Reflection on the development of the nurse consultant role

Alison Pottle

In September 1998, the UK prime minister Tony Blair announced the NHS nurse consultant role at the Nursing Standard's Nurse 98 awards (Martell 2000). The role was designed to have the same status as a medical consultant and plans for its implementation were outlined in the national strategy Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare (Department of Health (DH) 1999). The document provided guidance on consolidating nursing leadership, updating the nursing career framework, and modernising professional self-regulation, and invited NHS bodies to submit proposals to establish the first nurse consultant posts (Renshaw 2005).

Nurse consultant posts were intended to improve outcomes for patients by enhancing the quality of healthcare services and providing a new career path to retain experienced nurses in clinical practice. The existing nursing career structure at the time was limited, and many experienced nurses were leaving the profession to advance their careers and improve their earning potential. One aim of the nurse consultant post was to expand the top end of the nursing salary scale (DH 1999).

While nurse consultant posts were designed to meet the requirements of the specialty, setting or service in which they were to be established, each post had to be structured around four core functions (DH 1999):

» Expert practice.
» Professional leadership and consultancy.
» Education and development.
» Practice and service development linked to research and evaluation.

These functions were not viewed as distinct elements, but as interrelated roles. The time allocated to each function varied from post to post and within the same post over time. However, the nurse consultant role was to be based firmly in nursing practice and involved directly managing patients for at least 50% of the time.

Potential candidates for the nurse consultant role were those with a portfolio of career-long professional learning, relevant senior experience and formal education, usually up to or beyond master's degree level. Candidates also required...
substantial post-registration experience in the relevant specialty and would be able to demonstrate effective leadership, having previously held a position at the level of charge nurse or equivalent. The role would enable healthcare organisations to implement the new strategy for nursing, which would contribute to the NHS by strengthening evidence-based practice, clinical effectiveness, individual accountability and clinical governance (Manley 2000). Guidance from the DH outlined the process for establishing posts and making nurse consultant appointments (NHS Executive 1999).

**Becoming a nurse consultant**

I qualified as a registered nurse in 1985 at St Mary’s Hospital in London, and my first staff nurse post was on a cardiology ward. After one year, I moved to Harefield Hospital to work in cardiothoracic surgery, but left after nine months to undertake a prearranged national coronary care course at West Middlesex University Hospital in Isleworth. After completing the course, I worked on the coronary care unit at West Middlesex University Hospital for six months to consolidate my learning. However, I found that I missed the tertiary care environment and returned to Harefield Hospital to work on the cardiology unit in July 1987, becoming a ward sister one year later. In 1992, I accepted a dual post of ward sister in the cardiology high-dependency unit and resuscitation officer. To expand my knowledge, I undertook a Master of Science degree in Cardiology at Sussex University in Brighton from 1998-1999, which coincided with the development of the nurse consultant role.

The director of nursing at the Royal Brompton & Harefield NHS Foundation Trust was keen for the trust to be involved in the nurse consultant initiative and submitted applications for two nurse consultant posts, one in critical care and the other in cardiology. I was asked if I would like to be involved in the team at Harefield Hospital responsible for drafting the proposal and job description for the cardiology post. This was a challenging exercise, partly because the team were attempting to develop a role that did not exist, although we did have guidance on the remit of the role from the DH (NHS Executive 1999).

One significant challenge encountered by the team when drafting the proposal and job description for the cardiology post was how to define the difference between a nurse specialist and a nurse consultant. It was eventually agreed that the nurse consultant role had a broader remit than that of the nurse specialist and encompassed any aspect of the specialty. For example, a heart failure nurse specialist would focus exclusively on patients with heart failure, whereas the cardiology nurse consultant role would incorporate any area of cardiology. In addition, the nurse consultant post was more likely than the nurse specialist role to change over time to reflect clinical developments.

In January 2000, the then secretary of state for health Alan Milburn announced the establishment of 141 new nurse consultant posts, stating that these would ‘mean frontline nurses having more influence over the care patients receive’ (BBC News 2000). This first wave of nurse consultant posts was to be established across a range of services such as mental health, midwifery, cancer care, dermatology, elderly care, critical care, children’s services and diabetes. The Royal Brompton & Harefield NHS Foundation Trust was successful with its nurse consultant submissions for the cardiology post. This was an exciting development. In my interview presentation I also identified services that I was interested in developing, such as a nurse-led cardioversion clinic. I organised a meeting with the hospital’s three cardiology medical consultant colleagues and, after some constructive discussion, it was agreed that I would focus on two initial areas for development: setting up a nurse-led follow-up service for patients who had undergone percutaneous coronary intervention (PCI), and a rapid access chest pain (RACP) clinic. I subsequently accepted a third clinical challenge, which was to establish a lipoprotein apheresis service.

**Establishing nurse-led services**

**Percutaneous coronary intervention follow-up clinic**

PCI was relatively new in 2001. It was developed as an alternative to surgical bypass and enables narrowed coronary arteries to be expanded using a catheter that incorporates a stainless-steel mesh stent and a balloon. The catheter is inserted through an artery, usually in the patient’s wrist, and guided to the heart using fluoroscopy X-ray. The balloon is inflated, which expands the stent. When the balloon is deflated the stent remains in place, improving the blood flow in the coronary artery.

Before undertaking the nurse consultant role, I had no experience of leading an outpatient clinic. I had worked in clinics run by doctors, but I did not want to simply replicate the medical model of treatment. In addition to the medical aspects of patients’ care, I wanted to address their psychological well-being as well as incorporating secondary prevention such as providing smoking cessation advice and ensuring that patients’ blood pressure and cholesterol levels were adequately controlled.

I was also familiar with the staff in the outpatients’ department,
but had not worked closely with them. The idea of a nurse leading an outpatient clinic was questioned by some staff. Therefore, I arranged meetings to explain my role and the proposed format of the PCI follow-up clinic. There were to be two PCI follow-up clinics per week. These would run at the same time as the medical consultant cardiologist’s clinics to ensure that there was medical support available, should I need to discuss the care of a patient.

At the time, there were no national guidelines detailing the frequency or length of follow-up care required for patients who had undergone PCI. Therefore, with input from the medical staff, I wrote a protocol to ensure that all patients were treated according to a standard pathway. This would also enable the team to collect outcome data, which had been lacking previously.

The structure of the PCI follow-up service involved setting up a telephone clinic for some patients, which would enable long-term follow-up care without the need for further hospital appointments. This was another initiative that required negotiation with the administrative team, some of whom were unsure of how the telephone appointments would work in practice.

Rapid access chest pain clinics

The National Service Framework for Coronary Heart Disease (DH 2000b) was a ten-year evidence-based programme designed to ensure an equitable and high standard of care for specific cardiac conditions such as stable angina, revascularisation, cardiac rehabilitation and heart failure. It also recommended the establishment of RACP clinics to enable patients with a suspected diagnosis of angina to be seen by a specialist within two weeks, which would support early diagnosis and treatment for those with a potentially life-threatening condition.

There was no stipulation within the national service framework regarding the professional denomination of the specialist, and it was agreed by the cardiologists that I could fulfil this role. This would require me to develop new skills such as clinical examination, diagnosis and assessing the need for further investigation, which were a departure from the usual nursing role. I decided to set up two clinics each week on separate days to the PCI follow-up clinics.

Lipoprotein apheresis

Lipoprotein apheresis is a dialysis-type treatment that involves passing the blood externally through a machine that separates and removes the low-density lipoprotein cholesterol, then returns the treated blood back to the body. Lipoprotein apheresis is used in patients with hyperlipidaemia whose lipid levels remain above national target levels, despite lifestyle and pharmacological treatment. Hyperlipidaemia is a known risk for cardiovascular disease and strokes (Menet et al 2018).

I had no previous knowledge of lipoprotein apheresis and, while a study into the technique had been undertaken at the trust in the 1990s (Jefford 1993), it no longer offered this service. Two months after I started in the nurse consultant post, I was approached by one of the medical consultant cardiologists who wanted to set up a lipoprotein apheresis service and asked if I would be interested in leading it. My training involved one-to-one instruction on the lipoprotein apheresis machine from a German technician who travelled and asked if I would be interested in leading it. My training involved one-to-one instruction on the lipoprotein apheresis machine from a German technician who travelled and asked if I would be interested in leading it.

Challenges establishing nurse-led services

I originally planned a three-month set-up period for the clinics and envisaged that the first one would take place in October 2000. However, I soon learned that this timeframe was ambitious. For example, the first RACP and PCI follow-up clinics did not take place until January 2001, partly because incorporating the clinics onto the clinic booking system, establishing secretarial support and ensuring that everyone was aware of the new services took longer than anticipated.

Following my experience, I always advise nurses involved in setting up similar services to double their timeframes. The additional time spent in the planning stage – for example, calculating that I was able to incorporate several clinics into my weekly schedule – was beneficial and resulted in a reduced need for further changes once the clinics had been established. It is also important to be open to change and to accept when plans are not feasible and require alteration.

Making the transition from ward sister to nurse consultant was also challenging. However, my familiarity with the trust enabled me to spend time establishing the role, rather than establishing myself. For example, I already knew many of the staff and understood how services such as cardiology functioned. This familiarity also made it easier to identify the requirements of the cardiology service.

There was a degree of antagonism towards the creation of the nurse consultant role from some of the medical registrars. One registrar insisted on calling me ‘sister’, even when introducing me to patients, and questioned my ability to undertake some of the clinical tasks required by the nurse consultant role. The inference was that, unlike me, the medical staff had undergone years of training, which better-qualified them to lead clinics. At times, this attitude left me feeling isolated and negative about my new position, although the doctor in question has since become supportive of my role.

Nurses had varying responses to my new role. Some saw it as a positive development for the nursing profession, while others felt that the tasks involved in the
consultant role were primarily medical and inconsistent with the concept of nursing itself. In the first few years following my appointment, I spent a significant amount of time promoting the nurse consultant role.

The people most affected by the nurse consultant role were the patients. Patients can feel they are receiving a 'second-class' service if they are seen by a nurse consultant rather than a medical consultant (Paddison et al 2018). However, patients who attend a medical clinic are not automatically seen by a medical consultant. Also, in my experience, patients are generally happy to be seen by a nurse because nurses are often more accessible than medical consultants, offer them more time and provide them with information in a way that they can understand. However, patients continue to be confused about what a nurse consultant is, and I still have to explain the role to many patients. Some patients still even say ‘thank you, doctor’ as they leave the clinic room.

Balancing the various aspects of the nurse consultant role was also challenging. Initially, I felt that establishing the clinical aspect of the role should take priority. However, when I reflected on my first 18 months in post, I estimated that I had spent approximately 60% of my time in clinical practice, 10% in consultancy and 30% in education, research and service development. The allocation of my time to the various aspects of the role has continued to fluctuate year-on-year. However, I always try to ensure that my focus is predominantly clinical.

There were some unforeseen challenges to the nurse consultant role. For example, I was leading three services single-handedly with no cover for illness or annual leave. On one occasion when I attempted to book leave several weeks in advance, I was informed that there were already patients booked into the clinic that week. When the proposal for the role had been written, there was little appreciation of this type of challenge because nurses had not been considered for consultant roles previously. Furthermore, medical clinics generally have a team of doctors who cover each other’s time off-duty, or alternatively, patient numbers are reduced during these periods. I did not want the clinics to be covered by a doctor in my absence because this would contradict what I was trying to achieve in establishing nurse-led services.

The solution was to educate and support other experienced cardiac nurses to undertake the clinics in my absence. I managed to identify two nurses with several years’ experience who wanted to expand their roles. I developed a training programme for the PCI follow-up clinic and the two nurses eventually became full time nurse specialists. However, I did have to agree to the RACP clinic being undertaken by a medical colleague in my absence because my nurse colleagues did not possess the knowledge or skills to safely undertake it. This resulted in a new challenge, which was to develop a training programme for the RACP clinic.

**Changes in the nurse consultant role**

I have spent more time as a nurse consultant than any other role in my nursing career and during this time the role has grown significantly. The three clinics established when I undertook the post remain in operation. The Royal Brompton & Harefield NHS Foundation Trust has the largest lipoprotein apheresis unit in the UK, while the PCI follow-up clinic reviews 2,000-3,000 patients each year. The number of patients seen annually in the RACP clinic has trebled since 2001, from 130 patients to approximately 450 patients.

My role in establishing new services means that I no longer lead the PCI follow-up clinic and only supervise the lipoprotein apheresis clinic, whereas I once undertook every treatment. I lead one or two RACP clinics each week, but these are supported by a growing team of clinical nurse specialists. I have established pre-admission clinics for patients undergoing elective cardiology procedures and have been instrumental in ensuring that all patients undergoing elective cardiology procedures are reviewed in a pre-admission clinic.

In 2003, I qualified as an independent nurse prescriber and in 2010 established a nurse-led ward round in the cardiology unit with the aim of standardising PCI follow-up care, optimising secondary prevention and expediting patient discharge. By monitoring lengths of hospital stay, I was able to demonstrate that the nurse-led ward round reduced time spent in hospital and therefore reduced costs to the trust. The nurse-led ward round has become an established routine and I have also taught some of the clinical nurse specialists to undertake nurse-led discharge for patients undergoing elective cardiology procedures such as angiography and PCI in the day case unit.

I manage a team of 14 clinical nurse specialists, three healthcare support workers and four administrative staff. It is debatable whether nurse consultants should manage staff, since management was not part of the original nurse consultant remit (Woodward et al 2005). However, I would not have been able to develop the services effectively without the professional relationship I have with the clinical nurse specialists, which has been strengthened by directly managing them. As part of the nurse consultant role, I have compiled a significant portfolio of publications and regularly present at UK and international conferences. I am also involved with HEART UK, the cholesterol charity.

**Evaluating the nurse consultant role**

While the UK government’s target of 1,000 nurse consultants by 2004 was not met – the number of nurse consultants appointed by this date was 631 – the role did become firmly established (Godden and Pollock, 2009). When I was first appointed as a nurse consultant in the Royal Brompton & Harefield NHS Foundation Trust, I wrote a personal reflection examining the role and what I had achieved after the first three months and again at six months. I continued to compile an annual report, which has enabled me to review my progress as well as focusing on future priorities.
I have set up audit programmes for the nurse-led services, which use patient feedback to examine patient outcomes and potential cost savings to the organisation. These have demonstrated that the majority of patients seen by myself or the clinical nurse specialist team had a positive care experience. One patient who completed a feedback questionnaire in the first six months of the RACP clinic in 2001 commented: ‘The service was quick and efficient. The lay person would not know the difference between nursing and medical staff.’

Results from the biannual evaluation of the nurse-led PCI follow-up clinics were also positive. A total of 140 of 173 patients returned their questionnaires, with 96% (£=134) stating that they were happy to be seen by a nurse and 95% (£=133) reporting that attending the clinic was a satisfying experience.

**Conclusion**
The implementation of the nurse consultant role has provided career-defining opportunities within the nursing profession. While the debate about the respective roles of doctors and nurses will continue, if patient care continues to improve then the debate around professional boundaries may become unnecessary.

Becoming a nurse consultant has enabled me to achieve my ambitions as a nurse in a way that I did not consider possible when I first qualified. I feel the nurse consultant role is an important part of nursing and should not be lost. However, nursing as a profession must take responsibility for shaping its contribution to healthcare, rather than simply accepting change. Nurses require a defined career structure to retain experienced nurses in clinical practice. It is up to the nursing profession to ensure that nurse consultants continue to provide a high standard of care to patients.

**References**


