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An Evaluation of the Impact of Nurse, Midwife and Health Visitor Consultants

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Table of contents

List of tables and figures

List of appendices

Appendix 1: The Nurse, Midwife, Health Visitor Survey 2003
Chapter 1: Who are the consultants?
Chapter 2: What do the consultants do?
Chapter 3: The experience of the role
Chapter 4: Consultants' work attitudes

Appendix 7: Telephone interview case studies
Chapter 1: Consultant nurse in care of older people
Chapter 2: Disease specialist consultant nurse
Chapter 3: Consultant nurse in learning disabilities
Chapter 4: Consultant nurse in mental health
Chapter 5: Consultant nurse in child health
Chapter 6: Consultant midwife

Appendix 8: Report on the 2002 Survey
1: Methods
2: Sample
3: Demographic information
4: About the consultants and their jobs
5: Consultants' work experiences and attitudes
6: General evaluation of the consultant initiative
7: Conclusions

Appendix 9: Consultants' comments from the questionnaire surveys
Chapter 1: Summary of qualitative comments from Survey November 2002
Chapter 2: Summary of qualitative comments from Survey November 2003

Appendix 10: Methodological tools
1: Questionnaire survey 2003
2: Focus groups
3: Sponsor interviews
4: Leadership interviews
5: Telephone interviews

An Evaluation of the Impact of
Nurse, Midwife and Health Visitor Consultants

Executive Summary

1. The main aim of the study was to evaluate the impact of nurse, midwife and health visitor consultants on service delivery and patient care. Additional aims were to explore their role as leaders, to analyse how consultants craft their role and to determine factors associated with greater effectiveness.

2. A conceptual framework for the analysis of consultant impact was developed which emphasised their predominantly indirect impact on patient care through the development of systems and protocols and through the way they influence the behaviour of other staff.

3. A range of research methods were used including in-depth interviews and questionnaire surveys. Both cross-sectional and longitudinal approaches were adopted. The main source of information was the consultants themselves. Data were also collected from a small number of their sponsors. We would like to have involved a wider range of stakeholders but this did not prove feasible due to time and ethical/governance constraints.

4. The questionnaire survey covered all consultants in post in mid-2003. 528 were identified and 419 responded, a response rate of 79 per cent. Despite difficulties reported by the sponsors in finding suitable qualified candidates, educational standards have been maintained over time among those appointed. Only 3 per cent of consultants come from ethnic minorities.

5. Nearly 100 different job titles were identified and we were forced to impose our own broad classification. On the basis of this, 53 per cent of consultants work in a clinical-based specialty area such as A&E or care of older people; 23 per cent in mental health; 11 per cent in a condition-based specialty such as cancer care or diabetes; 8 per cent in midwifery and 5 per cent in community/ primary care. Only one person described herself as a health visitor.

6. The Department of Health identified four main functions for the consultants. 86 per cent were heavily engaged in leadership activities, 48 per cent in practice and service development, research and evaluation, 43 per cent in education, training and staff development and 33 per cent in expert practice. 15 per cent reported that they were heavily engaged in all four functions while 11 per cent said they were heavily engaged in none of them.

7. Consultants were set a broad target of spending 50 per cent of their time working directly with patients, clients and the community. In practice, the average was 43 per cent, which hides wide variations. The target appears to be less appropriate for certain types of consultant.

8. Although consultants reported being heavily engaged in leadership, they had difficulty defining it clearly. They generally supported the idea of leadership

without management authority. Despite an expectation that consultants would act as leaders but not managers, 11 per cent of consultants are heavily engaged in management activities. This varies widely from 32 per cent of those in community/ primary care roles to none in midwifery.

9. Consultants appeared to lead through a combination of impressive personal qualities and credibility and by adopting a facilitative, empowering style with staff and colleagues. There were also many instances of leadership by example. Both the consultants and more particularly their sponsors could identify cases where leadership had lead to improvements in treatment processes and in patient care.

10. Focus groups and interviews led to the identification of 17 areas in which consultants had an impact which could be divided into two groups reflecting improvements in processes (13) and more direct improvements in patient care (4). Areas of greatest process impact include "staff can more readily access support" (71% definite impact), "audit has identified areas needing improvement" (61%) and "services better meet patient needs" (59%). In terms of direct impact, 48 per cent claimed a high impact on "the standard of care received by patients" and 40 per cent on "improved follow-up care".

11. Overall, 44 per cent rated their impact as highly positive and most of the rest rated it as positive. Ratings of impact were most positive among those more fully engaged across the four functional areas, those with higher confidence in their ability to do the job and those with longer service. Those with higher educational qualifications reported a lower impact.

12. Asked about their most significant impact to date, 450 examples were provided. 72 consultants referred to making patient care more patient focused, 71 mentioned the development of new services and 52 mentioned improvements to current services. In the longitudinal panel interviews with 32 consultants, 271 references to impact were identified. Nearly a quarter referred to the development of procedures, processes and protocols to improve patient care. 18 per cent referred to leadership activities leading to improvement in efficiency, quality and practice improvements. Some referred to the problems of having an impact.

13. The key problems associated with the consultant role and with having an impact were lack of support, lack of resources and lack of authority. 30 per cent of consultants reported high support from senior management and 30 per cent from colleagues while 49 per cent reported low support from senior medical staff, 44 per cent from their professional manager and 41 per cent from their line manager. 19 per cent reported positive resource provision and 52 per cent low provision. Many said that their impact would be much greater if provided with adequate resources and support.

14. 86 per cent reported high control in their job, 60 per cent high clarity of role, 44 per cent high demands and 56 per cent high role overload. Those who undertook a wider range of activities reported higher work overload but they also reported being more effective. There was evidence of job crafting among those who had

been in the job for a while to establish priorities and make the role more manageable.

15. 73 per cent reported a high level of satisfaction with the role and 54 per cent agreed that it had met their expectations. 82 per cent reported a high level of professional commitment although only 57 per cent reported a high level of commitment to the NHS. Job satisfaction and commitment, as well as perceptions of growth and career opportunities in the job tended to decline among those who had been consultants for longer.

16. 40 per cent were satisfied and 37 per cent dissatisfied with the fairness of rewards. The issue appears to be less the level of pay than the absence of consistent processes for determining salary reviews and increases in pay. However those on higher pay reported higher satisfaction with reward fairness.

17. 28 per cent reported high levels of stress and 36 per cent low levels. Stress was higher among those working in community/primary care roles and more generally among those with a higher workload. It was lower among those who said the job had met their expectations and who had more professional qualifications.

18. 60 per cent of consultants intend to stay in the role while 18 per cent are fairly sure that they will not. Looking further ahead, in five years time, 48 per cent expect to be either in their current or in another consultant post. Most of those who have already left have either moved to more senior positions or into roles with managerial authority. It appears that most of those in these consultant posts do not regard them as the pinnacle of their career.

19. There is overwhelming support for the initiative to introduce nurse midwife and health visitor consultants. Well over 90 per cent believe the initiative was a good idea, good for the NHS and for improving service and quality and improving patient/client outcomes. However 80 per cent believe it has been poorly handled and implemented.

20. In summary, most consultants believe that they are having a positive impact on service delivery and patient care. They describe their jobs as busy and demanding but also exciting and involving and most feel satisfied and highly committed to their work. Predictably, they are strong supporters of the initiative to set up the nurse, midwife and health visitor consultants and believe it should be continued with stronger local support and resources. The report identifies a range of areas for future research, notably analysis of impact among other stakeholders, and a number of possible messages for policy-makers.

Chapter 1: Introduction

1.1 The background to the research

The new role of nurse, midwife and health visitor consultant was established in 2000. Health Service Circular 1999/217 formally sets out the aims for the posts:

> *help to provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwives and health visitors in practice.*

The same circular stated that each post should have:

> *- an expert practice function*
> *- a professional leadership and consultancy function*
> *- an education, training and development function and*
> *- a practice and service development, research and evaluation function*

The circular specified as a general guidance figure that 50 per cent of the role should be practice-based. In addition, it provided a detailed indication of the components of the role specification and set out criteria for appointment to posts.

In 2000, this research team was awarded a grant to undertake a preliminary evaluation of the establishment of nurse, midwife and health visitor consultants. Reporting in 2001, and based on information collected through telephone interviews, observation and a questionnaire survey which gained a response from 153 consultants (95 per cent of those in post), the study highlighted a range of issues:

- The early group of consultants was exceptionally well qualified. 65 per cent had either a PhD or MSc and 42 per cent had two or more directly relevant qualifications.
- The average length of NHS service was 21 years, the average age was 41 and there were considerable variations in salary, based on experience and regional variations.
- Prior to taking up the post, about two-thirds had a reasonable idea about the content of the job and their lines of authority but nearly a quarter were unclear about how their performance would be assessed, about criteria for success in the job and about the resources they would have.
- The consultants engaged in all four of the main elements of the job but typically gave greater priority to leadership and least to expert practice. 80 per cent reported high levels of autonomy and control and 40 per cent said the job was high in terms of its demands and complexity.
- On average 44 per cent of consultants' time was spent in practice, though this disguises considerable variation.
- Most of those who worked closely with the new consultants supported the idea of the new roles. The main exception was where they replaced an existing role, requiring some redistribution of workload.
- Consultants reported some problems with aspects of the role including ambiguity, overload and boundary management. Role overload, in particular, got worse rather than better with experience.

- Management support ameliorated the role problems. However only about a quarter of consultants reported adequate support and resources.
- Almost all the consultants supported the idea of the role and felt it could achieve the aims set out for it. However those who had been in the role longest were a little less optimistic.

It is against the background of this initial report, as well as the continuing growth in the number of consultants, that a second research project was commissioned. Furthermore, whereas the first report focused on the introduction of the new role and the initial experiences in the role, the broad concern for the second project was to determine whether the role has been successful in achieving its set objectives.

1.2 The aims of the research

Six key aims were identified:

1. To explore the impact of the consultant role on patient care and related outcomes.
2. To assess how far consultants are engaged in leadership; to identify what leadership means in this context; to determine the circumstances under which leadership is more likely to flourish; and to explore its consequences.
3. To conduct a fuller test of the job innovation model with a view to improving understanding of the process, reducing the time to arrive at a full contribution to patient care and providing policy guidelines
4. To examine how consultants are "crafting" the role and what other steps they take to ensure that the role remains manageable; that they remain effective, motivated and committed; and that they can maintain an acceptable work-non-work balance.
5. To determine whether information available at the point of selection of consultants and early role experiences predict the later performance, motivation, commitment and other relevant attitudes and behaviour of consultants.
6. To undertake a preliminary exploration of the "systems" implications of the consultant role in terms of its impact on the supply of high quality nurses, midwives and health visitors and on the careers of consultants and those in more junior grades.

1.3 The conceptual framework for the research

The research aims were informed by a body of theory and empirical literature based on studies conducted both inside and outside the health context. These focus in particular on issues associated with notions of performance and patient care; leadership; role management and role "crafting"; and the process of role innovation. Together with the core aims of the project, they served to guide both the research content and, to some extent, the research methodology.

1.3.1 The impact on patient care

A key aim for the study was to explore the impact of the consultants on performance. This required a complex model recognising that the consultants are part of a system of health care in which it is likely to be hard to detect a direct link between consultant behaviour and patient outcomes. In so far as it was possible to do so, the research therefore needed to trace and model these links so that the consultant contribution could be identified. To achieve this, we built on earlier research by members of the

team, using a collaborative approach to the identification of impact (Redfern and Norman, 1999; Redfern et al, 2000). We also adopted a form of stakeholder evaluation that recognises the range of interests of the different stakeholder and therefore the range of potentially relevant outcomes. In particular, we built on the work of Welbourne, Johnson and Erez (1998) to cover a range of outcomes from process innovations, systems improvements, team building and job performance, to patient-centred and employee-centred outcomes such as job satisfaction, work-life balance and intention to stay in the post and in the NHS.

1.3.2 Consultants as leaders

A key aspect of the consultant role is the exercise of leadership but not management. While there is a widespread literature on informal leadership, particularly at the group level and some research on leadership of professional groups, most analysis of leadership has been directed at those in formal positions in an organisational hierarchy with defined managerial responsibilities. In recent years, there has been the emergence of what is sometimes labelled "the new leadership" (Yukl, 2002). This is an approach that distinguishes between traditional "transactional" management, which is primarily concerned with getting the job done within defined boundaries of managerial roles and authority; and transformational leadership, which is based much more on the role of personal qualities and even charisma to motivate and enthuse staff and, possibly, to redefine processes and goal (Bass 1990; Conger and Kanungo, 1998; Antrobus and Kitson, 1999). This new approach places considerable emphasis on influencing skills and provides a potential framework within which to explore leadership as exercised by the nurse, midwife and health visitor consultants. An additional element in leadership research has been a growing interest in how subordinates view leaders and the way in which leadership qualities are ascribed to people in formal leadership roles (Lord and Maher, 1991). This has sometimes led to what has been termed "the romance of leadership" (Meindl, Ehrlich and Dukerich, 1985) whereby leaders are vested by subordinates with more influence than they really have. In short, "leadership" becomes a convenient basis for attributing outcomes. One core focus of the study is therefore on leadership, including how it is enacted, how it is perceived and, in this context, to what extent leadership is attributed to the consultants.

1.3.3 Role crafting

The first phase of the research highlighted the potential ambiguities and complexities in the role and the consequent high demand and stress experienced by some of the consultants. It also found that these appeared to become more rather than less of a problem as consultants spent more time in the role. Since the implied pressures can only be sustained for a while, some kind of accommodation is required. To explore this, we built in to our conceptual framework concepts from job design (Hackman and Oldham, 1980; Xie and Johns, 1995) to consider the optimal level of responsibility and autonomy; from notions of job crafting (Wrzesniewski and Dutton, 2001) to explore how consultants arrive at a view about what to prioritise and what to give up; and from theories of control and initiative (Frese, Kring, Soose and Zempel, 1996) to explore the processes whereby they use their autonomy to "manage" the role. In this context, a particular interest lay in establishing which components of the role receive a higher or lower priority from consultants and how far a balance across the role elements can be achieved.

1.3.4 Role socialisation and innovation

While there has been extensive research on innovation in roles, or on roles where it is possible to be innovative (Kanter, 1983), and extensive research on effective role socialisation processes (Ashforth and Saks, 1996; Chao et al, 1994), there has been far less research exploring socialisation into a new role. In the first study, evidence emerged of a range of activities associated with selection, induction, socialisation and subsequent support that were likely to facilitate or inhibit the speed with which consultants settled in to their new roles. A model of this process of role innovation was developed based on these findings with three phases labelled preparation, introduction and adjustment/ establishment (Guest et al, 2003). This second research project provided an opportunity to conduct a further exploration of this model. It was hypothesised that the time taken to make an effective contribution is likely to be determined in part by the extent to which these phases are successfully enacted. This study also provided an opportunity to explore any evidence of organisational learning, by examining whether those appointed more recently to consultant posts had different and better experiences of the process of role induction and associated role innovation. More generally, the longitudinal dimension to the study provided an opportunity to explore the way in which role innovation occurs over a period of time.

To explore these issues and address the aims set out above, two broad conceptual frameworks informed the study. These are set out in Figures 1 and 2 below. Figure 1 provides an over-arching framework that guided the overall study. It seeks to link the individual and role context, the support systems and the role content to attitudes, behaviour and impact. The core focus is therefore on influences on the role and on attitudes and behaviour. It is similar to the conceptual model that informed Phase 1 of the study and provides an important element of continuity with that study.

Figure 2 focuses more specifically on the impact of the role. It recognises the different ways in which the consultants might have an impact and seeks to model this process. Essentially, it distinguishes intended and unintended consequences of the role, direct and indirect impacts and the focus of any impact. In part it is intended to highlight the complexities of seeking to identify the consultant impact on patient care, an issue explored more fully in Chapter 3.

Figure 1.1: Extended framework for the analysis of consultant work attitudes and behaviours

Independent variables	Role and work experience variables	Balanced exchange Psychological contract	Attitudinal outcomes	Behavioural outcomes
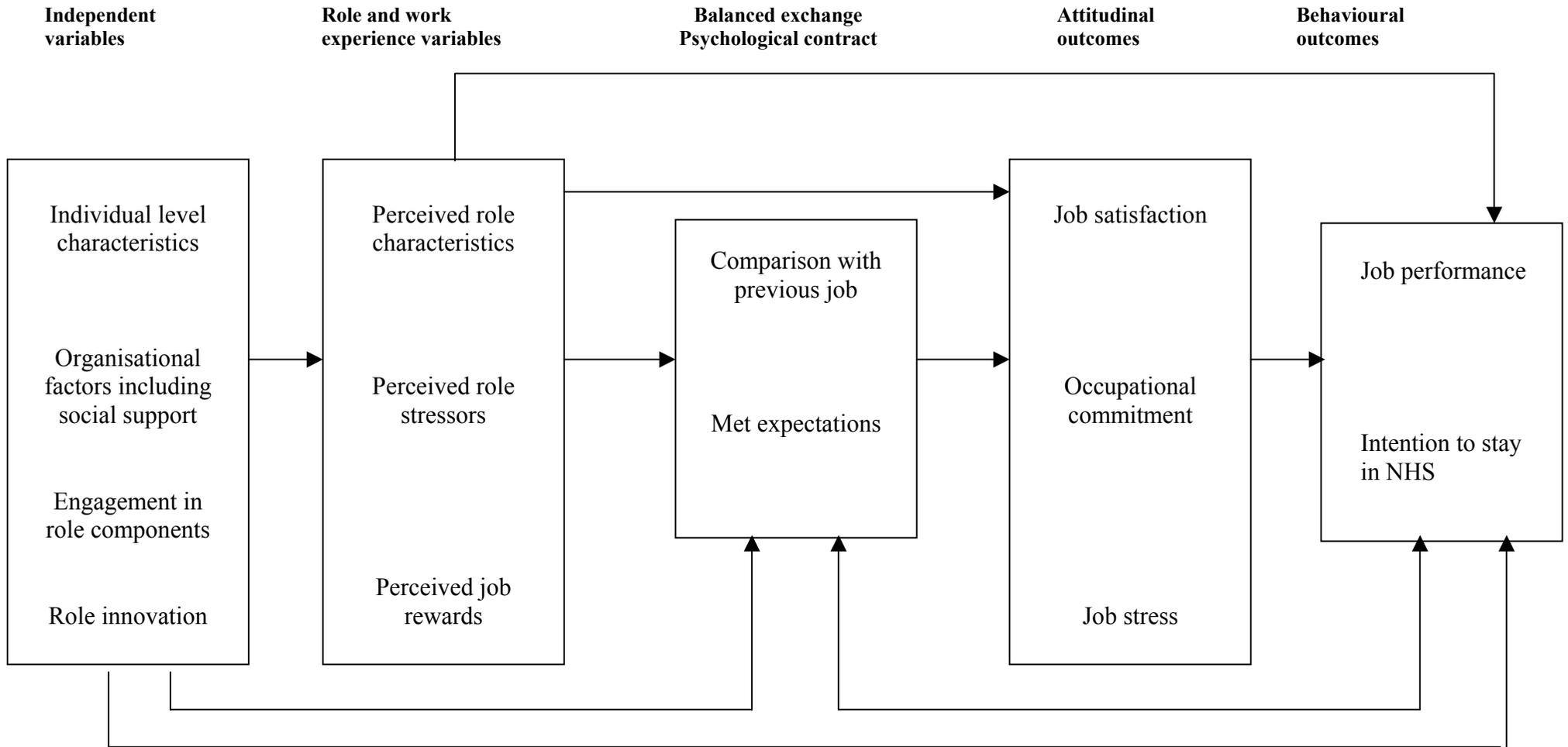
Figure 1.2: A model of the impact of consultants on patient care and other outcomes
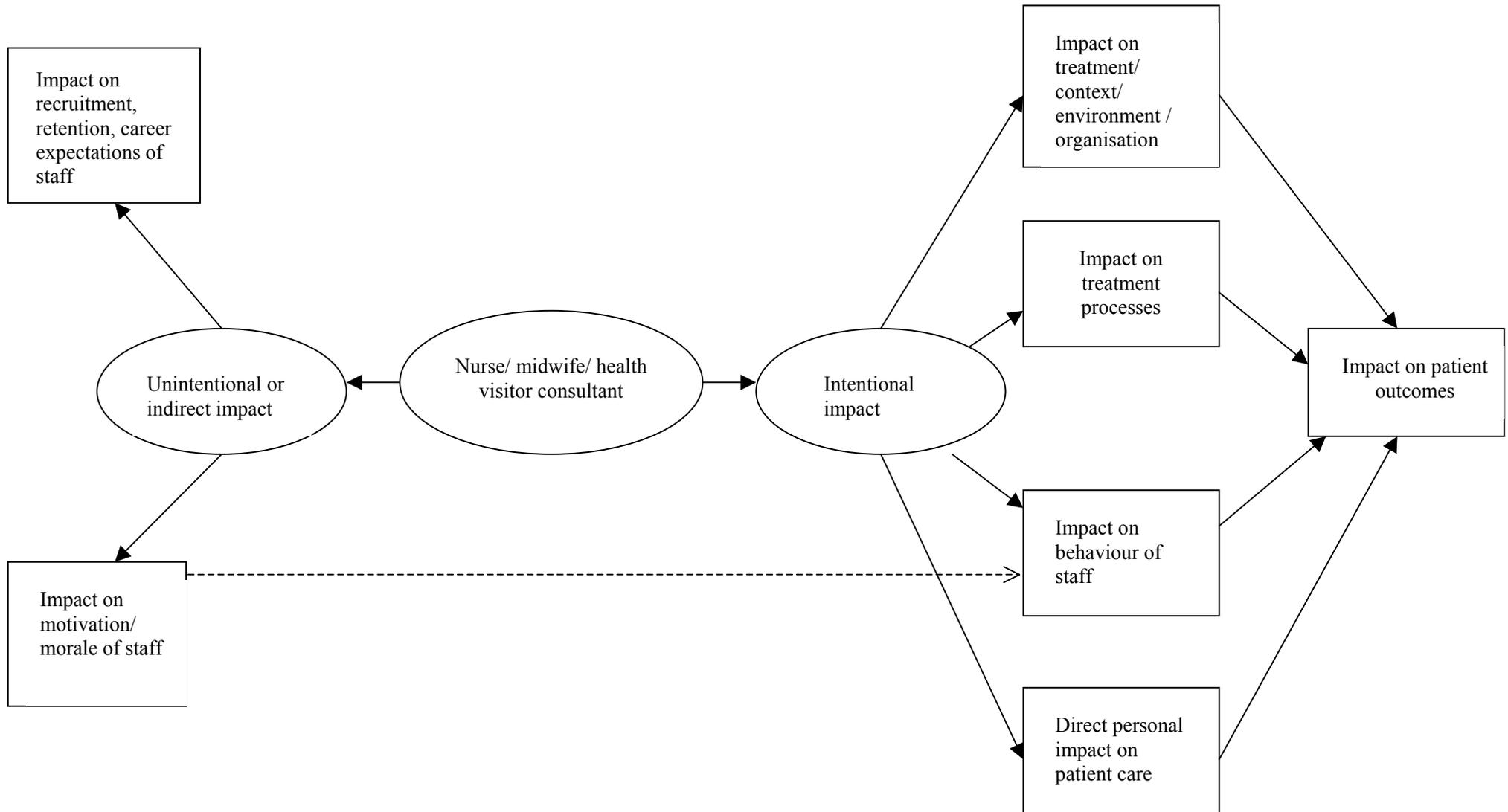
1.4 Research methodology

To explore the range of issues set out above, a multi-method approach was required. The full details of and justification for the various methods used are set out in the various appendices to this report. The four main methods adopted were:
- interviews (face-to-face and telephone)
- focus groups/ workshops
- questionnaire surveys
- longitudinal panel telephone interviews

All interviews and discussions were taped with the permission of the participants and transcribed.

In addition, we considered using observation, role network analysis, interviews with patients and a survey of more junior staff. In the first phase of the evaluation we made some use of observation and role network analysis and we concluded that although they can provide some insights, such methods are time consuming and difficult to analyse and much of the information can be collected through interview. A survey of junior staff would have been a considerable additional commitment if it were to be done properly. We are still pursuing the possibility of such work in collaboration with the King's College Nursing Research Unit. In our proposal we agreed to explore the feasibility of undertaking some longitudinal assessment of patient care. However contact with patients was ruled out by the anticipated problems of research governance and ethical clearance, which had already acted as a major constraint and delay on the project as a whole.

The specific methods used can be linked to the core aims of the project as follows:

1. *The impact of the consultant role on patient care* was achieved by using focus group-style workshops with experienced consultants to elicit performance criteria. These were then checked with the participants for accuracy and coverage. Critical incidents of successful, and occasionally unsuccessful, performance outcomes were collected through narratives in the longitudinal panel interviews. The indicators of impact that emerged, notably from the focus group workshops, provided the basis for a set of items that were included in the final questionnaire survey of all consultants. The surveys also contained a number of open-ended questions inviting consultants to describe incidents and examples of impact on patient care and related outcomes. In addition, as part of the interviews with a number of senior managers who had sponsored the consultant roles, information was collected on their perceptions of the impact of the consultant role.

2. *The leadership role of consultants* was explored through a set of eleven in-depth interviews with consultants exploring what leadership meant to them, how they enacted their leadership role and what impact they believed they had as leaders. This aspect of the consultant role was also explored through a specific question in the longitudinal panel interviews with 32 consultants.

3. *The test of the job innovation model* was explored through interviews with sponsors of the consultant role, through the longitudinal panel interviews; and through questions about sources of support in the questionnaire surveys.

4. *The crafting of the role* was explored through the longitudinal panel interviews, and in particular the critical incidents provided; and through a set of questions about role enactment in the questionnaire surveys. For both this aspect of the study and for the test of the job innovation model, the longitudinal element to the survey provides an opportunity to track changes over time both within cohorts and across cohorts.

5. *Predictors of attitudes, behaviour and performance* were explored mainly through the longitudinal elements of the questionnaire surveys.

6. *The systems implications*, particularly with respect to the supply of consultants and the retention of consultants and nursing, midwife and health visitors more generally were explored mainly within the questionnaire surveys. (This is where the views of other more junior staff would have been particularly helpful). We also interviewed nine consultants who had left their posts.

Full details of the content of the interviews and questionnaires can be found in the appendices.

1.5 Data analysis

Data from the questionnaire surveys were analysed using SPSS. A range of bivariate and multivariate statistics were used. The data from all other sources, which were more qualitative, were subjected to systematic content analysis with independent cross-checks by a second researcher. All data from the qualitative sections of the research (with the exception of the open response items in the questionnaires) were also fed back to the participants for a further check on accuracy and for their approval. Fuller information about the data analysis is provided in the various appendices.

1.6 The samples

The questionnaire survey was designed to be a comprehensive audit as well as a survey of attitudes and behaviour among consultants. As a result, it aimed to cover the entire population of consultants in England. This objective proved very hard to achieve since there is no central or regional database of consultants. A member of the research team therefore spent a considerable amount of time tracking down as many consultants as possible. At the time of the original survey in Phase 1 of this research, we had identified 162 consultants in post by February 2001 and obtained a response from 153 (95 per cent). In practice, a number were so new to their posts that they could not complete much of the questionnaire, and some others had only completed parts of it, leaving a final group of 137 for analysis. As part of this project, a second survey was conducted six months into this Phase 2 of the project at which point 448 consultants were identified and 370 (86.2 per cent) returned questionnaires. A primary purpose of this survey was to collect basic demographic and work experience data from the growing population of consultants, leaving more scope in the later survey to focus on issues of impact. The main descriptive demographic results from this survey are reported in Appendix 8. Six months from the end of the project, in September 2003 a third questionnaire was distributed. This was sent to 528 consultants and returned by 419 (79.4 per cent) in time for analysis.

The longitudinal panel interviews were conducted by telephone with 32 consultants, drawn from a stratified random sample to ensure that specialty and region were adequately represented. Only those with more than 12 months experience were included on the grounds that they would be in a better position to identify any impact.

The leadership interviews were conducted with eleven consultants in person or over the telephone. They were selected to ensure coverage of specialty and region and again included only those with substantial experience.

Four focus group workshops were held. These were conducted with groups from specialties with the greatest numbers of consultants, namely, mental health, older people's services, midwifery, and acute and critical care. In each case there were between three and seven consultants in the group and the groups involved 22 consultants in total. The discussion was facilitated by a senior member of the research team with another researcher present. They took place in different parts of the country.

The interviews with sponsors were conducted over the telephone or in person with eleven Directors or Heads of Nursing/ Midwifery located across all four new NHS regions. This number was arrived at pragmatically in the sense that while it would have been possible to conduct more interviews, by the later interviews, little new information was emerging.

The interviews with leavers were conducted by telephone with all the leavers who could be identified and contacted and who agreed to be interviewed. This resulted in nine interviews. We have no accurate information on the number of consultants who have left their post.

1.7 Ethical approval

The research gained ethical approval through MREC. It should be noted that the whole process of seeking ethical clearance was extremely time-consuming, placed unrealistic demands on the research process, significantly delayed progress on the project and limited the scope of the data collection.

1.8 The structure of the report

The main report is divided into eight chapters. The first provides some descriptive information about the consultants and what they do. The six subsequent chapters present the research findings that help to address the main aims of the study set out earlier in this chapter. The final chapter presents some conclusions.

This main report draws heavily on a series of more detailed reports that are included as appendices. These provide the detailed findings and methodology adopted for each of the main elements of the study including in particular the questionnaire surveys, the panel interviews, the leadership case studies, the focus groups and the interviews with sponsors.

Chapter 2: Who Are The Consultants and What Do They Do?

2.1 Introduction

The questionnaire surveys sought to cover the entire population of nurse/ midwife/ health visitor consultants in England. They therefore provide probably the most comprehensive information about the consultants in post in 2003. This chapter provides information about their education, types of post and other relevant demographic information. This serves as a background to the information in the subsequent chapters, which are written around the six main issues that the research set out to explore. The descriptive results that follow are based mainly on the third of the surveys, conducted in late 2003. However, certain information, such as educational qualifications, was only asked for once, in the first questionnaire completed by each consultant, and as a result it is possible that in a number of cases their circumstances have subsequently changed.

The study also provides a comprehensive account of what consultants do. In this background chapter we provide a summary of their main activities, based on information provided in the survey. A more detailed account of the background and activities of the consultants can be found in the full report of the third questionnaire survey in Appendix 1.

Data from the Department of Health suggest that 860 consultant posts were approved by April 2003. Thereafter approval was devolved to the newly formed Strategic Health Authorities and the number of approved posts became much more difficult to monitor. The survey sample is based on the Department of Health database of August 2003, which relies largely on information provided by Trusts. Thorough monitoring of advertisements led to a further 147 posts being identified. However there is a difference between approving a post, advertising it, appointing a consultant and the point at which the consultant takes up the post. As far as we were able to ascertain, towards the end of 2003, there were approximately 528 consultants in post. There are likely to be more, especially recently appointed consultants that we missed. The descriptive accounts are based on the 419 responses we received, after reminders, from the 528 consultants to whom questionnaires were sent.

2.2 Personal profile

78 per cent of the respondents were female and almost two-thirds were aged between 35 and 44 while the ages ranged from 29 to 59. 75 per cent were married or living with a partner and 55 per cent had dependent children. 97 per cent described their ethnicity as white, leaving just 13 consultants of non-white ethnic origin.

2.3 Education and training

65 per cent had a Masters degree or above while just over 7 per cent had no degree. However this question was asked when consultants completed the first questionnaire they received and may therefore be a slight under-estimate of the proportion with a higher degree. Many consultants noted on their completed surveys and in interviews that they were studying for higher degrees. 60 per cent had a single relevant

professional qualification, 29 per cent had two and just under 6 per cent had three. The remainder did not specify their qualifications. There is no evidence from the analysis of any change in education standards between those consultants in the initial tranches of appointments and those appointed more recently. Specifically, there is no reduction in the proportion with a higher degree qualification

2.4 Salary

The average salary of consultants at the end of 2003 was £39,112. No consultant earned less than £30,000 and only six earned more than £50,000, the highest being £55,000.

2.5 Work experience

Average length of professional service was 19.6 years and the average number of years working in the NHS was 22.5 years. The average time working as a consultant was 23.5 months. Over 90 per cent of consultants were working in their first consultancy post but 5 per cent claimed to be in their second and 4 per cent in their third post. This may be partly a reflection of Trust reorganisations and mergers. At least 18 consultants had left their posts, a point we return to later in the report.

2.6 Geographical/ regional location

42 per cent of consultants were located in the North region, 23 per cent in the South, 21 per cent in London and 14 per cent in Midlands and East region

2.7 Type of consultant post

92.4 per cent identified themselves as nurse consultants, 7.4 per cent as midwife consultants and only one person described themselves as a health visitor consultant. Almost 100 different job titles were provided. We collapsed these into five broad specialty areas, based on clinical area rather than location or type of organisation. This classification is inevitably somewhat arbitrary and it is possible that some of the consultants would have classified themselves differently. However, given the very wide diversity of titles, and in the absence of other information, this is the classification that the research team, after consultation, found the most useful. This resulted in the classification shown in chart 2.1 below.

The largest group, consultants in an area-based specialty, included 44 in critical care, 23 in intermediate care/ rehabilitation, 21 in A&E; and 14 in care of the elderly. Those falling within the condition-based specialty included 17 in cardiology and 12 in cancer care. It is important to bear in mind that this classification was constructed by the researchers and is based on those who returned questionnaires.
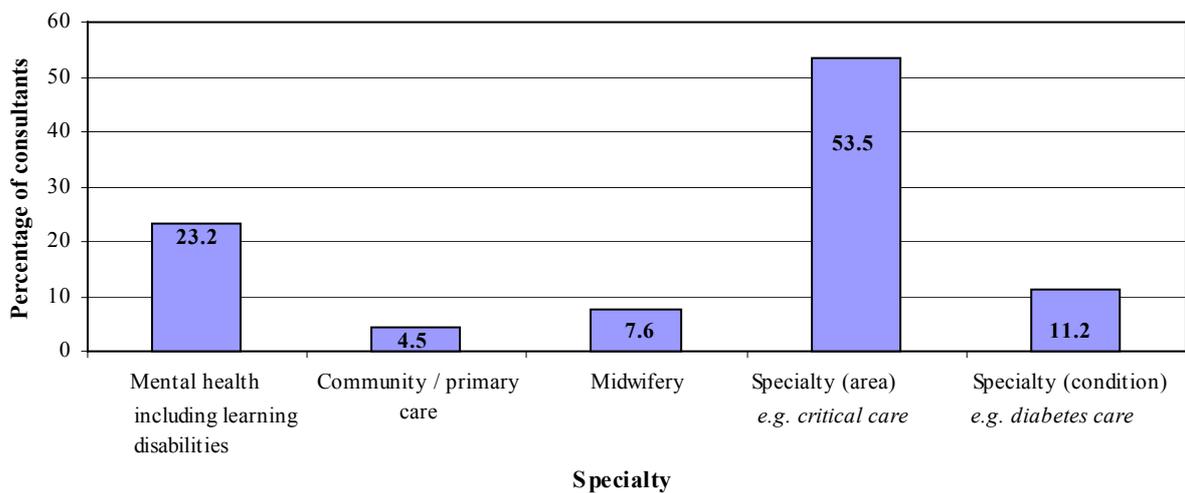
Chart 2.1: Breakdown of consultants by job specialty

2.8 Time of appointment

Appointments were approved in tranches and we divided the sample into eight six-monthly tranches starting in January 2000. The final tranche runs from July to September 2003 and is necessarily curtailed. In the sample, there is a concentration of appointments in the 18 months between January 2001 and June 2002. Leaving aside the final period, the number of appointments ranged from 21 between January and June 2001 to 88 between July and December 2001. There was no evidence of any consistent trend across tranches to suggest changes in the characteristics of the consultants recruited or in their previous work experience.
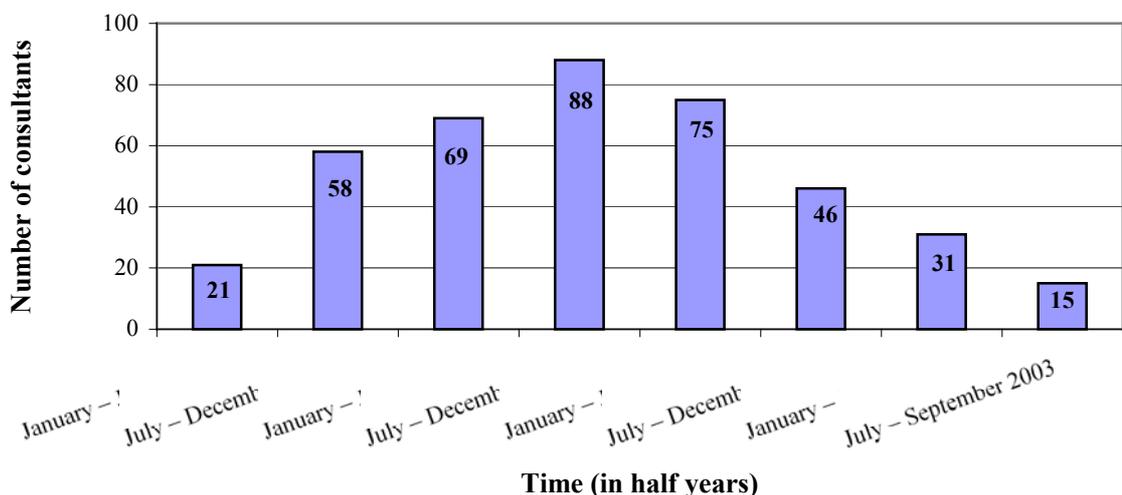
Chart 2.2: Recruitment of consultants over time

2.9 Perceived job competence

A measure of perceived job competence was used in the survey. This is a three-item measure of what is sometimes termed self-efficacy and which in this case addresses

confidence in competence to do the specific job of nurse, midwife or health visitor consultant. For convenience, we labelled this job competence. The results show that, as we might expect, this was strongly linked to length of service. Those reporting high perceptions of their own job competence ranged from 67 per cent in Tranche one, the longest serving tranche, to 33 per cent in Tranche eight, the most recently appointed group of consultants. There were no significant differences in competence ratings according to specialty. There is some evidence from the first phase questionnaire survey and from other research that this variable can have an impact on a range of outcomes. It is therefore included here as one of the background descriptive measures.

2.10 What do consultants do? Main activities

The original Department of Health specification for the consultant role set out four core functions and identified a range of activities within each. For the research we distilled these to 23 areas of activity. Seven fall within the core expert practice function; five fall within the professional leadership and consultancy function; five fall within the education, training and development function; and six fall within the practice and service development, research and evaluation function. In each of the three questionnaires we asked about engagement/ involvement in these activities. Responses were provided on a five-point scale from 'not involved at all' (1) to 'I take the lead in the activity' (5). Although consultants are explicitly excluded from management, the data collected by other means indicated that a number did appear to undertake managerial activities. Therefore, for the third questionnaire, we also asked about levels of engagement in a range of managerial activities. Finally, consultants are expected to spend at least half their time working directly with patients, clients or communities. All the findings in this section are based on the third and final questionnaire.

Scores indicating levels of engagement in each of the four core functions were obtained. Comparisons were made between what we have described as a high level of engagement represented by 'I take the lead in this activity' [5] and 'major involvement/ contribution' [4]; and a lower engagement represented by 'not involved at all' [1], 'minor involvement/ contribution' [2], and moderate involvement/ contribution' [3]. We constructed a number of indicators of engagement or involvement in the role. Firstly, a mean score of 4 or above on the activities falling within a single function, for example, expert practice, was taken to indicate a high level of engagement in that function. These results are shown in chart 2.3 (below). Secondly, an average of 4 or higher across all 23 activities was taken as an indication of high engagement across the whole role. Results are shown to the right of chart 2.3. However it is possible that this average hides some variation, so a third measure was constructed to count the number out of the four functions in which a high level of engagement was reported. The results are summarised in chart 2.4.

These results show that the leadership function is the one in which most consultants were likely to report a high level of engagement while expert practice was the function in which they were least engaged. It is also interesting to note that 11.5 per cent reported a high level of engagement in management activities. This was particularly the case for consultants in community/ primary care roles, where 32 per cent were heavily involved compared, at the other extreme, with none of the midwife

consultants. This appears to reflect the distinctive nature of community/ primary care roles.
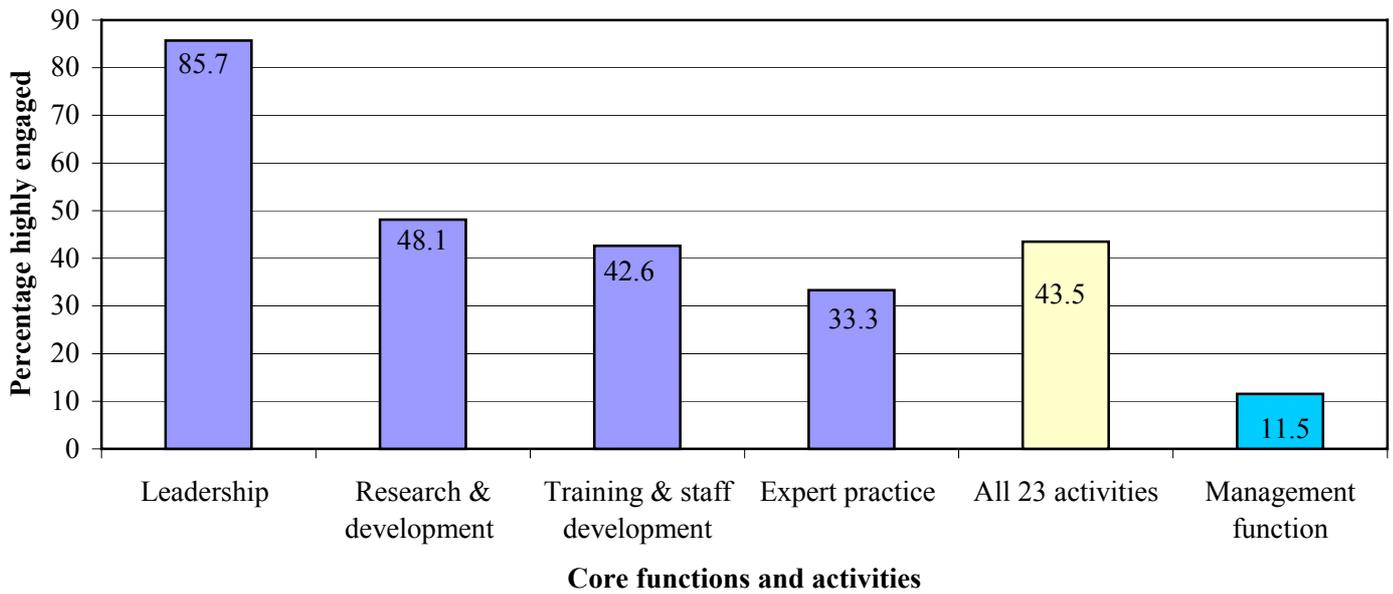
Chart 2.3: Levels of engagement in the consultant functions and activities
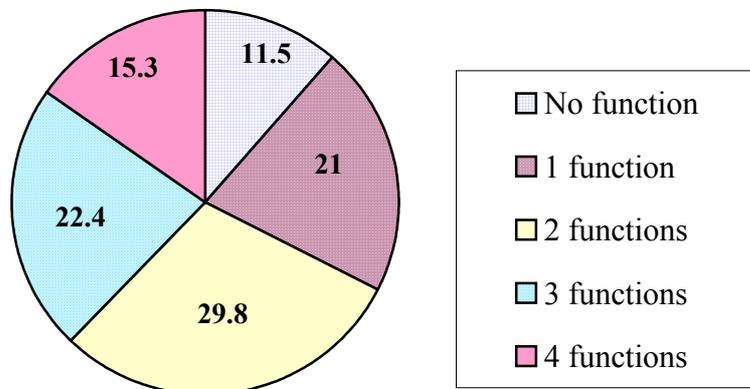
Chart 2.4: Proportion of consultants by number of functions in which they are highly engaged

Just over 43 per cent reported a high average level of engagement across all 23 core activities, but this may hide quite wide variations within individual roles. Support for this comes from the analysis of the number of core functions in which there is a high level of engagement. As table 2.1 shows, 11.5 per cent reported no high engagement in any of the functions while at the other extreme, 15.3 per cent reported a high level of engagement in all four functions. This falls well below the 43 per cent identified by the activity average.

The original specification of the role provided by the Department of Health implied that some level of engagement across all four main functions was expected. At the same time, it left open the possibility of some specialisation. It is less likely that the original specification can be interpreted as supporting an absence of depth of engagement in any one function. This measure of engagement across the functions will be used in the subsequent chapters and this will provide an opportunity to assess its significance. We will also explore the background factors associated with variation in levels of engagement in the role.

A key indicator specified by the Department of Health was that consultants should aim to spend 50 per cent of their time working directly with patients, clients or communities. The survey responses show that the average clinical time was 43 per cent, somewhat below the 50 per cent sought in the original Department of Health document, and very similar to the figure of 44 per cent reported in the first survey of the earliest tranches of consultants. However a number of written comments and information from interviews indicated that some consultants found it very difficult to define such work, particularly when they were advising and working with other staff who did have direct patient contact. There are also a growing number of consultants working in specialist areas such as infection control, for whom it does not make sense to aim for extensive clinical contact with patients.

2.11 Summary

The survey results show that educational standards are being maintained as more consultants are appointed and that pay levels have become more homogeneous than those identified in the first survey. Ethnic minorities still make up less than 3 per cent of consultants. Consultants have nearly 100 different job titles, with 53 per cent falling within area-based specialties such as critical care, intermediate care and A&E. There is a wide variation in the activities undertaken, with consultants most likely to be highly engaged in leadership activities while only a third are highly engaged in expert practice. Just over 11 per cent, concentrated mainly in community/ primary care roles, are highly engaged in management activities. Consultants report spending 43 per cent of their time on average working directly with patients, clients and the community. However this hides considerable variation and some difficulty in defining what constituted direct work with these groups.

Chapter 3: The Impact of the Consultant Role on Patient Care and Related Outcomes

3.1 Introduction

One of the main aims of the project was to assess the impact of the consultant role and in particular its impact on patient care. Because of the problems of gaining access to patients, this had to be achieved largely by seeking information from the consultants themselves. This has some potential shortcomings in so far as their views of the impact they have made may not be shared by managers, patients and other staff. On the other hand, the complexities of the process whereby consultants might have an impact makes any judgements subjective to some extent, whatever their source.

3.2 The analytic framework for considering consultant impact

The impact of the consultant role can be considered through both a stakeholder perspective and by modelling the impact process. From a stakeholder perspective, it is possible to envisage outcomes of concern to patients; the consultants themselves; other staff, including in particular other nursing and midwifery staff; and the Trust as a whole. It is also possible to consider outcomes by modelling the process whereby consultants might have an impact. First there may be direct impacts, since consultants are expected to spend at least half their time in practice. Secondly there may be a range of indirect impacts. These might include changes in systems and procedures; changes in training and development of other staff; and changes in culture and working relationships. The delivery of improved health care will be carried out by others, but the improvements may not have occurred without the leadership and initiative of the consultant. In addition, there may be longer-term indirect impacts on issues such as morale and career aspirations of staff. These different kinds of impact are reflected in the model set out in figure 2 in Chapter 1 (repeated with illustrations at the end of this chapter) and provides a framework for the material presented in this chapter.

3.3 Methods of assessing impact

Ideally, we would have collected information from the various stakeholder groups, including patients. However, given the major barriers encountered in seeking ethical clearance just to interview and send questionnaires to consultants, we decided against a stakeholder model. Instead we sought information mainly from the consultants themselves. While this can lead to potential biases in the information, we believed that they were in much the best position at this time to provide an account of their work and its impact. In particular, we felt that patients may be unable to identify any specific and distinctive consultant contribution. However, as a form of validation, we sought information from the role sponsors about impact.

Information on the impact of the consultant role was therefore obtained through five processes:
1. We conducted four focus groups with consultants to identify the indicators of impact that were likely to be most relevant.

2. We used the third questionnaire survey to collect systematic data that enabled us to explore impact across 15 main indicators that had been identified in the focus groups.
3. We used open-ended questions in the same survey to elicit examples of specific impacts allied to each of the 15 indicators. We also asked for a more general response about major impacts.
4. We used the longitudinal panel interviews to ask about specific examples of changes and improvements, and in particular improvements in patient care, that the 32 panel consultants had achieved. This also provided some information about how they had been able to arrive at these achievements.
5. As an important cross-check, we asked the sponsors who were interviewed for their assessment of the impact to date of the role.

We look at each of these in turn before integrating the findings.

3.4 The focus groups

Details about how the focus groups were formed and their conduct can be found in Appendix 3, together with a full account of the findings. Here we summarise some of the main issues identified. They are organised around the four main components of the consultancy role

3.4.1 Impact through leadership and consultancy

A recurring theme was the importance of achieving change through leadership and consultancy. Many consultants felt strongly that the essence of the consultants' impact on patient care should be through the development of staff and systems rather than their direct impact on patients. Indeed, this was seen as one of the key differences between their role and that of clinical nurse specialist. The impact of the consultants as leaders was reflected in four main areas:

- changing the culture of service provision, including bringing about a change in staff attitudes and behaviour and evidence-based care;
- providing strong nursing leadership, for example by acting as an advocate of staff views or by developing team morale;
- empowering staff by building confidence and encouraging extension of roles;
- providing and emphasising the importance of staff supervision.

It was acknowledged that there were considerable difficulties in demonstrating change in areas such as team climate and the culture of service provision and additional problems of attribution to the role of the consultant.

3.4.2 Impact through service development, research and evaluation

There was agreement that the consultant role provided the credibility to develop service improvements and a large number of successful initiatives were described. These included:

- introducing new services
- developing and improving existing nurse/ midwifery-led services;
- integrating best practices into services;
- developing clinical guidelines;
- engaging with vulnerable groups of patients;
- making services easier for patients to access.

These changes in service delivery were often time-consuming to implement. While the beneficial impact was sometimes clear-cut, it was often difficult to isolate the distinctive impact of the consultant, partly because changes often involved multi-disciplinary teams and partly because they were more likely to be responsible for development rather than the more visible delivery. There were also often problems of evaluation and demonstrating impact because of lack of any comparative, baseline or control group data or because the information available was often medical data which was not the most relevant. Research tends to be longer-term, so few research outcomes were cited.

3.4.3 Impact through education, training and development

Consultants reported a range of involvement in training and development activities. The two specific and most widely-cited areas of activity were:

- updating the skills of staff
- encouraging staff to engage more with research and development

Several consultants had devised and delivered training programmes for staff and could demonstrate benefits from such training on aspects of patient care. Others were less sure that they could see a direct link between training and improved practice. One achievement cited by some consultants, categorised under the heading of 'Service Development, Research and Evaluation', but perhaps more appropriately classified here, was to make staff more aware of research evidence and to help them to link their work to that evidence base.

3.4.4 Impact through expert practice

There was wide variation between consultants in their amount of clinical contact. Some had their own caseloads; others provided expert support and advice with difficult cases. The impact of consultants through expert practice was achieved by:

- providing expert consultancy to other staff, particularly in the most complex cases;
- developing the practice of others;
- acting as a role model;
- taking on the particularly complex cases.

There was some feeling that this element of the role, particularly when it mainly entailed dealing with complex cases, was not easily distinguishable from the role of clinical nurse specialist. However, the impact of the more distinctive consultant role, working with others to improve expert practice, was more difficult to demonstrate simply because a number of staff were involved.

In summary, the consultants who participated in the focus groups all believed they were having an impact or would do so. They emphasised that many of the changes they had embarked on took some considerable time to implement. They were enthusiastic about developing evidence of impact but also acutely aware of the difficulties of doing so convincingly. Nurse directors and general managers helped to set aims and goals and were supportive in their desire to demonstrate an impact, although, on the whole, they had done little to initiate formal evaluation. There was some indication that those consultants with broad roles and occasionally rather unclear aims were finding it more difficult to have an impact. There were also consistent accounts of barriers including resistance from staff, both nursing/ midwifery and, more generally, medical staff, lack of resources and role overload. A

few consultants felt that in a managerial role they would have more authority to acquire resources and allocate activities. Set against this, the consultants were conscious that they were pioneers in a new role that had the potential to have considerable impact on patient care and other outcomes. Importantly, the focus groups also provided valuable information about a wide range of impact indicators that could be incorporated into the final questionnaire survey.

3.5 The questionnaire survey

Indicators of impact identified in the focus groups were incorporated as items in the third questionnaire survey sent to all consultants. Nineteen main issues were covered. A factor analysis of the results indicated that they could be broadly divided into two logical groups. The first and larger group of 15 items concerned process issues such as improving staff motivation, ensuring services better meet the needs of patients and putting more protocols and guidelines in place. The second group, containing four items, concerned specific patient-focused outcomes relating to the treatment process, covering issues such as access, treatment, discharge and follow-up. In addition to the quantitative results, consultants were asked to provide qualitative explanations and illustrations of their responses. These are covered in the following section.

3.5.1 Impact on processes

Consultants were asked to rate whether their role had an impact using a five-point scale from 'not the case at all' (1) to 'yes, to a great extent' (5). They also had an opportunity to say that an item was not relevant to their role. In the event, 16 per cent said that "unnecessary expenditure has been reduced" was not relevant to their role while 10 per cent said the same about "patients are better informed about treatment". The results for the process impact items are are summarised in Table 3.1.

Impact statement	Percentage of consultants				
	Low (1-2)	Medium (3)	High (4-5)	Not Relevant	Missing
1. Patients are better informed about treatment	10	28	50	10	2
2. Staff can more readily access support	6	20	71	2	1
3. Research has led to practice developments	36	25	32	4	3
4. Audit has identified areas needing improvement	12	22	61	2	3
5. More patient-centred culture	20	31	41	5	3
6. Staff are more motivated in their work	21	36	37	2	4
7. Services better meet need of patients	12	26	59	1	3
8. Increase in nurse/ midwife-led interventions	18	23	49	6	4
9. Care delivery reflects best practice	15	31	48	2	4
10. More protocols/ guidelines are in place	17	25	53	1	3
11. Colleagues deal more effectively with challenges	17	32	45	2	4
12. Services span organisational boundaries	23	25	46	4	2
13. Communication across professions has improved	22	24	49	1	4
14. Financial resources are better directed	52	19	18	10	1
15. Unnecessary expenditure has been reduced	55	15	10	16	4

Table 3.1: Consultant ratings of their impact on processes

A count was undertaken of the items on which consultants agree that they had made either a 'definite' or 'a great deal' of impact. Over 50 per cent of consultants believed they have had a marked impact on five of the fifteen process items. These are:

- staff can more readily access support (71%)
- audit has identified areas needing improvement (61%)
- services better meet patient needs (59%)
- more protocols/ guidelines are in place (53%)
- patients are better informed about treatment (50%)

At the other extreme, financial issues were seen as less central to the non-managerial consultant role and only 18 per cent believed that they had an impact on ensuring that financial resources are better directed and just 10 per cent on reduction of unnecessary expenditure.

3.5.2 Differences in impact on the process items

There are some significant differences between consultant areas of specialism in rated impact on three of the items. On "changing services to better meet the needs of patients", 80 per cent of midwives but only 45 per cent of mental health consultants claimed to have had a marked impact. On "an increase in nurse-led interventions", 65 per cent of consultants in condition-based specialties reported a marked improvement compared with only 36 per cent of mental health consultants. And on "producing more protocols/ guidelines", 80 per cent of midwives but only 41.5 per cent of mental health consultants reported a marked impact. For whatever reason, mental health consultants appeared less likely to report that they have had a high impact. In addition to these variations by specialty, there were also statistically significant variations between tranches on several items, much in line with expectations. These consistently revealed that those who had been in post longer reported higher levels of impact.

3.5.3 Impact on patient outcomes

Consultants were less likely to rate themselves as having a high impact on the four patient-focused service delivery items. The results are summarised in Table 3.2.

Impact statement	Percentage of consultants				
	Low (1-2)	Medium (3)	High (4-5)	Not Relevant	Missing
16. Patients/ clients now have better access to the health services that they require	26	28	38	5	3
17. The standard of care received by patients/ clients in the service has improved	16	32	48	1	4
18. Procedures for discharging patients/ clients are now more streamlined	32	19	27	19	3
19. Patients/ clients receive improved follow up care	25	17	40	15	3

Table 3.2: Consultant ratings of their impact on patient-related outcomes

The responses ranged from 48 per cent who felt they had a marked impact on "the standard of care received by patients" to 27 per cent who claimed a marked impact on "procedures for discharging patients/ clients are now more streamlined". On this item, 19 per cent claimed it was not relevant to their job. Taking the four service impact items together, there was a significant difference across the specialisms with

50 per cent of the community/ primary care consultants claiming to have had a marked impact while only 18 per cent of the mental health consultants made this claim. There were also significant differences by tranche, with the more experienced consultants reporting a greater impact.

An additional item asked for an overall impact rating on a six-point scale from a negative to a major positive impact. Overall, 44 per cent of consultants rated their impact as highly positive and this ranged from 33 per cent of consultant midwives to 51 per cent of area specialty consultants. Again, the differences by length of time as a consultant were significant with 71 per cent of those in the first tranche of consultants appointed rating their impact as highly positive, but only 18 per cent of those in the most recent tranche.

3.5.4 Factors associated with general impact

A regression analysis revealed that three main factors are significantly associated with higher self-rated impact on processes, on patient outcomes and on the overall rating of impact. Those who had a high level of confidence in their ability to do the consultant job (high competence); those who were engaged across a full range of the 23 activities in the consultant role; and those longer in the consultant post were likely to provide higher positive ratings on all types of impact. In contrast, though less easy to explain, those with higher educational qualifications are less likely to report a high impact on processes and patient-related outcomes. Midwife consultants reported a higher impact on process items while mental health consultants reported lower impact on patient-focused service delivery and lower overall impact. Colleague support was associated with higher process impact while medical support was associated with higher overall impact. Greater control over the job was associated with higher patient-focused service impact. Reward equity was associated with lower overall impact, though the causality may be reversed in that those who believed they were having a high overall impact and who also had an extensive role engagement may have felt that their rewards were inequitable.

3.5.5 Perceived effectiveness

In addition to rating their impact, consultants were also asked to rate their overall effectiveness in the four core functions and to provide a rating of overall effectiveness. Using a five-point scale from relatively low to very high effectiveness, the proportion who gave themselves a positive rating ranged from 82 per cent on leadership, 79 per cent on expert practice and 71 per cent on training to 57 per cent on research and development. On the overall rating, 62 per cent claimed to be effective. Those with longer service as consultants rated themselves significantly more effective overall. Although consultants working in a condition-based specialty tended to rate themselves higher and those in community/ primary care tended to rate themselves lower across a number of items, these differences were not statistically significant. However a regression analysis found that some similar factors are associated with both higher impact and higher ratings of effectiveness. Specifically, those consultants engaged across a wider range of activities and those who reported high levels of confidence in their ability to do the job (job competence) had a higher overall effectiveness rating. Those who reported high job demands also reported higher ratings of effectiveness. More idiosyncratically, those with dependent children rated both their effectiveness and their impact more highly.

3.5.6 Section summary

Taken together, these results confirm that consultants believed that they were having an impact, both through a range of important processes and, although they were a little less confident about this, on the main aspects of service delivery to patients. The findings therefore support the conceptual model in showing a direct and an indirect impact on patient care. Those who had been in post longest were more confident that they are having an impact and operating effectively. There are some differences between areas of specialism but these are not consistent. However it does appear that those who engaged in a high number of activities across all four core consultant functions believed they were having a greater impact; so too do those who were confident in their ability to do the job. Support from peers and from medical staff was also associated with greater impact. This all suggests that it takes time to settle in to the role, but once consultants become established, gain confidence and can call upon a support network, they increasingly believe they are having an impact and operating effectively. It is, of course, important to bear in mind that these are self-ratings with all the potential risks of bias. At the same time, the complexities of the roles, the often indirect nature of the consultant impact and the lack of alternative more objective sources of information make it inevitable that subjective assessments are used. It is, however, important that they can be supported by some sort of evidence. This is addressed in the next section.

3.6 Qualitative illustrations of impact from the questionnaire survey

In addition to providing a rating, consultants were asked to provide some brief examples to support their rating in each of the 15 process areas of impact. These responses were analysed and are presented in full in Appendix 2. Below (table 3.3) we summarise some the key themes that emerged. The number of consultants providing examples varied according to the item. Inevitably, where the impact was rated as lower, fewer examples were provided. Generally, between a third and a half of those who rated their impact as high provided an illustration.

Category	Achievements
Patients are better informed about their treatment options	- development of patient information - spending more time advising patients - providing patients with greater choice regarding care - tailoring services to patient needs
Staff can more readily access support when dealing with challenging patient/ client problems	- providing specialist advice - providing supervision - providing training and guidance documents
Research provided by our team/ service has contributed to developments in practice	- participation in research projects - research projects that had demonstrated a need or deficit - research projects that had changed clinical practice.
Areas of the service requiring improvement have been identified through clinical audit and evaluation	- audits leading to the development of new staff and services - audits leading to improvement of existing services - audits leading to the development of guidelines - audits leading to improvements in training

There is now a more patient/ client centred culture	• creating a more patient-centred culture • obtaining patient views and developing user groups • providing better access to services for patients
Staff are more motivated in their work	• tangible impact of staff motivation on service provision • enhancing clinical skills and professional development • empowering staff to take on new roles and support and supervision
Services have been developed or changed to better meet the needs of patients/ clients	• improving access to the service • providing greater choice • developing new or modifying existing services • better outcomes/ faster more efficient treatment
The number of nurse/ midwife-led interventions has significantly increased	The achievements fall into two broad categories: nurse/ midwife-led interventions developed and the impact of these interventions
Care delivery now better reflects current standards of best practice.	• development of protocols and guidelines • implementing national guidelines and evidence-based healthcare • training staff to improve care.
There are more protocols/ guidelines in place to help staff provide effective care to patients/ clients	• development of general protocols • development of specialty-specific protocols.
Colleagues are now more competent to deal effectively with challenging patient/ client problems	• changes to staff behaviour • training staff to deal effectively with patients • providing guidelines • providing support
Services have been developed or changed to span organisational boundaries	• working collaboratively with other agencies • working with other departments.
Communication and decision making across different boundaries has improved	• multidisciplinary committees • multidisciplinary teams • communication with external agencies
Greater financial resources have been directed towards services which most need development	• obtaining new funds • redirecting resources. • complaints about problems with funding.
Unnecessary expenditure within the service has been reduced	• savings on equipment/ materials • reduction in unnecessary admissions/ length of stay • reorganisation of services to make them more efficient

Table 3.3: Key themes of qualitative comments about consultant impact

The categories listed above can seem rather general, however many consultants were able to provide quite specific illustrations of the impact they had had. It can also be

seen that certain activities, such as provision of training and development of protocols and guidelines, were reported under more than one impact heading.

3.7 The most significant impact to date

Consultants were asked to identify the most significant impact to date of their role. This provides some indication of key achievements and might be expected, at least in part, to complement the information from the focus groups and the other questionnaire data described above.

Over 450 comments were received, though it should be noted that not all consultants responded, and in some cases the responses were categorised in more than one theme. Ten major themes were identified which accounted for 370 of the responses, many including quite specific illustrations of positive impact. The full details are presented in Appendix 2. Here we present a brief summary.

- 72 comments were concerned with making patient care more patient-focused. This included providing greater accessibility of services, paying more attention to patient concerns and needs, improving patient information and increasing patient involvement.
- 71 mentioned the development of new nurse-led and non nurse-led services. These included critical outreach teams, stroke services, home treatment services, early intervention units, new specialist clinics and a consultant midwife's young people's clinic.
- 52 mentioned improvements to current services. These included a few cases of identifying the need for improvement and rather more where improvements had also been introduced resulting in a more reliable and streamlined service and where care standards had been improved.
- 33 cited improvements in education and training either of nursing staff specifically or, more often, of multi-disciplinary teams, leading to improvements in skills, in confidence to apply skills and more effective cross-functional team working.
- 33 mentioned their success in raising the profile of certain issues, activities or treatments either locally or nationally.
- 29 said their greatest impact had been through the development and/ or implementation of protocols, care pathways, guideline documents or more general encouragement of an evidence-based approach.
- 22 said their largest impact had come about through working across professional boundaries, for example by bringing different agencies together, by developing partnerships and networks or by getting different groups of professionals to work together.
- 19 consultants reported specific service improvements in a variety of areas including reduction in waiting times, reductions in admissions or readmissions, reductions in clinical interventions and reductions in risk of hospital acquired infections.
- 13 consultants said that their main achievement had been challenging the status quo. This entailed challenging entrenched attitudes by promoting evidence-based approaches, by a more positive 'can-do' approach, by challenging aspects of the medical model and by supporting nursing or midwifery staff.

The wide range of issues identified as the most significant impact of the consultant role highlights both the diversity of the roles and the range of priorities and achievements. The majority of achievements fell into the themes of developing new services or improving existing services to patients. Many others reflected a more indirect impact on patient care. This reflects some emphasis on the practice and service development element of the role. Other significant impacts reflected the leadership and training functions in the role, but there was rather less reference to impacts attributable to the expert practice function.

3.8 Evidence of impact from the longitudinal panel interviews

The 32 consultants who participated in the panel interviews were asked during each interview to provide examples of specific achievements as well as problems in trying to achieve an impact during the period since the previous interview. The content analysis revealed 271 relevant responses of which 74 per cent described achievements, 16 per cent identified problems and 10 per cent were less easily classified. A full description is provided in Appendix 6.

The achievements fell into seven main categories, which overlap with those identified in several of the earlier descriptions of impacts and achievements. The first, accounting for nearly a quarter of the examples, concerned the development of procedures, processes, protocols and plans to improve performance. The second, accounting for about 18 per cent of the examples, involved leadership to improve efficiency, quality and practice. The third (14% of examples) dealt more generally with making a difference because of being in the consultant position and having the necessary experience. The fourth (13% of examples) concerned with evidence of impact through networking, engaging others and raising the profile of the role. The fifth (11%) broadly pertained to meeting their own expectations or those of others. The sixth (10% of examples) included improving or having a specific impact on patient care. The final category, accounting for 9.5 per cent of examples, regarded having an influence through research, presentations and sharing knowledge.

On the negative side, there was less tendency to cite specific examples of failure to have an impact. Instead, the focus was on the explanations. These fell into five categories; lack of authority and influence (36% of examples), difficulties in developing and measuring the impact of the role (30%), lack of colleague support (16%), lack of resources (9%) and failing to meet their own expectations (9%).

These examples of achievements obtained through the panel interviews reflect consultants' perceptions over time. They highlight the important indirect impact achieved through developing new systems, procedures and protocols and the more general exercise of their leadership qualities and position.

3.9 Sponsors' views of impact

Sponsors of the consultants are likely to have a key role in evaluating their impact. All agreed that some form of systematic evaluation was essential. They also acknowledged that evaluation of the role was difficult, especially with respect to the more general consultant roles and that evaluation should not occur prematurely since it takes time to settle in to the role and have an impact.

Despite their concerns about the evaluation process, all sponsors were broadly positive about the impact of consultants in their Trusts. A number of specific patient-related outcomes were identified. Fuller details are provided in the sponsors report in Appendix 4.

- With respect to midwife roles, commonly cited criteria of impact were an increase in midwifery-led low-risk births, a decrease in medical interventions and an increase in breast-feeding. Some could already see a clear impact on these criteria.
- For community roles, evidence of impact was cited with respect to development of crisis intervention services and outreach teams. In primary care, sponsors cited examples of consultant contribution to intermediate care, care of the elderly and treatment of minor injuries.
- In mental health, consultants were having an impact on the number of people needing admission to acute wards.
- Some sponsors mentioned the impact of their outreach team on critical care and one noted that morbidity and mortality rates from outpatient emergencies had decreased. A number also mentioned the consultants' caseload and how it typically included cases that in the past would have been seen by doctors.
- In two A&E departments, the introduction of nurse-led care for minor injuries had streamlined A&E services, helping to achieve targets and reduce patient waiting time. Evaluation of some posts in older people's and cancer care showed that patients were happy to be seen by a consultant nurse, were seen more quickly and obtained medical outcomes as good as those obtained with medical staff.

In addition to evidence of specific impact, sponsors mentioned staff skills training provided by consultants to increase the patients they could treat and increased provision of supervision. Sponsors believed that the presence of a consultant contributed to a boost to morale and acted as a valued role model.

Factors influencing the degree of impact, according to sponsors, were the personality of the consultant, the way in which the role was structured, the political and organisational context into which the role was introduced and the way in which the role was implemented and supported. In particular, a strong personality and having a role with specific achievable goals were viewed as particularly important.

On the basis of their criteria, sponsors believed that most of the consultants had had an impact and had been effective to date.

3.10 Summary

An assessment of the impact of the consultant role is a central element of this evaluation study. The evaluation process has been significantly constrained by two factors. The first is the often indirect nature of the consultant impact on patient care since much of their work is concerned with improving systems and protocols and working through others. The second was the lack of access to other stakeholders, with the exception of a small sample of sponsors. As a result, this evaluation of impact is based mainly on accounts provided by the consultants themselves and the limitations that this imposes must be acknowledged. However we collected information from a large number of consultants using a variety of methods; and by using triangulation across the methods, a number of consistent findings emerge.

The first important finding is that the great majority of consultants and sponsors believe that the consultants are having a positive impact. The second is that the impact can be seen in both a wide variety of improved services and systems and in improvements in patient care. The third is that consultants are exercising leadership as a means of having an impact and using their role to improve motivation and morale, provide better training and development and more generally to raise issues and press for changes that might not otherwise have been championed with the same vigour. Numerous examples of all types of impact were provided by the consultants themselves and also by their sponsors.

On the negative side, many but by no means all consultants encountered problems in their role as leaders without a management function. They cited lack of authority, lack of support and lack of resources sometimes frustrating their attempts to bring about improvements and change.

There was some evidence of differences in level of impact. Mental health consultants tended to report a lower impact on some items. As we might expect, those who have been consultants for longer reported a greater impact. So did those who are more heavily engaged across all four functions, who reported being in control of their job and who hold a high level of confidence in their ability to do the job. Support, especially support from colleagues, was also helpful.

The findings support the conceptual model that anticipated a largely indirect but occasionally direct impact and an intentional but occasionally unintentional impact. The unintentional impact seemed to occur mainly through the impact of the consultant's presence on motivation and morale and as a role model, an impact highlighted in particular by the sponsors.

The central problem in this analysis is the question of attribution. Most consultants clearly believe they are having a positive impact. But because it is often indirect and difficult to measure, it is possible that others may not share their perception. Ideally, we would have supporting evidence from senior medical staff and from more junior staff. However it is reassuring that the sponsors' assessments reinforce and occasionally elaborate the reports from the consultants. On this basis, and acknowledging the sponsors strictures that evaluation should not take place prematurely, we can be reasonably confident that many and probably most consultants are having a positive impact, either directly or indirectly, on patient care.

Figure 3.1: An illustrated model of the impact of consultants on patient care and other outcomes

Impact on recruitment, retention, career expectations of staff

Impact on context etc.
e.g. more patient-centred culture; updating staff skills; easier patient access to services

Unintentional or indirect impact
e.g. leading by example; presence of a consultant in the unit; challenging the status quo.

Nurse/ midwife/ health visitor consultant

Intentional impact

Impact processes
e.g. developing clinical guidelines; implementing new treatment protocols; introducing new services

Impact on patient outcomes

Impact on staff behaviour
e.g. acting as advocate of staff views; empowering staff by building their confidence

Impact on motivation/ morale of staff

Direct impact on patient care
e.g. taking on complex cases; faster, more efficient treatments; new home treatment services

Chapter 4: Consultants as Leaders

4.1 Introduction

A distinctive and challenging feature of the role of the nurse, midwife and health visitor consultant is the emphasis on leadership but not management. Most studies of leadership are conducted on individuals in managerial roles where leadership can be bolstered by managerial authority (for a review, see Yukl, 2002). In a number of professional roles this is not the case. The medical consultant is one example of this; so too is the nurse, midwife and health visitor consultant. Therefore, a particular feature of the study was an exploration of how the leadership role was enacted and how the consultants addressed the challenges of leadership in the absence of management and in contexts where the credibility of the role had to be established.

Leadership was explored from several perspectives. Firstly, the questionnaire surveys asked about engagement in the leadership elements of the role. The final survey also asked about engagement in management activities and asked for a self-rating of effectiveness in the leadership function as well as in other core functions in the role (see Appendix 1). Secondly, a set of in-depth interviews with eleven consultants explored how they perceived and enacted their leadership roles (Appendix 5). Thirdly, the panel interviews with the cross-section of consultants were content analysed to identify leadership-related comments (Appendix 6). Finally, comments on leadership were provided in both the focus groups (Appendix 3) and the interviews with sponsors (Appendix 4). This chapter provides an integrative overview of the results from these different elements of the study.

4.2 Engagement in leadership activities

Five leadership activities were identified in the original Department of Health job specification that reflected the leadership function within the consultant role. In the questionnaire survey, 86 per cent of the sample reported a high level of engagement across these leadership activities. Far more consultants reported a high level of engagement in the leadership function than in any of the other core functions in the role. There was no significant variation across types of consultant. However higher reported levels of engagement in the leadership function were reported by those with more professional qualifications, by those with higher confidence in their ability to do the job and by those with stronger support from colleagues.

In the in-depth interviews, the consultants described leadership as having two major dimensions. One was concerned with having a direct impact by leading change; the other was more indirect and involved influencing and getting results through others. There was also reference to a consistent style that could be characterised as empowering or facilitating, reflected partly in nurturing others. This was contrasted with a more autocratic and directive style, which was seen as typically associated with medical consultants.

The sponsors were far more bullish about the leadership role than the consultants themselves. They considered that the leadership dimension was a key factor that

distinguished consultants from other posts such as clinical nurse specialists. This can be illustrated in the following comments:

The nurse or midwife consultant is likely to be leading the service redesign, leading service delivery and doing that freestanding… you can identify the nurse consultants because they are much more stand alone.

A key element of these posts is about leadership, about leading people forward and persuading them that they want to change, rather than instructing them to do things in a different way.

The leadership stuff is extremely important for me. And I think if you took that leadership aspect out, you'd just as well employ nurse specialists.

4.3 Leadership and management

In the questionnaire survey, 11 per cent of consultants reported a high level of engagement in management activities. This indicates that some consultants do engage in management despite the intention to avoid management responsibilities in the role. As Chapter 2 revealed, this was particularly likely to be the case among those working in community/ primary care roles. Among the eleven consultants who participated in the in-depth interviews, several engaged in some managerial responsibilities including four with significant managerial responsibilities.

The eleven consultants interviewed all felt they could distinguish between leadership and management. Management was conceived as concerned with budgets and targets whereas leadership was more focused on patients and both developing and addressing the emotional needs of staff. Management was viewed as typically narrow, reactive and rules bound whereas leadership was broader, developmental and strategic. In management, power was conferred through managerial positional authority whereas in leadership, power was earned through credibility and personality. In this context, the characteristics of effective leaders were described in terms possessing clinical credibility, having qualities such as passion, commitment and resilience and demonstrating communication and listening skills. Interestingly, political skills were scarcely mentioned. While most of the eleven consultants interviewed were adamant that they did not want managerial authority, several saw its absence as a problem, which is one reason why some were willing to accept a managerial element to their role. Asked how they achieved results without managerial authority, consultants said they used relationships that they had developed with power-holders and also, crucially, working through others by adopting a persuasive, facilitating and enabling style. One consultant described leadership activity in the following way:

It's more influencing, negotiating, selling, reassuring and actually [coping with] *quite a lot of conflict with certain people because I'm challenging really what they believe, even at senior levels.*

Another described the potential advantage of leadership rather than management:

I think really it's any responsibility to try to encourage people tow ant to work, and for me to lead the work, do you know what I mean? So in a way it's quite nice, when you think they're doing it because they want to, rather than because I'm managing them and telling them they ought to. So I think it has its benefits not having any managerial focus.

The sponsors were very positive about the capacity of the consultants to exert influence. Persuasive style and clinical credibility were again highlighted as effective mechanisms.

> *She's bringing... issues that perhaps even doctors have not thought about, but by bringing it in a non-threatening way, she's stimulating people to think in different ways as well as working with people who don't want to change.*

> *What really sticks out a mile when you're in a room with them, is that they can converse clinically on a level with the medics and challenge them very very effectively. And that's really powerful.*

The context appeared to have an important impact on leadership behaviour. It was suggested by the consultants that, in contrast with medical consultants to whom authority is more generally ascribed, they had to earn authority. This was probably easiest for those who were internally recruited and who already had an established reputation. There was also some suggestion that it might be easier for consultants in new Trusts where all roles were newly established and the turbulence and uncertainty together with the ambiguity about the consultant role provided an opportunity to create an impression. In more established settings, there was sometimes some resistance to the role from members of the existing role networks, making it necessary for each consultant to build a distinctive support network. While some consultants appreciated the support they received from their line management, most cited other sources of support as being more valuable. They were also rather doubtful about the value of objective setting and performance review, which in most cases tended to be anodyne and unhelpful in developing their role and more particularly the leadership dimension.

The panel interviews provide some insight into why some consultants engaged in management as well as leadership. While there were no explicit questions about leadership in the interviews, there was plenty of opportunity to refer to issues relating to leadership. A content analysis revealed 81 such instances across the sequence of interviews. These were grouped into four main themes concerned with autonomy, managerial authority, availability of resources and respect and influence. A persistent feature in the comments concerns the problems of leadership in the absence of managerial authority.

The comments about autonomy were concerned largely with the problems of autonomy in the absence of authority and the lack of a budget, or autonomy without support resulting in a sense of isolation. When linking autonomy and authority, there were references to personal authority, the important role of managers and context or, more generally, the range of influence processes that could be used to bolster authority. Comments under the specific heading of authority reinforced the concern about leadership without authority. Ways to overcome this seemed to be to work effectively with those who did have authority. Where such support was lacking there was a problem; where it did exist, then leadership without management authority could be managed. Once again it was noted that it was easier to establish personal authority in new or ambiguous situations than in well-established settings. The third theme concerned the availability of resources; again the issue was the lack of a budget and the absence of financial resources to bring about much needed changes. Typical examples were cited where a change was agreed but the resources to implement it were not provided. The need to sit on key committees or to possess considerable

powers of dogged persuasion to gain either internal or external resources was reiterated. The final issue concerned establishing respect and influence as a leader. Where respect was earned, it was cited as a significant achievement; however it was considered difficult in settings where consultants were excluded from decision-making committees and where there was some resistance among other staff to the new role. In summary, the majority of the spontaneous comments about leadership in the panel interviews concerned the problems of leadership without authority. There were relatively few comments providing guidance or insight about effective leadership. The comments provide further insight into why so many consultants engage in some more direct management activities in a desire to get results.

4.4 Evidence of impact through leadership

In spite of the challenges in the roles and contexts, consultants mainly see themselves operating effectively as leaders. In the questionnaire survey, a specific question asked for a self-rating of effectiveness in the leadership function. As noted in the previous chapter 82 per cent rated their own performance in the leadership function highly. Indeed, leadership was rated the most effective of the four functions. There was a tendency for those who had been in post longer to rate their leadership effectiveness more highly. For example approximately 90 per cent of those in the first two tranches of consultants compared with about 75 per cent of consultants in the two most recently appointed tranches rated their leadership effectiveness highly.

These high self-ratings may appear somewhat surprising given the difficulty in delivering leadership and identifying the impact of the leadership role among the consultants in the focus groups and in the eleven leadership interviews. For example, the focus group consultants acknowledged that this was the most difficult aspect of their role in which to demonstrate impact. Because the impact of leadership was invariably indirect, the question of attribution was recognised as a potential problem. Consultants were uncertain whether staff would acknowledge their leadership role and were therefore lukewarm about processes of systematically consulting other staff as a means of evaluating this aspect of their role.

Despite the problems of identifying the impact of leadership, in the focus groups evidence of leadership impact was described in terms of changing the culture of services, empowering staff, providing supervision and, more generally, providing strong nursing/ midwifery leadership. In the in-depth interviews, all eleven consultants could cite examples of the impact of their leadership and eight out of the eleven provided a clearly positive evaluation of their impact and effectiveness. Specific achievements reflecting the leadership element of the role included the development and introduction of new clinical roles, the introduction of diagnostic and informational resources to improve clinical quality and the development and implementation of training and development roles. These could equally be associated with the other main functions within the consultant role. This was summarised by one of the consultants:

> *Leadership for me is so much a part of what I should be doing that I don't separate it out from* [the other three roles]... *I don't say, now that I'm dealing with patients I'm not a leader because I'm being a leader all the time... or hopefully trying to and aspiring to be a leader all the time, because that's the role... it's integral for me.*

4.5 Summary

In this chapter, we have reviewed the key leadership role of consultants. It is an element of the role in which most consultants are heavily engaged and despite difficulties in defining their leadership, it is a part of the role where they believe they are generally effective. Effective leadership among the consultants is typically a product of impressive personal qualities and credibility and the use of a facilitative, empowering style in dealing with colleagues. The problem of leadership without formal management authority has troubled many of the consultants. However a minority do not see this as a particular issue. Many examples of constraints on bringing about change in the absence of authority and resources were cited. Partly as a result of these problems, a significant minority had assumed managerial elements to their role. The sponsors were very clear about the importance of the leadership dimension to the consultant role and were able to cite examples of such leadership. They appeared to be more confident than the consultants themselves about the impact they were having, although it should be noted that most consultants could cite examples of positive outcomes which could be attributed to their leadership. From whatever perspective, enacting and demonstrating leadership remains one of the major challenges in the consultant role. From a policy perspective, the findings also raise questions about the feasibility and possibly even the desirability of seeking to restrict the consultant role in all cases to one of leadership without management.

Chapter 5: "Crafting" the Consultant Role: Implications for Satisfaction and Work-Life Balance

5.1 Introduction

The nurse/ midwife/ health visitor consultant role is both a new role and a potentially very extensive and demanding role. Any newcomer to the post therefore has to make some choices about how to "manage" or to "craft" the role. While the focus of some posts is fairly specific and specialist, in other cases it is broader and more generalist. Nevertheless in both cases, the consultant starts with a broad specification with four main functions, at least 23 possible activities and a requirement to spend at least half the time involved with patients, clients and/ or the community. There was some indication from the Preliminary Report (Guest et al, 2001) that those who had been in post longer were feeling more overloaded and less satisfied. This strengthens the view that there is some need to craft out an acceptable role that enables the consultant to be effective in the job, in a position to gain satisfaction from the job and to maintain a reasonable work-life balance.

This chapter looks at how far consultants have been able to craft the role, what methods have been used to achieve it and what the consequences are for satisfaction and work-life balance. The chapter starts by considering the way the role has been crafted, including the extent to which consultants have been successful in generating resources and gaining support; it then explores perceptions of the role, addressing issues such as the level of job demand, role clarity and work overload. Finally, it looks at aspects of satisfaction, work-life balance and the extent to which the role has met the consultants' expectations. It draws on data from the questionnaire surveys and on information from the panel interviews.

5.2 Crafting the consultant role

In Chapter 2, describing the role, we outlined how far consultants were engaged in the various functions and activities. This revealed that a sizeable minority of consultants had a high average score on engagement across all 23 activities identified in the original job specification. Far fewer were consistently highly engaged across all four functions. Evidence presented in the same chapter also revealed that many consultants are also engaged in a certain amount of management activity; indeed, 11 per cent are highly engaged in management activities. This suggests that to succeed in the role, some consultants believe it is necessary to obtain a degree of managerial authority, a point reinforced by some of the focus group and interview comments.

It seems plausible to expect that the balance of activities might vary between types of consultant and might change over time. Comparison across the specialties revealed no significant differences in the main functions. However those working in community/ primary care posts were significantly more likely to report that they engaged in managerial activities. A high degree of engagement in management was reported by 32 per cent of these consultants compared with 4 per cent of those in mental health and none of those in midwifery posts. This may reflect the broader and more novel nature of the community/ primary care consultant role.

A comparison of those who have been in the job for longer or shorter periods reveals no significant trend in either the number of activities or the pattern of activities. Those most recently appointed reported the highest levels of engagement in the expert practice and training and development functions and there was a slight but non-significant tendency for those who had been in post longer to report a generally lower level of engagement across all activities. What was perhaps more revealing was the analysis of the number of consultants who were heavily engaged across a number of functions. The analysis revealed that 15 per cent were highly engaged across all four main functions (excluding management), 22 per cent were highly engaged in three of the four, 30 per cent were heavily engaged in two and 21 per cent were heavily engaged in one. This left 11 per cent who said they were not highly engaged in any of the four main functions. It should be borne in mind that the criterion for "highly engaged" is reporting high involvement in over half the activities in the functional area. When we used this measure to compare levels of engagement of consultants with more or less experience, the results showed a tendency for those with more experience to become more engaged across the functions. The average level of high engagement increased from 1.73 functions for the most recently appointed tranche of consultants to 2.14 for the most experienced tranche.

An important role requirement is that half the time is spent with patients. There was no evidence that the proportion of time in contact with patients, clients or the community varied according to experience in the post. Each tranche reported spending between 40 and 47 per cent of their time with patients. However there was variation by specialty with those in area-based or condition-based specialties spending an average of 46 per cent of time with patients, while midwife consultants spent only 36 per cent and community/ primary care consultants only 28 per cent of their time in contact with patients, clients or the community. This seems likely to reflect the difference between the narrowly and more broadly focused consultant roles as well as the difference between working in a hospital or wider community setting.

More qualitative evidence about crafting the role was also obtained from the telephone panel interviews. A specific question asked about how the role had changed over time. Several referred to the time it took to grow into the role and to the uncertainties in the early months:

Over the last, I would say, six to eight months there's been a gradual growing into being a consultant nurse. And people told me right at the very beginning it would take two years. And that's true. That's what it's taken.

I think the job was thought of without a great deal of discussion around what the person would do… But I was as guilty as any of them really then of not thinking through what the implications of the role were. Which seems laughable now, but it was a very shaky way in which to start a project.

It took me so long to make, to get to know the organisation and where I fit in… On the first of July I'll have been in post two years, and I just now feel I'm fully functioning.

The need to craft the role became apparent after a while:

I think at first it's hard because you're not that clear yourself what the role is. And there's a very clear chain that you start off – you're not clear what the role is and you know you're keen to get involved and get to know people and get working, so you get into all sorts of things that you probably shouldn't get into. Then you achieve a sort of clarity of role, and then you have to start getting out of all those other things that you've got into that you really shouldn't have done.

I set objectives when I first came into the post, and she [her manager] *reviewed them with me. Then I had to cut them back drastically because I was trying to do too much. And we just reviewed my objectives a year in post and actually cut them back again, because again I started to get more realistic.*

Part of the process of crafting the job meant building relationships.

I think it's probably related to developing a new relationship with our new Director of Nursing. I think it's probably about being proactive, and about putting together a plan and taking that forward.

The main changes I feel have been in the last 6-9 months really and that's down to the change in my line manager. The first, the initial 18 months were, as you probably may recall, I said were very, very traumatic. The last you know nine months or so have been completely different. I now feel quite reasonably confident in where I sit within the organisation and the fact that my views etc. are valued, and I'm actually being included in decision-making rather than being excluded.

I sat down with the manager of A&E who in not directly my line manager, but is the person with whom I work most closely, or I should do, and we started again by looking at the job description, by looking at what worked, what didn't work, what was realistic, what was unrealistic, what suited my skills and personality and interests and what didn't. And almost rewrote the job description again, and then started from there with you know twelve eighteen months experience of it not working well.

A problem faced by some consultants, particularly if they had been internal appointments, was that they felt they had to fight to establish an appropriate set of activities. Comments from internal appointments who had previously been clinical nurse specialists illustrate the point:

I have certainly in my IPR had, made some very strong suggestions because I really felt that I was being looked at more as a clinical nurse specialist than a nurse consultant.

I go through periods when I think 'yep, that's definitely my job'. And then you want to put me in a clinical nurse specialist box. Nobody understands what I'm doing… its very clear in terms of the expert practice – that is completely clear. What it's not clear about is the other elements of the role.

I don't actually feel my job has changed a huge amount. I think the title itself kind of makes you feel that you need to have more credibility, need to be more credible in the role. But I just feel that my actual clinical level of my work etc hasn't really changed very much…

Other consultants also faced a problem of being directed to undertake more clinical work than they wanted to do and had been unable to craft an appropriate role for themselves:

Another pair of hands… Initially it wasn't too bad and I was managing to do the fifty-fifty, but I would say for the last eight months it's probably got worse and certainly for the last two months it's certainly been 95% clinical.

Continuing care assessments should be done by a specialist assessor and not by the nurse consultant. The nurse [consultant] *should have more of a coordinating, strategic, decision-making and monitoring role plus advising on complex patient problems. It is important not to get bogged down with routine care, otherwise you can't move forward on new ideas.*

According to the consultants, explanations for being forced into a restricted role lie with the management.

I feel in my clinics I'm fulfilling the role of a specialist nurse… But I don't have the support of my manager, and she's quite happy for me to just sit there doing the heart failure clinics, then the resources aren't bid for a heart failure specialist nurse. And conflict with managers over interpretation of the role leaves little room for growth…

I don't think I've got the authority. And I think that the problem is I work with a brilliant [medical] consultant, but he's definitely got some very clear views on how he thinks the service should develop… and the service manager has not made the transition from nurse specialist to nurse consultant.

Despite these problems for a minority, most consultants reported that they had the freedom and autonomy to develop the role.

Authority was given, by the Director of Nursing… And I had to find my own pathways and to be involved in everything that I did, my own contacts.

I suppose you come into it… because it was a new role… and although I suppose people had vague ideas how they saw it to be, I had to develop my ideas and I think by the time you develop your ideas you've got yourself caught up in all sorts of other things… I mean I have to say I have been given a lot of freedom to develop it as I see fit really.

I guess that I have just decided to shape the job as I see fit within… bearing in mind the parameters of the consultant nurse role… And that's been the wonderful thing… suddenly having a role in the health service where you're not being managed in a destructive way. That, you know, I've just had the flexibility to think 'right, I'm doing this, I'm doing that, and this is how it fits, and I can justify that and…' It's just been, you know it's been wonderful actually. But actually I have been very much on my own. But part of me loves that.

It's very evolutional and can go in whatever way that… I have quite a great say on what I actually do. And so I can direct it in ways I want it to go really, obviously in line with what's needed nationally and locally. But I have quite a lot of flexibility in that.

For those consultants who had been in post for a while and who had the freedom to shape the role in the way they want, three kinds of development seemed to be emerging. These concerned strategy, learning within the Trust about the role and adjusting the level of clinical practice.

I think I've actually got more of a corporate role now, as opposed to working specifically within the learning disability directorate. Doing a lot more generally with regards to leadership in nursing across the whole Trust because of me getting known across the Trust.

I think it's gone from being sort of something that people are aware the job's there but not sure what they're doing with it, to a lot more of a strategic position. I think I actually now have a place within that strategic level.

I think it was quite difficult for people to understand what a consultant role is to start with and I think there is a tendency to try to slot you into the management structure, which has to be rectified and avoided. And I think… I suppose it has changed to a much more consultancy type role.

When I first started I was clinical really 100% of the time or a very high percentage of the time and now I'm 50% clinical, which has been fantastic because it means now I can concentrate on doing other aspects of the consultancy role.

I need to be a bit more disciplined in actually leaving the clinical area, and it may be that I have to rethink the way in which I work. So rather than being in the clinical area every day, just have two days that I'm in the clinical area and the rest of it I'm not.

What these various comments illustrate is that in most cases the role evolves, often from an uncertain start. The way in which it evolves varies considerably and can be analysed along a number of dimensions. Firstly, consultants identified a number of facilitators or constraints on the scope to craft the job including their previous role and the novelty of the context. Secondly, and linked to this, other staff, and in particular management, could act as a significant source of support or as a major barrier to the development of the role. A variant on support was leaving the consultant almost

completely alone to develop the role as they wished. A third dimension lies with the consultants themselves; they appeared to vary in the degree of proactivity or passive acceptance of the way others perceive the role. Some consultants acknowledged that they had to learn through experience, and often with help, how best to craft the role. Early freedom led to the temptation to try to do too much; but that freedom appears to have been used subsequently, at least in some of the cases, to rein in and reduce the size of the role. By implication, there may be a sequence that some consultants go through of enthusiastically expanding the role, experiencing overload and then contracting the role to a more manageable scale.

In short, there is often considerable scope to craft the job; the extent to which this is permitted depends on the context and in particular aspects of the support system while the extent to which it is utilised depends, in part, upon the extent to which the consultant is prepared to use initiative and make challenging choices. The subsequent decisions may well determine whether the role is seen as sufficiently clear, manageable and rewarding.

5.3 Perceptions of the role

In both the questionnaire surveys and the panel interviews we sought views about the availability of resources and support in the consultant role, as well as perceptions of task characteristics such as level of control over and demands in the job. We also collected information on role clarity, role conflict and role overload. These are all issues that are likely to be a consequence of the extent to which consultants have been working in supportive settings and have been successful in crafting for themselves an acceptable role.

5.3.1 Resources and support in the role

We have already noted concerns about the size and scope of the consultant role and cited examples of lack of support. In this section we start by exploring how systematic and extensive such concerns are.

Support from:	Percentage		
	Low (1-2)	Medium (3)	High (4-5)
line managers	41	38	21
professional managers	44	35	21
senior managers	20	43	37
senior medical staff	49	34	17
peers/ colleagues	25	45	30
Resource provision	52	29	19

Table 5.1: Resources and support

In the third questionnaire, resource adequacy was measured with two items simply asking consultants whether they had adequate resources and administrative support to do their jobs. The results are summarised in table 5.1 above. Based on the combined response to these two items, only 19 per cent agreed that they had adequate resources. This ranged from 21 per cent of those in community and primary care to just 6 per

cent of those in midwifery; however these differences are not statistically significant. There were no differences linked to when consultants were appointed.

Support in the consultant role can come from a variety of sources. We sought information by asking about support from the line manager, the professional manager, the senior medical staff, senior management and colleagues. In each case, the same five questions were asked concerning support through feedback, concern, information, help and praise. The questions concerning senior management support were slightly different (see Appendix 10 for details). The results are summarised in table 5.1. On the whole, consultants felt they received only low levels of support. 37 per cent reported high support from senior management, 30 per cent from peers, 21 per cent from both line managers and professional managers and only 17 per cent from senior medical staff. Because the questions about support from senior managers were worded differently, this may possibly explain part of the somewhat more positive response about their support. There was no consistent pattern by specialty. Consultants in primary/ community care reported the highest level of line management support (32%) while mental health consultants reported the lowest (19%). Those working in a condition-based specialty reported the highest level of professional manager support (30%) while mental health consultants reported the lowest (17%). Midwives reported the highest level of senior management support (41%) while those working in an area-based specialty reported the lowest (35%). Those in a condition-based specialty reported the highest level of senior medical support (19%) while midwives reported the lowest (65%). Finally, those in an area-based specialty reported highest levels of peer support (32%) while midwives reported the lowest (19%).

Many open-ended comments and observations about support were made by the panel interviewees, highlighting the importance of support and the variations in the level of support provided. There was sometimes a distinction between a laissez-faire attitude in which absence of active support provided the autonomy for consultants to craft a role and the lack of support that acts as a constraint on the consultants' perceived ability to exercise authority and to engage in those activities that they see as central to their role. Clearly this was a sensitive area for consultants and one where many felt they were being failed by managers.

5.3.2 Job control and job demands
Lack of support may be less of a problem for those who feel that they have control over their job and can manage its demands. These two issues were explored using standard survey questions. Job control was covered by five questions asking about the extent to which consultants could plan their work and choose what and how to do it. Job demands were measured with a seven-item scale including statements such as "I have to react quickly to prevent things going wrong" and "I am required to deal with problems that are difficult to solve". The results are summarised in Table 5.2 (below).

Levels of job control were high, indeed 86 per cent reported high levels of job control. This ranged from 91 per cent of midwife consultants to 74 per cent of community/ primary care consultants. It also ranged from 90.5 per cent of those in the first tranche of consultants to 79 per cent of those in the most recently appointed tranche.

	Percentage		
	Low (1-2)	Medium (3)	High (4-5)
Job control	1	13	86
Job demands	7	49	44
Role clarity	7	33	60
Role conflict	49	35	17
Role overload	10	34	56

Table 5.2: Perceptions of the consultant role

Job demands were rated as high by 44 per cent of consultants. The proportion reporting high demands ranged from 58 per cent of consultants in community and primary care to 37.5 per cent of consultant midwives; and between 52 per cent of those in the first tranche of consultants appointed to 21 per cent of those in the most recently appointed tranche.

Although none of the differences in perceived job control and job demands were statistically significant, there did appear to be a pattern whereby the most recently appointed consultants perceived that they had less control but also that the job was less demanding. This may reflect an early honeymoon period in the job before the reality of their challenge sinks in. They had not yet reached the stage where the demands of the job required serious crafting of the role.

A regression analysis took account of a wider range of potential influences on job control and job demands. This revealed that those in community and primary care work did report significantly lower levels of job control. It also demonstrated that those who reported high levels of senior management support reported higher levels of job control as did those who were highly engaged across the range of functions. The regression analysis confirmed that those who had been in the consultant job longer reported significantly higher levels of job demand. So, too, did those in community/ primary care roles. Those in highly formalised roles reported lower levels of job demand, while those with senior management support reported higher levels of demand. The reasons why senior management support should be associated with higher job demand is unclear, unless this support is a necessary prerequisite for engaging in more complex activities. One feature that did emerge from the regression analysis is that consultants in community and primary care roles reported both higher demand and lower control in their jobs. In some well-established research, this is seen as a recipe for higher stress.

5.3.3 Role clarity, conflict and overload

A particular risk in the consultant role is that if the job description and the key focus and objectives of the role are not specified and agreed at local level, it can be left highly ambiguous. On balance, it is to be expected that consultants will prefer a degree of job clarity. A second risk is that there will be conflicting pressures in the job both because of competing demands made by those who have an interest in the role; and because of the potential size of the role and the need to undertake the four core functions and spend 50 per cent of time in contact with patients, clients and the community. Thirdly, and linked to this second concern, there is a risk that some consultants will find that they are seriously overloaded, with possible implications

both for their ability to do the job effectively and for their own satisfaction, stress and work-life balance. This section therefore looks at these three issues in greater detail. Again information is provided from both the surveys and the panel interviews.

Role clarity was measured in the questionnaire survey using three items from a standard scale. These asked about knowing the responsibilities, knowing what is expected and knowing what has to be done in the job. Overall, 60 per cent reported a high level of role clarity with only relatively small variations between specialties, ranging from 66 per cent of midwife consultants who reported high role clarity to 54 per cent of those who worked in a condition-based specialty. Perhaps not surprisingly, job clarity increased with time in the job. It increased from 50 per cent of those in the most recently appointed tranche to 76 per cent of those in the first tranche of consultants. In fact, role clarity was lowest among those who had been in post for about a year before gradually improving. These differences were statistically significant. The significance of tenure for role clarity was confirmed in the regression analysis. This also revealed that those who scored highly on the measure labelled job competence, the indicator of confidence in ability to do the job, also reported higher role clarity. As we might expect, those who reported a high level of job formalisation also reported higher role clarity, as did those with stronger line management support and those who engaged across the full range of consultant activities. In contrast, the regression analysis confirmed that those who were older and those working in a specialty-based condition had lower job clarity and more surprisingly, so did those who reported strong support from senior medical staff.

Role conflict was measured in the questionnaire survey using three items from a standard scale and focuses on conflict arising from competing demands made by others. Levels of role conflict were generally low. Overall, only 16.5 per cent of consultants reported high levels of role conflict. This ranged from 14 per cent of those working in an area-based specialty to 26 per cent of those in community/ primary care roles. There were no significant differences by tranche although it was notable that none of those in the most recently appointed tranche reported a high level of role conflict; given the higher levels among the other tranches, this again suggests that they are in something of a honeymoon period in their roles. The regression analysis shed some further light on the influences on role conflict. It was higher among those with higher educational qualifications and among those who rated their own confidence in their ability to do the job highly. On the other hand, it was lower among those who had a high level of job formalisation, as well as high levels of support from senior medical staff and from senior management.

The third role-related measure explored work overload. This was another three-item measure adapted from a standard scale and the results revealed that 56 per cent of consultants reported a high level of work overload. This ranged from 47 per cent in a condition specialty to 66 per cent among midwife consultants. These differences were not significant. There were few variations by tranche with the exception of the most recently appointed tranche who reported much lower levels of overload (29 per cent). The regression analysis indicated that consultants working in community/ primary care and also those working in mental health reported higher levels of work overload than others and notably those in area-based specialties. Not surprisingly, those who undertook a wider range of activities in the role reported higher levels of work

overload. In contrast, those with a high level of job formalisation and those with strong professional support reported lower levels of overload.

In summary, there is some evidence of an early honeymoon period among consultants in the first months in post, during which time the job seems manageable. However the situation changes with time in the job and the requirement for role crafting comes to the fore. Across the sample of consultants, over half reported high demands and high work overload; but over half also reported a high level of job clarity and the great majority felt that they were in control of their work. There is some indication that with longer experience the demands stay high but the level of clarity and control increases, while the conflict in the role decreases and the workload becomes more stable. This suggests that the consultants learn how to manage the role. An exception to the general pattern is found among the consultants working in community and primary care. They were more likely to report high demands, lower control, high work overload and higher role conflict. They were also the group most likely to have become highly involved in management activity. This suggests that there are particular features of their role and context that make the work of the consultant more challenging.

5.4 Consultants' job satisfaction and commitment

One of the important issues raised by the variations in role engagement, success in role crafting and perceptions of control and overload is the impact on the well-being of the consultants themselves. The following sections address this question. We start by exploring the extent to which consultants are satisfied with their work and committed to their profession and to the health service. First we examine three related issues of how far the job has met consultants' expectations, their general job satisfaction and their satisfaction with pay. We then set out the evidence about commitment. The descriptive findings for these sections are summarised in table 5.3.

	Percentage		
	Low (1-2)	**Medium (3)**	**High (4-5)**
Met expectations	24	22	54
Job satisfaction	6	21	73
Reward fairness/ satisfaction	37	23	40
Professional commitment	3	16	82
Commitment to the NHS	11	32	57
Job stress	36	36	28

Table 5.3: Consultants' satisfaction, commitment and stress

5.4.1 Satisfaction and met expectations

The four-item measure of met expectations was designed to assess the extent to which the consultant role has lived up to expectations or in some ways been a disappointment to postholders. 54 per cent agreed that the job has lived up to expectations. There was very little difference among specialties in the extent to which expectations had been met. There was some variation across tranches in that the proportion who said the job had met expectations reached above 60 per cent in the first two tranches, dropped to just over 50 per cent for most of the other tranches and

then rose to 77 per cent for the most recently appointed tranche. However these differences were not significant.

The regression analysis, which allowed us to control for other background factors, revealed a rather different set of results. Firstly, it indicated that community/ primary care and midwife consultants reported a significantly higher level of met expectations in the role than other consultants and more particularly those in an area-based specialty. Secondly, those who reported higher levels of senior management and senior medical staff support reported higher met expectations. Thirdly, those who had a detailed job description, high levels of role clarity and low levels of role conflict reported higher levels of met expectations. Fourthly, those who had already held more than one consultant post were more likely to say the job had met their expectations. On the negative side, women were more likely than men to say the job had not met their expectations. Taken together, the various background factors account for an impressive 44 per cent of the variation in responses on met expectations.

Data on job satisfaction were collected using a standard five-item measure in the questionnaire survey. 73 per cent expressed overall satisfaction with their job. This varied across specialty with 84 per cent of both community/ primary care consultants and midwife consultants expressing high levels of satisfaction compared with only 70 per cent of those in a condition-based specialty. Job satisfaction also tended to be higher among the more recently appointed tranches of consultants.

Some of these descriptive findings are confirmed in the regression analysis. This revealed that community/ primary care and midwife consultants reported significantly higher levels of job satisfaction while those with a longer tenure reported lower job satisfaction. Strong senior management and senior medical support was associated with higher job satisfaction. So too was a higher workload, perceptions of reward equity and a perception of good career opportunities (some of these issues are explored in more detail in a later chapter). Above all, met expectations were very strongly associated with job satisfaction. On the negative side, there was an unexpected association between strong line manager support and lower job satisfaction. The reasons for this were hard to discern. More generally, however, there was some indication that those who were engaged in the more broadly-based jobs, which often seemed to be the more challenging and had heavier workloads, reported higher levels of satisfaction with their jobs.

A three-item measure of reward equity explored perceptions of fairness of rewards in relations to effort, responsibilities and training and education required in the job. 40 per cent expressed satisfaction with the fairness of rewards. This ranged between 43 percent of those in a condition-based specialty to 30 per cent of those in an area-based specialty. There were wide variations by tranche, with 16 per cent of those in the sixth tranche compared with 61.5 per cent of those in the most recent tranche expressing satisfaction with rewards. While there was no significant trend, those in tranche six did report lower levels of pay than those in the other tranches.

The regression analysis was more revealing in that it confirmed that those on higher pay reported higher levels of fairness of rewards. Women reported higher reward fairness than men, but those with high self-rated confidence in their ability to do their

job (job competence) reported lower fairness, perhaps reflecting a view that their competence is not adequately recognised and rewarded. Those who reported higher levels of resource provision and higher levels of senior management support also reported higher levels of fairness of rewards. The various background and role-related items explained 18 per cent of the variation in perceptions of reward fairness.

Salary issues were mentioned 24 times in the panel interviews and most of the comments were concerned either with a lack of equity of a lack of transparency and clarity in the process for determining initial pay and more particularly pay rises. As one consultant noted, after a meeting where comparisons were made:

> *I mean in salary terms there are differences of £10,000 starting salary. And certainly at our last meeting we were discussing things around salary and the vast difference in salary scales and also the fact that some people had increment dates and some people didn't have increment dates. And it all seemed a little bit vague.*

In some cases increments depended on performance reviews but staff had difficulty getting a performance review. In other cases, there were equity issues beyond comparisons with other consultants. As one noted:

> *I'm tired of working so long for so little reward. I mean I have to say that my salary at the moment is a huge issue... And you know, an appointment of a new modern matron is on a higher salary scale and range than I am. And that's a huge bone of contention.*

Despite the mainly negative comments about pay comparisons and pay equity, there were cases where consultants had been able to put forward a convincing case and had gained valued increments or at the very least a willingness to look sympathetically at their case.

5.4.2 Commitment

The third survey included two measures of commitment, namely commitment to the profession and commitment to the NHS. Inspection of the results revealed that these are very highly inter-correlated – the correlation is 0.90. We therefore combined them into a single measure, re-labelled occupational commitment.

Despite the high correlation, there were quite marked differences in the levels of commitment to the profession and the NHS. 82 per cent of consultants reported high levels of commitment to their profession while only 57 per cent reported high commitment to the NHS. There was very little variation between the tranches with respect to professional commitment but commitment to the NHS did vary somewhat, with those working in community/ primary care reporting much higher commitment to the NHS, at 68 per cent, than any of the other specialties. Professional commitment appeared to be lower among the longer serving consultants. It ranged from 71 per cent among those in the first tranche to 93 per cent among those in the most recently appointed tranche. In contrast, only 36 per cent of those in the most recent tranche reported high commitment to the NHS but there was no clear pattern among the other tranches.

Regressions were conducted on the combined measure. This revealed that "occupational commitment" was higher among those reporting high levels of job competence, strong professional management support, a high workload, good career opportunities and a high level of met expectations. Together, the background and role variables explained 18 per cent of the variation in responses.

5.5 Stress at work and work-life balance

One possible concern about the consultant role is that it is potentially very broad and time consuming, creating a risk of overload and stress and damage to work-life balance. These issues were explored mainly through the qualitative panel interviews. However work-related stress was also assessed through a standard three-item measure in the questionnaire survey. The results showed that 28 per cent of the consultants claimed high levels of work-related stress. Levels of stress were similar across the specialties, with the exception of consultants working in community/ primary care, 47 per cent of whom reported high levels of stress. This is to be expected since this group reported higher demands and lower control over their jobs and were more likely to have taken on a wide range of activities including management activities. There were no clear differences between tranches, although there was tendency for those in the early tranches and who had therefore been in their jobs longer, to report lower levels of stress.

The regression analysis confirmed that stress is significantly higher among consultants working in the community/ primary care roles. It was also, as we might expect, strongly associated with a higher reported workload. It was lower among those who had more professional qualifications and among those who reported high levels of met expectations in the job. The various background and role-related factors accounted for nearly 44 per cent of the variation in levels of stress.

In the panel interviews there were many comments about pressure and stress, mainly linked to work overload. There were also many comments about having too much to do in the time available and about the need to meet constant deadlines. These were often linked to comments about lack of support, illustrated, for example, by the lack of cover during holidays resulting in a huge workload on return. Another illustration was the time taken by cross-site travelling. Demands made by management were a constant source of extra work and pressure, as were requests from outside the Trust to become involved in conferences or other activities. The consequences of high workload and stress included excessive tiredness, a sense of exhaustion and some somatic complaints.

> *I mean what I find is that by the time you leave the clinical area at sort of 6 o'clock, you're just too exhausted to do anything so I find that what I should be doing, what I can do, I've been taking home and particularly at weekends.*

Various ways of coping with stress were described. One was to learn to say no to additional demands, another was to work extra hours while yet another was to take on everything. Others reported attempts to delegate, although some felt guilty about doing so. In a number of cases, certain aspects of the job had to be neglected for a while, with evaluation and research being the most frequently cited. One consultant built in time for reflection and record-keeping; another took up relaxation exercises; others sought advice and support from their manager.

Despite the pressures of work overload, there were relatively few negative comments about work-life balance. A number described getting into a position where they were taking a lot of work home and had to adjust. Others described a range of practices such as cutting off at the end of the day, taking reading material home during weekdays but avoiding weekend work. Several consultants commented on the

benefits of flexible working; some even mentioned feelings of guilt about leaving work early on occasion. However there were exceptions:

> *And considering they're saying I must spend a minimum of 25% on audit and research, and then being told that I have to do it at home if I haven't got time at work. So you know to do what they expect, I have to do an awful lot of stuff in my own time… When I started the post with the travelling involved, I made a key decision that I was not going to work at weekends or evenings. I mean, I get home at 7 o'clock on most days, sometimes later… and I want a couple of hours at home with no work… But it's not like that at the moment. And certainly you know having to spend Easter weekend working is not something that I want to do.*

5.6 Summary

This chapter has explored the ways in which consultants are able to 'craft' their jobs to make them manageable and also, potentially, rewarding and satisfying. The findings show both high levels of demand and high levels of control over job content. There is some evidence that over time, many consultants are able to craft their jobs and to manage workload more effectively, although there is still evidence that those who have been in their jobs longer are less satisfied. However some seem to opt for a heavy workload and while this is associated with higher stress, it is also associated with higher job satisfaction. In the panel interviews, there were many comments about excessive workload and concerns about resources and support. But the consultants appeared to be coping reasonably effectively with the pressures and there were fewer negative comments about work-life balance than perhaps we might have expected. The key evidence is that almost three-quarters expressed positive satisfaction with their job and 'only' 28 per cent reported high levels of stress.

The findings in this chapter have consistently identified the community/ primary care consultants as outliers. They engage in a high range of activities, have high demands but report rather less control over their jobs than most other consultants. This is a standard recipe for high stress and it is therefore not surprising to find that they report a higher level of work overload and higher levels of stress. However they are also among the most satisfied, the most highly committed and the most likely to report that their expectations are being met in the job. More generally, this implies that a number of consultants, more particularly in the newer and evolving community/ primary care posts are choosing a high involvement/ high commitment/ high pressure approach and finding it rewarding and satisfying. There is consistent evidence that strong support from senior management and senior medical staff is helpful in coping with the demands and pressures of the job. More broadly, the findings in this chapter confirm that the job of a nurse, midwife and health visitor consultant is a busy and demanding one, but that for many it is also exciting and involving and that most consultants feel satisfied and committed in their work.

Chapter 8 takes these findings a step further. If the personal evaluation of the role is positive in most cases, what are the implications for the careers both of the consultants themselves and of those who are at earlier stages in their careers? And what of the prospects for the minority who do not feel so positive about the role, some of whom have already left their posts?

Chapter 6: Selecting, Designing and Supporting the Consultant Role: Implications for Impact and Effectiveness

6.1 Introduction

The analysis in chapter 3, describing factors associated with consultants' impact and effectiveness, highlighted three main sets of factors. The first concerned personal qualities and circumstances. Those with higher self-confidence rated themselves as having a greater impact while those with higher educational qualifications reported a lower impact. If we accept these results, they have implications for selection. Secondly, those who were fully engaged across all four functions reported higher impact. This has implications for job design. Thirdly, certain types of support are associated with impact, specifically, peer and senior medical support are rated as important. As the previous chapter, exploring aspects of the role and their implications for satisfaction, highlighted, other types of support, and in particular senior management support, are also associated with key outcomes as well as with ability to craft the role. This suggests that we need to take the issue of support in the role very seriously.

This chapter explores the issues of selection, job design and support in more depth since they appear to have an important bearing on success and satisfaction in the consultant role. In doing so, it extends the material on job crafting presented in the previous chapter. This chapter draws on two main elements in the data collection, namely the sponsor interviews, which can shed some light in particular on selection; and the qualitative panel interviews which collected data on role design and on support and can provide a more nuanced picture of the consultant experience to complement the quantitative analysis presented in the chapter on impact.

6.2 The selection of consultants

In much of the analysis of factors associated with impact and satisfaction, the variable that measures self-efficacy or confidence in ability to do the job well emerged strongly. While there are inevitably some issues concerning cause and effect, there is evidence from the longitudinal analysis (see details in the next chapter) that this measure of self-rated competence at the time of the first survey is associated with higher ratings of impact at the time of the third survey. Without explicitly highlighting this variable, sponsors had views about the importance of selecting those with clinical credibility and ability to communicate and persuade. First, however, to set this in context, we report some of the comments from the sponsors about the processes of recruitment, selection and socialisation.

A majority of sponsors were critical of the traditional process of obtaining approval for consultant posts, indicating that it was slow, cumbersome and bureaucratic. There was insufficient information to indicate whether the move to a more local approach had resulted in any improvement.

Prior to seeking approval externally, most sponsors had had to work hard to gain internal support and funding for the post, often in the face of initial opposition and scepticism. It was generally felt that the case for a post was more impressive where

those who would be working closely with the consultant had been heavily involved in making the business case. However the opposition had often come from medical and indeed nursing/ midwifery staff and personal persuasion had sometimes been necessary to gain their acquiescence. Once an initial appointment had been made and had been a success, there was generally more support for further appointments. As one sponsor put it:

> *We did recruit very high calibre people and they've done the hard work for me, because they've gone into the post, they've done what we asked them to do, they performed at the right level, they've got the right credibility and people are saying 'these are good aren't they, can we have some more?'*

Selection had proved difficult for most but not all sponsors. Those who had recruited from within their Trust had generally found the process relatively straightforward. Those who sought to recruit nationally had faced more difficulties and sometimes considerable delays in finding the right person. This was largely attributed to two factors. The first was the general shortage of applicants of the right quality, a problem which they judged to be getting worse over time. The second was the specific issue of seeking the right educational qualifications. Interestingly, in the light of the negative association between higher educational qualifications and consultants' self-rated overall impact in the job, several sponsors were doubtful about the emphasis on the educational criterion in selection and were willing to lower educational standards somewhat to get the "right" person. The "right" person was invariably someone with good clinical experience, communication skills and personal qualities of an outgoing sort that reflected energy, leadership and acceptability. One sponsor described such candidates as follows:

> *Keen to work with parts of the team, you know, pleasant with people, got a nice attitude to life, work-balance, work ethics, all of those things, rather than someone who's got their PhD but is interpersonally stunted. The thing I never compromise on is getting the right person, because I think you can teach people to use an endoscope but you can't give them a personality transplant…*

While it was generally easier to recruit from within, and some Trusts had set up programmes to identify and develop potential future consultants, even to the point of setting up "trainee consultant" roles, there were mixed views about the desirability of recruiting internally. Some took the view that consultants should be recruited from outside the Trust because of the fresh ideas they were likely to bring. Despite the evidence from the analysis of the questionnaire surveys and the issues raised by sponsors about the relative importance of personal qualities and competence rather than educational qualifications, together with reports of increasing problems of finding candidates with the necessary qualifications, we could find no evidence of any reduction in educational standards among the more recently recruited cohorts.

6.3 Issues of job design

Many aspects of job design were addressed in the chapter on job crafting. The evidence from the quantitative analysis consistently indicates that higher impact is associated with being highly involved across all four functions. At the same time, this is clearly a major challenge with all the attendant risks of role overload. The sponsors had fairly consistent views on two issues relevant to job design. Firstly, all sponsors maintained that their consultants had no direct managerial authority. Instead they used terms like "clinical authority" or clinical leadership" which, as we have seen in previous chapters, were considered problematic by a number of the consultants.

Secondly, most sponsors favoured specific consultant roles with clear and achievable objectives. They had concerns about some of the more generalist and all-encompassing posts that had been developed in the smaller Trusts and PCTs. They felt these would inevitably involve too much, including aspects of service management, thereby failing to meet the design criteria for the consultant role.

The consultants themselves had many comments to make in the telephone interviews about the design of the job and the nature of their roles. At the heart was a recognition of the flexibility in the role of most but not all consultants. This was viewed by many as a key advantage though a few saw it as a problem:

> *It's very busy, and you need to be very flexible in the way you do things. Because you know the next hour you could be doing something else, your mindset has to change very quickly. I mean I think you have to be very alive, mentally alive. Mental agility… you are dealing with lots of different types of scenarios and people, different networks of people, locally, regionally… You have to be able to plan 12 months ahead.*

Most of the consultants who participated in the panel interviews claimed to achieve their 50 per cent of time on clinical practice. However this could create pressure on other activities and there was often an implicit prioritising in the role whereby clinical practice had priority alongside service developments. Thereafter training and development activities come to the fore while research activities generally attracted the lowest priority except among those involved in doctoral work. Over time these priorities may change and consultants who had been in the role for over two years were likely to be undertaking some research. However research, like leadership, is often unclearly defined and there was therefore some uncertainty about the boundaries between these and other activities.

In practice, the nature of the consultant role is bound up with the interpretation and interaction between the four domains of the role. To be successful, consultants need to have the freedom and skills to move across the whole spectrum of practice from the specific one-to-one practical clinical activity to advising on national policy. This requires outstanding self-management, interpersonal, organisational and professional skills. Those who can meet these challenges find the role satisfying and fulfilling and believe they have a positive impact on patient care. Those who do not, experience frustration and stress. The necessary flexibility and freedom in the role brings with it the disadvantage of structural ambiguity and potentially limited power that some consultants found very difficult to deal with.

6.4 Supporting the consultant role

In previous chapters we have presented data from the questionnaire survey indicating that consultants have very mixed views about the levels of support they receive, with over 40 per cent reporting low levels of support from their line and professional managers and from senior medical staff. They were rather more positive about support from senior mangers and colleagues. We have also noted that various forms of social support are associated with greater reported impact in the role and greater satisfaction. In this section, we look more closely at how the consultants perceived the support they received. Most of the sponsors we spoke to said the consultants reported to them. They claimed that typically they would meet with consultants on a formal basis either monthly or quarterly but that in addition they would encounter them in a variety of contexts. They therefore fulfilled the main line support role. In

this context, we might note that the analysis of the questionnaire responses showed that line manager support was the type of support least likely to have a positive impact on any type of outcome.

In the panel interviews, the consultants made many comments on support and also on the role of colleagues at work. The majority of comments concerned aspects of management support. Some of the concerns about the job reflected the nature of the role and the structural arrangements, rather than management attitudes and behaviour. One consultant described the problem as follows:

> *I work across the interface of two very large services, and so at the moment where I'm professionally accountable to the chief nurse* [and managerially accountable] *to the chief executive, I'm also managerially responsible to the director of learning disability. So there's a little bit of tension there.*

As we might expect, there were a number of comments about lack of management support, particularly in trying to bring about service improvements. There were also concerns about the lack of feedback and the limits of the appraisal system. For example;

> *Our Deputy Director of Nursing is meant to arrange a monthly meeting with all of the nurse consultants… and that has been cancelled consistently every month for the last six months.*

> *I do have regular, regular appraisal. I wouldn't say it's the best one I've ever had. It's more a case of 'look, you write it down and let us know what you're doing, and we'll just sign off the forms'… and I'd like a little more discussion around it.*

In extreme cases, the absence of support was leading consultants to take on a managerial role:

> *No directorate manager and the* [medical] *consultant has resigned… We've been in limbo for two years. It puts me in a very, very difficult position because I have no managerial responsibility or accountability for the unit and yet, quite frankly, I can't allow somebody without that experience to make the decisions… I mean if I wasn't doing it the unit would be leaderless.*

Another consultant had agreed to step into a managerial role on a temporary basis and felt she been exploited by management:

> *So in fact the advert hadn't gone out before the nurse actually left, and she gave three month's notice. So we knew there was going to be a gap, and I said I would be prepared to fill that gap for a three month period. In fact that was over a year ago. So I agreed for a three month period but as I say that was more than a year and I'm still running both services single-handedly.*

There were also many positive comments highlighting the benefits of management support. For example, with respect to specific ideas for change, there were several comments such as:

> *Everyone's been supportive. You know there's always been the encouragement and you know my boss has pointed me in the right direction about clinical governance committees and things like that.*

> *The Chief Executive and the Director of Nursing realised that this had to be signed off fairly quickly, and have basically let me… given me a free rein really to do exactly as I wanted to do it. Which has been great and I've actually had some secretarial support to do this, this time.*

There were also several positive comments about supervision and appraisal:

Oh tremendously [helpful], *yes. Because we have, or I have, supervision from a variety of people, partly because of doing the doctorate, but also because of the work I was doing. Then yes. And it's not just clinical supervision, it's professional supervision as well, so that I can deal with those issues.*

We had a lengthy appraisal – it was very very useful actually.

Peer support was provided from a variety of sources including networks of consultants:

I'm fortunate we've got other nurse consultants in the area that we can sort of sit down and sort of do a bit of peer work and sort of share the difficulties that we're actually having.

I had a fabulous meeting with all the cardiac nurse consultants throughout the UK, there are about 22 of us now… And that was really quite inspiring, to see what everyone was doing, and the work that was underway.

Medical support was only mentioned eight times in the interviews and there was some reference to uncooperative doctors. There was at least one long-running case of continuous obstruction and harassment by a medical consultant that had eventually led to disciplinary action. However more comments were positive with respect, for example, both to effective collaboration and to support:

Again it's from physician colleagues, one particular physician where we work very closely together. And we do sort of a bit of mutual clinical supervision for each other over these issues, because I think we both really feel the impact of it.

The [medical consultant] *I spoke to last week and… I said would they put it in writing that they support me doing this? And he said 'Yes they would be happy to do that'.*

An issue of concern to many consultants was the lack of support with respect to resources. This was mentioned 77 times in the interviews and there were considerably more negative than positive comments. We have mentioned elsewhere the lack of resources to support service development. This was mentioned again as one persisting theme:

Although the Trust recognised that to actually provide a service across the Trust we would need to, you know, be committed and put some resources in, the bottom line was that we don't have any. We don't have any finances to invest in that position and to actually develop the service.

Whilst I've got all these great ideas, and you know good clinical innovation, you can't do it… you could do it a little bit, but you can't do it properly if you don't have enough staff and enough equipment.

In this context, the lack of managerial authority was cited as a problem. So too was the time-consuming bureaucratic process of seeking funds. The key resource shortage was usually staff.

The first [problem] *is always staff shortages, and that's just from a purely fundamental running of the unit.*

The vast, vast majority of it [time] *is hand-on clinical care and again it comes back to the same old story, that we don't have enough midwives to cover the number of women coming in.*

In addition to concerns about lack of finance and staff, an absence of administrative support upset some consultants because it wasted so much of their time.

But I don't think I should've been doing a lot of the kind of dogsbody work… doing the kind of operational stuff of the writing and the checking and looking at the BNF and all that

phase… But there's nobody to take up that… I say this all the time 'right, if you want me to type I'll type, but I'm very expensive and bad at it'.

I guess the major problem, I would say, is admin… which sounds very trivial. But I would suggest that you know that's a critical issue in terms of the efficacy of nurse consultants. If they don't have the right admin support then things grind very slowly.

When support arrived, it made a big difference, leading to a number of positive comments:

I was very angry with the lack of support I'd been given. And so having admin psychologically was a huge boost, and somehow I just decided well I wasn't doing stress at work… I think I've been able to be much clearer, much more focused.

In summary, support issues are of great concern to many consultants and while there were many examples of positive support from managers, peers and others, there were also major concerns about lack of support from the management system, often reflected in lack of resources to progress projects as well as a lack of basic administrative back-up to enable them to do their job properly. While some consultants felt that they were being unfairly treated and there was some concern about the lack of management power in the role when the issue of resources was raised, others seemed to acknowledge that shortage of finances and staff was endemic to the health service, despite the recent investments.

6.5 Summary

The sponsor interviews revealed some problems with recruitment and selection, partly because of the educational requirements for the post. Analysis of factors associated with self-rated effectiveness and impact indicate that those with higher educational qualifications rate themselves as having less impact. Those with higher confidence in their ability to do the job consistently rate their effectiveness and performance more highly.

The flexibility and autonomy in the job is a major advantage to some consultants and a major problem for others, depending mainly on the level of support and resources they received. In using the autonomy of the job to deal with the demands of undertaking the four main functions, consultants tended to give priority to clinical practice, the expert function and service development. Other aspects of the core functions, such as research, only came to the fore at a later stage.

The job was made much easier when support, including the active involvement of senior management, together with the necessary resources were provided. A risk was a tendency of sections of management to give the role a relatively low priority. The medical staff could provide strong support but any opposition from them could be a major problem. Support from peers, including opportunities to compare experiences with other consultants, was valued. In many cases, the absence of resources, particularly resources to support development, was a key problem. In addition, a lack of administrative support was a source of considerable anger and frustration. Despite the vehemence with which a number of consultants expressed their concerns, in many cases, there were positive accounts of support and resource provision allied to accounts of positive impact and effectiveness.

Chapter 7: The Evolution of the Consultant Role Over Time

7.1 Introduction

The sponsors of consultant roles expressed the view that any evaluation should not be conducted prematurely because it inevitably took some time to settle into a new role and have an impact. One of the advantages of undertaking longitudinal research is that it is possible to explore how consultants settle into their roles and adapt over time and to analyse the survey evidence to determine how far factors that were identified during the first survey in 2001 are associated with outcomes at the time of the third survey towards the end of 2003. We have explored this issue indirectly in presenting many of the survey findings by reporting any differences associated with when the various tranches of consultants were appointed. This allows us to determine whether those who have been in post longer behave differently from those more recently appointed. While this tells us about differences between tranches that may be due to a variety of factors, a second approach is to explore changes over time in the same cohort of consultants. The findings may have implications for selection, socialisation, job design and the organisation of support systems and resources for the consultants.

This chapter presents the longitudinal data derived from the questionnaire surveys. More specifically, it explores changes over time in the responses of the 90 consultants who completed questionnaires as part of the initial survey in 2001 and then again in the third survey towards the end of 2003. It is important to bear in mind that these consultants, who are among the earliest appointed, may not be representative of the whole population of consultants. On the other hand, we found few differences between the different tranches in terms of their personal characteristics and backgrounds. Supporting this quantitative analysis, we developed some detailed case studies of six of the consultants who formed part of the telephone interview panel. They constitute a rather different form of longitudinal research since it is possible to explore more specific issues they addressed over time to see how they were resolved.

7.2 Changes over time

The first part of the quantitative analysis reports any significant changes between the first and the third survey among those who completed both questionnaires. These are summarised in table 7.1. It should be noted that only the items on which significant changes have occurred are shown. The significance levels on the right hand side provide some indication of the size of the change with the higher number of asterisks indicating a more highly statistically significant change over time.

The results appear to be mixed although closer inspection reveals a broad pattern. Most of the items on which there was a significantly higher score at Time 3 than at Time 1 were related to the role. For example more time was now spent on R&D activities, which many consultants admitted were neglected early on in the job. There was an increase in the perceived demands of the role and in both role clarity and role conflict. Resources provided for the job had improved but professional and senior management support had decreased, possibly because it was needed less. Perhaps of more significance, engagement across the four functions had gone down, suggesting that despite the increased demands, consultants were trying to focus their activities. As we might expect, the consultants reported that they had become more effective.

We cannot make any assessment of changes in impact. Questions on impact were not asked in the first survey, which was conducted only a short period after the initial tranches of appointments and which had a different purpose.

	Direction of Change		
	Increase	Decrease	Sig
Role engagement			
High engagement across all four functions		X	*
Research and development activities	X		**
Support			
Resources available	X		*
Professional support		X	*
Management support		X	**
Role characteristics			
Role demands	X		**
Role clarity	X		***
Role conflict	X		*
Attitudinal Outcomes			
Job satisfaction		X	*
Occupational commitment		X	**
Growth and Career Outcomes			
Growth opportunities		X	***
Career opportunities		X	*
Performance Effectiveness			
Effectiveness	X		*
Views about the Consultant Initiative		X	***

Table 7.1: Changes over time

Key: *p=< 0.05: ** p=< 0.01: *** p=<.001

While the evidence suggests that over time there have been changes in the way in which the role is enacted and supported that have some plausibility, the attitudinal changes are consistently less positive. Over time, these consultants who were pioneers in the role have become less satisfied, less committed, less positive in their overall evaluation of the consultant initiative and less positive about the growth and career opportunities. All this indicates the beginnings of some degree of disaffection at a personal level. While this may be a cause of some concern, it must be set in the context of the still high levels of job satisfaction and overwhelmingly positive views about the consultant initiative.

7.2.1 What predicts level of role engagement?

The second element in the longitudinal statistical analysis explored which factors measured in the first survey predict responses in the third survey. This is important if we are to detect early signs of disaffection and equally to understand factors associated with greater impact and effectiveness. Only those variables measured at Time 3 where there were significant factors that predicted them at Time 1 are described below.

Role engagement at the time of the third survey (Time 3) was higher among those who had been in the job longer at the time of the first survey (Time 1) and among those who received strong peer and professional support at the time of the first survey. In contrast, it was lower among those who received stronger line management support at Time 1.

7.2.2 What predicts features of the role?

Job control at Time 3 was higher among women rather than men and among those who report lower line management support and higher peer support at Time 1. Greater job clarity at Time 3 was predicted by the nature of the previous job, but was lower among those reporting high line management support at Time 1. Work overload at Time 3 was higher among those who have fewer professional qualifications.

7.2.3 What predicts attitudes?

Commitment and met expectations at Time 3 were predicted by level of confidence in ability at Time 1. Satisfaction with fairness of rewards was predicted by having a clear job description at the start of the job. Higher stress at Time 3 was predicted by longer tenure in the job, being in community/ primary care work and having fewer resources at Time 1.

7.2.4 What predicts growth and career outcomes?

Those who were younger, had stronger peer support at time 1 and had a clear job description when they started their job reported better career opportunities at Time 3. Those reporting stronger support from senior medical staff at time 1 were more likely to intend to stay in the consultant role at Time 3.

7.2.5 What predicts job performance?

Greater self-rated effectiveness, ratings of overall impact, greater impact on processes and greater impact on patient-related outcomes at Time 3 were all predicted by higher confidence in ability at Time 1. Self-rated effectiveness and impact on patient-related outcomes were also higher among those who had strong support from senior medical staff at Time 1, but they were lower among those who had a clear job description at the start of their jobs. Self-rated effectiveness was also higher among those reporting more resources available to them at Time 1.

7.2.6 What predicts general views about the role?

More positive views about the consultant role at Time 3 were associated with fewer professional qualifications at Time 1 and higher confidence in ability to do the job; but were more negative among those who had a realistic preview of the job before starting.

These results indicate that there are only a limited number of factors in the early months in the job that predict subsequent attitudes and behaviour. In relation to potentially important outcomes such as job satisfaction and intention to stay in or leave the NHS, nothing acts as a significant predictor. A few variables stand out, of which the most relevant is the measure of self-efficacy. Those with a high level of confidence in their own ability to do the job at Time 1 were more positive, particularly with respect to their performance impact. Various types of support from managers and peers at Time 1 had an impact on subsequent performance; so too did

availability of resources. Finally, some personal background factors such as professional qualifications, and also gender and age made a difference on specific variables. The apparently negative role of line managers deserves comment. Higher line support was associated with lower engagement, lower clarity and lower control at Time 3. This implies that line managers had some role in 'managing' what consultants do and that those who lent support may be helping to shape the role in ways that are not altogether advantageous. This has possible implications for the induction process, particularly since all other sources of support and resources appear to have a positive impact on subsequent attitudes and behaviour.

7.3 Case histories

The individual accounts, based on six interviews with each consultant over a period of six months provide a rich account of the ways in which their roles have evolved and of the pattern of challenges and achievements that each faced. The full account of each case is presented in Appendix 7. Here a number of recurring themes are selected that illustrate the kind of developments and issues that were typically highlighted. Most are also referred to at other points in the report.

7.3.1 The growth of confidence

A feature of the quantitative analysis has been the importance of consultants' confidence in their ability to do the job. The histories reveal how the consultants varied in their levels of initial confidence. Those who had been internal appointments in specialist roles often started out with a high level of confidence in their clinical competence. Those who did not have this advantage had to gain confidence, often from a starting point of uncertainty and lack of support. As one noted:

I think perhaps I have been too quiet, at work… That comes from bad experiences in the past… but so many people unfortunately have agendas, and I just have to be careful. I don't want to upset people, but I think sometimes perhaps you do have to upset people. I think I've learnt how to do it properly. But everyone's just so busy meeting targets, trying to catch their tail, that there's no… there's just no cohesion, there's no common policies, no common anything.

By a later interview, this consultant was reappraising her approach: *"So I know that if I want to influence things, I have to become a little more political. Not really up my street but…".*

In a similar vein, another consultant noted: *"So I mean that's the challenge for me, and I think that's the most difficult… thinking about my own self-confidence and my own knowledge base really. It's challenging that".* A little later she commented that she now felt better able to: *"Bring an air of confidence about me, around you know… this person does feel confident that I can do* [the job].*"*

A lack of confidence often meant that early on consultants agreed to do everything that was asked of them. This resulted in either problems of overload or, in other cases, a serious imbalance with, in particular, a tendency to do too much clinical work. As time went on, they gained the confidence to plan their workloads and to delegate, to stop doing certain things, to say no to others and thereby establish realistic priorities. In some cases, consultants learnt to do this through experience; in others they sought support, either from a manager or a peer.

7.3.2 The development of role balance

As noted above, some consultants started with a heavily unbalanced role. Typically, they undertook too much clinical work. Unless, they were studying for a PhD, it was research work that usually suffered. Over time, in most cases there was a shift towards a greater emphasis on service development and many of the growing number of achievements related to successful service development projects. As one consultant triumphantly noted:

> *Fantastic! Up and running… The great thing is that the stroke unit actually feels as though it's achieving something that it's been trying to do for the last four years, and get this TIA service off the ground… they're getting the patients in through the doors and they're doing what they wanted to do – which is give people an easy-access, one stop service.*

For some consultants, the imbalance between elements of the role was a concern; for others, it was not perceived as a major issue. Some never quite got it right. For example, one consultant noted:

> *Well I run a variety of clinics and patients can be referred to me directly by GPs. I make the decisions about their treatment. I carry out the treatments, do the letters, follow up. That's my decision entirely.*

She then goes on to say:

> *Strategic development? Well, you wouldn't even think I was there. You know you have all these people who don't work in clinical practice, who don't actually know what they're talking about, who are leading the development.*

This same consultant, who is quoted above in relation to her political skills, gradually began to become more involved in strategic issues, but only after a struggle.

The other issue of role balance was the threat of taking on too much and experiencing work overload. There was good evidence of learning about how to deal with this as one consultant acknowledged:

> *About managing time… Apart from the fact that because so many things are interesting you think 'oh yes I'd like to take that on'. And that's very much what I was guilty of in the first two years, grasping on to things because I thought that's what a nurse consultant should be doing. I have learned to do that.*

7.3.3 Resource acquisition and support

Responses to the questionnaire surveys highlighted the problem of a lack of resources. This is a recurring theme in the sequences of interviews, with on-going accounts of battles to acquire a part-time secretary, for example. Perhaps more seriously, several key developments were hindered by the absence of resources; typically, this concerned the lack of staff rather than finances. As one consultant noted:

> *We've been a victim of our own success, because its been going very well. Which is great, very positive. At the same time, it's quite frustrating because it's not about money. It's actually about people with the right skills, the right expertise, and the authority to make decisions.*

In this context, the lack of management authority became an issue and part of the learning concerned developing skills in working through managers and learning how to gain support. As one consultant noted, this had mixed success:

> *But the resources are not there for me to bring everyone forward… I have brought quite a lot of people forward and developed some services, but it's always been in spite of, not with the assistance of… you know, in spite of the fact that there's nothing there.*

In most cases there was a mix of successes and failures. One of the significant barriers for some of the consultants was Trust reorganisation and merger which provided a reason for delays in general and could mean the breakdown of carefully built relationships. One consultant, whose role had grown more difficult in some respects noted:

> *I think Trust mergers have created more difficulties than anything else to the role of nurse consultants… It's because the original vision for the nurse consultants is held by the initiator Trust which is not always shared*

One of the issues in gaining support concerned relationships with the line manager. This varied and there were several instances of examples that seemed fine on paper not working well in practice. Specific cases were cited of disappointment with an initial appraisal session or a failure to set helpful objectives. This resulted over time either in confronting the manager in question and resolving the problem or switching to an alternative source of support and guidance. If the lack of support was more pervasive, then it operated as a more significant constraint. As one consultant complained:

> *I certainly don't feel that I have had managerial support and I don't really feel that I've had the right sort of support from very senior management in the Trust… And I don't feel that I'm functioning properly.*

This particular consultant remained disillusioned with the role. She had nine clinical sessions a week, which seriously limited the time for other activities. At various interviews she described feeling *"insulted"* by the lack of basic support, was dismayed by an unsatisfactory appraisal and summed it up by asking *"Why am I banging my head against a brick wall?"* Fortunately, this example was the exception.

7.3.4 From isolation and opposition to integration and positive regard

A recurring theme was the potential loneliness of the job. The problem was exacerbated if there was uncertainty about the nature of the role. One consultant, who was perhaps an extreme case, and whose circumstances subsequently improved as a result of an external audit, described this quite vividly:

> *It's difficult as a nurse consultant to be accepted; first of all you're ridiculed and laughed at and 'who do you think you are?' And there's a lot of suspicion about it… You don't seem to fit in anywhere, do you understand me? You don't fit in anywhere. You're not a doctor; you're not really a nurse, although you are a nurse. It's very difficult.*

If the consultant sat back and waited for something to happen, then this problem persisted. It was therefore essential to spend early time establishing networks and relationships and explaining the role. Even so, in almost every case there were examples of opposition, often from staff in their own specialist area who perhaps felt threatened by the presence of a consultant. It was necessary for all the consultants to establish support systems as part of the process of becoming integrated. In at least one case this was achieved through a consultant network rather than through the normal internal sources. It was then necessary to demonstrate their worth, either through clinical competence or successful service development projects. As a consequence, most cases provided accounts of moving from local activity to more strategic issues as acceptance grew. This was invariably a source of considerable achievement, though it could bring with it costs in terms of overload.

A consultant who at one point had considered leaving as a result of the frustrations in the job summed up her progress:

I don't think they really understood what they wanted to do with the post when they actually first had me in the post. So I think it's gone from being sort of something that people are aware the job's there but not sure what they're doing with it, to a lot more strategic position. I think I now actually have a place within that strategic level.

7.3.5 Problems of ambiguity and impact

While there was progress on many fronts, some consultants never quite overcame the uncertainties in the role. Most commented on and valued the autonomy and flexibility in the role; but they also at times felt vulnerable because the role was never very clearly defined and because it was difficult to establish the direct impact of the role. One consultant summed this up nicely:

I'm [keen to have an impact on] outcomes for people. The only thing is… but I suppose that is going to be an aim of the job… is to prove that it's myself that has that outcome, you know. I mean I have to ask myself 'what would happen if I wasn't here?' And I don't think those things would've happened. But the outcome's going to be shared, very much, with direct clinicians. So it's… I can't do anything without other people working with me can I?

With greater confidence, this diminished as an issue. But a change of management could bring it back to the fore. In this context, there were marked variations in perceptions about how long it would take to have an impact in the role. Those who moved into specialist clinical roles felt that they could demonstrate an impact through their clinical expertise in a matter of months. Others in more generalist roles felt that they were just about having an impact after two years, but it might take five years to have a full impact. Thus one consultant, on celebrating a year in the job noted:

It's starting to crystallise now for me… I really just hope that… it's one of those roles that gets the opportunity to grow and to blossom, and that people recognise that it does take time. It's not one of those things that people look at in three years and say 'oh well, consultant nurses haven't been able to do anything so let's just forget all about them', you know.

Another consultant, in a broader midwife role, took a much longer time perspective. In the second interview she noted:

It took me so long to make… to get to know the organisation and where I fit in, that I think 'well if I just sort of, you know, do that, then this'll happen'. Well obviously it doesn't… So I'm starting to, you know, get more assertive. Now I know where I am going.

By the fourth interview she was able to claim: *"[Soon] I'll have been in post for two years, and I just feel now I'm fully functioning"*.

And on the question of impact:

I mean I don't think consultant midwives will really have a huge impact (until they have) been in post about five years. I would say, I'm two years in now, I know what I'm doing, where I'm going.

7.3.6 Career implications

The consultants were aware of the parallels with the medical consultant role. However few felt the same level of long-term commitment. Views tended to be influenced by recent experiences, as well as by perceptions of the role. Therefore one consultant in a specialist clinical role who had been internally appointed was feeling bored in the job after less than two years, possibly because of a specific view of the nature of the role. In contrast, others saw endless possibilities for development over a long period. However few seemed to see it as an end point and there was evidence of job applications and a certain restlessness. This seemed to grow with time in the job

and has implications for the stability of the role. The uncertainties were summed up by one consultant in her final interview:

> *I think it's quite a difficult one really. I don't know what my future is. A short while ago I was adamant that I wanted to move on and look for further posts. I'm not quite so sure about that. I'm not sure I want to stay as a nurse consultant either. I just feel that there are so many difficulties within being a nurse consultant, and they aren't always easy to manage. I'm not sure that any other job would actually be any different, although I know that's not true. My previous jobs have not had the political difficulties I experience with being a nurse consultant, I have to say. But, the job has also provided a number of challenges, and a fair degree of autonomy that is actually really helpful.*

Another consultant, who had found a new job as a Deputy Director of Nursing by the final interview was already noting the limitations of job in her third interview and in marked contrast to those who might be driven away from the job by work overload commented: *"It ticks along without having lots and lots of input, so I don't think I'm actually being stretched now. So I'm getting bored at work…"*

In the next interview this was reinforced:

> *I've established the role and I'm not sure where else it can go. And I think I have come to the end of the road with the Trust, in a bigger way than probably the job actually. I can't see myself sat in this role for the next ten years.*

Others are more settled, at least for a while:

> *I mean at the moment I'm really enjoying the nurse consultant role. I see me staying in this job for quite a while, because I really want to see this organisation through to its final point of wherever it's going to be managed from. I guess I see myself in this nurse consultant post for at least the next two years.*

7.4 Summary

This chapter has attempted to provide some indication of how the consultant role has changed over the time since it was introduced. The evidence has been drawn from two very different types of longitudinal data. The qualitative information provides an indication of the importance of learning how to cope with workload, to become more assertive and to generate resources. The quantitative data highlight the importance of self-confidence in ability to do the job at the outset as an important predictor of a number of subsequent outcomes. It also highlights the importance of appropriate support. The qualitative comments reinforce these findings.

Both sets of data report a growing belief on the part of the consultants that over time they are gaining a clearer picture of the role, recognise the demands and conflicts inherent in it, improve their capacity to generate resources and become more effective. However there is also a downside. The consultants appointed in the first year and who took part in both the first and the third survey, report a decline in job satisfaction, in occupational commitment and in their perception of the opportunities for growth and careers provided by the consultant role. They also become less positive about the consultant initiative as a whole, although their views still represent a very positive endorsement of the initiative and of the impact it is having.

Chapter 8: Implications of the Consultant Initiative for Careers and Retention

8.1 Introduction

The aim of this chapter is to review the consultants' views about the impact of the introduction of the consultant role, firstly for the consultants' own development and careers; secondly for the development and careers of other nurses, midwives and health visitors; and thirdly for the effective functioning of the NHS and its ability to deliver services to patients, clients and the community.

8.2 Consultants' growth and career opportunities

Given the nature of the consultant role, we might expect that it would provide opportunities for personal growth and development. However it can also be seen in some respects as the pinnacle of the professional career and therefore while there may be opportunities for growth within it, there may be fewer opportunities for career progress beyond it. We explored perceptions of these issues in the questionnaire survey. Two three-item scales were constructed to measure perceived growth opportunities and career opportunities arising from the consultant role. The responses to these and items on intention to stay in the role are summarised in Table 8.1.

	Percentage		
	Negative (1-2)	Neutral (3)	Positive (4-5)
Growth opportunities	4	18	78
Career opportunities	15	44	41

Table 8.1: Growth and career opportunities

78 per cent of all consultants agreed that the role provided them with positive opportunities for personal growth and development as professionals. There were no significant differences by specialty with the midwife consultants the most positive (81% see opportunities for growth) and the condition-based specialty consultants the least positive (70% see growth opportunities). There were also no differences by length of time as a consultant and no discernible trend in the pattern of responses. The regression analysis, where it was possible to control for other factors, was rather more revealing. This confirmed that the condition-based specialty consultants were significantly less likely to see good growth opportunities in the consultant role. It also indicated that those who find themselves more heavily engaged in managerial duties see fewer growth opportunities, posting a warning to those tempted or persuaded to engage in management activities. On the positive side, growth opportunities were perceived as greater by those who rated their confidence in their job competence highly, those who reported high levels of medical and senior management support and those who were engaged across the full range of consultant activities. The various background and role-related items account for 22 per cent of the variation in responses on opportunities for growth.

As we might expect, the consultants were rather less positive about the likely impact of the role on their career opportunities and scope for further advancement. In the

event, 41 per cent agreed that the role opened up career opportunities. There were considerable variations between the specialty areas with 68 per cent of community/ primary care consultants seeing career opportunities compared with only 28 per cent of condition-based specialty consultants. Surprisingly, these differences did not reach statistical significance. There were no marked differences according to length of service and no pattern to the results. The regression analysis revealed that the various background and role-related items accounted for only nine per cent of the variation in responses to the career opportunity scale. It suggested that those new to the role were more positive about the career opportunities. So too were those who reported high senior management support while older consultants were less positive about the career opportunities.

One of the open-ended questions in the third survey asked about the most significant impact of the consultant role on them personally. 447 comments were made and there were four positive comments for every negative one. The largest number of positive comments concerned growth in personal confidence, increased job satisfaction, freedom to work at a strategic level, the level of patient contact, professional development and being able to make a difference. All these were cited by twenty or more consultants. Other items referred to personal development, gaining leadership skills and development of political skills and knowledge. In short, personal growth featured heavily as one of the major impacts of the role, as judged by individual consultants. On the negative side three major impacts were cited as being the most significant: these concerned stress and frustration, feeling bullied and undervalued and increased workload and fatigue. Therefore, while for the majority, the spontaneous comments about the major personal impact concerned opportunities for growth, learning and satisfaction through having an impact, for a minority the key feature was a negative one.

8.3 Future career plans

The consultants were asked about their future plans and where they saw themselves in five years time. They were given a number of options to choose from. The responses indicated a considerable degree of uncertainty. 38 per cent said they expected to be in their current post while 10 per cent expected to be in another consultant post. However nearly 24 per cent admitted they did not know what they would be doing and 10 per cent selected an option outside the wide range of options provided. Only 1 per cent expected to leave the NHS and nursing to do something different and just another 1 per cent expected to leave the NHS for the private sector. The only other categories to attract significant support were a senior nursing post (6%), retired (4%), a role in higher education (3%) and a senior general management role in the NHS (2%). Those working in community/ primary care posts were least likely to expect to stay in a consultant role. Instead a higher proportion of them expected either to retire or to go into higher education. In contrast, a majority of those in mental health (59%) expected to stay in a consultancy role. There were no trends linked to length of time as a consultant. Indeed, the results suggested that those in both the very first tranche of appointments and those in the two most recent tranches were the most likely to expect to remain in consultancy in five years time.

Medical consultants often stay in their roles for many years. It appears that this possibility is less attractive for a significant proportion of nurse, midwife and health

visitor consultants. Admittedly, many are understandably uncertain about where they will be in five years time, but less than half firmly expect to be in a consultant post at that time. This has implications for issues such as succession planning.

8.4 Intention to stay in the consultant role and in the NHS

To pursue this issue more specifically, we asked consultants about their intention to stay in or leave the consultant role. It is worth bearing in mind that there is an extensive body of research that indicates that intention to quit is the best predictor available of whether people actually leave their jobs. For the survey, we adapted established measures to explore both intention to stay in consultancy and in the NHS. In each case, no specific time frame was involved. The responses are summarised below in table 8.2.

	Percentage		
	No (1-2)	Unsure (3)	Yes (4-5)
Intend to stay in consultant role	18	22	60
Intend to stay in NHS	12	32	56

Table 8.2: Intention to stay

The results show that 60 per cent signalled an intention to stay in the consultant role while 56 per cent said they intended to stay in the NHS. Since the vast majority of consultant roles exist within the NHS, there is a slight contradiction in these results. However it may reflect the relative strength of intention to say in the consultant role. Those in community/ primary care expressed the strongest intention to say in the consultancy role (68%) while those in midwifery were the least positive (53%). With respect to the NHS, those in a condition-based specialty were most enthusiastic about staying (60%) while only 53 per cent of those in community/ primary care said they intended to stay in the NHS. Differences between specialties were not significant. There were also no significant differences linked to time of appointment, although those in the first tranche of consultants were among the least enthusiastic about staying in a consultancy role (52%) while in the most recently appointed tranche, 92 per cent expressed an intention to stay in the role. At the same time, only 50 per cent of the most recently appointed tranche expressed a strong desire to stay in the NHS.

The figures in table 8.21 imply that 18 per cent of consultants do not intend to stay in a consultancy role. However, within this group only 19 consultants, 4.5 per cent of the total, said they definitely intend to leave the job. The further 13.5 per cent were considering leaving and were clearly more inclined to stay but had not reached a firm view. With respect to leaving the NHS, 3 per cent were definite in their plans, while 9 per cent were leaning towards leaving.

The regression analysis confirms that neither specialty nor length of service was associated with intention to stay in consultancy. Instead, those who intended to stay were more satisfied with their job, were more likely to report that their expectations had been met, showed higher levels of occupational commitment and saw growth opportunities in the job. They had also held more consultant posts. Set against this, they saw poorer career opportunities. The background, role and attitudinal factors explained 56 per cent of the variation in responses. Intention to stay in the NHS was

strongly associated with a high level of occupational commitment and also with job satisfaction but with no other items. The analysis explained 40 per cent of the variation in responses.

The search for the full sample of consultants for the questionnaire survey, together with feedback from a number who received the questionnaire, helped us to identify a small number of people who had already left their posts as consultants. We were able to identify at least eighteen and to interview nine of these, four of whom belonged to the panel interview group, to gain some insight into why they were leaving. Although we could only identify a small number of consultants who had left their posts, it is interesting to note that of the first 32 consultants selected through a random numbers process for the panel interviews, six had left their posts. Two more were on long-term sick leave. When we sought substitutes, we initially selected two more who had left and another on long-term sick leave. As well as those we were unable to contact because they were already absent through long-term sickness, two of the 32 in our sample were lost at some point after the first interview because of long-term sickness. We may therefore be under-estimating the proportion of consultants who have left their post and neglecting a sub-group who, for whatever reasons, are on long-term sick leave. Because the number of leavers interviewed was very small, it is obviously dangerous to make any generalisations, and the variety of the circumstances make this difficult in any case. Despite this, some themes emerge.

The leavers had been in their jobs for between 3 years 11 months and one year. Since leaving their consultant posts, all had moved to roles in some way linked to the health sector, the most tenuous being one that combined a part-time academic post with research and strategy development for a Strategic Health Authority. Two had left not out of any dissatisfaction with the consultant post but because good opportunities arose at deputy director/ deputy chief nurse level which they saw as a natural progression. One had moved to another and potentially even better consultant post with the advantage that it considerably reduced commuting. Two had returned to ostensibly lower level nursing roles. One had become a clinical nurse practitioner and another who had two part-time jobs, one as a consultant and one as a modern matron, had found that workloads were so heavy that both had in effect become full-time so she gave up the consultant post. Three others had moved into roles that had more of a managerial element to them.

Reasons for leaving consultant posts varied but two themes were repeated. One was a lack of management support, often resulting from a change in management, and this was allied to concerns about inability to get things done and being caught up in internal political battles. A second was a feeling that the original job specification was wrong. Typically it had not been sufficiently thought through resulting either in too broad a role, too junior a role or a lack of agreement about what the role should be; as a result, it was very difficult to make any kind of strategic contribution or to bring about change and the post-holder never had a real chance of succeeding. More generally, there was concern about both the post and the postholder being undervalued. We must be careful in accepting attributions from such a small sample, but it does appear that aspects of management, including the way in which managers set up the consultant post, the lack of agreement among managers about the role and the rapid turnover and reorganisation among managers led to some disaffection among post-holders, influencing their decision to quit.

8.5 Consultants' views on the wider implications of the initiative

Consultants were asked for their views on the initiative to introduce consultant nurses, midwives and health visitors. The results are summarised in Table 8.2. Their views were overwhelmingly positive. Most notably, 94 per cent believed that it is resulting in improvements in services and in quality and in better outcomes for patients. 79 per cent believed it is helping to retain experienced and expert staff. In summary, the consultants themselves were strongly of the view that the consultant role does bring about the wider systems benefits envisaged for it both in terms of patient care and in terms of providing improved career opportunities and better chances of retaining key experienced staff within the NHS.

There was only one sour note in the set of responses about the establishment of the consultancy role. 80 per cent felt that the initiative had been poorly handled and implemented. The previous chapters help to illustrate why so many should adopt this view. In addition, 23 per cent believed that restructuring has made their job more difficult. In earlier chapters there are examples of the negative impact of restructuring and of a change in management on the consultant role.

Do you feel the establishment of the consultant role:	Yes
Has been a good idea?	96
Is good for the NHS?	95.5
Is helping to improve services and quality?	94
Is helping to provide better outcomes for patients/ clients?	94
Is helping to strengthen leadership in the relevant specialties?	93
Is helping to provide new career opportunities for nurses/ midwives/ health visitors?	92
Is helping to retain experienced and expert nurses/ midwives/ health visitors in the NHS?	78.5
Is helping to increase the status and prestige of nurses/ midwives/ health visitors in the NHS?	79
Has been well handled and implemented?	20
Recent trust restructuring has made my job more difficult.	23

Table 8.3: Perceptions of the wider impact of the consultant role

There was a tendency for the consultants in community/ primary care and midwifery to be most positive across the various items while those in the other specialties were slightly less enthusiastic. Consultants in a condition-based specialty were most likely to believe that the initiative had been poorly handled, while mental health consultants were most likely to say that restructuring was making their role more difficult. There were no significant differences associated with time in the role, based on the bivariate analysis. A regression analysis indicated that the most positive views on the initiative were provided by those who were the most satisfied and committed and who could see good career opportunities. In contrast, the least positive were those who were older, had been in the role longer and who were less satisfied about the fairness of their pay.

8.6 Summary

This chapter has presented evidence indicating that the consultants themselves are overwhelmingly positive about the introduction of the consultant role. In particular, they believe the idea is a good one which is having a positive impact on patient care, on quality of treatment and on the leadership and retention of professional staff. They are less impressed about the way in which the roles have been introduced and about the impact on the role of constant reorganisation. By and large, the positive views of the initiative and its impact are endorsed in the comments of sponsors of the consultant role. With respect to both groups, we should acknowledge that their views may contain some bias associated with their close involvement in the initiative.

Given the positive evaluation of the role, we might expect consultants to be content to stay in it. However only 60 per cent indicated a firm intention to stay in the role and only 48 per cent expected still to be in a consultant role in five years time. It is possible that these consultants are accustomed to quite frequent career moves and have not adopted the long-term perspective on the role of many medical consultants. The evidence from the very small numbers who have already left their consultant posts also indicates the potential for some disaffection linked to what they perceive as the restrictive or inappropriate way in which the post has been set up or to the consequences of organisational and staff change. The survey clearly indicates that these systems implications have an important bearing on the role and place some responsibility on senior management to provide the appropriate support. As we have seen from several of the regression analyses, strong senior management support tends to be associated with a range of positive outcomes. Conversely, its absence is perceived by the consultants to be associated with more negative outcomes for patients and for the consultants themselves.

Chapter 9: Conclusions

9.1 The conceptual framework and methodology

The central aim of the research study on which this report is based was to evaluate the impact of the role of the nurse, midwife and health visitor consultant. It was noted in the introductory chapter that any attempt to establish the impact of the role on patient care was fraught with difficulties because the impact was likely to be largely indirect. To accommodate this, a conceptual framework was presented which sought to identify the various routes through which the consultants might have an impact. While this included the possibility of a direct impact through their clinical practice, it was more likely to be indirect through the planned impact on treatment processes, contexts and organisation and through the impact on the behaviour of staff. It could also have an impact more indirectly and perhaps less intentionally through the presence of a consultant as a role model and through the opportunities created by the consultant role for the motivation, morale and career ambitions of staff. The findings suggest that all these routes, exercised in particular through the leadership and through engagement in practice and service development elements of the role, are important. This reinforces the importance of using appropriate conceptual frameworks to explore the impact of the role.

Any evaluation of impact also requires the use of appropriate methodologies. Mainly because of the indirect nature of the impact of the role, a decision was taken early in the study not to attempt to collect information from patients. Ethical considerations played a part in this decision. We also formed a view that the variety of consultant roles (we identified about one hundred different job titles) meant that any attempt to collect "objective" outcome measures that were robust enough to provide comparisons across roles and stood up to the challenge of establishing attribution to the consultant input was not feasible. As a result, we were forced to use some combination of illustrative case study material and subjective accounts of impact.

Given the inevitable restrictions on the types of information, we then had a choice of sources. At the outset, we favoured a stakeholder perspective and recognised a range of stakeholders including patients, a variety of managers, senior medical staff, nurses and midwives and the consultants themselves. Ideally, we would have collected information from as many of these stakeholders as possible. However we faced two major constraints. One was time and resources; the other was the inordinate delays and barriers presented by the requirements of research governance and the problems of obtaining ethical clearance. So many difficulties and delays were placed in our path as we sought to have any contact even with the consultants and their sponsors that there was insufficient time, and unclear chances of success in any attempt to collect information from other stakeholders. We therefore restricted our sources of data to the consultants and a small sample of their sponsors. We did submit an application jointly with the Nursing Research Unit of King's College, London, to conduct survey research which would have explored the perceptions of nurses and midwives of the consultant role and its impact. However the bid was not successful. There remains a need to undertake this broader stakeholder evaluation of the consultant role.

Since the focus of our data collection was on the consultants themselves, with the obvious risks of bias in their responses, we took care to use a range of methods in an attempt to triangulate the methods even if we could not triangulate the sources of information. As a result we used a range of complementary methods. These included focus groups to highlight impact issues, longitudinal panel interviews to collect qualitative information about the roles, resources, impacts and constraints as well as the personal experience of being a consultant, in-depth interviews with a small sample to explore the issue of leadership, and a longitudinal questionnaire survey to collect systematic information on the role and its impact both on service development and delivery but also on the satisfaction and commitment of the consultants. The surveys also contained open-ended questions to provide scope to elaborate and illustrate responses on issues such as impact of the role. There was therefore both a qualitative and a quantitative longitudinal element to the study. Furthermore, while the qualitative element included a carefully selected sample of 32 consultants, the survey sought to cover the entire population of consultants. Finally, we had the opportunity to cross-check some of the consultant responses through the interviews with a number of senior sponsors. The report has sought to integrate the findings resulting from these various methods. It is reassuring that in almost all cases, the findings from one approach complement those obtained using others.

9.2 Who are consultants and what do they do?

One of the subsidiary aims of the research was to identify who the consultants are, since there is no other established source of information, and to identify what they do. With respect to the characteristics of the consultants, three findings are of particular note. The first is that there is no evidence of any change over time in the educational standards of those appointed. Those in the more recently appointed tranches are just as likely as the early appointments to possess a graduate qualification. On the other hand, the sponsors noted that it was becoming more difficult to find good applicants with the necessary educational qualifications. This may help to account for what appears to be a large difference between the number of posts which have been agreed and the number of consultants in post. The sponsors were also rather critical of the emphasis given to the educational qualification and felt that the personal qualities and experience of the potential consultant counted for more. In the survey results there was consistent evidence that those with higher educational qualifications were generally less positive about their impact and about the consultant role in general. The reasons for this are unclear; it may be that they set higher standards or have a more sophisticated view of the evidence required. Alternatively, they may genuinely feel that they are rather less effective and be less positive about the role. It is just possible that some of the most highly educated consultants, some of whom may have been working in academic contexts, may be finding the return to a more clinical role challenging. Whatever the reasons, the responses raise some questions about the weight given to the educational criterion in the selection of consultants.

The second issue that emerges from the analysis is the continuing small proportion of consultants from ethnic minorities. We were able to identify just 13, constituting about 3 per cent of our sample. While this is a considerable increase compared with the initial survey where we identified only one consultant from a non-white ethnic background, it still reflects a considerable under-representation in relation to both the

ethnic mix of the nursing and midwife population and the patient population they serve.

The third issue at the personal level is the importance of the measure of self-efficacy or confidence in ability to do the job. This is a personal attribute that might be expected to alter as familiarity with the role increases. However there was strong evidence both in the cross-sectional analysis in the third survey and in the longitudinal analysis, that those who report a higher level of self-confidence in their ability to do the job report a greater impact, greater satisfaction and a range of other positive attitudes. It is just possible that the measure captures an indicator of positive affect. Alternatively, it may reflect a kind of personal quality close to that described by the consultant sponsors which is enthusiastic, proactive and confident in their ability to have an impact which in turn is reflected in the way in which they go about their job. If this is the case, then it has further implications for the selection of consultants as well as for their development.

Turning to what the consultants do, it proved very difficult to classify the very wide variety of roles in a coherent way. Just over half of our sample work in what we defined as an area-based clinical specialty such as A&E or critical care, while almost a quarter work in mental health including learning disabilities. Only one consultant described herself as a health visitor; set against this, there has been a marked growth since the first survey in consultants who work in the community or primary care. These, together with the 8 per cent in midwifery typically have fairly broad roles; in contrast, the 11 per cent working in what we termed condition-based specialties such as diabetes or cancer had narrower more specialised roles. This contrast between a narrow or broader role seemed to have an impact on how they spend their time. Those in the broader roles seemed to try to do more and sometimes to spread themselves more thinly. The target of 50 per cent of the time in clinical practice was feasible from many of those in specialist roles but made little sense to some of those in broader roles or to some of the newer types of consultant role. One example is the emergence of consultants specialising in infection control where an emphasis on clinical practice may be less relevant. It is acknowledged that the 50 per cent figure is a flexible target. Our evidence suggests that the diversity of consultant roles reinforces the importance of emphasising that this is a very general target rather than a formal requirement.

There was considerable variety, even within the different types of consultant in how far they were engaged across the different elements of the role. In the first survey, we had detected some evidence that as consultants became more established they also became more overloaded. By the time of the third survey, there was good evidence that most consultants who had been in post for a while had learnt how to craft their role. They were establishing priorities, shifting the emphasis among functions and in some cases reducing the range of activities. On the other hand, there was consistent evidence that those who were fully engaged across the four main elements of the role reported more positive impact and were more satisfied with and committed to the role. They also typically reported higher levels of pressure but usually had sufficient control to manage this pressure. In short, there appear to be advantages to a consultant role in which the consultant is engaged across the four core functions.

9.3 Leadership, management, support for consultants and the role of the community/ primary care consultants

One of the aims of the study was to attempt to gain a better understanding of how leadership was enacted in the consultant role. The survey data confirm that this was the element of the role in which consultants were most likely to say that they were heavily engaged. Despite this, they accepted that they had difficulty in tying down the leadership element of their work. The in-depth interviews confirmed that in the absence of a management dimension to their role, this meant, to use the academic distinction, that they engaged primarily in transformational rather than transactional leadership activities. Essentially, they exercised leadership through example, particularly example reflected in their professional competence and expertise, and by facilitating and empowering others to get things done. They also acted in line with what is sometimes described as the path-goal theory of leadership; in other words, they helped to define priorities, to improve procedures, to provide feedback and encouragement and, occasionally, remove obstacles in the path of staff who were pursuing the priorities. Some fell into this role quite readily. For others, partly because of their own experience and more often because of the circumstances in which they found themselves, this was less straightforward. In such cases, there was concern about the lack of resources, support and authority.

In the absence of management authority vested in the role and also because of the novelty of the role for those entering it, the issue of support was of considerable importance. This was also an area in which there were contradictory findings. The sponsors, who in practice sometimes acted as line managers to consultants, described how they provided positive support. In contrast, in both the surveys and in many specific examples, consultants described how they were rendered less effective in their roles by the absence of support or, allied to this, resources. The resource problem ranged from irritants such as lack of office space and more particularly secretarial support, to the lack of finances and more often staffing to support innovations for which they had gained approval. In the surveys, the general feeling was that there was at best limited support from line and professional managers and from senior medical staff and somewhat better support from senior management and from colleagues. The evidence suggests that a lack of support, particularly from line management in the early months in the job could hinder development in the role. This supports the model of role innovation which gives some emphasis to social support at the stage of initial socialisation. By the time consultants had been in the role for over two years and had established their own role networks, and developed their skills in acquiring resources, support from line and senior management appeared to become a little less important. The exception was in cases where Trust mergers and other reorganisations meant a change in the management hierarchy and a loss of the initial sponsorship.

One of the strongest criticisms made by the consultants related to the way in which their roles were set up. Indeed, 80 per cent agreed that the establishment of the role was poorly handled and implemented. Their particular concerns focussed on the lack of initial support and resources and a general feeling of being thrown in at the deep end and left to fend for themselves. A related comment, highlighted in particular by some of those who had left the role but also mentioned by a number of others, was that the original remit they had been given for their particular role had been poorly

specified and did not fit well with the intentions for the consultant position. In such cases, some consultants were more successful than others in agreeing and/or simply implementing a change in structure and priorities. In short, there appears to be a continuing concern about the planning and support among managers in the early stages. One message emerging from this set of findings is that there is still scope to give greater thought and commitment to the planning for and then socialisation into consultant roles. Another is that there may be a case for a major formal review of how the role is structured in addition to, but possibly separate from appraisal of the role incumbent after about a year.

Despite the frustrations of a lack of resources, most consultants were adamant that they did not want to act as managers. Nevertheless, for various reasons, a number of the consultants found that it was necessary to do so. One of the main reasons for this was a management vacuum caused by a vacancy which the consultants preferred to fill themselves rather than leave by default to others who were less qualified. The other main context was in the broader roles, notably those in the community and primary care. Overall, just over 11 per cent reported a high level of engagement in management activities but among community/primary care consultants, this rose to 32 per cent. In contrast, although the midwives often also had broad roles, none of them reported a high level of engagement in management activities. This suggests that there is something distinctive about the new roles in the complex context of primary care. These consultants were also distinctive in a number of other ways. For example, they reported higher demands and lower control than other types of consultant and, perhaps not surprisingly, higher levels of stress. At the same time, they were among the most satisfied and committed but, paradoxically, among the most likely to indicate that they did not expect to stay in a consultant role in the long term. In short, there appear to be a number of distinctive features about the roles of consultants working in the community and in primary care that may repay further investigation to ensure that as more experience is gained of the new primary care organisations and the midwife, health visitor and midwife consultant roles within them, that they are appropriately designed and supported in such a way that the need to engage in management activities is minimised. At the same time, the research raises the wider issue of whether it remains sensible to maintain the sharp distinction whereby consultants are not meant to engage in management activities if it seems essential to do so for those in certain circumstances or in certain types of consultant role. Related to this, and given the repeated concerns about lack of resources to introduce improved systems and procedures, the issue of whether a distinctive budget should be attached to consultancy roles may be worth considering.

A key element in the consultancy role appears to be the ability to manage boundaries. This includes internal boundaries between the four core functions in the role as well as the practice-based activity to ensure that they have a feasible workload. It includes boundaries between themselves and their role network within the Trust where they have to possess the distinctive skills discussed above to exercise leadership and influence without managerial authority. In this context, they have to define the range of their role network(s) to ensure that they can be managed effectively and serve the purpose of ensuring that the role is successfully enacted. It extends to managing the boundary between internal Trust-based demands and the frequently cited requests to support national initiatives and to speak at conferences. Finally, they have to manage the boundary between life at work and life outside work. In preparing for the role,

some consideration might usefully be given to alerting those coming into the role for the first time of the range of boundary management issues that they are likely to face.

9.4 Satisfaction, stress and careers

A concern arising from the first report was that those who had been in the consultancy role for longer reported higher demands and stress and lower satisfaction. Some of these findings were repeated in the final survey. Longer service consultants remain less satisfied and generally less optimistic about the impact and viability of the role. However any differences should be seen in the context of an overwhelmingly positive set of responses with 73 per cent reporting high levels of job satisfaction and 82 per cent high levels of commitment. There were much more mixed views about satisfaction with, and perceptions of fairness of rewards. 40 per cent reported high satisfaction and 37 per cent low satisfaction. Less concern was expressed with starting salaries, which had been an issue in the first survey, and more with systems of salary progression. Judging by the number of comments in the interviews and on the questionnaires, a number of Trusts have not thought through a systematic process for determining salary reviews and increases or have not communicated them to the consultants. In some cases, a salary review was linked to performance appraisal, but a fair number of consultants were dissatisfied with the appraisal process. One of the messages emerging is that some thought has to be given to systems for salary review of consultants. A related message concerns the more general relationship with the line manager. In the questionnaire, the level of support from the immediate line manager and the professional manager, who may sometimes be the same person, was often rated as low. While this did not emerge so consistently in the interviews, there was some indication that other senior management support was more highly valued and more useful and, in the present context, the line manager did not always handle the appraisal process in a way that consultants found helpful. Ironically, the survey evidence indicates that stronger line management support was not consistently associated with positive outcomes.

28 per cent reported high levels of job stress. As noted above, stress was higher among those in community and primary care roles and among those with high workloads. It was lower among those whose expectations about the job had been met, reinforcing the importance of realistic preview of the role as well as effective induction and support. In contrast to the first survey, there was no indication that those in the role longer experienced more stress; indeed, as noted above, they appeared to have found ways of coping by crafting their role. Given the often heavy workloads, there was also less concern than we might have expected about work-life balance. Several consultants commented positively about the flexibility in the role, including some flexibility of hours and they also outlined how they created boundaries as necessary between work and home life. A message to emerge from this is that the flexibility to manage work-life balance is valued and should be reinforced and encouraged to help to ensure that the role is manageable. In this context, one of the unanticipated outcomes from the survey was that those with dependent children had significantly more positive responses on a number of variables.

Despite the high levels of satisfaction and relatively moderate levels of stress, we found indirect evidence of pressures in the job that may be a cause for concern. Firstly we identified a number of leavers; from those we contacted, we found that

some had left for positive reasons such as an evidently better job. But others had left because of the lack of authority to get things done or because of what they saw as an inappropriate design of the role. Secondly, our process of selecting a stratified random sample for interview and the subsequent experience with those some of those we interviewed, indicated that a proportion of consultants may be absent on long-term sick leave. If this is the case, there may be a more serious problem of pressure in the role which was not identified through our work with the more resilient consultants with whom we were in contact. Thirdly, only 60 per cent expressed a clear intention to stay in a consultancy role in the medium term. This was strongly linked to satisfaction, commitment and met expectations and was most strongly expressed by those in the challenging but also satisfying community and primary care roles. It therefore appears that many nurse and midwife consultants do not yet regard their consultant role as comparable to the medical consultant and as the pinnacle of their career. They are still looking for somewhere to move onwards and upwards towards. In this case, it is also important to consider how to manage the throughput of consultants. We cited cases of trainee consultants; one of the messages is that succession planning needs to be taken more seriously both locally and possibly at regional level. Some concept of trainee consultant offers one route to easing this path. These emerging career issues, together with the time taken to have an impact, discussed below, suggest that there may be value in a follow-up survey of consultants some two years after the 2003 survey presented in this report.

9.5 Impact

In this final section of the Conclusion, we review the core issue of impact. The results from all sources strongly support the value of the model of impact set out at the start of the report and the start of this Conclusion. Most consultants claimed that they were having a positive impact on patient services and patient care, most acknowledged that this was largely indirect and most acknowledged that there were potential questions of attribution. The issue of impact was the one we addressed using the greatest variety of methods and by obtaining views from sponsors as well as the consultants. Whatever the sources, the conclusion is the same; in the great majority of cases, the role has been successful because it has resulted in improved systems, procedures and protocols and has improved the motivation and competence of staff, resulting in better patient services and patient care. The sponsors were at least as positive as the consultants themselves about their impact. Despite this systematically positive assessment, it is not possible to provide anything other than a very broad classification of the specific benefits. Most of the positive outcomes are context specific and reflect the particular circumstances in which the consultants are working. It would therefore be invalid to impose categories that are more specific than those provided in this report. There are impressive examples of accelerated or more effective patient treatment, better patient information and clearly improved protocols; but these are not additive across cases. On the other hand, some will be generalisable and the networks of consultants offer one potentially useful route for this generalisation across types of consultant, types of specialty and treatment or types of Trust.

There were hundreds of examples provided of many different kinds of impact. Some consultants posed the question of whether the improvements would have come about if they had not been there; and invariably they felt that they would not. However proof that they made the difference is hard to come by and we are very conscious of

the bias inherent in our sources of information as well as possible challenges to the attribution of the improvements to the consultants. For this reason, there is a need for further research that explores the perceptions of other key stakeholders to test the conclusions derived from the evidence of the consultants and their sponsors.

There are a few qualifications to the generally positive picture of impact derived from our data. Firstly, there is some indication that mental health consultants are less likely to report a positive impact than those in other consultant roles. In the first survey, the mental health consultants had emerged as the most negative in a number of respects. This was less apparent by the third survey, but it persists with respect to impact. Secondly, it takes time to have an impact. As we might expect, those in post longer report a greater impact and it may be that we should be delaying any general assessment of impact until most consultants have at least two years of experience in the role. It was also notable that those consultants who were more fully engaged across the core functions in the role reported a higher impact. Finally, support makes a difference to impact and there were many examples of consultants who reported that they were convinced that they were having a positive impact but would have even more of an impact if they were provided with the support and resources they felt they deserved. In other words, there is good evidence that the consultants are having a positive impact. Given more support and resources, it could be even greater.

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