



Scoping the Role of the Nurse Consultant

**A report commissioned by HENCEL and produced
on behalf of Middlesex University, School of Health
and Education**

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Terms of Reference

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Summary

Project Summary

Middlesex University is funded by HENCEL to undertake the following project: “**Scoping the Role of the Nurse Consultant**”. The project aims to provide HENCEL with a detailed review of progress of nursing research and development (R&D) being delivered through the Nurse and Midwife Consultant role across North Central and East London. This interim report covers the period from December 1st 2013 to 31st March 2014. The report considers progress of phase one and phase two (see below)

Project Description: The project has two phases:

Phase One: Survey

- Analysis (numbers and distribution) of Nurse and Midwife Consultant roles across North, Central and East London.
- Analysis of any workforce challenges associated with these roles in developing R&D output.
- Analysis of post holders’ progress in gaining research degree qualifications (e.g. MS/MSc, MRes, PhD/Doctorate).
- Analysis of the proportion of time typically being spent engaged in R&D.
- Evidence of R&D output (e.g. papers and publications).

Phase Two: Interviews

- Any emerging ideas/innovations in the development of Clinical Academic Nursing and Midwifery roles.
- Opportunities there may be for Health Education North Central and East London to more systematically support the development of nurses and midwives into these roles and their on-going academic development once in post.

Main Findings:

Nurse consultants report heavy clinical workloads, with the result that little time is available for research. Where nurse consultants are engaged in research this is often reported to be both medically focused and medically directed. Nurse consultants recognise this as a lost opportunity for nursing research to positively impact on clinical practice through identification of nursing problems and design of research studies to specifically address nursing questions.

Nurse consultants report a lack of organisational will for nursing research, with

organisations and trusts prioritising nurse consultants' time on clinical work, service development/evaluation, management and audit. This, according to informants, is in contradiction to the prioritisation of medical research which is viewed by organisation/Trusts as key to the achievement of organisational objectives.

Main Conclusions

Nurse consultants were created as an occupational position without an initial precise definition of their role. Their numbers and their remits have therefore developed organically, with no agreed set of activities that define the role. Under pressures of endemic staff shortages, changing political priorities, increased targets, and above all with the development of Trusts as distinct bodies, judged in a competitive hierarchy against other, and therefore with organizational disincentives to scrutinize their own practices, the research element of nurse consultant posts has been constructed as peripheral work. This is in spite of public declarations of support both from NHS Trusts and from nurse consultants themselves. As a consequence, only a nurse consultant willing to work counter to prevailing cultures and to commit considerable personal resources to the endeavour, is likely to engage in any significant amounts of research. If more good quality research is to be undertaken in the NHS, it would require either a ring-fencing of nurse consultant-researcher posts or much more open access to NHS organizations by university researchers.

Recommendations

1. Organisations/Trusts need to consider ways of supporting and facilitating nursing research, in ways similar to medical research. One way might be to provide in house or externally sourced research training programmes specifically for nurse consultants as a means of up skilling senior nurses to fully engage and become confident in identifying and solving nursing problems.
2. Organisations/Trusts need to prioritise nursing research alongside medical research through a clear commitment to protected time and available resources for nurse consultants to engage with nursing research. This might involve the allocation of monies for research training and doctoral level study.
3. Organisations/Trusts should consider formal and informal mentorship schemes specifically focused on nursing research mentorship. This might involve a `buddy system` whereby a nurse consultant is paired with or becomes part of an existing nursing research project within a HEI, or another research driven organisation.
4. Organisations/Trusts need to clarify the role of the nurse consultant, thereby making clear to nurses considering these positions to what extent they are expected to engage in research. This clarity of role will ensure that nurse consultants are able to articulate when the research element of the role is being compromised by competing priorities. If research is not considered an important aspect of the nurse consultant role then this needs to be clear to all stakeholders.
5. Organisations/Trusts should consider separating the role of the nurse consultant as clinical expert, teacher, manger, and project leader, from nurse consultant researcher, perhaps making the latter a super-numerary and thus protected function.
6. Organisations/Trusts might need to consider removing research from the remit of the nurse consultant. This would require nursing research to become

the remit of university researchers who would need to be granted access and freedom to publish. University researchers would then need to work in partnership with nurse consultants to identify nursing problems, to design appropriate research methods and tools, and to ensure research findings have application to nursing practice.

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Introduction

In 1998 then Prime Minister, Tony Blair, announced the introduction of the Nurse Consultant. Anecdote has it that the news came as a surprise to senior figures in the profession. These posts were announced as providing 'new career opportunities for experienced and expert nurses, midwives and health visitors who wished to remain in clinical practice'. The Nurse Consultants' roles were to be structured around four core functions:

Expert practice: delivering high quality care to patients, enabling other practitioners to maintain professional expertise, and exercising a high degree of personal autonomy within their role. They were expected to spend at least half the time available in direct contact with clients, patients or communities.

Education, training and development: contributing to the training and education of others, establishing formal links with local education providers and contributing to the development of qualified staff in their specialist fields.

Professional leadership and consultancy: exhibiting leadership skills to support and motivate others in order to continuously improve quality of care and standards of practice.

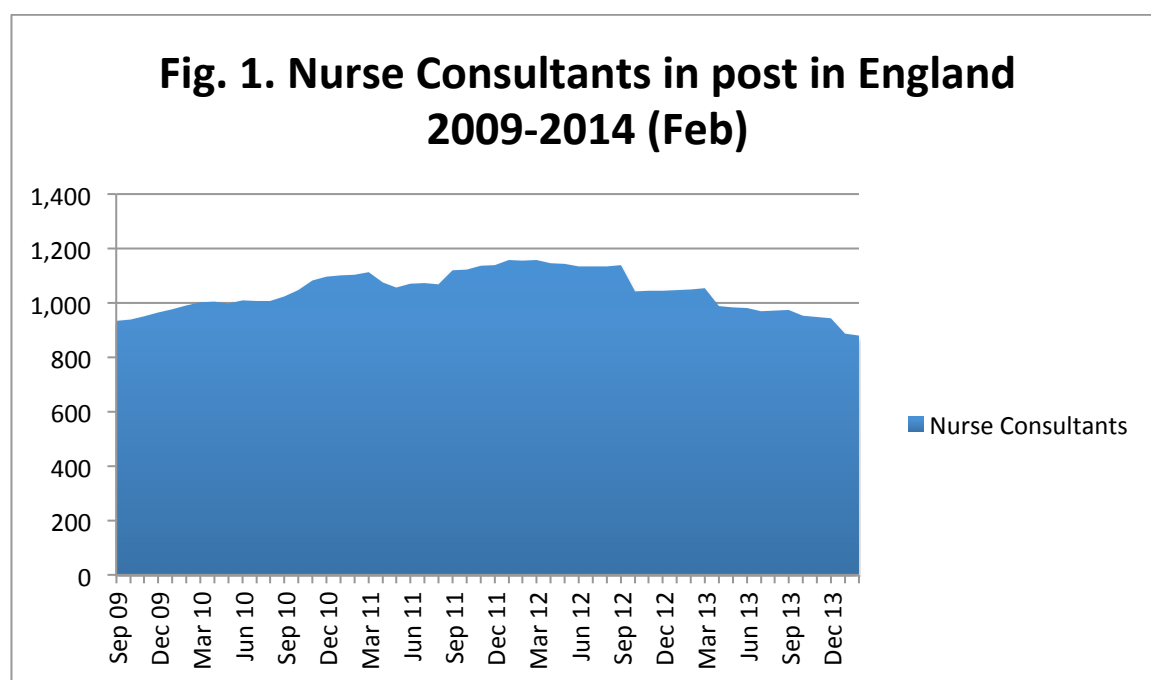
Practice, service development, research and evaluation: contributing to the development of professional practice, through the promotion of evidence-based practice, audit of standards of care with a role in research and evaluation of practice within their specialist fields (Department of Health, 1999).

Under the Blair administration, nursing received unprecedented attention as that government attempted to rebalance its reliance upon the medical profession and medicine's power within the health service. Many new nursing roles, such as specialist and advanced practice roles, as well as consultants, can be seen as physician substitutes or at least part of an attempt to reshape the NHS workforce across traditional professional boundaries. Like the introduction and extensions of nurse prescribing, this new policy attention was attractive to the profession. However, in a reflection on the future of such roles published in 2007, the National Nursing Research Unit observed that despite emerging evidence of effectiveness, the roles were vulnerable in times of financial stringency:

- Role substitution by nurse specialists and practitioners replacing doctors has been shown to have a positive impact on patient outcomes and experiences
- Consultant nurses have so far made their greatest impact in practice and service development rather than in patient outcome and cost-benefit
- It is difficult for consultant nurses to demonstrate impact when their effects are made indirectly through the work of others
- However, evidence of positive impact by consultant nurses on patient outcome is beginning to emerge, in critical care for example
- Sustainability of new roles depends on continued organizational support from managers, peers, other professionals and funding
- Consultants have been left to cope without support after the posts have been established and filled when what they need, in particular, is support to improve their leadership skills (National Nursing Research Unit, 2007)

Evaluations and other examinations of nurse consultant roles during the first decade of their introduction noted a wide variety of job descriptions and qualifications required (Buchan and Calman, 2004) and in more recent years NHS funding cuts have fallen disproportionately on nurses in specialist and consultant roles with evidence of recruitment freeze and downbanding of posts as employers attempt to make savings (RCN, 2013).

Figure 1, taken from NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics shows the rise and fall of nurse consultant numbers in England since September 2009.



Clinical academic careers

Because of the clinical research expectation for the nurse consultant role we summarise recent moves to enhance and enable this contribution. In 2007 the UK Clinical Research Collaboration released a report (The Finch report) on clinical academic careers, highlighting the difficulties nurses and midwives face in developing such careers and offering measures to overcome these problems. It recommended a research training framework along with some indicative targets for recruitment at each level (UK Clinical Research Collaboration, 2007) however; subsequently these targets have failed to be reached (Council of Deans, 2012). Along with the Modernising Nursing Careers initiative launched in 2005, the Finch report promoted the advantages of a future nursing workforce that would be both better trained and more active in research. For example, nurses would have more opportunities to shape the evidence base that informs their clinical practice and to influence the broader agenda of health research, so that it contributes clearly to high quality health services and patient care (UK Clinical Research Collaboration, 2007:

p. 15). Among the recommendations made by the Council of Deans in 2012 were that Health Education England be given responsibility for ensuring that appropriate infrastructures and funding mechanisms are in place for sustaining clinical academic careers to ensure that focused local implementation is achieved through Local Education and Training Boards (LETBs), and Academic Health Science Networks (AHSNs) where appropriate.

However, it could be that NHS trusts have more pressing and contradictory priorities at present. These involve ensuring safe staffing levels within an overall decreasing staffing budget. According to the King's Fund, The Foundation Trust Network's recently published aggregate of individual trust business plans [2013], showed that trusts were planning a significant level of nurse recruitment in that financial year, in part as a response to safe staffing concerns raised by the Francis report, but were projecting significant staffing reductions in subsequent years (Buchan, 2013).

Methods

Phase 1: the survey

We devised a short series of survey questions aimed at providing information about nurse consultants in post. We identified the senior nurse managers in the HENCEL area trusts and contacted them asking for details of any nurse consultants currently employed in their organisations. Most supplied these while a small number asked the nurses themselves to contact us.

According to these responses, Nurse Consultants were identified as working across the following Trusts and hospitals within the area covered by HENCEL:

- Whittington Health (n=5)
- Camden and Islington (n=1)
- The Royal Free (n=5)
- Barking, Havering and Redbridge (n=1)
- Barnett, Enfield and Haringey Mental Health Trust (n=8)
- Great Ormond Street (n=5)
- Barnett and Chase Farm (n=1)
- North East London (n=2 names not supplied, not invited)
- East London (n=1)
- Bart's Health (n=12)
- Royal National Orthopaedic (n=2)
- Moorfields Eye Hospital (n=0)
- Homerton (n=8)
- University College London (n=8)
- Tavistock & Portman (n=2)
- North Middlesex (n=5)
- Total = 66

We used the web based Survey Monkey® for our survey of nurse consultants. We undertook a small pilot study in February and ran the full survey between May and June 2014. One survey question asked whether respondents would be willing to participate in a telephone interview in order to explore the research questions in more depth. From responses we selected a subsample for phase two of the study. (see Appendix 1 for a list of the survey questions)

Ethical aspects: The project was considered by NOCLOR as service evaluation therefore no further NHS ethical application was required. (see Appendix 2.)

Phase 2: telephone interviews

We conducted 16 telephone interviews, during May 2014, with the aim of further exploring the issues raised in the survey. Some 35 survey respondents had agreed to being included in this part of the research. From these we selected a sample of 20 respondents across the trusts represented in the survey. Four declined or were not able to schedule an interview within the time frame of the project, and 16 interviews were conducted by telephone. The interviews lasted on average 25 minutes (range 13 minutes-26 minutes) were audio-recorded with the permission of the respondent, and then transcribed in full using the services of a professional transcription agency. After 16 interviews were completed a strong consensus with no new themes had emerged. See Appendix 3 for a list of questions used.

Results

The survey

We sent survey invitations to 64 nurse consultants and 44 nurses (69% response) completed the survey. Table 1 shows the abbreviated job title of respondents.

Table 1 Job titles of respondents

	Number	Percent
ACERS	1	2.3
Acting Consultant	1	2.3
Acute Care	1	2.3
Acute care & Resuscitation	1	2.3
Allergy	1	2.3
Cancer and Supportive Care	1	2.3
Colorectal surgery	1	2.3
Community Children's Nursing	1	2.3
Consultant (not specified)	11	25.0
Consultant Midwife	4	9.1
Critical Care	1	2.3
Critical Care outreach	2	4.5
Diabetes	2	4.5
Drugs and alcohol	1	2.3
Gastroenterology	2	4.5
Gynaecology	1	2.3
Haemophilia	1	2.3
Heart Failure	1	2.3
HIV	1	2.3
Intellectual (Learning) Disabilities	1	2.3
Intermediate Care	1	2.3
Macmillan Nurse Consultant In Palliative Care	1	2.3
Nephrology	1	2.3
Older people	1	2.3
Paediatric Emergency Medicine	1	2.3
Personality Disorder	1	2.3
Renal	1	2.3
Teenagers and Young Adults with Cancer	1	2.3
Total	44	100.0

The mean number of years in post as a consultant was 6.3, the maximum 13 while 1 respondent was just about to come into post. Five (including one nurse who identified herself as Acting Nurse Consultant) had been in post one year or less.

Table 2 shows the employing NHS organisation of the respondents.

Table 2 Employing NHS organisation

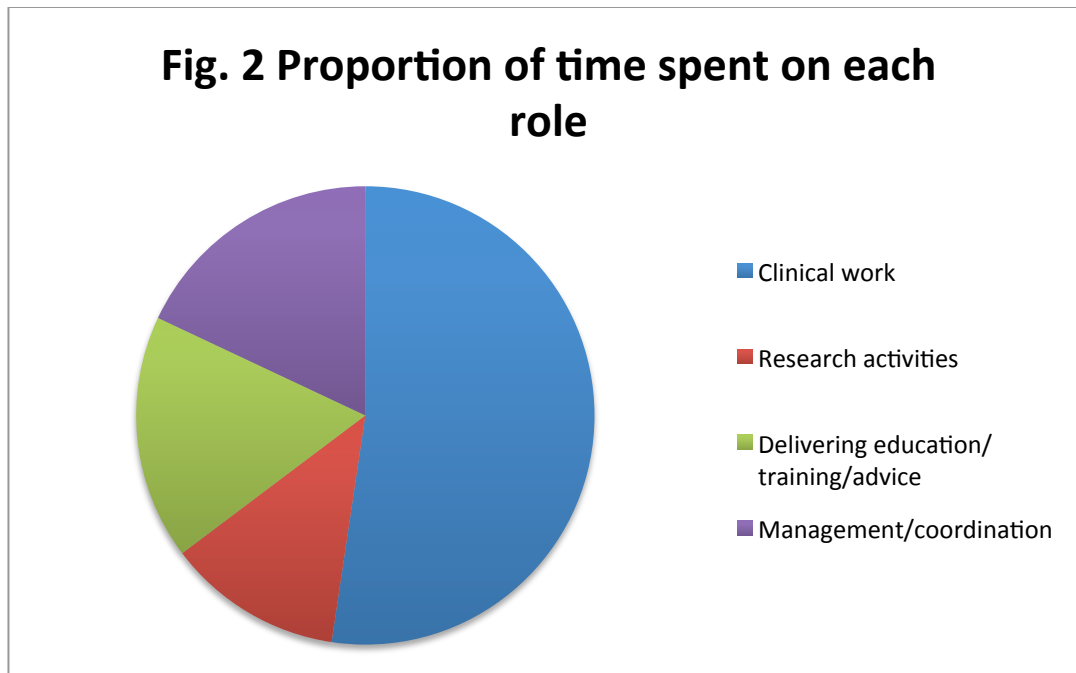
	Number	Percent
Barking, Havering and Redbridge University Hospitals NHS Trust	1	2.3
Barnet, Enfield & Haringey Mental health Trust	4	9.1
BartsHealth NHS Trust	7	15.9
Camden & Islington NHS Foundation Trust	1	2.3
Great Ormond Street Hospital for Children NHS Trust	6	13.6
Homerton University Hospital NHS Foundation Trust	6	13.6
North East London Foundation Trust	1	2.3
North Middlesex University Hospital	4	9.1
Royal Free London NHS Foundation Trust	4	9.1
Royal National Orthopaedic Hospital	1	2.3
UCLH NHS Foundation Trust	5	11.4
Whittington ICO	4	9.1
Total	44	100.0

Qualifications: of our sample, all but 4 wrote that they had a Master's degree and one had completed a PhD. Two participants said they were currently registered for a PhD. A number had more than one Master's degree. All had many combinations of other qualifications and certifications in addition, the most common being non-medical prescribing (10 respondents). Four respondents identified that they were either working toward professional doctorates or had Masters level professional qualifications (e.g. MProf).

All but two respondents gave details of the qualifications required for their roles. Of these, 40 told us that a Master's degree was required with three (from UCLH, GOS and Homerton) adding that the post holder was required to be working toward a PhD.

We asked respondents to estimate what proportion of their time they spent on the key areas that are said to characterise the work of nurse consultants. Figure 1 shows their response. The maximum percentage of time spent on research by any respondent was 40% and the minimum 0%. The maximum percentage spent on clinical work was 90% and the minimum 10%. There was no association between time spent on research and years in post. There appeared to be no association between time spent on research and type of trust or job title. Time spent on

management work ranged from 0% to 50% and on training and education, 2% to 40%.



We asked about other roles undertaken in addition to these main areas. Of the 8 nurses who provided this additional information, the largest group was of 3 nurses who identified leadership or strategic service development roles.

Outputs: nineteen respondents said that they had produced peer-reviewed publications while in post. The number varied from 1 such output (8 respondents) to 10 (1 respondent) with five producing 2 outputs and 3 saying they had produced 4, and 1 person producing 5 peer-reviewed outputs. There was no association between years in post and number of outputs. There was a slight tendency for those who said they spent more of their time in research work to report a higher number of peer-reviewed outputs. There was, however, some ambiguity in the way a small number of respondents answered this question. Respondents also produced a great many other types of output. Twenty-five had been involved in developing guidelines, policies or pathways, 6 had produced conference posters or presentations, 22 produced internal or external reports and 5 completed audits. Some respondents had produced many of such outputs. Four had produced book chapters.

Finally, 35 respondents expressed a willingness to undertake a telephone interview, indicating an interest in this project.

The interviews

BACKGROUND

Although research was intended to be one of the activities that defined the nurse consultant role, and appears on job descriptions, the capacity of different Trusts to determine their own job descriptions has led to two related uncertainties, namely what are the range of activities that are carried out by nurse consultants as part of their role, and to what extent and in what ways are they engaged in research. This part of the project was designed to explore these questions in depth.

METHODS

We used a semi structured interview guide comprising three parts (see appendix 3). Part one was concerned with what nurse consultants currently do and perceived barriers in fulfilling the role, with particular emphasis on capacity and ability to carry out or participate in research activities. Part two was concerned with whether or not engagement in research featured in career aspirations, while part three provided an opportunity for nurse consultants to engage in a dialogue with HENCEL around how involvement in research might be facilitated/enhanced within the role and remit of the nurse consultant. While we were minded not to direct the interviews we needed to meet the requirements set out by HENCEL, which were to review progress of nursing research and development (R&D) being delivered through the Nurse and Midwife Consultant role across North Central and East London.

As previously mentioned, the project was considered a service evaluation; as such ethical approval was not sought (see appendix). However ethical principles for research conduct were adhered to, with data treated as confidential and respondents assured of confidentiality within the written report. Interviewees are numbered 1 – 16, no names or locations are included. However details of nurse consultant specialities and length of time in current post are provided to illustrate representativeness within the sample.

FINDINGS

Of the interviewees, two nurse consultants were male and 14 were female. They had been in their current nurse consultant posts for an average of 6 years (range 7 months to 13 years) [See Table 3].

We have organized our presentation of the responses into three broad categories: (1) the activities that characterize the role of nurse consultants (and by implication the activities that they do not currently undertake) and what are the perceived barriers to undertaking research as a nurse consultant; (2) what research activities the nurse consultants are currently engaged in, and what barriers to participation in research they perceive; and (3) what actions might facilitate further engagement with research.

Table 3 Nurse Consultants Specialties

Specialties	Time in post
Acute care and resuscitation	13 years
Paediatric care	5 years
Palliative care	11 years
Gastroenterology	6 years
Cognitive disorders	10 years
Rehabilitation and pain management	3 years
Cancer and supportive care	12 years
Critical care outreach	5 years
Personality disorder	3 years
Drugs and alcohol addiction	4 years
Surgery	10 years
Teenage and young adults with cancer	7 months
Older people	4.5 years
Diabetes	4 years
Acute care	5 years
Renal	4 years

(1) The Role of Nurse Consultants and Perceived Barriers to Research

All sixteen nurse consultants reported that front line clinical work formed a considerable part of their overall work profile. This clearly formed a core part of their professional identity, as the following nurse consultant explained:

“So obviously the role is grounded in [clinical] practice and it starts in practice. ...there might be ward rounds going on and I’m picking up on how people are working and who the key complex patients are. That’s quite a short activity but it absolutely essential” (Nurse Consultant 3)

This suggests that nurse consultants operate with a notion of hierarchies of work, in which certain activities are regarded as core and others as peripheral. The nurse consultants were aided in their foregrounding of clinical work as core, in that this orientation was encouraged by the Trusts. The following nurse consultant expressed the view that the nurse consultant role is fundamentally about clinical work, which fits with personal and organisational expectations:

“I enjoy the clinical work and that’s a fundamental part of why I’m a nurse consultant, it’s about patients. The organisation doesn’t have an official line on nurse consultants, but they want nurses doing more clinical work and that’s about saving money” (Nurse Consultant 4)

When questioned specifically about barriers to research nurse consultants reported organisational resistance around the potential for nursing research to benefit the organisation. While Trusts/organisations were not actively preventing nurse consultants from undertaking research, they were not actively facilitating or prioritising nursing research. On the one hand research undertaken by the medical team was seen as key in meeting organisational objectives, whereas on the other hand nurse consultants were expected to

prioritise a different set of organisational objectives, for example clinical work, managing people, leadership, service improvement/development, and audit.

“I don’t think the organisation is focused on research at all. I think when I say to my line manager oh, I had this published and I thought you might like to know, they’re delighted but they’re not driving that” (Nurse Consultant 10)

A lack of organisational will, coupled with a high clinical workload and a lack of protected time all constitute a clear and present barrier to nurse consultants’ engagement with research. An anti-academic culture within nursing hierarchy, originally described by the United Kingdom Clinical Research subcommittee (UKCRC) 2007) perpetuates the problem in so far as any research that is undertaken is likely to be medically driven and not nursing focused:

“The (name of organisation) is a teaching organisation, research has to underpin any business case, any discussion we have about changing how we work, it’s absolutely fundamental but only from a medical perspective, there’s no nursing perspective in it” (Nurse Consultant 8)

(2) Current Research Activities and Barriers to Participation in Research

Nurse consultants, for the most part, are not engaged in research. When asked about involvement in research one nurse consultant referred to age as a mitigating factor. Although somewhat `tongue in cheek` this nurse consultant was making the point that nurses need to be supported to undertake research early in their careers, which included both time and financial support:

“I’m 53 years old and heading to retirement. It’s sort of being suggested to me now that I might like to do a PhD, and I think if I was going to do one, wouldn’t I have done it when I was 25?” (Nurse consultant 5)

This nurse consultant suggested any expectation for nurse consultants to undertake research is unrealistic given the lack of funding for research training:

“PhD studentships are rarely advertised for nurses, and you really need to get people early in their careers, I think, when you can live on twenty grand a year salary and you can spend three years just focusing on research” (Nurse Consultant 10)

This is a valid point in light of the fact that both generic and specific funding and training schemes are relatively recent, with many still under development, for example schemes funded by HEFCE, NHS, and NIHR (UKCRC 2007).

Where nurse consultants are involved in research, collaboration with academic partners was in evidence, which supported the activities and provided a framework for the research:

“We’re doing a few at the moment in collaboration with (name of Higher Education Institution) and (name of academic). I see (name of academic) quite often because we’re doing a couple of studies with them.” (Nurse Consultant 14)

Nurse consultants often referred to service evaluation and audit when asked about research. They appeared to know the difference but indicated Trusts/organisations compelled them to undertake these types of activities as opposed to ‘proper’ research:

“I suppose I do quite a lot of evaluation work which you wouldn’t really call...it’s service development and evaluation of services, more than detailed evaluation research” (Nurse Consultant 7)

Audit is a word which has acquired different meanings over time in relation to health care quality. The Department of Health defines clinical audit as systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient (DH 1993). Essentially, clinical audit provides a method for systematically reflecting on and reviewing practice. Given the current financial climate NHS organisations will be minded to focus on service evaluation and audit as opposed to investment in nursing research. While nurse consultants may be engaged in research this is almost exclusively medically dominated, whereas service evaluation and audit may be both medically and nursing focused.

(3) Factors Reported as Likely to Facilitate Research Participation

Nurse consultants identified a number of ways research activity might be facilitated by their organisations. Support in the form of time and funding to undertake research modules, either as stand-alone courses or as part of a master’s level programme was identified as key to engagement with nursing focused research. Respondents told us that in reality support of this nature was not in evidence. Available resources were seen to be targeted on service evaluation and audit as opposed to research. Nurse consultants who were or had undertaken research training were self-motivated and self-funded:

“I can’t think (name of Trust) has supported us in anything to do with research and I don’t know if it’s because it’s a small trust – we’re not a big Trust, maybe research or academia itself isn’t a huge focus for the Trust. So they haven’t put anything on to support us or show us anything in terms of do you want to do any research, this is how you do it but it’s been none of that. Everything I’ve done has been externally through my own initiative” (Nurse Consultant 8)

Encouragement and mentorship were seen by nurse consultants as a prerequisite for undertaking research. However, nurse consultants appeared caught in a

professional dilemma in that the very seniority of the nurse consultant role effectively placed them above the need for mentorship:

“But you see, at the level of consultant nurse, you shouldn’t need to be encouraged to do it (research). You should see the importance of it yourself and I think maybe a change in culture in that people don’t just pay lip service to the fact that as a consultant nurse you’re meant to engage in research. I think maybe a bit of engagement and mentorship” (Nurse Consultant 11)

When asked how HENCEL might facilitate and support research participation the issue of mentorship was returned to. Mentorship for research from an external body appeared more acceptable when provided by an outside organisation such as HENCEL, as opposed to mentorship within the organisation, which might be focused on leadership, people management and project management:

“I think what I’m lacking is peer support or something like that. I certainly think a regional organisation could perhaps bring consultant nurses or groups of like-minded people together, or something like that, you know, with a research focus. There’s no support network for people doing research” (Nurse Consultant 11)

Providing mentorship for senior nurses such as nurse consultants is a costly business. The nature of any such mentorship i.e. around high level research skills might not be readily available within a given organisation, thus requiring potentially costly external requisition. In the absence of research-focused mentorship nurse consultants will need to find other ways to acquire both the skills and the support to fully engage with the research process in nursing, from defining the research problem to designing and carrying out the project, disseminating and publishing the findings. As an alternative to formal mentorship nurse consultants identified networks as potentially helpful. However, the diversity of roles and specialities within nurse consultants working across the North Central and East London coupled with a lack of clarity around the role of the nurse consultant poses a challenge to the formation of meaningful networks.

In summary, all nurse consultants reported significant clinical workloads. While nurse consultants unequivocally believed their *raison d’être* to be clinical practice, nevertheless a degree of dissatisfaction was expressed at the lack of time dedicated to nursing research. Nurse consultants generally perceived this to be a lost opportunity for nursing research to impact on patient care. If nurse consultants are to undertake research a high degree of self-motivation and the ability to identify sources of and to self-fund research training is required. In the absence of these prerequisites it is difficult to envisage any improvement in the current situation. The majority of research occurring in clinical practice was reported by nurse consultants

as being medically orientated, as opposed to nursing focused. Reasons for nurse consultants' lack of engagement with research are summarised as due to: lack of protected time, lack of human and financial resources, and lack of support and mentorship, compounded by a lack of organisational will for nurse consultants to engage in research, in favour of an emphasis on clinical work, service development and evaluation and audit.

Discussion

The nurse consultants regarded different work activities as carrying different qualities in terms of importance to their professional identity, or as sacrificeable because they were activities viewed as peripheral to their nurse consultant identity. However, in determining what was regarded as central to their worldview, nurse consultants were faced with a dilemma. On the one hand their promotion to a consultant post had inevitably taken them away from day-to-day clinical nursing work, yet on the other hand this clinical nursing work, and their expertise in it, was the very basis of their professional identity. This is why we feel that in their interviews so many of the nurse consultants kept returning to the theme of how important clinical work remained in their working lives, particularly when pressures or staff shortages meant that they were required to step in to ensure continuity of good clinical care.

The other dimension in shaping their identities concerned their relationship to the Trust and the Trust's overall operational priorities. Thus when faced with a certain operational challenges, nurse consultants reported that Trusts looked to them to lead a particular short-term project. The one activity beyond clinical care and project management that they reported they were able to undertake was some clinical teaching, but this was regarded as having greater legitimacy than undertaking research. For all the above reasons research was constructed as peripheral in the work of the consultant nurse. We surmise that the orientation of the Trusts further strengthened this attitude, because service pressures are key factors in how Trusts perceive they are scrutinized: a failure of "care and compassion" is a critical incident that exposes the Trust to immediate scrutiny and carries negative consequences (increased client complaints, failure to meet set targets, adverse media publicity, or ultimately legal action). A failure to undertake research, even research that might improve practice, is not an institutional risk compared to other managerial risks.

Moreover, were research to expose systemic poor practice, this would not be in the interests of a Trust as an organization to publicize, a factor that runs counter to the principles of good research, namely that research access is not compromised by organizational governance, that research processes are auditable, that research findings are shared openly, and that research is subject to open discussion and critical review. Thus it is not in the interests of Trusts as organizations to lay themselves open to research scrutinies. As an employee of the Trust the nurse consultant does not have the research freedom to conduct research that may be critical of practice or organizational context, and which may implicitly undermine a Trust's promotion of itself as an institution. This is why we feel that the managers of the nurse consultants feel that they have to pay lip-service to research as a desirable activity (because in an era of evidence-based practice no-one can be publicly seen to be against research), but at the same time have no incentive to act with any

determination to ensure research activity is undertaken. Whilst one or two of the nurse consultants were making serious attempts to overcome the significant barriers to research (for example, registering for a PhD) the discourses of the majority permitted them to construct research as a peripheral extra, not a priority in the “real world” where nurse consultants prioritized support for clinical care and Trusts prioritized project management of organizational challenges. Both nurse consultants and their Trusts were then able to express sorrow at the lack of research without necessarily then addressing the actual structural challenges to undertaking high quality research. The main challenge in this respect is that Trusts would have to become “open” organizations. Open organizations would permit researchers to define the problems, and access would not be through research sponsorship that influenced definition of the research problem, methods permitted and open scrutiny of findings.

Our participants produced a large number of outputs. Most had produced reports of various kinds while under half had produced peer-reviewed papers. There was a large variety in productivity of these papers that did not appear to be explainable in terms of job role, trust or years in post. This variability, along with a general failure to be involved in research activity that emerged from the telephone interviews clearly points to an aspect of the role that has not met the original expectations.

It seems clear that there is a contradiction at the heart of the role of the nurse consultant that makes it difficult to envisage any situation in which they would be active researchers. There would appear to be two main alternatives: one would be to separate the role of nurse consultant (clinical expert, clinical teacher and project manager) from that of a supernumerary nurse consultant-researcher, perhaps working in partnership with university researchers, whose role would be ring-fenced to undertake research. The other would be to confine research to external university researchers, granted both access and freedom to publish.

Conclusion

Nurse consultants were created as an occupational position without an initial precise definition of their role. Their numbers and their precise remits have therefore developed organically, with no necessary agreed set of activities that define the role. Under pressures of endemic staff shortages, changing political priorities, increased targets, and above all with the development of Trusts as distinct bodies, judged in a competitive hierarchy against other, and therefore with organizational disincentives to scrutinize their own practices, the research element of nurse consultant posts has been in practice constructed as peripheral work, notwithstanding public declarations of support both from the Trust and from nurse consultants themselves. As a consequence, only a nurse consultant willing to work counter to prevailing cultures and to commit considerable personal resources to the endeavour, is likely to engage in any significant amounts of research. If more good quality research is to be undertaken in the NHS, it would require either a ring-fencing of nurse consultant-researcher posts or much more open access to NHS organizations to university researchers.

Recommendations

1. Organisations/Trusts need to consider ways of supporting and facilitating nursing research, in ways similar to medical research. One way might be to provide in house or externally sourced research training programmes specifically for nurse consultants as a means of up skilling senior nurses to fully engage and become confident in identifying and solving nursing problems.
2. Organisations/Trusts need to prioritise nursing research alongside medical research through a clear commitment to protected time and available resources for nurse consultants to engage with nursing research. This might involve the allocation of monies for research training and doctoral level study.
3. Organisations/Trusts should consider formal and informal mentorship schemes specifically focused on nursing research mentorship. This might involve a `buddy system` whereby a nurse consultant is paired with or becomes part of an existing nursing research project within a HEI, or another research driven organisation.
4. Organisations/Trusts need to clarify the role of the nurse consultant, thereby making clear to nurses considering these positions to what extent they are expected to engage in research. This clarity of role will ensure that nurse consultants are able to articulate when the research element of the role is being compromised by competing priorities. If research is not considered an important aspect of the nurse consultant role then this needs to be clear to all stakeholders.
5. Organisations/Trusts should consider separating the role of the nurse consultant as clinical expert, teacher, manger, and project leader, from nurse consultant researcher, perhaps making the latter a super-numerary and thus protected function.
6. Organisations/Trusts might need to consider removing research from the remit of the nurse consultant. This would require nursing research to become the remit of university researchers who would need to be granted access and freedom to publish. University researchers would then need to work in partnership with nurse consultants to identify nursing problems, to design appropriate research methods and tools, and to ensure research findings have application to nursing practice.

Appendices

Appendix 1: Survey questions

Dear Nurse Consultant,

We have been funded by Health Education North Central and East London (HENCEL) to scope the role of Nurse Consultants across the area. The aims of the project are to understand:

- numbers and distribution of Nurse and Midwife Consultants
- post-holders' status regarding research degree qualifications (e.g. MS/MSc, MRes, PhD/Doctorate)
- the proportion of time typically being spent in Research & Development (R&D) work
- R&D outputs (e.g. papers and publications)
- workforce challenges associated with these roles regarding R&D work

We would be grateful if you could help by completing this brief questionnaire.

The questionnaire is in two parts. Part one is about you. Part two focuses on your role as a Nurse Consultant. The questionnaire should take approximately 10-15 minutes to complete. Please answer as many questions as you can.

Results will only be reported as aggregated data, so your individual response remains anonymous.

We would also like to invite you to participate in a short telephone interview on this topic. If this is something you would be prepared to do, please tick the box at the end of the questionnaire and provide us with your contact details.

On behalf of HENCEL and the research team at Middlesex University, thank you for your interest in this study and for taking the time to complete this questionnaire.

NOCLOR have designated this project as a service evaluation. Any queries please contact Prof Sue Dyson at s.dyson@mdx.ac.uk or +44 (0) 208 411 2887 or Prof Michael Traynor at m.traynor@mdx.ac.uk or +44 (0) 208 411 2536

Part one: about you. Please tell us:

Q1. Your job title:

Q2. How long have you been in this post?

Q3. What is the name of your employing organisation/trust?

Q4. What qualifications do you have?

Q5. Which of the above qualifications were requirements for your post?

Q6. Any qualifications you are currently studying for:

Part Two: What you do

Q6. Typically nurse consultants' work takes place across the four domains of clinical, research, leadership and education. Please can you estimate the proportion of your time over the last 6 months you have spent on each of these:

	Percentage of time
Clinical work	
Research activities	
Delivering education/training/advice	
Management/coordination	
Other	

Q7. Please describe briefly any research outputs you have produced over the last year. Outputs include but are not limited to: guidelines for practice, internal and external reports, peer-reviewed articles.

e.g. 2 peer reviewed articles, 4 internal reports.

Q8. Finally, would you agree to participate in a short (15-25 minute) telephone interview to further discuss the research aspects of your role? If so, please provide a contact number and give an indication of the best time to speak with you.

Thank you for your help with this survey for HENCEL.

Appendix 2: Letter from NOCLOR



Research Support Service

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21 January 2014

Professor Sue Dyson
School of Health and Education
Middlesex University
Room WG63, Williams Building
The Burroughs
Hendon
London
NW4 4BT

Dear Professor Sue Dyson

Study Title: Scoping the Role of the Nurse Consultant

Thank you for submitting and registering the above project. Projects are registered with noclor if they utilise patients, staff, records, facilities or other resources of **Barnet, Enfield and Haringey Mental Health Trust**.

As we deem your study as a service evaluation, you will not need to register with us, nor gain a favourable opinion from the National Research Ethics Service, nor seek our permission for commencement of this project. Only the approval of the service in which the study will be conducted is required prior to the study commencing.

I wish you every success with your research

Yours sincerely,

A handwritten signature in black ink, appearing to read 'M. Saili'.

Mabel Saili
Research Management & Governance Manager

Cc: Dr Gordon Weller (Sponsor Contact)

Appendix 3: Topic guide for telephone interviews

Introduce self,

- **Remind interviewee about project,**
 - **thank for completing survey and for agreeing to be interviewed**
 - **Explain purpose of interview i.e. explore in more detail issues around research activity and research time within the role of the NC, and explore facilitators/barriers to undertaking research including organisation issues.**
 - **Ensure participant confidentiality (not a research project i.e. audit but same ethical principles respected)**
 - **Check participant agreement to record interview**
-

Background: what they currently do and barriers

1. How long have you been in the Role of NC?
2. Can you tell me about your role as a nurse consultant, perhaps describe one day in your working week including the range of activities you might be engaged in?
3. Focusing on research activities and outputs now: how much are you able to get involved in research as part of your role as NC?
 - I. explore what these research activities are/have been esp. outputs*
 - II. explore the barriers e.g. does the organisation value research as part of your role*
 - III. Explore re: a mismatch between your expectation of the NC role and your organisation's expectation of the NC role, in relation to research activities*

Career aspirations

1. How important is it to you personally and professionally to engage with research and to develop your research profile – for example do you hope to have a clinical research career?

Ideas about helpful initiatives

1. **Is there anything that either you have done or your organisation has done that has helped you develop your involvement in research and your research career?**
4. **What would need to happen to enable you to engage with research activities, either from an organisational point of view or from a personal perspective?**

5. Is there anything that Health Education North Central and East London could do to support the development of nurses and midwives in these roles and their academic development once in post?

Many thanks for taking the time to participate in this interview

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