Consultant Nurse Group Roundtable

Report of a meeting held at The Belfry Hotel, Birmingham

A Consultant Nurse Group Roundtable discussion was held at The Belfry Hotel on 12 February 2004. Supported by an educational grant from Novo Nordisk and Lilly, and chaired by Simon Breed, Publisher of *Journal of Diabetes Nursing*, the aim of the meeting was to discuss various aspects of the consultant nurse (CN) role and its development in relation to the needs of diabetes nursing in general.

The CNs present were:

- Lorraine Avery
- Mags Bannister
- Jo Butler
- Sue Cradock
- Heather Daly
- Gill Hill
- Jane Pennington
- Eileen Turner
- Maureen Wallymahmed

With 12 CNs now appointed within diabetes – working in diverse areas across the country – the need for continual dialogue has never been greater. An assimilation of ideas and challenges was felt essential if the group was to move forward in a consistent and unified manner so as to support and promote the major interests of diabetes nurses and the people for whom they care.

The roundtable discussion revolved around several key questions:

1. What is the role of a consultant nurse and how should this best be articulated to other healthcare professionals?
2. If the role is said to incorporate 50% clinical practice, is this realistic and practicable?
3. How does a consultant nurse differ from a senior DSN?
4. Is there a way of measuring the effectiveness of the role in practice?

Four cornerstone criteria define the role

The CN role is defined by four cornerstone criteria:

- Expert practice
- Research and development
- Leadership and consultancy
- Education and training.

The Belfry provided a lovely setting for the Consultant Nurse Group Roundtable.

However, it is clear that different individuals will be placing varying levels of emphasis on each criterion at different times. This will depend on local need as well as the particular inclination and background of the individual nurse. The role therefore needs to be viewed as a continuum rather than in terms of all four criteria being fulfilled five days a week.

Amount of clinical practice within the role

A much heralded complaint from some DSNs is in relation to the amount of 'clinical practice' CNs are meant to perform. The job specification states that clinical practice should represent 50% of the role; however, some DSNs express a belief that this is less in practice.

What is key here is the definition of clinical practice. Does it mean simply face-to-face contact with patients or should it be viewed in a wider context to incorporate the setting up and development of education programmes, clinical supervision and other elements that impact upon clinical outcomes? If the narrower definition is accepted, then this might explain a perception that the 50% mark is not always attained by CNs.

Sue Cradock explained that if CNs are to have the positive impact they are meant to have both on diabetes nursing and diabetes care in general, it is essential that they are perceived as maintaining their links with clinical care. Indeed the make-up of the very framework within which they work was established to protect the clinical workload of those who move into senior nursing positions.

'If we are to model good clinical practice to all nurses, we need to be seen to be providing this ourselves. In addition, I see my role as developing and altering clinical practice, so what I was doing 2 years ago is not what I am doing now – I certainly need to be providing clinical care in order to know how to change it. I would therefore define clinical practice in a way that includes the setting up and development of structural educational programmes.'

Difference between a CN and a DSN

There also seems to be confusion among some nurses as to the difference between a CN and a senior DSN – what do they do that is different? The answer would appear to be found in the role definition within which CNs work. While some DSNs will be carrying out clinical work at the same level, they may not be fulfilling the three other criteria around which the CN role revolves.

It is also important to understand that within any such definition, there will always be differences from one

nurse to another. According to Lorraine Avery:

'The consultant nurse role differs from person to person and from region to region. The reasons for this can be divided into environmental factors and individual preferences.'

Environmental factors include, for example, the differences between a primary and secondary care post, the level of existing diabetes services in the area and the demographics of the region. In addition, local interpretation of national policy may differ from place to place.

In terms of the impact of individual preference, it was felt that although the post itself was usually established to fill a perceived gap in the service, the choice of how exactly to carry out the role will differ from person to person. For example, someone with a bias towards research may choose to develop that area as a means to providing solutions to local problems. Although all CNs will be working within the four cornerstone criteria that define their practice, the emphasis they place on each will rarely be the same. The very structure of the framework encourages such flexibility and adaptability.

While enjoying this opportunity to come at the role from different angles, it is also essential that CNs encourage DSNs to widen the perspective of their own roles. You do not have to be a CN to have that privilege.

While CNs are different because of the four component parts of the framework within which they practise, they should be seen by DSNs not as a threat but rather as providing a major opportunity for development. The same rules about appropriate distribution of time should be applied to DSNs as well as CNs.

A key aspect of the CN role is to enable local DSNs to re-examine their workload in a way that allows them to make changes where appropriate.

An example of this was provided by Mags Bannister:

'One of the big issues I had in Bradford was the DSN workload, particularly those working in the community who had been employed to support a service that is now three times its initial size. I therefore did an exercise with them to identify what would be the gold standard of care and what they themselves could cope with within this model.

It was subsequently agreed that the equivalent of three weekly satellite clinics was as much as one DSN could support because these generated the equivalent of a further six clinical sessions including associated administration. This left them one session a week to deal with issues of personal and professional development and any audits. As a result, we ended up getting two additional DSNs. Although a DSN could have attained the same goal, I believe the added status provided by my title was helpful in negotiating with the local PCT.'

Influence on local *and* national policy

CNs can influence diabetes care not only in their capacity as individuals in their local area but also nationally as members of the CN Group. National policy can be influenced by the group either directly by approaching decision-making bodies or indirectly via already established diabetes nursing organisations such as the UK Association of DSNs and the RCN Diabetes Nursing Forum. It was felt that at present, the small number of CNs and their wide geographical spread meant that it might be more effective to opt for the latter route. However, in the future, a more direct approach might be preferable.

The value of the CN role, both to diabetes nurses and to diabetes care in general, will only truly be seen as the role develops over time. However, without ways of measuring the effectiveness of the role, it is difficult to create an evidence base to support its worth.

According to Jo Butler, it is important to get feedback from others on their perceptions of the value of the role:

'We have designed a questionnaire which has gone to people in the PCT to ask them about the role of the consultant nurse: how has it impacted on them and the service? Has it improved education? How often have they seen the CN? How well have the four core functions been carried out? The responses will go to the clinical governance staff who will produce a review paper around which my success can be gauged. I see it as a win-win situation: if the results are positive, this may pave the way for more CNs to be appointed in the trust. However, if there are negative comments, these may not mean I am doing a bad job; rather they may highlight areas in which I need to improve.'

As the CN role develops, it is essential that it becomes more transparent to other healthcare professionals so as to remove any confusion that may exist. All CNs will be working within the four core functions; however, people need to understand that it is perfectly acceptable for different individuals to place varying levels of emphasis on each.

The CN role represents opportunities not only for CNs themselves but also for the diabetes nurses with whom they work. It is hoped that measurements of effectiveness will help to illustrate this in the future.

Tell us what you think...

We would like to receive feedback from readers of the Journal of Diabetes Nursing on any aspect of the consultant nurse role. Please write to:

editorial@sbcommunicationsgroup.com