities during a three month period benchmarked against the domains of the NC role and national data[2]

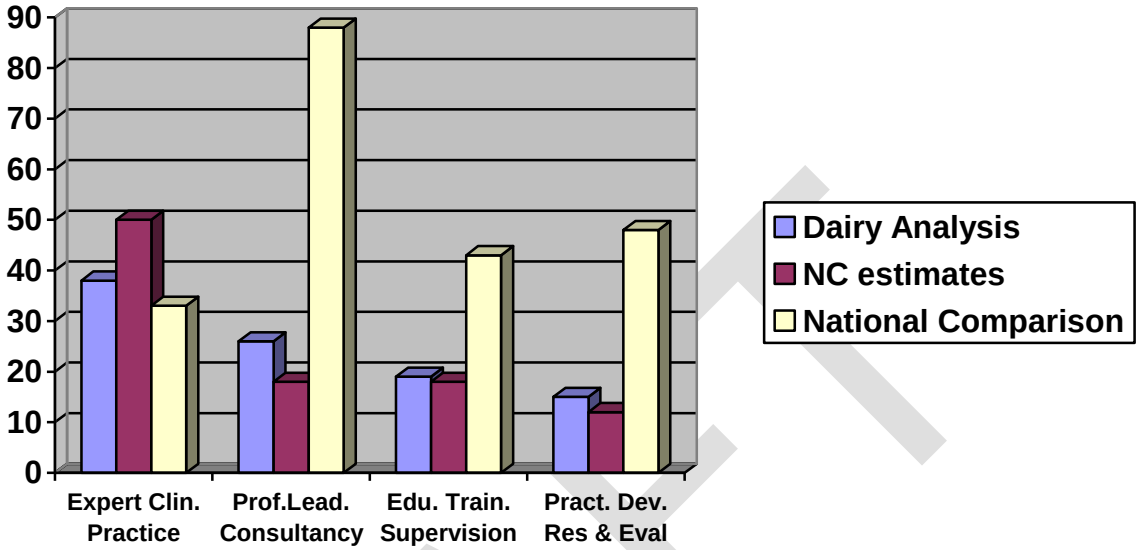


Table 2 shows the time spent in hours on each domain for each NC as shown from the diary analysis.

Table 2: Time spent in hours (%) on each domain for each NC as shown from the diary analysis during three month period

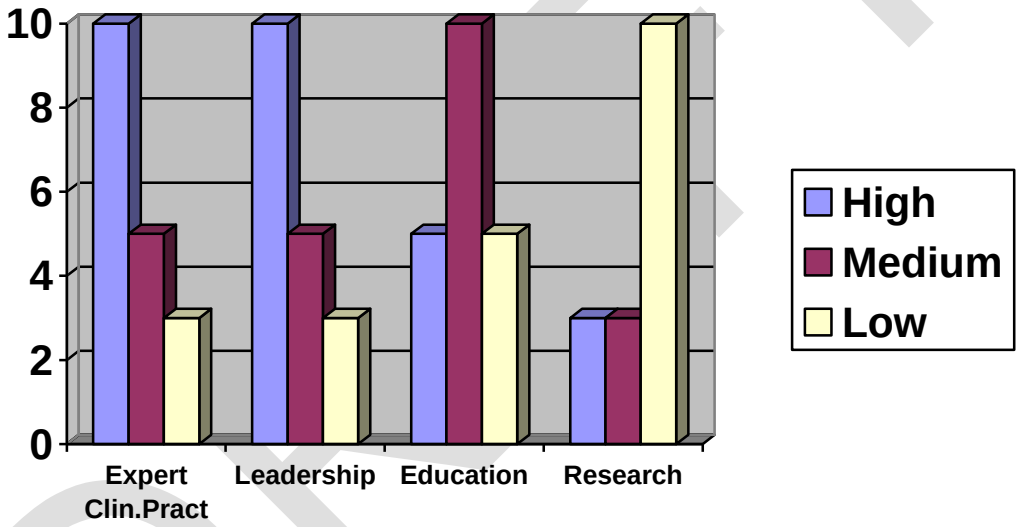
Nurse Consultant	*Expert Clinical Practice*	*Professional Leadership and Consultancy*	*Education Training And Supervision*	*Practice Development and Research*
NC1	36 (8%)	116 (26)	18 (4)	169 (38)
NC2	207 (46)	69 (15)	99 (22)	58 (13)
NC3	93 (21)	80 (18)	84 (19)	97 (22)
NC4	182 (40)	36 (8)	82 (19)	97 (22)
NC5	55 (10)	170 (32)	232 (43)	80 (15)
NC6	214 (48)	161 (36)	78 (17)	65 (14)
NC7	93 (21)	145 (32)	69 (15)	7 (2)
NC8	106 (38)	77 (27)	55 (20)	44 (16)
NC9	220 (42)	110 (21)	136 (26)	60 (11)
NC10	180 (40)	130 (29)	76 (17)	54 (12)
NC11	108 (25)	95 (22)	119 (27)	111 (26)

[2] Guest et al (2004) DH commissioned national study of 419 NC

NC highlighted that the domains encapsulated the role well, should not carry management responsibility but political activities, astuteness and operational responsibilities should be acknowledged within domain definitions

The authors asked NC, General Managers/Clinical Directors (GM/CD) and Service Users and Carers (SUC) to state the priorities they attached to each of the domains of the role. Figure 3 shows these results. The data from GM and CD are combined due to the number of GM/CDs who have NC working in their directorates, and the similarities of the responses from those who do have them under their purview.

Figure 3: Priorities NC, GM/CD and SUC attached to each domain of the role



Results from the 360⁰ appraisal of NC

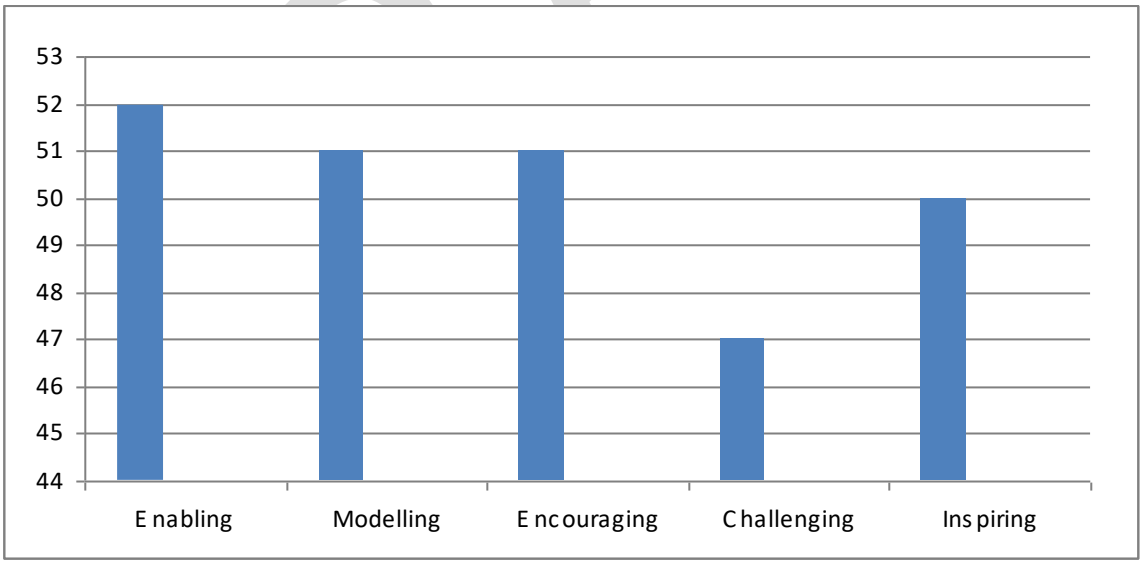
The 360 degree evaluation questionnaire has 30 items measuring aspects of leadership along five factors: Enabling, Modelling, Encouraging, Challenging and Inspiring. Each factor is measured by six items and the score for each factor is determined by adding the total for each item representing that factor anchored by 1 – almost never to 10 almost always. The range of possible scores for each factor is 10 — 60. Table 3 shows the results for each NC on each factor. Figure 4 shows the distribution of scores for each factor.

Table 3: 360⁰ appraisal scores for each NC

Nurse Consultant	*Enabling*	*Modelling*	*Encouraging*	*Challenging*	*Inspiring*	*Mean*
NC3	56	56	45	58	56	54
NC5	54	51	51	54	53	53
NC1	59	58	58	58	57	58
NC11	22	30	30	33	26	28
NC9*	47.5	43	45.5	44	46	45
NC4	52	52	51	46	46	51⁺
NC2*	55.5	51.5	55	47.5	50.5	52
NC8*	53.5	50.5	54	49.5	50.5	52
NC10*	50.5	48	50.5	42	45	47
NC7*	34.5	38.5	35	39.5	40	36
NC6	49	53	51	51	51	51
Median for factor	52	51	51	47	50	51

*Mean ratings from 2 colleagues
⁺Median

Figure 4: Distribution of 360⁰ appraisal scores



Perceptions of the NC role at Nottinghamshire Healthcare NHS Trust

We asked NC and GM/CD to state what they regarded as the positive features of the role, and give an example of the impact of the role. These results are shown in table 4.

Table 4: NC and GM/CD perceptions of the positive features and impact of NC role

	Positive features of the NC role	**Impact of the NC role**
General Managers/Clinical Directors	Expert clinician Supporting others Positive role model for nurses Space to innovate and implement	Leadership Clinical expertise Contributing to the development of clinical strategy
Nurse Consultants	Being at forefront of service delivery and development Flexibility and freedom to practice Autonomy - being creative, just getting on with things. It's brilliant. Difference role can make to patients and nurses Delivering training programmes and teaching Empowering others The role values competency and expertise Working with patients	Improved professionalism Raised profile of nursing Demonstrable evidence that patient experience and outcomes have improved Undertaking research that changes practice Nurse lead treatment programs – extending the nurses role Resource for other disciplines; helping them work together Writing integrated business and service development plans

The chair of the Standing Nursing and Allied Health professionals Advisory Group (SNAAC); the Trust Project officer and Chair of the Modern Matrons forum, perceptions of NC varied considerably, individually they were unable to outline what percentage of the working week they thought Nurse Consultants should spend on the four domains, collectively they felt some did more than others but were unable to comment further as they generally only dealt with individual Nurse Consultants. All felt there wasn't enough discussion about what the Nurse Consultants' key roles and responsibilities were and noted that the profiles of some were higher than others in terms of receptiveness and visibility. Their value in driving forward groups such as SNAAC, working closely with modern matrons, challenging the medical model, being inspirational leaders and mentors were highlighted by all three respondents. Prescribing or being responsible clinicians under the Mental Health Act, were two areas mentioned when exploring Nurse Consultants taking on additional roles and responsibilities. Other notable themes from the interviews included: the importance of maintaining a high profile, the roles vulnerability during cost improvement initiatives and relationships with general managers and clinical directors when considering what conditions hinder or help the role flourish.

NC and GM/CD were asked to state what added roles NC should adopt. The themes that emerged from these discussions are reported in table 5.

Table 5: NC and GM/CD views on what should be added to the NC role

Nurse Consultants	**General Managers/Clinical Directors**
Power to bring about change More involvement in day to day running with clinical director Dedicated secretarial support Succession planning Have a broader influence across Trust: a corporate identify Dedicated research time	Strategic leadership of directorate Drive through IBP objectives as senior member of Directorate Management Team Programme development, delivery, Evaluation and quality monitoring/control

When exploring the reasons for the additions to the role reported in table 5, NC stated that the role lacked authority, needed an organisational attitude shift regarding how NC can support service development, their experience when

administrative support was available was hugely positive, many NC believed that the jump from a band 7 to 8 was too big and there was an unclear career structure. Also, NC believed that the role could be much better used if it was freer and suggested that Trust wide work should be considered about in the context of the post. Whilst recognising the difficulty in making comparisons to psychology consultants, NC believed that they should have dedicated research time as they were under pressure to participate in research, and publish.

General Managers and Clinical Directors did not provide reasons for the additions they recommended should be added to the NC role.

We asked NC and GM/CD to state what impact they perceived the NC had on business, workforce or service development plans. These results are reported in figures 5 and 6.

Figure 5: NC perception of the impact of their role on business, workforce and service development plans

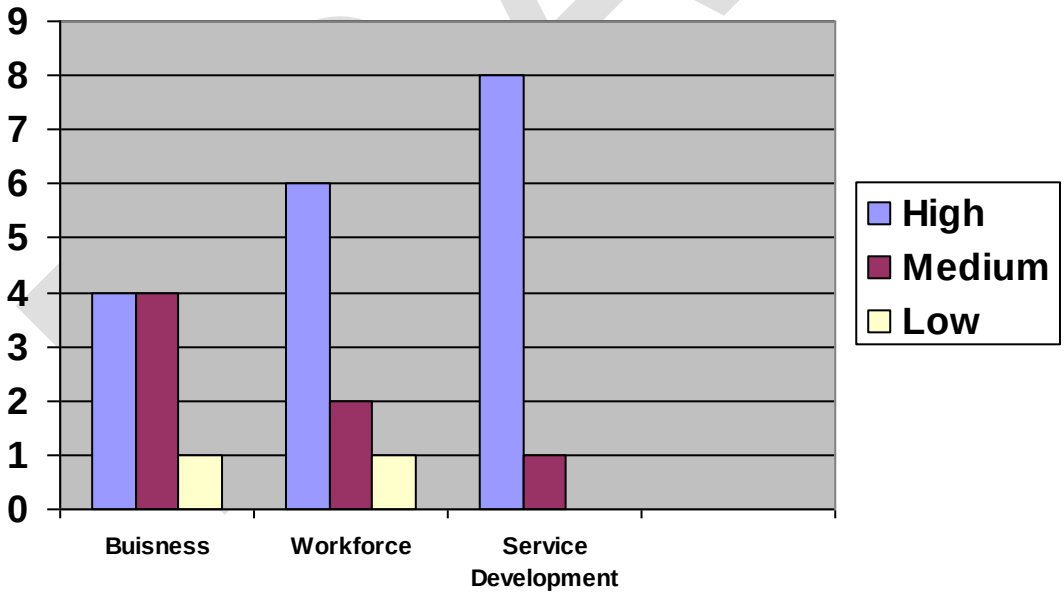
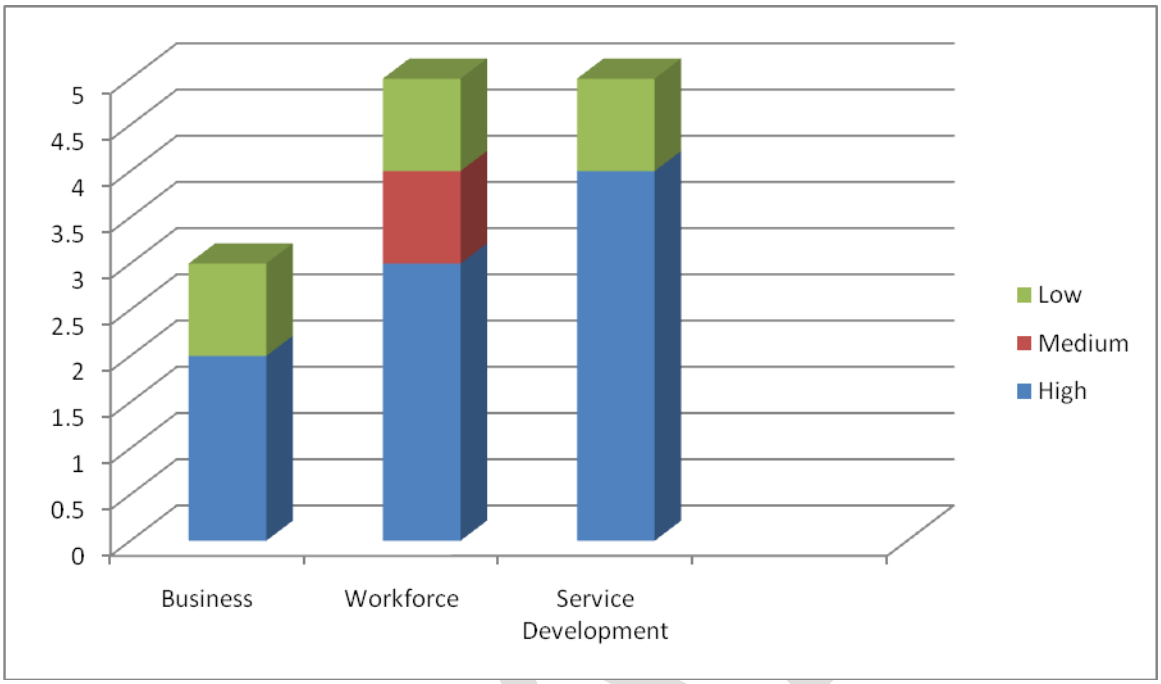
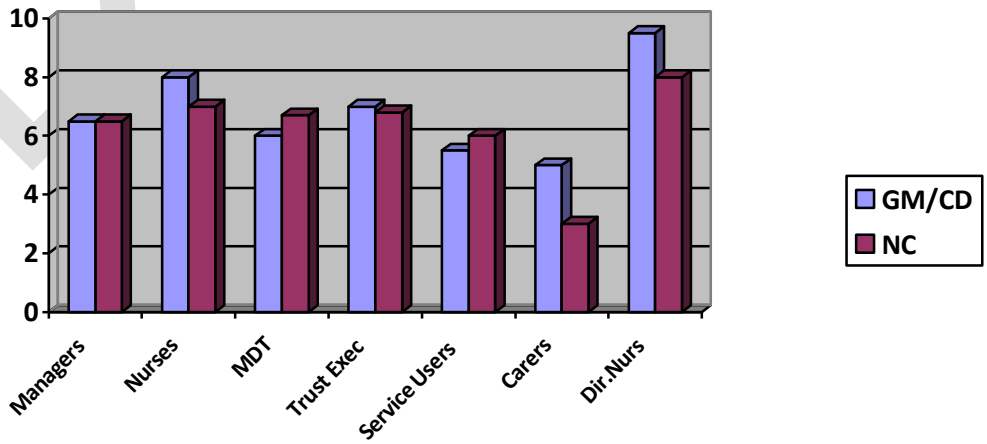


Figure 6: GM/CD perceptions of impact of NC on business, workforce or service development plans



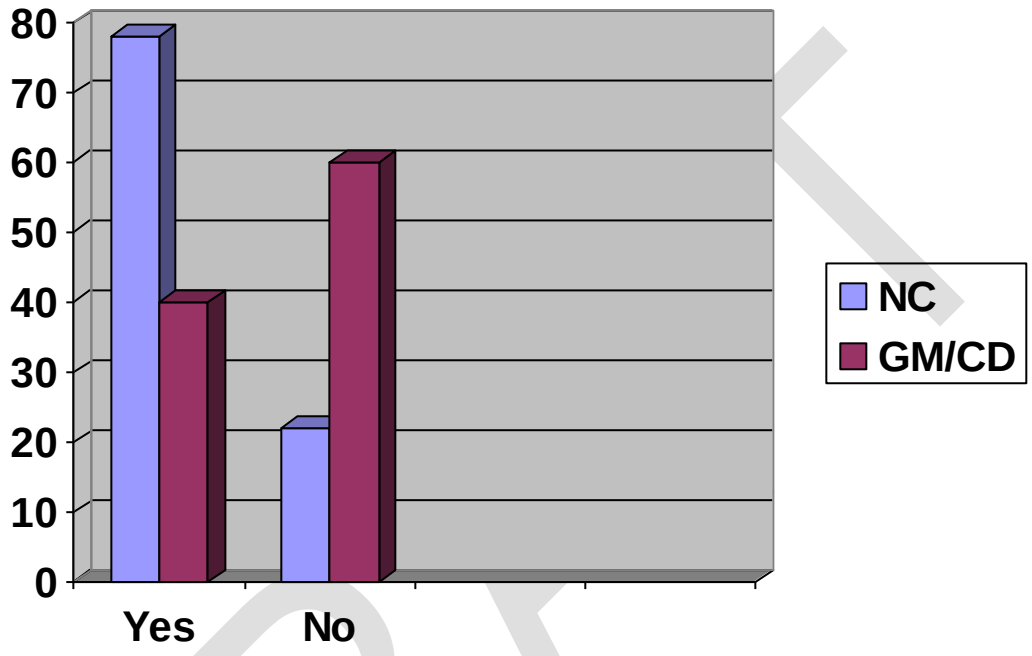
NC and GM/CD were asked to give an impression of how valued from 1 not at all valued to 10 highly valued the NC role was to others, these results are reported in Figure 7.

Figure 7: NC and GM/CD view of how valued is the NC role by others



NC and GM/CD were asked whether agenda for change affected the NC role. Figure 8 shows these results.

Figure 8: The percentage of NC and GM/CD reporting whether agenda for change affected the NC role.



We asked NC and GM/CD to state the reasons for their responses reported in figure 7. None of the GM/CD answered this question. Table 6 shows the themes that emerged from NC responses.

Table 6: Themes from the reasons NC gave as to why agenda for change affected their role

NC roles carry a lot of responsibility and accountability. Psychologists have been banded at 8c without the same responsibility
If you are not banded the same, the organisation doesn't hold you in the same esteem as other consultant colleagues
Common banding across the group is regretful. Some roles are not the same.
Had high hopes but lost role flexibility and career progression now
Not changed how individual NC work, but it has changed perceptions of the role
There is no career pathway progression for aspiring NC now
Nurse Consultants are seen as an expensive commodity without any rationalisation for why this is the case.

During the semi-structured interviews with NC, the authors explored the conditions under which they flourished, and what factors hindered them in their role. The themes that emerged from these interviews are shown in table 7.

Table 7: Conditions under which the NC role flourished and were hindered

The conditions under which the NC role flourished	• Working with/in a mutually trustworthy, respectful team • An effective support network • Good relationships are pivotal as having a vision and a focus • Strong, credible Director of Nursing leadership • Working closely with CNS • Being responsive to trust objectives • Stability which allows autonomy to get on and deliver • Clear understanding of what the role is expected to do • Service value it & see its impact • Knowing what to make an impact on
Factors that hindered NC	• Constraining organisational relationships • Not being as valued as other consultant colleagues • Others not respecting the skills, expertise and knowledge NC have • No time to study or write • Not being good at personal PR • Giving the role managerial responsibility • Losing enlightened team members • Not being in a strategic position • No administration or direct secretary support • Cost improvements, target driven mentality A lack of career pathway or sustainability structure

The authors explored the issue of autonomy. The majority of NC (66.6%) stated they were able to act autonomously 90-100% of the time; this was attributed to managers letting post holders get on with it and working closely with them. The remaining NC (33.3%) reported that although they had autonomy, it had been hard to get their managers to accept this due, in their view, to managers' struggles with the concept of self governance.

The career aspirations of NC

Regarding their career aspirations, Nurse Consultants' responses ranged from getting another consultant nurse post, holding a joint academic position, becoming a clinical director and working across services doing consultancy work.

Previous research has shown that certain professional, organisational and resource constraints have hampered the potential of some consultant nurse roles (Guest et al, 2004). The NC interviewed in this review perceived these issues differently and use alternative strategies to address them. Table 8 shows the categories and sub-categories that emerged from this discussion.

Table 8: Issues NC reported as influencing the development of their role

Organisational Issues
Managers need to positively endorse activity
Length in time in post ensures developments run smoothly so now can devote time to research
The general manager is an extremely experienced nurse – fantastic.
Being valued
It is all about the organisational structure. That is what makes the job what it is.
Effective nurse executive leadership
It's refreshing to talk to somebody who knows what the nurse consultant role is
Bit of a lone voice being the only one who isn't operational
The clinical director needs to be approachable.
NURSE CONSULTANTS' Organisation Skills
Being persistent and challenging
Extremely organised
Having practical things like administration support
Developing clear annual objectives and goals
Working more hours, flexibly at times
Being clear and assertive
NURSE CONSULTANTS' Interpersonal Beliefs
Meeting the domains is a constant dilemma
Having the capacity to make a real difference to patient care and nurses who deliver it
You have to oversell it and that can be tedious
Having a clear idea of what the nurse consultant role is paves the way
Lack of parity with consultant colleagues - you spend your time proving its worth rather than doing the job
NURSE CONSULTANTS' Interpersonal Skills
Developing good working relationships
Good at selling yourself and fighting your corner
Being consistently passionate
Dogged determination
Never being satisfied with the answer

The view from service users and carers

Service users and carers had varied experience of NC; all agreed that this was an important role. Table 9 shows the two categories and several sub-categories that emerged from the focus group with service users and carers.

Table 9: Service users and carers' perceptions of NC

What Nurse Consultants should do	How Nurse Consultants' impact should be assessed
Hands on care Nurse Consultants needed on acute wards NC should facilitate change of culture and monitor this happens Train staff in higher level skills, e.g. handling challenging behaviour Mentor other nursing staff Work therapeutically with carers	Reductions hospital stay Quality of services as experienced by service users Degree of consistency and continuity of care Frequency and nature of interaction between other staff and service users

5. DISCUSSION

This review was concerned with providing the Trust with a picture of the current role and remit of NC, individually, and collectively with a view to ensure that the role and responsibilities of NC are aligned to the evidence on best practice, reflect the Trust's priorities, and that there is a well understood model in operation. This report addresses these concerns.

The demographic pattern of NC at this Trust differs in many respects to the national picture of NC in general Guest et al (2004) reported; nationally 78% of NC are female, compared to 55% at this Trust. NC here have three more years experience in general, and have been in post slightly longer. The percentage of NC at this Trust with a Masters degree or above - initially considered the minimum qualification for a NC role – is 91% which compares favourably with 65% nationally. In relation to the ethnic mix of NC, in the national sample 3% came from BME communities, none of

the NC at this Trust come from these groups. The number of NC at this Trust (11) is more than double than the number of NC at other mental health Trusts in the UK as evidenced from the results of the straw poll of Executive Directors of Nursing of mental health Trusts in the UK, 11 of whom responded, accessed via the Nurse Directors Forum that was canvassed to help us contextualize the results from this review (see appendix 2). This poll showed that the largest number of NC was 5, reported by three Trusts.

It is suggested that the NC role has four domains – expert practice, leadership, education and research (Manley, 1997) – and that at least 50% of Nurse Consultants' time should be spent on the first of these domains (DH, 1999a). NC at Nottinghamshire Healthcare NHS Trust are engaged in all four domains, but there is a discrepancy between their estimates of these activities and the activity recorded in their diaries. The widest discrepancy relates to expert clinical practice where Nurse Consultants estimate their level of activity at 50%; the actual level of activity recorded in their diaries is approximately 38%. Nevertheless, this figure is greater than the national average taken from Guest et al (2004) where expert practice accounted for 33% of activity Nurse Consultants reported. There is wide variation in the degree of expert practice among NC in this Trust ranging from 8% to 48%, a finding mirrored in most published studies of NC (Guest et al, 2004; Humphreys et al, 2007). This variation may be linked to the management responsibilities of some NC restricting the time they have for practice and this is borne out by some of the factors NC identified as hindering their work as shown in table 8. The variation may also be due to how individual Nurse Consultants define and record their activity. Manley's (1997) definition (see box 1) includes indirect clinical work, such as supervision, developing practice protocols and exploring practice issues. Yet this was largely missed by the majority of respondents when describing their practice activity. There is, however, little discrepancy between respondents' views of the priorities of the NC role and the actual practice of NC. With one exception, Nurse Consultants' practice development and research activities are being compromised to the other domains, a finding consistent with some published data (Humphreys et al, 2007; Gamble et al, 2008), but far short of the 48% reported by Guest at al (2004). There is concern among many NC at this position, with some suggesting that protected time for research is indicated. In general, NC accepted the domains of the role, but they also suggested additions where they believed the role could have added influence.

Whilst there is wide variation in Nurse Consultants' engagement of the suggested domains, there is little discrepancy in the salaries paid to NC. Given the degree of autonomy afforded to most NC, and the lack of Trust guidance on the expectations required of NC, it is unsurprising that NC have adapted the role to reflect their perceptions of the demand of the services within which they work. Given that all but two of the NC in this review had the median salary it is invidious to consider the relationship between salary and perceptions of NC, nevertheless it is interesting to note that the two NC whose salaries are almost £10,000 less than their counterparts, scored higher on many of the leadership scores from the 360 degree evaluations. One of the NC with the lowest salary had the highest 360 degree evaluation scores; two NC with the highest salary had the lowest 360 degree evaluation scores, one of whom had a scathing report from a GM/CD. The salary bands of NC in UK mental health Trusts is commonly 8b, but the results from our poll of Directors of Nursing in other Trusts, show that of the 38 NC in these Trusts, 14 were banded 8c. There was little variation in the bands of NC within each of these Trusts.

Despite the importance attached to the leadership expectations that NC, GM/CD and Service Users and Carers have of NC, one of the impediments to the role NC identify is the lack of a strategic position. In their systematic review, Humphreys et al (2007) reported that Nurse Consultants' leadership functions are largely operational, and this is the case among NC in this Trust. General Manages/Clinical Directors suggest that having strategic leadership in directorates is added to the role of NC. The amount of time spent on leadership activities in this review was 26% and this is well short of data from the national study commissioned by the DH from Guest et al (2007) where NC reported spending approximately 86% engaged in leadership. Despite the perceived lack of a strategic position, NC contribution to the development of clinical strategies in directorates is acknowledged by general managers and clinical directorates (see table 4). There is now a NC in the Trust who shares a clinical directorate position, the first example of this at the Trust, and a possible marker for future developments.

In general, there is a positive view of NC among general managers and clinical directors; service users and carers and other colleagues recognise the importance of the role towards improving patient care. There is evidence from the perceptions of GM and CD that NC are making a positive impact, especially in service development plans and this concurs with Nurse Consultants' view of their impact. The generally

positive view of NC concurs with national data reported from empirical evaluations of NC (e.g. Guest et al, 2004; Humphreys et al, 2007; McSherry et al, 2007; Woodward et al, 2005). There is not unanimous agreement on the positive features and impact of the role. One general manager/clinical director remarked that the NC added little to the work of the directorate. The systematic review Humphreys et al (2007) reported concludes that there is no evidence of the actual impact of NC. There is evidence from this review, of the actual impact of NC on the care of service users. For example, during the interviews with NC, several NC provided empirical and systematically collected data showing the effect of their interventions with different service users including those with severe mental health problems and who present with challenging behaviours. Some of these data have been reported by NC at various external and internal conferences and seminars, but they are seldom published, a glaring and regretful omission from the literature.

The results of respondents' views of the leadership qualities of NC are shown by their responses to the 360 degree evaluation exercise. With two exceptions, there is general agreement that NC are enabling, positive role models, encouraging, inspiring and, to a lesser extent, challenging others. These results chime with the original expectations of NC outlined in *Making a Difference* (DH, 1999a) and match the early suggestions of what NC could offer health services (Manley, 1997). The authors could find no published evidence reporting 360 degree evaluations of NC. Notwithstanding this omission from the literature, there is evidence of NC demonstrating similar qualities to those captured by the 360 degree evaluation reported here (Guest et al, 2004; Humphreys et al, 2007; Manley 2000).

Whilst service users and carers were positive about the NC role, they were critical that there were no NC working in acute mental health wards. They also provided specific examples of what they believe NC should do (see table 10) and how their impact could be assessed in ways that would be meaningful to service users and carers. There is little published literature showing the actual impact of NC on service users' outcomes. However, in one study (Currie et al, 2004), the success of nursing interventions were attributed to the qualities in coordinating nurse-led services shown by the NC.

As shown in table 1, there is little difference in the bands, grade point, and salaries of NC across the Trust and this is a source of concern among some NC who reported

that common banding is regretful as some roles are not the same. NC also expressed concern about the perceived discrepancy in salary banding between themselves and other consultant colleagues, e.g. consultant psychologists. According to NC, they carry more responsibility and accountability than psychologists who have higher salaries than them. Consequently, NC reported that this discrepancy lessened the esteem in which the Trust holds them. There is some evidence for the latter view from the results reported here. The NC in this Trust have a salary that is higher than some Consultant Psychologists on Bands 7 and 8a, but lower than some on band 8c. With the exception of two people, the Nurse Consultants in this Trust have a higher salary than a Consultant OT.

On salary alone, NC cost the Trust £569,942 per year, mean = £51,812, lower than the mean cost of Consultant Psychiatrists and some Consultant Psychologists, but higher than the mean costs of a Consultant Allied Health Professional. We did not conduct a cost-benefit, or cost-effectiveness analysis of the value of NC to the Trust. However, the data reported here provides evidence of the value, albeit with some dissension, to the Trust of NC, at least as reported by Nurse Consultants' colleagues. This finding is consistent with data from national studies of NC (Guess et al, 2004, Brooker et al, 2002, Humphreys et al, 2007).

6. CONCLUSIONS

The practices of Nurse Consultants at Nottinghamshire Healthcare Trust reflect the suggested domains of the role, but they fall short of national expectations of the percentage time NC should spend on expert clinical practice. There is widespread recognition of the positive impact of the role on service development and evidence of the positive impact of Nurse Consultants on practice. In general, colleagues recognise that Nurse Consultants are positive role models, who inspire, challenge, encourage and enable others. There is a widespread belief in the untapped potential for Nurse Consultants to play a more strategic leadership role in the Trust.

7. RECOMMENDATIONS

1. The role of Nurse Consultants is adjusted to meet the national expectations of spending at least 50% of time in expert clinical practice.

2. Nurse Consultants are given protected time for practice development, research and evaluation – the opportunities provided by the CLARHC study could be exploited by NC to meet this recommendation
3. All Nurse Consultants collect routine data demonstrating their impact on practice using outcomes that service users and carers find meaningful to them.
4. Increased opportunities for Nurse Consultants to play an enhanced role in directorate strategic planning and management are explored.
5. The Trust conducts a similar review of other consultant positions to identify how the Nurse Consultant role compares with similar roles.
6. The banding, grade point, and salaries of future Nurse Consultant posts are reviewed to consider whether a common banding for all is indicated.
7. The Trust provides guidance on the expected percentage of time each NC should spend on each domain of practice.
8. Actions are taken to support all Nurse Consultants to demonstrate the clinical leadership qualities shown by many.
9. The Trust considers appointing Nurse Consultants to acute mental health wards.
10. Establish more coherent links with Universities so research activity can be consistently supported and NC expertise is utilised in pre and post graduate training
11. Sustainable, coherent career structure which supports newly established NC post being mentored and supervised by senior peers.
12. Expertise/specialism of individual Nurse Consultants is promoted more widely and utilised by other teams across Trust
13. The Trust should consider how the leadership skills of NC are developed
14. The Trust should consider how it might attract people from BME groups to the NC role.

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APPENDIX 1: RESULTS OF STARW POLL OF EXCUTIVE DIRECTORS OF NURSING OF MENTAL HEALTH TRUSTS IN THE UK

Trust	Speciality	Do they manage anyone?	Is this a nurse led service?	Banding	See review in April
Sussex Partnership	CAMHS	N	N	8c	Yes
	WAMHS	N	N	8c	
	Dual Diagnosis	N	N	8c	
	Psychological Therapies	N	N	8c	
	Child Protection	N	N	8c	
Worcester MH	Older Adult	N	N	8b	Yes
AWP	Liaison Psychiatry	N	Y	8b	
	Acute Care	N	N	8b	
	Crisis & Home Treatment	N	N	8b	
	Dual Diagnosis	N	Y	8b	
	Family Work	N	Y	8b	
CWP	Learning Disabilities, health access	N	Y	8b	Yes
	Learning Disabilities, forensic services	N	N	8b	
	Acute inpatient care	N	N	8b	
	CAMHS tier 4	N	N	8b	
CPFT	CAMHS	N	N	8b	Yes
	Assertive Outreach	N	N	8b	
	PD	N	N	8c	
Oxford & Bucks	Child and adolescent	Y	N	8d	
	Acute Care	N	N	8b	
	Older Adult	N	N	8b	
	PSI	N	N	8c	
Greater Manchester	Suicide and self harm	?	?	8b	
	Clinical risk	?	?	8b	
	Young pesons mental health	?	?	8b	
	Dual Diagnosis	?	?	8b	
	Psychotherapy	?	?	8b	
Glos NHS	Psycho social intervention	N	N	8b	
	Low secure / PICU	N	Y	8c	
	Dual Diagnosis	N	N	8b	
	Learning disability	N	N	8b	

NWMHP	Forensic	N	N	8c	
	Older People	N	N	8c	
	Infection Control	N	N	8c	
Cornwall partnership	Acute / Inpatient	N	N	8b	Yes
North Wales NHS Trust	Adult Mental Health In-Patients	N	N	8c	Yes
	Substance misuse	N	Y	8c	
	Specialist psychological therapies	N	Y	8c	