New nursing roles: the experience of Scotland's consultant nurse/midwives

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Introduction

Consultant nurse/midwife (CN/M) posts were introduced to the National Health Service in Scotland (NHS Scotland) in Spring 2000 and are the most senior clinical roles within the nursing and midwifery professional career structure. The aim of the posts is to achieve improved outcomes for patients and strengthen leadership within the professions. The Strategy for Nursing and Midwifery in Scotland – Caring for Scotland (Scottish Executive Health Department (SEHD) 2001a) recognized the roles as providing an important opportunity for nurses and midwives to retain and develop clinical expertise whilst establishing professional leadership and consultancy, practice and service development, education and research within a specific area of practice. A small study exploring the experiences and initial impact of the first three consultant level posts in Scotland has recently been published (McIntosh et al., 2002). While identifying with the findings of this study,
the wider CN/Ms group felt there was a need for formal evaluation of the collective experiences of the larger group, with the purpose of capturing further aspects of the role and its implementation during the initial stages, to inform future role developments and workforce planning initiatives in Scotland such as ‘Facing the Future’ (SEHD 2001b).

### Background

Health care policy is driving the development of advanced practice roles in nursing (Williams et al. 2001, Bryant-Lukosius et al. 2004). The demand for improved models of health care delivery and service developments, in response to drivers such as the EC Working Time Directive, new GP and Medical Consultant contracts and nurse/midwife recruitment and retention issues, is leading to a proliferation of new roles. The health care modernization agenda recognizes the increasing expectations of service users and aims to put patients firmly at the centre of health services (Swinkels et al. 2002). This has encouraged the review of many traditional roles across all health care professions and the development of increasingly innovative approaches to ensuring the provision of health care that is patient-focused and demonstrably ‘best practice’. Within nursing and midwifery, this ongoing transformation has resulted in the introduction of a senior level clinical role, in the form of the CN/M, announced by the Prime Minister in 1998 and first introduced to Scotland in June 2000. Yet there is little to guide nurses, patients, other health care professionals and policy makers to understand the concept of the consultant role, the contribution and likely impact, and the mechanisms and pathways that enable nurses and midwives to achieve such a role. In addition, the evidence reported to date is largely anecdotal and opinion-based and consequently the role has generated substantial debate. This debate is fuelled by the lack of consensus on the distinctions between the various different advanced nursing roles including clinical nurse specialist, nurse practitioner, specialist nurse practitioner, advanced nurse practitioner (Williams et al. 2001), leading to a general confusion among health care professionals, patients and carers alike about the nature of these roles and what can be expected of the postholders. The small, but developing, evidence base to date shows clear differences between the CN/M and other ‘advanced’ roles, particularly with regard to the breadth of remit and the strategic nature of role activity (Da Costa 2002, McIntosh et al. 2002).

Whilst a number of methods and varied sources of evidence may contribute to the development of greater clarity in the overall picture, an important component is the perspective and experiences of those who fulfil such roles. With respect to the consultant role, externally led evaluation is essential to the development of an objective bedrock of knowledge however, of equal value to the extent and nature of understanding must be the internally generated experiences of those in post.

### Consultant nurses/midwives

The original concept of the CN/M was proposed as a means of enabling expert nurses and midwives to continue to practise, delivering direct patient care to the highest level, concurrent with a direct input to strategy and the shaping of services and service delivery models. Within Scotland, a framework for consultant level roles was developed (SEHD 2001c) which was based on four core functions of:

- expert practice,
- professional leadership and consultancy,
- education and research and
- service development.

It is of note that the introduction of these roles was a government decision, not a professional imperative and, like the role of the modern matron that closely followed, these roles have political as well as clinical credence being directly associated with the NHS modernization programme. The implication in the title is that these roles mirror medical consultant roles (Sturdy 2004) in terms of clinical influence, practice and service strategy, and status and there is less controversy over the role title than for other advanced roles (Carlisle 2003). There are currently 27 CN/M in post throughout NHS Scotland with a further six posts approved. However, at the time this survey was undertaken there were 16 established CN/M and nine new posts approved but not yet filled. The ministerial target for NHS Scotland, announced in ‘A partnership for a better Scotland: partnership agreement’ (2003) is 54 posts by 2007, a figure which was recently confirmed by the new Chief Nursing Officer (O’Dowd 2004). Because these are new professional roles and the aim is to increase the numbers of posts throughout NHS Scotland, it is important to gain insight into the background, experiences and views of existing CN/Ms in order to help inform future role developments and recruitment. The impetus for this study occurred during a peer support meeting where it emerged that each of the four core functions in the role appears to be interpreted locally;
consequently the scope of individual posts is varied and wide-ranging. In contrast to our medical consultant colleagues, no formal career pathway has, as yet, been identified for the CN/Ms. We therefore sought to identify the career pathways of those people currently in post, their background characteristics and experiences. In addition, clarification of their views on factors relevant to the initiation, ongoing development and progression of these roles was sought. This type of understanding will facilitate the establishment of consultant roles within the mainstream of nursing and midwifery structures, ensuring they are central to the leadership and development of the professions.

Aim of study

To describe the background characteristics and career pathways of CN/Ms in Scotland and identify the postholders views on key factors in role initiation, development and progression to inform future development and appointment of nurse/midwife consultants in NHS Scotland.

Methodology

A 26-item questionnaire was designed by four consultant nurses drawing from personal experiences and from the literature on the consultant nurse and other advanced practice roles. The questionnaire was circulated to three additional members of the Consultant Nurse Network for comments and amendments prior to surveying the whole group. The questionnaire consisted of a mix of open and closed questions in order to capture the depth of information required to meet the study aims. It was designed to elicit three forms of information about the individual posts and postholders. First, factual information was sought on individual background and current role structures including clinical experience; previous roles; career pathway; educational preparation and training; terms and conditions of service and formal support for the consultant post. Secondly, information on the individual’s interpretation of their role was described including the breakdown of priority given to each of the four core functions. Thirdly, the CN/Ms views on facilitatory factors and barriers encountered since commencing the role, in addition to the identification of any perceived gaps in support mechanisms and their views on the future development of such posts, were sought. The questionnaire was mailed to all the CN/M in post throughout NHS Scotland at the time of the survey. Non-respondents were sent a repeat questionnaire once and an e-mail reminder, with the option to complete and return the survey on-line.

Sample

At the time the survey was carried out there were 16 CN/Ms in post throughout NHS Scotland. All 16 were included in the cohort and were individually mailed the questionnaire. A total of 13 questionnaires were returned (81%).

Analysis

In view of the small population, descriptive statistics only were used for the quantitative elements of the analysis. The answers given to the open-ended questions were subject to content analysis using the approach of Miles and Huberman (1994). This was undertaken by a consultant nurse and an academic researcher (formerly a consultant nurse), who independently organized the data and identified themes, before coming together to agree the thematic framework and assign findings accordingly. In this process there was broad agreement on the themes and only minor amendments were required to reach consensus.

Findings

Background characteristics and career pathway

Table 1 demonstrates the cohort of CN/Ms to be experienced clinicians. The mean time since qualification, prior to being appointed as a consultant nurse or midwife, was 19.6 years, with significant experience in their specialist field (mean: 13 years). A mean of 13.7 years (range: 2–18) was spent at senior levels of F-grade, or equivalent, and above. Within the medical professions the period of training to reach consultant level is 10–11 years, with specified educational attainments at predetermined milestones in the process. The findings for the CN/Ms indicate a greater level of experience than is required of a medical consultant.

<table>
<thead>
<tr>
<th>Table 1: Previous clinical experience</th>
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</thead>
<tbody>
<tr>
<td><strong>Mean</strong> (years)</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Length of time qualified</td>
</tr>
<tr>
<td>Length of time in specialty</td>
</tr>
<tr>
<td>Length of time at F-grade (or equivalent) or above</td>
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</tbody>
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however as yet, there is no formally identified educational route to prepare for the role. There were a variety of academic qualifications held by the cohort as illustrated in Figure 1. This indicates the qualifications held at the time of the survey but did not include further study, which was known to be in progress for a number of the group. All CN/Ms were prepared at a minimum of Bachelors degree and the majority had at least one higher level academic qualification.

Terms and conditions of service

Consultants were asked for information about their employment situation, which included terms and conditions of employment, lines of communication, reporting responsibility and accountability. The findings are shown in Table 2. The majority of posts \((n = 8)\) were the responsibility of single employers, either Trust, Health Board or special Health Board. Five of the posts were joint clinical/academic posts where the consultants were responsible to a Trust and a University.

Table 2
Current terms of employment

<table>
<thead>
<tr>
<th>Employer</th>
<th>Number of posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single division</td>
<td>4</td>
</tr>
<tr>
<td>Division and University</td>
<td>4</td>
</tr>
<tr>
<td>Division, NHS Board and University</td>
<td>1</td>
</tr>
<tr>
<td>National Body</td>
<td>2</td>
</tr>
<tr>
<td>Single NHS Board</td>
<td>2</td>
</tr>
<tr>
<td>Line management</td>
<td></td>
</tr>
<tr>
<td>General Manager</td>
<td>2</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>6</td>
</tr>
<tr>
<td>Deputy Director of Nursing</td>
<td>1</td>
</tr>
<tr>
<td>Director of specialty</td>
<td>1</td>
</tr>
<tr>
<td>Unclear</td>
<td>3</td>
</tr>
</tbody>
</table>

| Annual leave                                   |                 |
| 25 A/L + 10 PH                                 | 8               |
| 30 A/L + 10 PH                                 | 5               |

| Annual salary (2003/04)                        |                 |
| Mean                                          | 40 000          |
| Range                                         | 35–48 000       |
| Median                                        | 38 000          |

With regard to conditions of service, variability was again noted. Seven posts had an annual leave entitlement of 25 days, whereas for six postholders this was 30 days. In addition, there was wide divergence in salary with a range of £35–48 000 per annum across the group. This discrepancy appeared to be unrelated to individual experience, qualifications or role.

Functions of consultant nurse/midwife role

Respondents were asked to estimate the percentage of time spent in each of the four core functions of the CN/M role. As in Williams et al. (2001) study of senior nursing roles, all stated that it was difficult to specifically separate individual elements of the role and function overlap was the norm, however for the purposes of the study estimates were given in overall percentages of time, as shown in Table 3. At the time of the survey there were no requirements for specific proportions of time to be devoted to any of the functions however, within this cohort, the highest proportion of time was attributed to the expert practice domain (mean 32.5%). While this was the most prevalent function, on average very similar amounts of time were devoted to the other three functions (20–26%). There was, however, substantial variation in the range of occurrence across all four functions (10/20–40/55%), again indicating the individual interpretation and the absence of a standardized model of role enactment.

The ‘expert practice’ role domain had been the stimulus for debate among CN/Ms from the outset. Questions centred on understanding what is meant by ‘practice’, and whether it was necessary for this to include direct care delivery. In addition, the meaning of ‘expert’ in the context of these posts was a source of

Table 3
Percentage time devoted to consultant nurse role functions

<table>
<thead>
<tr>
<th>Function</th>
<th>Mean (%)</th>
<th>Median (%)</th>
<th>Range (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert practice</td>
<td>32.5</td>
<td>30</td>
<td>20–55</td>
</tr>
<tr>
<td>Education/research</td>
<td>20</td>
<td>17.5</td>
<td>10–40</td>
</tr>
<tr>
<td>Service development</td>
<td>22</td>
<td>20</td>
<td>10–40</td>
</tr>
<tr>
<td>Leadership and consultancy</td>
<td>26</td>
<td>25</td>
<td>10–50</td>
</tr>
</tbody>
</table>
discussion. The question was posed that given the wide remit of these roles, can the postholder reasonably be expected to have ‘expertise’ across all areas? The questionnaire was not designed to provide the answers to these ongoing debates however it was able to illuminate the interpretation of the function by the current role incumbents.

Direct patient care

Respondents were asked about the provision of specific ‘hands on’ care to patient groups. As with the other functions variability within this domain was commonly found. Two-thirds of respondents continued to deliver direct patient care whilst one-third did not. A breakdown of where this direct and indirect care was provided in relation to outpatient/clinic environment, inpatient setting or patients’ home, is outlined in Figure 2. Respondents reported the delivery of direct care in both primary and secondary care settings, most identifying practice within both as routine.

Formal support for the role

The group were asked to indicate arrangements for formal support within their role. Eight CN/Ms indicated they had an identified mentor and six were in receipt of clinical supervision. Eleven received regular performance appraisal however, two of the cohort had not received any appraisal or formal feedback on performance since commencing their post.

Postholders views on the consultant nurse/midwife role

Participants were asked to comment on four main areas – what they had found helpful in developing their role since taking up post; what barriers they had experienced; if there had been gaps in support and if so what they were; and what they thought would be useful for the future to enable consultant posts to develop and flourish.

Key themes were identified in each of the four areas.

What was helpful

Three clear facilitatory factors emerged from the survey. Formal support for the postholders in the form of mentorship, clinical supervision and appraisal was cited as important, despite it not being universally available. In addition, respondents stated that clarity of role was essential and this necessitated a clear job description and identified objectives. A further positive influence was the perceived autonomy associated with the role, which enabled alternative and often innovative approaches to service improvements to be pursued. The relative freedom to develop the role was also seen to facilitate cross-boundary working.

Barriers

A greater number of themes emerged that were considered by CN/Ms to represent barriers to their role fulfilment than were facilitative. Many perceived barriers related to the CN/M role within the wider organization. Specific themes were suggestive of role confusion, manifesting as a lack of clarity and understanding of the role among colleagues within the organization and the CN/Ms themselves. The lack of preparation within the organization for the introduction of the CN/M role was also cited, as were the negative perceptions of the posts by nursing management colleagues and clinical colleagues who felt that they themselves were working in similar roles. A further barrier described by the CN/Ms was the scope of the role. Role overload was commonly highlighted in relation to wide role remits, large geographical areas to cover, the general size of the workload/caseload and professional isolation.

Gaps in support

These were concentrated around two areas: first, the lack of formal mechanisms for support provision such as mentorship, supervision and performance appraisal, and the need for an active support network. Secondly, deficiencies in infrastructure were highlighted by the CN/M including suitable office accommodation, administrative support, IT equipment, resources for continuous professional development and the lack of appropriate reporting structures.

What would be useful in the future?

With regard to what the respondents considered to be useful in the future the themes reflected two perspectives: a reflection of personal experiences and a wider strategic consideration of roles. In relation to personal experiences the need to improve the preparation of the organization at all levels for the introduction of the post
and organizational support such as adequate infrastructure and remuneration reflecting the scope of the role emerged as issues. Additionally all respondents felt that having clarity in their role on purpose, function and both others and one’s own expectations at an early stage would have been of great benefit.

On a wider scale the need to develop a recognized career pathway for aspiring CN/Ms was highlighted. In recognition of the strategic nature of these roles and national role in professional leadership and consultancy, respondents felt that it would be very useful if their posts were directly linked into SEHD in a formal manner.

**Discussion**

In light of the political and media attention paid to the introduction of the CN/M role to the NHS and the commitment to increasing the numbers further, it is perhaps surprising that little formal role evaluation has been published. Currently, preliminary work has been completed in England (Guest et al. 2001) and in Scotland (McIntosh et al. 2002). This study contributes to the emergent body of knowledge. It is relatively early days in the establishment of consultant posts within the nursing and midwifery profession in NHS Scotland but it is clear from this study that the experiences of those already in post can inform the development of further posts. The study is small, but comprehensive, reflecting the perspectives of the CN/M group within Scotland at the time of the survey. At this time (October 2003) many of the posts were new, with the maximum length of time in post being 3 years. Thus, the experiences described were a reflection of the incumbents’ views during the early stages of developing these pioneering roles. The methodology was simple but effective, combining self-report of objective role features and subjective views on aspects of role performance that CN/Ms were comfortable sharing.

The main finding to emerge, which had resonance and impact across the posts, was the variability. Like other studies (Bryant-Lukosius et al. 2004) this work demonstrated that despite the framework in the form of the SEHD HDL (2001) outlining the core functions, there is great variability in the enactment of these complex roles. For instance with regard to employment terms and conditions the variations within such a small group had the potential to cause great dissatisfaction. This related not only to salary and annual leave entitlement but also to the post’s line management where factors such as access to the predominant leadership within the organization was greatly valued. Where line management was the responsibility of a person with perceived lesser status, whether this was in terms of professional position or because the person was in a ‘management’ rather than a ‘clinical’ post, dissatisfaction was evident.

The SEHD (2001b) released guidance for NHS organizations to follow when submitting proposals for CN/M posts following consensus that guidance and standards should be agreed (SEHD 2001a). Pay arrangements have been negotiated on a UK basis but it is at the discretion of individual NHS organizations as to how they apply the guidance regarding pay and conditions for individual posts. As results show there is a £13 000 difference in salary between the posts in Scotland and there are also discrepancies in leave entitlement. There was no correlation between those consultants on higher salaries receiving less annual leave entitlement. The implementation of agenda for change may resolve some of the issues.

Akin to this variation was the variability in infrastructure found across the posts where some consultants had administrative support, IT and communications equipment, ready access to funds for Continuing Professional Development and an equipment budget. These were not universally available and this ongoing lack of infrastructure was a source of dissatisfaction and increased stress (McIntosh et al. 2002).

Autonomy in the roles was described as a benefit in this study. McGee and Castledine (1999) found that a differentiating factor between advanced and specialist nurses was the greater autonomy associated with advanced roles, coupled with higher levels of education and a broader focus. They also found that advanced roles tended to be based on medical/technical rather than ‘nursing’ activities. In contrast, this study concurred with McIntosh et al. (2002) findings that the focus of the CN/M roles was very clearly nursing or midwifery and there was no evidence of medical role substitution from any of the respondents.

An important factor in CN/M posts is the opportunity to remain in clinical practice whilst developing a wide range of skills and expertise in other associated areas. Traditionally nurses and midwives have either had to follow a management or a teaching/academic career pathway and generally could not progress to senior posts whilst retaining clinical case work. Consultant posts now add a third pathway – the clinical career pathway, however the nature of the clinical role is interpreted widely. This study indicates that consultants nurses/midwives are innovative in the ways in which they practice clinically, perhaps through clinical supervision of others or working in collaboration with...
colleagues in their work with wider communities. Nevertheless, the clinical component of the role is what makes these posts different from managerial or academic posts. It is suggested that the expert practice function should, where appropriate, be in the form of direct patient care to maintain the clinical credibility of the posts.

An important point to emerge from the study is the professional isolation, described by many of the cohort yet not highlighted in other studies. It was clearly identified as an issue in this study, as it was in the preliminary report to the Department of Health (DOH) (Guest et al. 2001). It may be an artefact of the Scottish situation where geographical isolation and relatively small numbers of CN/M in post may contribute.

**Conclusion**

The findings from the present study concur with the findings of the smaller, but more in-depth study of the first three CN/M posts in Scotland. Further insight has been gained into issues such as professional isolation and the importance of autonomy within a supportive professional and organizational structure. There seems to be a preference for a 'professionally-led' management model, which may reflect tensions around the status and position of CN/M in relation to traditional nursing and organizational hierarchies.

This study adds to the body of knowledge around new role development and is timely, given the recently reiterated commitment to an expansion in the number of consultant level posts in Scotland (O'Dowd 2004). CN/M posts are important for the profession within NHS Scotland and provide individuals with many opportunities and challenges to develop both professionally and personally. As such, they should be further developed and enabled to flourish.

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**References**


