**The nurse consultant in mental health services: a national, mixed methods study of an advanced practice role**

**Abstract**

*Introduction*

The nurse consultant is an advanced practice role providing expert clinical practice, consultancy and professional leadership. To date, few studies have examined this role within mental health services and none have described the professional characteristics of post holders.

*Aims*

The main aims of the study were to identify changes in nurse consultant numbers in mental health services, identify post holder characteristics and factors influencing number of posts.

*Method*

We used a triangulated mixed methods approach comprised of a longitudinal examination of national workforce data, a national cross-sectional survey of post holder characteristics and semi structured interviews with directors of nursing.

*Results*

Of 58 mental health organisations, 51 (88%) responded, identifying 123 nurse consultant posts, and a range of 0-12 posts per organisation. One in 229 mental health nurses and 1 in 186 learning disability nurses was a nurse consultant. An average of 40% of nurse consultants’ worktime was reported as being in clinical practice. Themes identified as important in relation to role sustainability were; cost and value, contribution of individual post holders, role clarity and domains of work.

*Discussion*

Nurse consultants are represented to a greater extent in the mental health service workforce than in nursing generally, but their roles often lack clarity. Attitudes of local professional leaders and national policies are likely to affect post numbers.

*Implications for practice*

Developing and sustaining nurse consultant roles requires role clarity and active support from nurse leaders. Roles need to demonstrate their value to the clinical systems in which they work.

**Key words**: Advanced Practice, Learning Disabilities, Non-Medical Prescribing, Nursing Role, Workforce Issues

**Relevance Statement**

The nurse consultant role is the most senior clinical role open to nurses in the United Kingdom. This paper presents the results of a national survey, which describes characteristics of nurse consultants in mental health services. The data provides a basis for comparison with other advanced practice nursing roles nationally and internationally. This will allow individual organisations to benchmark their own workforces. Data from interviews with nurse directors highlight issues of lack of role clarity. This issue can affect the creation and sustainability of senior clinical nursing roles in mental health services and affects similar advanced roles internationally.

**Accessible summary**

**What is known on the subject?**

* Internationally, systematic reviews have identified evidence of equal or improved clinical outcomes comparing advanced practitioner treatment with medical treatment as usual, across a range of specialities.
* Studies of nurse consultants in the United Kingdom have largely been non–empirical. Most studies specifically related to nurse consultant roles in mental health services are case studies or reports of views on this role.

**What this paper adds to existing knowledge?**

* The study demonstrates that nurse consultant numbers vary over time and by clinical specialty. This is influenced by the value invested in the role by local nursing leadership and by national policy change.
* A lack of role clarity affects the uptake and sustainability of advanced practice roles internationally and is also an issue for the nurse consultant role in England’s mental health services.

**What are the implications for practice?**

* Successfully introducing advanced practice nursing roles in mental health services requires role clarity and support from local nurse directors.
* The continued absence of robust evidence as to the clinical/cost effectiveness of nurse consultant roles in mental health settings places an onus on individual posts to generate data to justify the role at a time of financial constraint.
* Detailed post holder characteristics reported in this paper provide a basis for future comparison with other advanced practice roles in mental health services and other specialties nationally and internationally.

**The nurse consultant in mental health services: a national, mixed methods study of an advanced practice role**

**Introduction**

This study investigates the development of an advanced practice role, the nurse consultant (NC), within England’s National Health Service (NHS). In the UK, there are four registered fields of nursing practice: adult, children’s, learning disability and mental health (Nursing and Midwifery Council 2018). A mixed methods approach was used to gather data on the distribution and characteristics of mental health (MH) and learning disability (LD) NCs and to identify factors potentially linked to the creation and removal of such roles. Most clinical LD services in the NHS are provided by MH organisations and the majority of patients in these services have dual MH and LD diagnoses.

The potential benefits of advanced practice by nurses has been extensively debated and creating such roles has been seen as a potential solution to many healthcare challenges, particularly in primary care, health education and health promotion ((Bryant‐Lukosius et al. 2004; Lowe et al 2012; Iglehart 2013). Numbers of these roles are increasing in many countries (Pulcini et al 2010; Lowe et al 2012). Systematic reviews have identified evidence of equivocal or improved clinical outcomes and patient satisfaction compared to medical treatment from various types of advanced practitioner across a range of specialities (Newhouse et al 2011; Donald et al 2013; Morilla-Herrera 2016), although confusion persists in the terminology used to describe these roles (Lowe et al 2012; Jokiniemi et al 2012).

The NC role in the United Kingdom (UK) was established in 1999 by the Department of Health (NHS Executive 1999). Nurses working in new senior clinical roles were seen as a means of strengthening health services, particularly by working across professional and organisational boundaries (Department of Health 2002). Prior to this, the terms nurse consultant and advanced practitioner had been largely interchangeable (Manley 1997). The new NC role was established with four core functions or domains (Department of Health 1999):

* Expert clinical practice (direct or indirect involvement with patients, to a recommended minimum of half of working hours),
* Professional leadership and consultancy,
* Education, training and development,
* Practice and service development, research and evaluation.

There has been some evaluation of the impact of NC roles, as evidenced in a mixed methods systematic review by Kennedy (2012), which identified 36 studies. Most were non-empirical and none focused on MH or LD NCs. In 2012, the Royal College of Nursing (RCN) expressed concern that the NC role in the UK, particularly in MH services, was gradually being erased, despite early optimism as to its potential (Royal College of Nursing 2012). In 2013, a survey reported on the prevalence of NCs in a sample of 52 NHS organisations (trusts) in England and indicated static numbers of posts in MH and LD services compared to increases in other areas of nursing (Nursing Standard 2013).

We identified publications in peer reviewed journals specifically focusing on aspects of the work of MH NCs. Medline and CINAHL databases were searched using the terms ‘mental health’ OR ‘learning disabilit\*’ AND ‘nurse consultant’ OR ‘consultant nurse’ for the period 2000 to 2018, for any language. Inclusion criteria were that papers described, discussed or evaluated the work of NCs in MH services (including LD specialist NCs). News items were excluded. Eighteen papers were identified as meeting the criteria and two further papers (Woodward et al 2005; Lee et al 2013), were identified from other sources. Both reported data concerning NCs from a range of specialties, but specifically for those in MH, and therefore met criteria for inclusion. Seventeen papers were from the UK, 2 from Australia and 1 from Hong Kong.

The twenty papers can be grouped into 4 categories:

* Case reports of the work of individual NCs (n =7) - Clarke 2001; Mc George 2005; Jones et al 2006; Hughes 2008; Forsyth 2008; Langton 2008; Allen 2018
* Collected views regarding NCs’ current and future roles (n = 4) - Chalder and Nolan 2001; Jinks and Chalder 2007; Gamble et al 2008; Barron et al 2013.
* Commentaries/opinion papers on NCs current and future roles (n = 5) - McMillan 2002; McDougall 2003; Braynion 2004; Hayes and Harrison 2004; McDougall 2005.
* Comparisons with interventions from other professionals (n = 4) - Happell et al 2002; Happell et al 2003; Woodward et al 2005; Lee et al 2013.

Happell and colleagues (Happell et al 2002; Happell et al 2003) compared triage assessments carried out in an Australian emergency department (ED) by MH NCs and those carried out on the same patients by ED nurses, finding the NCs less likely to assess presentations as requiring urgent intervention. A study by Lee et al (2013) in Hong Kong used a matched controlled design to compare bed use and satisfaction between nurse consultant treatment vs. treatment as usual. Their findings indicated comparative benefits from treatment by the MH NC, but gave no detail as to the nature of the NC intervention.

The 2006 Chief Nursing Officer’s Review of Mental Health Nursing in England (Department of Health 2006) responded to concerns from nursing organisations that NCs were not involved sufficiently in research, by recommending that all NC roles be examined to ensure such engagement took place, either directly or by supporting colleagues. Gamble et al (2008) reported results from two workshops involving MH NCs and academic staff. Participants believed that NC roles could contribute to research, although there were reservations as to the availability of time and the competencies of NCs to become principal investigators in large studies. More recently, a sample of MH NCs reported that research was only a small component of their practice (Barron et al. 2013), whilst NCs from a wide range of specialties in one geographical area reported little organisational support for nursing research (Dyson et al 2014).

The findings from this literature review demonstrate a lack of large scale studies into the work of NCs in MH services. Neither do existing studies describe personal and professional characteristics of a large sample of NC post holders, or the clinical foci of their roles or examine the numbers and distribution of NCs over time within mental health services. This paper attempts to address the dearth of evidence in these areas. However, due to funding limitations we were unable to explore the important area of the impact of MH NC roles on service user/patient, staff or service outcomes.

**Aims of the study**

a) To identify changes, if any, in nurse consultant numbers within MH services.

b) To identify post holder characteristics and factors influencing the number of posts.

 **Objectives**

1. To identify numbers of NCs employed over time using best available NHS workforce census data, comparing numbers and trends of NCs in MH and LD services with those in all other healthcare areas.

2. To identify all NCs working in NHS trusts providing MH and LD services in England, and describe their:

* Distribution
* Educational and professional qualifications
* Area of clinical practice
* Clinical experience
* Proportion of time spent in each of the four domains of work

3. To describe previous and planned changes in numbers of NC posts in each of the NHS trusts

4. To explore the views of a sub-sample of directors of nursing (DoNs) in relation to the value of NC posts and to factors influencing changes to their numbers.

**Methods**

We chose to include NCs from two different fields of practice; mental health and learning disability, since the majority of both nursing specialties in the NHS are employed in MH trusts. We could therefore collect data on both types of NC and explore how changes in numbers of NCs may have differed between fields of practice. Inclusion of both groups also allowed us to evaluate the impact of policies on NC roles in these different areas.

We adopted a triangulated mixed methods design for this study, utilising both quantitative methods in the form of surveys and qualitative methods in the form of semi structured interviews. The rationale for adopting this method was that the use of quantitative and qualitative approaches in combination would provide a better understanding of the topic than either approach alone (Hanson et al 2005; Creswell and Piano Clark 2007).

The research process comprised:

1. Gathering national workforce data from the NHS Digital website and by direct email request to the NHS digital team. These data included the number of staff who were employed at each time point, but not vacant posts. Numbers of nurses practicing in each field of practice is reported in national workforce surveys, which are recorded retrospectively on a monthly basis (NHS Digital 2015).
2. DoNs in all of the 58 MH trusts in England at the time of the survey were contacted by email to request their participation. Information on the study was provided in the initial contact along with the survey questionnaire. The survey questionnaire and semi-structured interview schedule was developed by author 6 and modified following review and comment by members of the National Mental Health Nurse Directors’ Forum (NMHND Forum). Consent to participate was implied by returning the completed questionnaire or agreeing to complete it with the researcher by telephone. Non-responders were followed up by telephone and emails. DoNs were asked to provide information on numbers and areas of practice for NCs in their organisation, any previous or planned changes to these posts and contact details for the NCs, so that the researchers could approach them directly to obtain details on their qualifications, experience, time in their post and their estimate of the proportion of their time they individually spent on each of the four domains of the role.
3. A sub-sample of 12 trusts was purposively selected to ensure inclusion of at least 4 in each of these 3 categories: those demonstrating a reduction in NC numbers, those that had increased NC numbers, and those planning to increase NC numbers. The categories were not mutually exclusive, so a trust could be included in the sample if it had, both, reduced numbers and was planning to increase numbers in the future. The DoNs in these trusts were emailed to request their participation in telephone interviews to explore their views on the value of NCs and factors which they felt influenced their effectiveness. The anticipated duration of the interviews was less than half an hour and they were carried out by a research assistant (Author 4) with experience of research interviewing, who had had no previous contact with the participants. Author 4 recorded participant responses in handwritten or typed notes during the interview, as close to verbatim as possible and later transcribed them into word documents for analysis. The processes for gathering and analyzing data were informed by the ‘Consolidated criteria for reporting qualitative research’ (COREQ) checklist (Tong et al 2007) (Appendix A).

**Data collection**

Data collection took place between March and December 2014. NHS Census data were obtained for the period from 2000 to 2017.

**Reflexivity and rigor**

Rigor in gathering and analyzing qualitative data was ensured by ongoing self‐critique and self‐appraisal (Koch and Harrington 2002), as all researchers were aware of the potential for individual experiences and views of researchers to influence data and the need to monitor researcher subjectivity in generating credible findings (Darawsheh 2014). Bias was also potentially reduced by the interviewer not having a nursing background and by involving different team members in checking the thematic review of the data.

**Ethical considerations**

Health Research Authority guidance at the time of the study (HRA 2014) was for a self-assessment form to be completed by the research team to determine whether ethical review by an NHS Research Ethics Committee was required for a study to take place. The decision matrix contained in the form indicated that the study did not involve any procedures which necessitated further ethical review, in particular that there was no involvement of patients or patient data in any component.

**Data analysis**

Analysis of NHS Digital workforce data was carried out using Microsoft Office Excel 2016, employing descriptive statistics. Ratios between group sizes, i.e. the proportion of all nursing posts which were nurse consultant posts, were calculated by field of practice. Quantitative data from the national survey were analysed using SPSS v.22 (IBM Corp 2013), employing descriptive statistics.

Qualitative data from telephone interviews were analysed using a thematic analysis framework to identify, interpret and report themes (Braun & Clarke, 2006). Software was not used to analyse the data. Initial thematic analysis was conducted by a research assistant (Author 6), who had not carried out the interview but had experience of undertaking qualitative analyses. (Author 6) read and reread interview transcripts in order to become familiarised with the data before developing descriptive codes for the text. Author 6 captured relationships between the codes in the overarching themes, which she then reviewed to ensure that they were derived directly from the comments made by participants by revisiting the raw data. The analysis was reviewed independently by Author 2 and Author 1 again, to assess its credibility, in confirming that the information drawn from the data was plausible and appeared to correctly interpret the participants’ original views (Graneheim and Lundman, 2004; Lincoln and Guba 1985), albeit within the limitations of data recorded from a brief semi-structured phone interview.

**Results**

**a) NHS Census data: number and characteristics of nurse consultants**

Data from 2000 to 2008 for England were obtained directly from NHS Digital via email, which advised that the information for this period was ‘methodologically incompatible’ with later data due to re-categorisation of staff groups and trusts (NHS Digital, personal communication 4th October 2017). Therefore, these data are used only to illustrate general changes in numbers of NC posts prior to 2009 and indicate a relatively steady rise in numbers for both LD (0 to 33) and MH NCs (0 to 137) (Table 1)

**Insert Table 1: Nurse consultant numbers, 2000-2008**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** |
| All NCs | 0 | 125 | 314 | 444 | 609 | 697 | 758 | 781 | 805 |
| Learning disability NCs  | 0 | 4 | 15 | 10 | 20 | 22 | 23 | 33 | 33 |
| Mental health NCs | 0 | 32 | 55 | 84 | 106 | 117 | 118 | 127 | 137 |

Workforce data from October 2009 to April 2017 (NHS Digital 2017) are presented at annual data points in Table 2, and provide numbers of MH and LD nurses and NCs and of all NHS nurses and NCs.

**Insert Table 2. Total numbers of nurses and nurse consultants, 2009-2017**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Oct-09 | Oct-10 | Oct-11 | Oct-12 | Oct-13 | Oct-14 | Oct-15 | Oct-16 | Apr-17 |
| All nurse NCs | 912 | 1,018 | 1,083 | 991 | 916 | 858 | 860 | 934 | 945 |
| Learning disability (LD) NCs | 39 | 38 | 29 | 31 | 32 | 24 | 25 | 27 | 18 |
| Mental health (MH) NCs | 142 | 150 | 148 | 156 | 138 | 121 | 129 | 150 | 156 |
| All nurses | 280,700 | 281,477 | 278,094 | 273,561 | 277,014 | 281,437 | 284,870 | 287,197 | 284,619 |
| All learning disability nurses | 5,543 | 5,120 | 4,613 | 4,289 | 3,999 | 3,774 | 3,616 | 3,481 | 3,397 |
| All mental health nurses | 40,682 | 40,228 | 39,178 | 38,329 | 37,536 | 36,719 | 36,074 | 35,943 | 35,563 |
| Ratio –LD nurse consultants: LD nurses  | 1:142 | 1:135 | 1:159 | 1:138 | 1:125 | 1:157 | 1:145 | 1:129 | 1:189 |
| Ratio –MH nurse consultants: all MH nurses | 1:287 | 1:268 | 1:265 | 1:246 | 1:272 | 1:303 | 1:280 | 1:240 | 1:228 |
| Ratio – All nurse consultants: All nurses | 1:308 | 1:277 | 1:257 | 1:276 | 1:302 | 1:328 | 1:331 | 1:308 | 1:301 |

Between 2009 and 2017 there was a 10% increase in MH NCs, from 142 to 156 with numbers dropping below 141 between mid-2013 and the beginning of 2016. The total number of MH nurses employed in the NHS decreased by 12.6% from 40,682 to 35,563 (Table 2). The highest number of MH NCs was in 161 in March 2017, whilst the ratio of MH NCs to all MH nurses in 2009 was 1:287 (0.35%) and had decreased in 2017 to 1:228 (0.44%).

The number of LD NCs more than halved (from 39 to 18) in this eight-year period, whilst total LD nurse numbers reduced by 39% from 5,543 to 3,397. The ratio of LD NCs to all LD nurses was 1:142 (0.65%) in 2009 and 1:189 (0.53%) in 2017.

There was a slight rise (1.4%) in the number of nurses employed across all services in the NHS, from 280,700 in 2009 to 284,619 in 2017. Total NCs increased by 3.6% in that period; from 912 in October 2009 to 945 in April 2017. The ratio of all NCs to all nurses was 1:308 in 2009 (0.32%) and 1:301 in 2017 (0.33%).

We analysed data from the workforce census of April 2017 (NHS Digital) in order to identify the proportion of NCs from each of the four fields of nursing and from midwifery. We identified 931 NC posts, following exclusion of NCs in ‘education’ (n = 15), as their field of practice was not known. We allocated the remaining NCs to fields of registration based on the classification of the service in which they were employed. All figures are therefore estimations, based on best available evidence. Allocations to the different fields were: 619 (66.5%) adult acute nurses (acute hospital or community healthcare services), 157 (16.9%) MH nurses, 80 (8.6%) midwives, 57 (6.1%) paediatric nurses (neo natal, paediatric and school nursing services) and 18 (1.9%) were LD nurses.

**b) Survey**

Responses were obtained from 51 of the 58 MH trusts (87.9%). The responding trusts identified 123 NCs in total, with a range of 0 to 12 per trust (*M* = 2.4; *SD* = 2.7). Eleven (21.6%) had no NCs, a further 11 had one each and 3 had 10 or more.

NHS workforce census data for April 2014 (Table 2) indicates 151 MH and LD NCs were employed in the NHS. The 123 posts identified through our survey were 28 (18.5%) less than the census. Assuming an average of 2.4 posts in each of the 7 non-responding trusts would yield an additional 17, or 140 in total. By these calculations, the survey would have identified an estimated 11 (7.3%) NCs less than the census, if all trusts had responded. This figure is an approximation, as this process of mean imputation may underestimate variation (Eekhout and de Boer 2012).

Fifty-eight (47.2%) of the 123 identified NCs were male. Information on ethnicity was obtained for 92, of whom 87 (95 %) were white British. Data on age were available for only 69, of which 31 (45%) were aged 50 or over. The youngest were aged 36-40 (n = 2). The average number of years since qualifying as a nurse was 27.2, ranging from 15 to 36 (*N* = 89, *SD* = 4.59) and the average number of years in their current post was 7.2.

**Clinical settings**

Respondents (N = 106) identified 19 clinical practice settings (Table 3). The three most frequently identified were inpatient acute (n = 15), child and adolescent mental health services (n = 12) and older people’s mental health services (n = 12).

**Table 3: Nurse Consultant clinical practice settings**

|  |  |  |
| --- | --- | --- |
|  | N= 106 | % |
| Inpatient acute | 15 | 14.2 |
| Child and adolescent mental health | 12 | 11.3 |
| Older people’s mental health | 12 | 11.3 |
| Generic mental health | 10 | 9.4 |
| Dual diagnosis | 9 | 8.5 |
| Learning disability | 9 | 8.5 |
| Forensic | 7 | 6.6 |
| Community | 6 | 5.7 |
| Psychiatric Intensive Care | 4 | 3.8 |
| Personality Disorder | 3 | 2.8 |
| Liaison mental health | 3 | 2.8 |
| Physical health care | 3 | 2.8 |
| Psychological therapies | 3 | 2.8 |
| Rehabilitation | 2 | 1.9 |
| Challenging behaviour | 2 | 1.9 |
| Psychosis/Recovery | 2 | 1.9 |
| Eating Disorder | 2 | 1.9 |
| Crisis/home treatment | 1 | 0.9 |
| Primary care | 1 | 0.9 |

**Qualifications and additional roles**

A postgraduate qualification at either master’s or doctorate level was held by 98 (95%) NCs (n=103 who responded) Twenty-three (25.8%) of 89 respondents held a doctoral qualification, and 25 of 70 respondents (35.7%) were qualified prescribers.

Nine NCs (n = 58, 15.5%) were ‘responsible clinicians’. The responsible clinician is the lead clinician for patients detained under MH law (Mental Health Act 2007). Five of the 9 NCs were also prescribers. Twenty-two NCs (28.2% of 78 who replied to this question) had line management responsibility for other staff.

**Time spent in each of the four domains**

Thirty-nine (38.2%) of 102 respondents reported that 50% or more of their time was allocated to Expert Practice, with the median proportion of time reported in this domain being 40.0% (Table 4). Twenty-one NCs (20.6 %) reported spending between 40 and 50 % of time in expert practice. There was considerable variation in reported time spent in each domain, with interquartile ranges from 15.1 to 38.8%, (excluding the ‘Other’ activity category). The largest interquartile range was found in the Expert Practice domain (38.8 %).

**Table 4. Nurse Consultant self-reported proportions of time (%) spent in domains of**

**practice**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Expert practice** | **Education, Training & Development** | **Practice & Service Development** | **Professional Leadership & Consultancy** | **Other responsibilities** |
| **Median** | 40.00 | 15.00 | 15.00 | 20.00 | 5.00 |
| **Range** | 0 - 100 | 0 - 55 | 0 - 75 | 0 - 70 | 0 - 60 |
| **Interquartile range** | 26 | 10 | 15 | 15 | 10 |

**Changes in number of posts**

Fifty-five NC posts were identified as having been deleted by 28 (54.9%) of the responding 51 trusts: 15 trusts had removed one post, six removed two, four removed three, two removed five and one removed six. Four reasons for terminating the posts were provided, in 25 cases, with reasons for the other 23 not being reported. These were; the post holder had left (n = 8), the post holder had retired (n = 6), there were organisational restructuring or loss of funding (n = 8) and the post was perceived to be ineffective (n = 3).

**C) Exploring the views of Directors of Nursing in relation to NC role**

All 12 of the DoNs approached to participate in telephone interviews agreed to do so. Eight DoNs were from trusts where NC posts had previously been removed, although two of these organisations were currently planning to establish new posts. Four DoNs were from trusts that had not previously removed posts, two of which had plans for new posts.

We identified four main themes from the interviews; cost and value of the role, personal attributes of the NCs, understanding of the role and domains of work.

*Theme 1: Cost and value in the context of austerity*

Some DoNs explicitly cited austerity and cost improvements as contributing to declining numbers of NCs. Cost was identified by five DoNs, four of whom were from trusts which had lost at least one NC post, and one where the numbers had been maintained.

*‘…austerity measures added to the conditions leading to the end of two NC roles’ (DoN 3)*

[The NCs] *‘Could not demonstrate value for money in a highly competitive environment’ (DoN 9)*

Participants presented the role of the NC as particularly vulnerable to cost savings or service reconfigurations and to require justification in a way that more established roles, such as consultant psychiatrists, did not.

*‘.. the (NCs) need to produce the numbers ….to make it clear that the expensive nature of their role is worth it’ (DoN 2)*

However, participants valuing the roles appeared to act as a protective factor.

“*The NCs provide a very high quality service…they are paving the way for more NCs.*” (DoN 8)

Consideration of cost was also identified as important in setting up the posts, for example, when noting a beneficial impact of NC roles in reducing the need for medical time. Overall, the most positive views about NCs were expressed by DoNs from trusts where posts had been maintained or increased whilst the converse was apparent in those from trusts where numbers had decreased.

*Theme 2: What the individual brings to the role*

Participants attributed a large part of the success of NC posts to post holders’ personal and professional characteristics. Personal qualities of being ‘hardworking’ and ‘self-motivated’ were specifically mentioned. Duration of clinical experience, especially specialist experience, was appreciated by the DoNs as well as an advanced (at least to masters) level of education (DoN 12).

Two instances were presented where NC posts were seen as ‘failing’ due to the personal characteristics of the post holders. The characteristics identified in these cases were ‘having a negative attitude’ (DoN 5) and ‘not being generally suitable’ for the role (DoN 6).

The quality of potential candidates for posts was identified as important to the future success of the role. Some felt there was a lack of good candidates, but there was dissention from one DoN working in a trust where posts had been reduced.

“*Many members of staff exist in the trust who are able to fulfill the needs of this role…lack of positions not a lack of people’ (*DoN 3)

*Theme 3: Lack of clarity and understanding of the NC role*

There was a general consensus, particularly from DoNs in trusts which had reduced NC numbers, that the role lacked clarity. They also expressed confusion about the aims, accountability and focus and indicated that this feeling was shared by other professions.

“*This perception of the roles being rather ‘hollow’ developed due to a lack of specificity and content for the roles.*” (DoN 6)

“*The primary issues were with the definition of the role, it was very hard to determine the relationship between the different functions and responsibilities of the CN to the point where it was not known how they should function.*” (DoN 5)

This lack of clarity was identified as presenting a challenge in justifying the cost of employing NCs and in measuring their impact (as in Theme 1). DoNs saw the absence of robust measures to assess the impact and cost-effectiveness of posts as creating additional pressure for NCs to justify their positions.

“*There are still difficulties with measuring outcome amongst the NCs due to the incredibly varied nature of the roles and the influence that personal characteristics have on the role.*” (DoN 2)

In addition to the lack of clarity around job roles, some respondents felt that too much was demanded of these roles and that NCs were inadvertently being set up to fail. They felt comparison with medical consultants was confusing, as the NCs were not attributed with the same level of clinical seniority nor did they have other forms of authority, such as managing staff and budgets.

*‘The term of NC is not helpful as it leads to an expectation of parity with medical consultants’* (DoN 9)

 [They were] *..slightly impotent, as not managing service budgets*.” (DoN 1)

It was suggested that NCs may have been used to fill gaps in clinical services resulting in them being overstretched and reducing the impact of their specialist knowledge.

*‘The most important lesson was to define the role of the NC… if this is not done the role becomes diluted and the value of the role diminishes.’* (DoN 2)

*Theme 4: Domains of work*

Participants identified areas of practice that they saw as particularly important, referring to the four domains of NC practice including ‘research, although none mentioned ‘education’.

[Strengths of the role are] ‘*being clinically active and championing clinical activities.... involvement in research and development and publication....* (DoN 4)

“*They look outward as well as inward… they influence within and outside the trust.*” (DoN 12)

[What’s required is] *..‘leadership, interest in research, promoting recovery.’* (DoN 10)

**Discussion**

This study explores an advanced practice role created by national policy, in two fields of nursing. To date, the majority of publications in peer reviewed journals, specifically related to NCs practicing in mental health services, are descriptions of the work of individuals and views expressed regarding the future of the role. This paper provides an analysis of trends in MH and LD NC numbers, a quantitative description of professional and personal characteristics of the majority of MH and LD NC post holders nationally and as well as reports on their domains of practice and patterns of employment). It also presents an analysis of the views of DoNs as to factors that affect the establishment and continuation of NC roles and considers the effect of national policies on NC numbers.

*Numbers of nurse consultants*

National NHS workforce data demonstrated an increase in the number of NC roles in both LD and MH services from 2000 to 2008. There was a further rise of 12% between 2009 and 2017 in MH NCs, although an unexplained decrease of 15% was apparent between 2013 and 2014 (144 to 122). The increase from 2009 and 2017 took place at the same time as a 12.7% reduction in overall numbers of MH nurses, and suggests a relatively strong commitment to the role in MH services compared to the NHS overall, where NC numbers for the same period increased by only 4.4%.

Despite a large reduction in the number of LD nurses in the NHS between 2009 and 2017, the comparatively high proportion of NCs in the remaining LD workforce suggests that they continued to be valued by service planners. This may relate to the treatment approaches used in this sector, which are likely to focus on social and psychological domains, rather than bio medical. One interpretation of this finding is that NCs roles may be more easily established and maintained in clinical areas where their skill set is not so contested by other professions.

Overall, it is clear that, even with modest increases in numbers of NCs in MH services, they remain rare. Only one in every 229 MH nurses was employed in such a role in 2017. The distribution of NC posts was very uneven, varying per trust between 0 to 12. Eleven trusts had no NCs at all. Wide variation in the adoption of advanced MH nursing roles between organisations is not unusual in England or internationally (Delaney et al 2018). For example, nurse prescribers in English MH services are unevenly distributed between trusts despite governmental support for the role (Dobel-Ober and Brimblecombe 2016). The variation in numbers of prescribers and of NCs is within the context of a lack of mental health specific empirical evidence on the impact of both of these roles on patient and staff outcomes. However, economic arguments in support of advanced practice roles appears to greatly increase their uptake, demonstrated by the increase of nurse prescribers in substance misuse services (Mundt-Leach and Hill 2014).

*Characteristics of nurse consultants*

The NCs we identified were highly experienced and had worked in clinical practice for an average of 27 years. They were well educated, indicated by 95% of respondents having a post graduate qualification to at least master’s level and 26% of respondents having a doctorate. The most frequently reported ethnic group of respondents was white British (n= 87, 95%). This indicates an under-representation of black and minority ethnic groups, who constitute 21% of the total MH nursing workforce (NHS Digital 2015) and reflects the low numbers, throughout the NHS, of ethnic minority nurses in senior clinical positions (Kline 2014).

NCs worked in a range of clinical specialties within mental health services, although the majority were in community settings. This may have been influenced by the relative increased availability of trainee medical staff in inpatient care areas.

*Factors affecting NC numbers*

The DoNs identified four factors that affected whether NC roles were created and retained. These were: issues related to the demonstrable value of NCs at times of cost pressures, the personal characteristics, experience and skills of individual NCs, the challenges arising from a lack of role clarity and the value in being able to work in the four domains of practice. Cost pressures were seen as problematic particularly when combined with a lack of evidence as to the value of the NC roles in some trusts. It is interesting that most of the published papers describing the work of individual NCs was written by the NCs themselves, possibly in response to this issue. DoNs highlighted that, in newly introduced roles and without evidence to support their impact, the individual characteristics of NCs are likely to be particularly important, as reported in other studies. McIntosh and Colson (2009) cited the need for NCs to have strong interpersonal skills and capacity for intellectual effort in order to meet the demands of the role, whilst Riten et al (2017) reported Australian nurse consultants’ views that that personal attributes, including motivation and communication skills, were key drivers to role performance.

*Impact of nurse leaders*

The interviews with DoNs in NHS trusts suggested that local leaders may strongly influence take up of nationally supported roles, based on their personal beliefs and experiences. DoNs varied in their attitudes toward the potential of the NC role. Some were positive, whilst others, who reported poor previous experiences, were not. Although most DoNs spoke of the cost and value of NC posts in the context of recent austerity in the NHS, where in trusts where NCs were valued by DoNs, posts were retained and often more were planned. The power of individual local nursing leaders to impact on the successful introduction of new advanced practice roles would be useful to investigate in future studies.

*Policy impact*

The workforce census data tentatively suggests that national policies can differentially affect clinical specialties and this may explain some of the variation in numbers of NCs. However, the outcome of policy change can be difficult to predict. For example, the long term national policy, recently reenergized, of delivering care to people with a learning disability in non-institutional and particularly non-NHS institutions (Department of Health 2002; Department of Health 2012) has led to drastically reduced LD nurse staffing numbers over time, with an unsurprising reduction in NC numbers in that specialty as a consequence. However, the policy change to enable non-medical senior clinicians to become responsible clinicians (Mental Health Act 2007) could have created significant new opportunities for NC roles in both MH and LD services, but appears to have had very limited impact. Our survey identified only 9 NCs who were responsible clinicians.

*Role clarity and role title*

The views of DoNs around a ‘lack of clarity in and of the role’ of NC, reflect those reported elsewhere. Mullen et al. (2011) noted that organisational understanding of the role is key to its success, Riten et al (2017) identified lack of managerial support and lack of understanding of the role by other health professionals, whilst Franks and Howarth (2012) reported NCs’ perceptions that a lack of inter-professional understanding and support meant that their worth was often not appreciated by decision-makers. Similarly, the introduction of other advanced practice roles has led to problems of role conflict and variable stakeholder acceptance (Bryant-Lukosius et al 2004).

The NC role in England (and the United Kingdom) is unusual in being originally conceptualised by the government as distinct from, and more senior to, clinical nurse specialists and nurse practitioners, a position not reflected in other countries such as Australia and the United States (Kennedy et al 2011). Recent national guidance (Health Education England (2017), aims to clarify the role and requirements for advanced practitioners. It does not, however, address how advanced practice and consultant level practice should differ, thus perpetuating any current lack of clarity.

The term ‘nurse consultant’ is used in several countries to refer to nurses working in advanced practice or specialised roles. Differences in either local or national expectations of similarly named roles may lead to lack of clarity around job responsibilities and competencies and can raise doubt as to whether research on a named role in one country or area is transferable to similarly or differently named roles. In considering this issue, Jokiniemi et al. (2012) conducted a systematic review to compare the roles of NCs in the UK with that of ‘clinical nurse specialists’ in the USA and ‘clinical nurse consultants’ in Australia. They did find similarities across the three countries and attributed variations in roles as originating from differences between organisations.

We sought to to understand the NC role in MH services in the context of internationally varied approaches to advanced practice roles. Although we have reflected on apparent similarities, such as a lack of role clarity, more detailed comparisons have proven difficult. We identified no published data about NCs in other countries that provided a similar level of descriptive detail to that reported in this study, and it is unclear as to which roles with other titles might truly be similar to NCs in England. However, the data in this paper will facilitate more detailed future comparison, for example in terms of the educational level, field of practice, level of experience and range of activities carried out by MH or LD advanced practitioners elsewhere in the world.

**Study limitations**

The number of NC posts identified by the national workforce census was higher than in our survey, equating to approximately eleven more posts, once non-responding trusts were taken into account.

Information as to how NCs spent their time at work relied on self-reports rather than observation, and therefore carries a high risk of inaccuracy (Ampt et al 2007). Also, using the four domains of practice to describe time allocation is of somewhat limited value because of the breadth of each. Research and practice, for example, are reported within the same domain.

Funding for the study was limited and much of the data collection was carried out by research assistants in a voluntary capacity. Collating other data, such as patient or staff experience of the nurse consultant role, would doubtless have added value to our findings, but was not feasible within the resources available.

Interview data were gathered by a research assistant with some clinical experience as a support worker. This had a potential benefit of encouraging potentially useful ‘naïve’ questions regarding more strategic issues such as workforce strategy, recruitment and trust finances, so that greater clarity could be found in responses. However, it also limited the ability of the interviewer to have insight into some areas where more in-depth clarification may have been warranted. Participants did not have a direct opportunity to feedback on the findings of the analysis, however, several of the DoNs were present when findings were presented to a larger group and engaged in discussion about those findings.

**Conclusion**

This study of two specialist fields of nursing operating in an advanced practice role in mental health services shows marked variation in numbers of NCs between organisations and suggests that successful introduction and continuation of new roles may be affected by both the views of senior professional leaders and by national policies. The lack of robust evidence of clinical and cost effectiveness in specific clinical specialties remains a major barrier to NC roles and requires further research. The study provides a detailed description of characteristics of two nurse consultant specialties that will allow comparison with other advanced practitioners in mental health services and in other clinical specialties, nationally and internationally. It also demonstrates NCs to have been, typically, highly qualified academically and with many years of experience. The low levels of non-white British NCs suggests that more effort is needed to support nurses of other ethnicities to develop their careers, so they can compete equally for such posts.

A lack of clarity regarding the unique contribution of NC roles as compared to other advanced practice roles and to other professions is a barrier to implementation. This has been found in other countries in a range of advanced nurse practice roles, although the evidence for distinct types of advanced practitioner varies widely.

Measuring impact from the work of a single practitioner is challenging and a broader approach may be required to evaluate the whole system in which these senior posts operate. Outcome measures should demonstrate the impact of these roles within the wider system on service user outcomes, in addition to staff experience and workforce development. Further investigation of NC’s contribution to research and evaluation in terms of time, type of activity and academic output is also warranted.

**What are the implications for practice?**

Successfully introducing advanced practice nursing roles in mental health services requires role clarity and support from local nurse directors.

The continued absence of robust evidence as to the clinical/cost effectiveness of nurse consultant roles in mental health settings places an onus on individual posts to generate outcome data to justify the role at a time of financial constraint. Outcome measures should demonstrate the impact of these roles as part of the wider system in which they work. in terms of staff experience, workforce development and, ultimately, patient outcomes. Further investigation of NC’s contribution to research and evaluation in terms of time, type of activity and academic output is also warranted.

The detailed post holder characteristics presented in this paper provide a basis for future comparison with other advanced practice roles in mental health and other specialties nationally and internationally.

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