Abstract
The role of nurse consultant was established in 1999 as part of the national ‘Making a Difference’ nursing strategy. This article explores the qualities and skills required to successfully undertake the role, and uses important aspects of the author's experience of being a clinical nurse consultant in infection prevention and control to illustrate that one of the most strategic clinical leadership roles in healthcare is uniquely innovative and made a difference in the author's organisation.

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Role of the nurse consultant in infection prevention and control

The concept of the role of clinical nurse consultant was first discussed by several authors in the 1970s (Ashworth 1975, Royal College of Nursing (RCN) 1975, Kratz 1976), but it would take another 25 years for the notion to become a reality in the UK. The role of nurse consultant was formally established in England, Wales and Northern Ireland in 1999, as part of the national strategy Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare (Department of Health (DH) 1999). The first nurse consultants commenced in post in early 2000.

In 1975, when authors such as Ashworth were discussing the role of clinical nurse consultant, I was still at school and had not considered nursing as a potential career. By 2000, I was a busy clinical nurse specialist in infection control, and a mother of two young children. I came to infection control nursing via general...
and neurological critical care nursing, with the lead infection control nurse in my healthcare organisation encouraging and mentoring me in this career pathway.

The first nurse consultant I encountered worked for a Scottish national body as a nurse consultant epidemiologist; the second was the first public health nurse consultant appointed to the health protection team in the NHS board for which I worked. Both these posts were appointed in the early 2000s, and by 2002 there were 13 nurse and midwife consultants in Scotland (Scottish Executive Health Department 2002).

By 2008 there were around 120 nurse consultants, midwives and allied health professionals in Scotland, of whom ten were in the disciplines of infection control and public health. Among the 15 NHS boards in Scotland, there were six nurse consultants in infection prevention and control, of whom I was one, distributed between five mainland health boards. There was also one health protection nurse consultant in post in public health, and two other mainland boards were seeking funding for nurse consultants in infection prevention and control. In addition, there were three nurse consultant epidemiologists working at Health Protection Scotland in a national, strategic capacity.

In 2018, there were two nurse consultants in infection prevention and control in mainland health boards, no board health protection nurse consultant posts in public health, and five nurse consultants in infection prevention and control at Health Protection Scotland. By 2019, there will only be one nurse consultant in infection prevention and control left in clinical practice in Scotland.

### Box 1. Attributes and role of the nurse consultant

**Knowledge, skills and expertise in integrated sub-roles**

- Nursing practice as a generalist and/or specialist
- Research and evaluation in practice
- Practice development and the facilitation of structural, cultural and practice change
- Education and learning in practice
- Consultancy - clinical to organisational
- Management, leadership and strategic vision

**Personal qualities and attributes**

- Person-centred
- Available, accessible, generous and flexible
- Enthusiastic
- Self-aware and attuned to others
- A collaborator and a catalyst
- Possessing a vision for nursing and healthcare
- Strategic and demonstrating political leadership
- Academic

**Transformational leadership processes**

- Developing a shared vision
- Inspiring and communicating
- Valuing others
- Challenging and stimulating
- Developing trust
- Enabling

**Processes of emancipation**

- Clarifying and working with values, beliefs and assumptions, and challenging contradictions
- Developing critical intent of individuals and groups
- Developing moral intent
- Focusing on the effects of the context and system on practice, as well as practice itself
- Using self-reflection and fostering reflection in others
- Enabling others to ‘see the possibilities’
- Fostering widening participation and collaboration by all involved

**Practising expertly as a practitioner, researcher, educator, consultant and practice developer**

- Role modeller
- Facilitating individual, collective and organisational learning
- Facilitating change, practice and service development

(Manley and Titchen 2012)

### Responsibilities, attributes and skills of nurse consultants

Manley and Titchen (2012) summarised the defining attributes and role of the nurse consultant (Box 1).

Using the skills and attributes identified in Box 1, the nurse consultant works to a set of criteria defined by the DH (1999) and the Scottish Executive Health Department (2001), with four main functions:

- Expert practice.
- Professional leadership and consultancy.
- Education and research.
- Service development.

In practice, the time a nurse consultant spends undertaking each of these domains will depend on their specialty, as well as the expectations, opportunities and constraints in the organisation. Generally, it is accepted that around 50% of a nurse consultant’s time should be spent in expert practice (Hughes 2002, Redfern 2003). The time spent on the other domains depends on personal, local and national priorities, as well as service drivers, but is likely to be fluid over the course of the nurse consultant’s career. However, it is essential that the nurse consultant engages in all the core functions of the role, including conducting research and working with academia (Hourahane et al 2012).

It is generally understood that a nurse consultant would not manage a specialist service, but will lead and develop that service using leadership, role modelling and influencing skills. Rosser et al (2017a) confirmed that the role has remained well-aligned to its founding criteria, while developing in response to the changing needs of the local health and social care economy, and to ongoing policy changes in the NHS. In the ten years that I have been a nurse consultant in infection prevention and control, delivery of healthcare in Scotland has changed significantly and I have had to adapt my practice to accommodate those changes.

Several authors note that the effectiveness of the nurse consultant role is constrained if there is insufficient support available from their organisation (Guest et al 2004, Woodward et al 2005, McIntosh and Tolson 2009, Rosser et al 2017b). For the nurse consultant, it is important to establish a network of supportive peers to share challenging experiences with and identify ways to progress the role. Supportive clinical supervision can also assist the nurse consultant to change and challenge practice and be a ‘cutting-edge’ clinical leader (Redfern 2003, Hourahane et al 2012). Rosser et al (2017b) noted that using an action learning set assisted a group of nurse consultants to enhance their clinical leadership skills and extend their scope and confidence more strategically. Action learning is an approach to problem-solving that involves taking action and reflecting on the results, which can improve the problem-solving process and the solutions developed by the team.

The nurse consultants in Rosser et al’s (2017b) study had significant...
effects in their organisation, and their development into high-functioning expert practitioners within the four domains of the role was hastened by the peer support enabled through the action learning set.

The nurse consultant is expected to be educated to master's level in an appropriate subject (Scottish Executive Health Department 2001, Campbell and Gavaghan 2005, Hourahane et al 2012, Jokiniemi et al 2012). In addition to expertise in their subject area, it is important for nurse consultants to take a holistic view of each patient (Castledine 1998), which involves ensuring that patient care reflects each individual's physical and psychological needs, as well as considering the patient's environment and the potential effects of organisational systems and culture on the care process. Thus, the nurse consultant’s practice must be person-centred, while also ensuring engagement, acceptance and support for their role from medical, nursing and allied health professional colleagues in the organisation. To achieve this, the nurse consultant should have effective technical skills and specialist knowledge, but should also ‘be astute in organisational politics and have the interpersonal skills of a high-level diplomat’ (Redfern 2003).

It is implicit in the role that the nurse consultant is accountable to themselves, works across all professional boundaries at a senior level and takes risks to innovate (Rosser et al 2017a). Humphreys et al (2007) asserted that the nurse consultant requires the freedom to act independently of the established systems to lead and develop practice.

**My journey as a nurse consultant in infection prevention and control**

Transformational leadership and fostering effective teamworking

When I was appointed as nurse consultant in infection prevention and control in NHS Fife in 2008, the senior management team believed that this role was required to realign the infection control service. The service had evolved from three nursing teams that had differing structures and disparate working practices. Each team also had opposing views of their role and function in delivering infection prevention and control for the organisation. The mandate was to bring together these three teams into one cohesive infection control nursing team that was forward-thinking, engaged with the organisation’s values and aspirations, and readily accessible to all staff in the organisation.

One month after taking up my post, I began work on a programme of team-building and development, with the aim of unifying the infection control nursing team. Underpinning this would be: team development events; a programme of personal and professional development for each nurse tailored to that individual, but cognisant of organisational and service needs; one-to-one working with each infection control nurse; and my role modelling of the behaviours required from the team.

I had undertaken the RCN Liberating Leadership course two years previously, which aimed to provide senior clinical nurses with the skills to change the largely medical model of clinical care delivered in the NHS. The course was based on the principles of transformational leadership, and introduced concepts such as organisational culture, change management, political awareness and networking. In addition, by 2008 I had been a practising infection control nurse for more than 13 years and had held the posts of lead infection control nurse and the new post of infection control manager in different NHS boards. These management roles enabled me to enhance my leadership skills.

Building on this experience and working with the infection prevention and control team service manager, and the organisational development department, I developed a series of workshops to overcome some of the barriers to effective teamworking and establish one cohesive team with shared goals. Dialogic methodology (Bohm 1996) and the Myers-Briggs Type Indicator (Myers 1962) were used to facilitate the workshops, break down barriers and enact change. Dialogic methodology involves ‘a sustained collective inquiry into the process, assumptions and certainties that compose everyday practice’ (Isaacs 1993). The goal is to increase the quality of human interactions, thus promoting organisational and individual transformation (Stewart et al 2004). Kolb’s (1976) Learning Styles Inventory and the Myers-Briggs Type Indicator (Myers 1962) enabled me to explore the different personality types in the team and establish what benefits and challenges our particular mix provided. Bradley and Hebert (1997) suggested that diversity and balance in the personality types of team members generally results in successful team performance.

I undertook a series of exercises on how teams work, which included reflecting on our own assumptions and practices and how we might evolve these. I also encouraged the team members to challenge fixed notions of their roles, and I stimulated debate to support them to become more confident and innovative in their practice.

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**Key points**

- **The role of nurse consultant** was formally established in England, Wales and Northern Ireland in 1999, as part of the national strategy Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare (Department of Health 1999)

- **The aim of the nurse and midwife consultant posts** was threefold: to provide better outcomes for patients by improving services and quality of care; to provide new career opportunities to retain experienced and expert nurses in clinical practice; and to strengthen nursing leadership in clinical practice

- McIntosh and Tolson (2009) asserted that nurse consultant posts require appropriate support if they are to be sustainable, with Mitchell et al (2010) adding that unless the nurse consultant role is valued for its contribution to improving patient care, especially in times of austerity, then sustainability of the role is uncertain
They learned to trust their own and others’ abilities and to look to themselves and each other for novel problem-solving ideas.

Over two years, we became an infection control team that had developed strong cohesion and mutual respect. This was articulated through the team’s purpose that was formulated in the phrase ‘Enabling everyone to prevent infections in Fife’, which had been developed by the team during the workshops. This resulted in significant improvement in the infection control nurses’ decision-making, so that the patient was at the centre of all the nurses’ decisions. Their practice became increasingly inclusive and based on partnership and problem-solving.

**Expert practice and service development**

Along with the facilitated team development events, I worked to develop strong, positive working relationships with clinical and support service colleagues with whom infection prevention and control practice is enacted. Much of this change centred on showing the infection control nurses that infection prevention and control guidance could be implemented effectively while ensuring their practice remained person-centred. Infection control is process-driven and practitioners often mistakenly assume that guidelines or policies must be strictly adhered to. Often, the effect of this type of practice is that it ‘sets staff up to fail’, since the infection control nurse’s expectations may not be able to be met in a particular clinical environment with a particular patient, current staffing levels, patient dependency and other conflicting organisational priorities. I taught my team to assess each situation holistically and to work with the clinical team to enable safe practice in the ward, in accordance with the team’s purpose. This usually means that a compromise has to be reached, so fostering effective and trusting working relationships with clinical teams is essential, even if this initially means that best practice is not achievable.

Infection prevention and control practice involves moving unsafe practice through the spectrum of improved practices to eventually achieve best practice. This applies equally to the management of a patient in isolation as to a decontamination process and may take years to achieve. Therefore, specialist infection control practitioners require tenacity and attention to detail. The essence of the nurse consultant role is expert practice (Harker 2001), and I established a portfolio that drew on the main areas of my expert knowledge. I became the lead consultant for the built environment, the planning and management of norovirus outbreaks, and clinical patient care in complex care environments or with unusual organisms. The day-to-day management of straightforward cases was the responsibility of the infection control nurses, but both they and the clinical teams asked me for guidance in complex situations.

**Improvement programme for medical device processing**

I took on strategic clinical responsibility for decontamination of invasive medical devices and led the development of an improvement programme for medical device processing in NHS Fife. It took nearly five years of small improvement steps in the Ear, Nose and Throat (ENT) outpatient department’s decontamination practice until best practice could be implemented. Enablers in this process included: the willingness of the estates department to provide improved decontamination facilities in the building; the willingness of the senior charge nurse and ENT consultants to enable a new process to be developed and implemented; and the organisation providing resources in a new purpose-built facility for the decontamination of invasive medical devices. These enablers led to best practice decontamination of ENT nasendoscopes (small, angled endoscopes that are inserted into a nostril and used to visualise the nose, sinuses, pharynx and larynx). I developed a mutually respectful and open relationship with the estates department and nurse managers, who were integral in providing momentum for the change process. It was particularly gratifying when the Healthcare Environment Inspectorate commended us on our process and flagged us as a gold standard exemplar for NHS Scotland.

**Outbreak management**

According to Sherman (1995), ‘contemporary leadership seems to be a matter of aligning people toward common goals and empowering them to take the actions needed to reach them’. Early in my career in NHS Fife, NHS Scotland experienced high norovirus activity in the winters of 2008-10 (Health Protection Scotland 2010a, 2010b). These had significant effects in our hospitals, with high numbers of norovirus cases and impaired winter bed flow. When the entire trauma unit was closed, radical steps were required to address the issue of patient safety. These steps require innovation and courage, which are important elements of the nurse consultant role (Redfern 2003). I introduced several outbreak management techniques that had not been used before in the organisation (Box 2).

These actions enabled the safe and effective management of the bed crisis, and ensured that the spread of the outbreak was contained. Effective communication during and in-between outbreak meetings was central to successful compliance with the outbreak management process and supported staff to take ownership of this process.

As a result of this success, I was asked to chair a multidisciplinary norovirus outbreak preparation group that commenced every August, and which was invaluable at a time when our hospitals and services were undergoing radical changes. I also formed a liaison group with the support services department that included outbreak planning and management in its core remit. This work enabled the norovirus outbreak management process to become embedded in the working practice of all healthcare service disciplines. It also ensured an efficient and timely response from all teams before, during and
after an infection outbreak, which enhanced patient care.

Planning and implementation of new facilities

When I commenced my nurse consultant in infection control post, the organisation was undergoing an estate replacement programme of its acute and primary care premises. In the winter of 2011-12, a new wing was opened on the site of the organisation’s second acute hospital and all acute services were moved to this location. I was involved in the planning and implementation of the build, as well as in the major redesign of surgical, medical and other services to enable effective use of the new facilities, which focused on ensuring the environment maximised the ability of the clinical teams to deliver safe and effective patient care. My extensive knowledge of the built environment and considerable experience in the application of these principles to healthcare delivery enabled me to actively participate in this project. I had close working relationships with the clinical planners, the architects and the building company during the development and building phases, and was part of the group who coordinated the move to the new facility.

Research and education

I commenced my master’s degree in Advancing Nursing Practice one year after taking up my post. During this time, I strengthened my practice and expertise in my discipline by incorporating what I had learned in my clinical practice into my master’s degree modules. This meant that I was able to reflect on and assess the effects of my practice in detail and I improved my ability to apply nursing research in clinical practice. I also made new contacts in higher education and was an invited lecturer at the University of Edinburgh, both requirements of the nurse consultant post (Scottish Executive Health Department 2001).

My development as an effective consultant was aided by my introduction to human factors science and the effects of organisational systems and culture on human behaviour in the workplace. Human factors science explores how humans make mistakes and how they interact with equipment and their environment to affect an outcome. It enables infection control practitioners to identify how and why healthcare practitioners make lapses in practice, and assists the infection control practitioners in accommodating these influences when developing guidance and policy, and providing advice on the management of a patient or system. This knowledge assisted me to understand why some infection prevention and control strategies were not effective, as well as indicating potential new routes to success.

As a nurse, my aim is to ensure effective patient care, yet much infection prevention and control practice ‘wastes valuable resources’, ‘damages efforts to improve quality of care’ and generates ‘a high level of cynicism’ within the healthcare practitioners whose practice we seek to influence (Wilson 2018). Iwami et al (2016) suggested that the indicators used to measure the efficacy of infection prevention and control interventions require regular appraisal, and that macro influences must also be acknowledged, such as: staffing levels; organisational and ward culture; the effects of the environment and equipment; and the effects of a target-driven culture. As Waterson (2009a, 2009b) reflected, one person cannot change the culture of an organisation alone, but an understanding of how an organisation influences and often hinders change can increase the effectiveness of that person’s practice.

Effects and barriers

Effective time management and visibility are essential to ensure that provision of ad hoc expert advice by the nurse consultant is delivered in a timely manner (Harker 2001). Guest et al (2004) and Manley and Titchen (2012) identified that role complexity and competing demands may have an adverse effect on the effectiveness of the nurse consultant. Booth et al’s (2006) study of Scottish nurse and midwife consultants identified that barriers to role fulfilment included role confusion and a lack of preparation for the role within an organisation and on behalf of the nurse consultant, as well as role overload.

In an organisation with little experience of the nurse consultant role, I found that role ambiguity, overload and the conflicting expectations of colleagues were challenging. Over the past ten years, I have observed that this has led to differing views regarding the effect and success of the nurse consultant in an infection prevention and control role. Guest et al (2004) observed that ‘it is not possible to

Box 2. Outbreak management techniques introduced in NHS Fife

- Convening a multidisciplinary hospital control team, chaired by the chief executive, that met daily and made decisions based on the business continuity and the requirements of the infection prevention and control team
- Agreeing enhanced laboratory surveillance of norovirus cases and the screening of emergency referrals to the hospitals to provide early confirmation of or exposure to norovirus, thus enhancing ease of management of suspected and confirmed cases
- Assigning dedicated allied health professionals to the outbreak areas to ensure that patients continued to receive rehabilitation when they were well enough to do so
- Negotiating with health and social care providers, through the local council, to enable the continued assessment of patients for discharge to community care packages in outbreak areas
- Initiating daily norovirus updates at the winter teleconferencing meeting between the acute and primary care management teams
- Sending regular updates to GPs advising them of outbreak status and capacity issues in the hospitals
- Ensuring enhanced, proactive communication with the public through local print, broadcast and electronic media, to raise awareness regarding the effect of visiting hospitals during norovirus season while symptomatic with gastrointestinal disease
- Ensuring continuous infection control nurse presence in outbreak wards during the peak phase to provide advice and support to clinical managers and staff
provide anything other than a very broad classification of the specific benefits to an organisation of the nurse consultant role. However, Humphreys et al (2007) asserted that the effects, cost-effectiveness and added value of nurse consultant roles need to be evaluated. Gerrish et al (2011) developed a toolkit for nurse consultants to capture the effects of their role, allowing for the fluidity and different applications of the role in different organisations and specialities.

Rosser et al (2017b) suggested that research must demonstrate the worth of the nurse consultant role. McIntosh and Tolson (2009) asserted that nurse consultant posts require appropriate support if they are to be sustainable, with Mitchell et al (2010) adding that unless the nurse consultant role is valued for its contribution to improving patient care, especially in times of austerity, then sustainability of the role is uncertain. I suggest that the declining number of nurse consultants in infection prevention and control clinical posts in NHS Scotland, as well as the 7% reduction of all nurse consultant posts in the past few years in England (Rosser 2017b), support Mitchell et al’s (2010) view. This may indicate that there is insufficient or inappropriate support for the role, or a lack of recognition of its effect locally and within the wider NHS, to sustain these posts on a long-term basis.

Conclusion
I have found working as a nurse consultant in infection prevention and control demanding, exciting and rewarding. This post has enabled me to fulfill my career ambition to make a positive difference to nursing practice by using my skills to provide a clear vision and direction, develop evidence-based practice and pace change management, and motivate and inspire others. However, the sustainability of nurse consultant posts in the UK has reached a crucial point. Unless there is increasing recognition of the value this role provides, the role will continue to decline, in the same way as that of the nurse consultant in infection prevention and control in Scotland. The potential loss to nursing practice and patient outcomes must be emphasised when serious deficiencies in clinical leadership in nursing in the UK are being identified.

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