The Queen's Institute of Community Nursing

Community Nurse Consultant

HANDBOOK

The Queen's Institute of Community Nursing is a charity dedicated to improving nursing care for people at home and in the community.

Every year, millions of people of all ages need professional nursing care, in or close to home. People today live longer, often with complex health conditions, and they are discharged from hospital more quickly. Those patients can make a better recovery, and can avoid unnecessary hospital re-admissions, if they have the support of skilled community nurses.

We work with nurses, managers and policy makers to make sure that high quality nursing is available for everyone in their homes and communities.

Our aim is to ensure that people receive high quality care when and where they need it, from the right nurse, with the right skills.

We help nurses to improve care:

- Through our national networks that connect community nurses in specific fields of practice, enabling them to share innovations that improve care
- Through our network of Queen's Nurses, who are committed to the highest standards of care and who lead and inspire others
- Through our bespoke transformational leadership programmes which offer career-changing learning to community nurses
- By funding nurses' own ideas to improve patient care
- By publishing research into nursing practice, workforce and education, improving knowledge and standards
- By influencing government and policy makers, and campaigning for investment in high quality community nursing services
- By helping working and retired community nurses in times of financial need or life crisis
- By linking up working and retired nurses for regular telephone contact, with our Keep in Touch project.

The Queen's Nursing Institute rebranded to The Queen's Institute of Community Nursing in March 2025.

Contents

Author: Dr Barbara Stilwell, Global Health and Nursing Consultant

Foreword

As part of a road to recovery, the government in England have set out three shifts which need to happen to ensure the NHS is fit for the future. The three shifts include a move from hospital to community, from analogue to digital and from sickness to prevention (DHSC, 2025).

These major shifts will require leadership at all levels; given the vital role of nurses in delivering healthcare, their leadership within community nursing will be essential to ensure the design of safe and effective nurse-led services. Community Nurse Consultants (CNCs) are ideally placed to lead on the transformation agenda. Introduced in the late 1990s, nurse consultants were designed to provide a clinical career pathway which both strengthened leadership, improved patient outcomes and enhanced the quality of services and care (Pottle, 2018). Manley (1997) developed a conceptual framework for advanced practitioner and consultant nurse roles which lay the foundation for the four pillars we see today. Manley (1997) described the nurse consultant as being an expert practitioner, a researcher, educator, and transformational leader.

Nurses make up the majority of the healthcare workforce in the UK, caring for people across the life course and working with people at every stage of a care journey from screening through diagnosis, treatment and rehabilitation or palliative care. The likelihood that many of us will live with chronic disease as we age grows by the decade, and we will probably be cared for at home, with our families and in our communities, by nurses.

Planning, supporting, monitoring and leading the care will be a Community Nurse Consultant (CNC), a senior experienced nurse who excels in clinical care, systems leadership, learning and research. This handbook sets out what it takes to become a CNC, how they work and what they offer to a multi-disciplinary team in the community.

The role of the CNC has been developing over two decades and has engaged multiple stakeholders in the way it has been shaped. The result of this collaborative process is a shared vision of a role designed to support excellence in community healthcare and at the same time address the evolving needs of the health economy through systems leadership.

This handbook describes the development of the CNC role from its inception and sets out the research that underpins it. It links the role to its foundations in nursing

‘Nurses make up the majority of the healthcare workforce in the UK, caring for people across the life course and working with people at every stage of a care journey from screening through diagnosis, treatment and rehabilitation or palliative care.’

theory and explores the value of nursing care to clinical outcomes. Importantly, the handbook was initially developed by a group of CNCs themselves, so it is nested in practice, experience and reality. The work of CNCs is showcased through case studies in each chapter to illustrate the way the role is implemented.

The goal in producing the handbook is to share the aspirations for the CNC role with nursing colleagues, but also with colleagues from other disciplines. Understanding the depth and breadth of the role is essential for it to be accepted and used to its full potential. The CNC is a senior leader, with systems leadership skills appropriate to overseeing the complex environments of community care, and clinical experience and knowledge to guide clinically focused decisions and drive innovative approaches to problem-solving.

Current evidence (Greenhalgh and Papoutsi, 2018) suggests that when the CNC role is implemented it is best done so flexibly, and each role shaped to meet local need. While this presents challenges in terms of standardisation, it is testament to the ways that nurses use their problem-solving skills to find a pathway through the new challenges they face every day. Developing adaptive solutions is largely overlooked as a skill of nursing, but it has been pointed out that it is this that 'keeps the show on the road' (Greenhalgh and Papoutsi, 2018) – meaning that it may be how care is able to be continued in unexpected situations.

Professional identity as a CNC is far more important than often credited. It is part of the self-efficacy that has been developed over a career that gets consultants to these positions. However, a lack of clarity and support for CNC roles can sap their confidence, leading to attrition and failure in the role. Understanding and articulating role boundaries and professional identity can be helpful in avoiding tensions around scope of practice and titles, which can be supported through standardising roles and education. Professional identity is also critical for workforce planners and researchers, and it is hoped that this handbook will help to bring clarity regarding role definition, preparation and scope of practice.

This handbook highlights the robust evidence around the value of a CNC, especially in facilitating home care for those who wish to stay at home and in caring for people that have been hard to reach, such as those who are not housed, or those with mental health challenges. CNCs have much to be proud of in the ways that their roles meet the need for, and champion, person-centred care. It is hoped that this handbook will encourage more CNC roles to be implemented and evaluated and will show all nurses that a CNC role is richly rewarding.

Professor John Unsworth OBE, PhD, RN, FAAN
Chair of Council, The Queen's Institute of Community Nursing

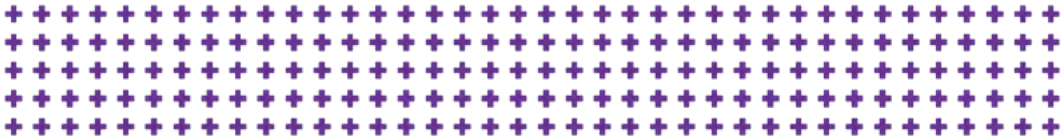
Refererences

DHSC (2025). Road to recovery: the government's 2025 mandate to NHS England. DHSC: London.

Greenhalgh T, & Papoutsi C. (2018). Studying complexity in health services research: desperately seeking an overdue paradigm shift. BMC Med. 16(1):95. https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-10 89-4
Manley K. (1997). A conceptual framework for advanced practice: an action research project operationalizing an advanced practitioner/consultant nurse role. Journal of clinical nursing, 6(3), 179–190.

Pottle A (2018). Reflection on the development of the nurse consultant role. Nursing Standard. https://doi.org/10.7748/ns.2018.e11251

Word Cloud: what is your identity as a Community Nurse Consultant?
(50 responses)



Executive Summary

The Role of Community Nurse Consultants (CNCs)
Community Nurse Consultants (CNCs) play a vital role in the UK healthcare system, providing advanced clinical care, systems leadership, research, and education. They are pivotal in addressing the evolving needs of community healthcare, particularly as chronic disease management and home-based care become increasingly necessary. This summary explores the key aspects of the CNC role, its impact on healthcare, and examples of its success in practice.

Development and Purpose of the CNC Role
Over the past two decades, the CNC role has been shaped through collaboration with multiple stakeholders, leading to a shared vision of excellence in community healthcare. CNCs bridge the gap between policy and practice, ensuring that high-level healthcare strategies are effectively implemented in local contexts. Their work is underpinned by nursing theory and evidence-based practice, demonstrating the value of nursing expertise in clinical outcomes. The role is flexible and adaptive, allowing CNCs to respond to the specific needs of their communities while maintaining core professional standards.

Key Functions and Contributions of CNCs

1. Clinical Excellence and Leadership
CNCs bring a high level of expertise in patient care, ensuring best practices in community health settings. Their leadership extends to multidisciplinary teams, guiding clinical decision-making and fostering innovative, problem-solving approaches. Through case studies, the handbook illustrates how CNCs navigate complex healthcare environments, balancing policy with hands-on care.

2. Systems Leadership and Policy Implementation
A critical aspect of CNC work involves translating national healthcare policies into practical applications at the community level. They operate across macro (policy), meso (institutional), and micro (individual patient) levels, ensuring policies are implemented effectively and equitably. Their ability to move between these levels highlights the importance of their role in integrating policy with real-world healthcare needs.

3. Professional Identity and Workforce Development
The professional identity of CNCs is a crucial factor in their success. The role requires confidence, self-efficacy, and a clear understanding of scope and responsibilities. However, lack of clarity in role definitions and inadequate support structures can undermine CNC effectiveness, leading to attrition. Standardizing

education, role expectations, and career pathways can help reinforce CNC identity and sustain their contributions to healthcare.

4. Addressing Healthcare Inequalities

CNCs play an essential role in delivering person-centred care, particularly for underserved populations such as the unhoused and those with mental health challenges. They facilitate home care for patients who prefer to remain in their communities, advocating for equitable healthcare access and tailored interventions. Their efforts contribute to reducing disparities in healthcare delivery.

5. Sustainability and Environmental Health

As healthcare systems face increasing environmental challenges, CNCs have an opportunity to lead sustainable healthcare initiatives. The International Council of Nurses (ICN) emphasises the role of nurses in mitigating climate change and adapting healthcare systems to environmental shifts. CNCs can advocate for and implement sustainable practices, such as reducing unnecessary travel, promoting green healthcare policies, and incorporating environmental factors into health assessments.

Challenges Facing CNCs

Despite their invaluable contributions, CNCs encounter several challenges that may hinder their full potential:

+ Role Recognition and Support: if organisational structures fail to adequately support CNCs, it can lead to workload strain and lack of recognition.
+ Workforce Planning and Standardisation: the CNC role is implemented flexibly, which, while beneficial in some cases, also presents challenges in terms of standardising education, career progression, and role expectations.
+ Stereotypes and Professional Perception: Outdated stereotypes about nursing can lead to undervaluation of CNCs, affecting morale and recruitment. Promoting the professional image of CNCs through education and advocacy is essential for overcoming these perceptions.

‘While the role had much support among the professions, its successful implementation depended on managerial backing and adequate resources, which were frequently missing.’

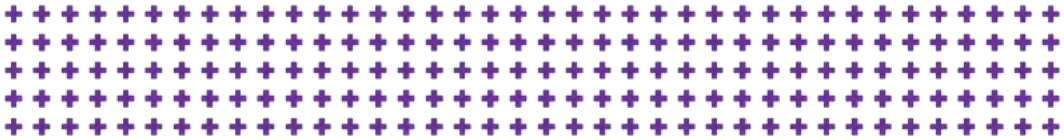
Introduction

The role of nurse consultant has been developing for over 20 years, alongside consultancy roles in other health professions. In 1999, a National Health Service (NHS) circular on the role of nurses, midwives and health visitors stated that consultant nurses would:

'…help to provide better outcomes for patients by improving services and quality, to strengthen leadership and to provide a new career opportunity to help retain experienced and expert nurses, midwifes [sic] and health visitors in practice.' (NHS Executive 1999).

Reflecting on this statement, it seems that 25 years later the NHS system faces similar needs for improvement, though for different reasons. Retaining nurses remains a challenge in the NHS, influenced by the aftershocks of the COVID-19 pandemic: leadership is still needed as evidenced by the proliferation of leadership programmes for nurses: and quality of service delivery, especially linked to adequate staffing, is of contemporary concern.

The role envisaged in 1999 was to contain four key elements: expert clinical practice, leadership, education and development, and research. What happened in practice was that roles were developed in response to local situations, some emerging from specialist nursing roles and others in response to the needs of a particular NHS Hospital Trust vision (Redwood et al., 2005). In an extensive evaluation of the nurse, midwife and health visitor consultant roles, Guest et al., (2005) found that while the role had much support among the professions, its successful implementation depended on managerial backing and adequate resources, which were frequently missing. A further challenge was role ambiguity, where boundaries of practice were unclear. Using collaborative action research, Manley & Titchen (2016) supported nurse consultants to recognise and balance their multiple roles so that evidence of effectiveness could be demonstrated to



their employing organisations. Despite the emerging evidence of effectiveness, the value of the nurse consultant role was often not appreciated by decision-makers (Franks, 2014).

The 2019 NHS Long Term Plan (NHS 2019) pledged to reduce hospital admissions by investing resources in 'care closer to home'. This delivery model was tested during the pandemic, when services for delivering care at home had to be put in place as a matter of urgency. There was rapid innovation in, and adoption of, service delivery processes in many community settings, with an emphasis on remote consultations and accelerated use of digital technology. Supporting and extending this commitment to care at home, the 2023/24 NHS priorities (NHS, 2023) commit to investment in digital infrastructure, the health workforce and all the resources needed to build community care capacity – so that people have high quality care at the right time, in the right setting through the development and expansion of virtual wards, including Hospital at Home services.

All of these developments set the scene for the Community Nurse Consultant – a role a long time in development but which has now come of age, driven by the compelling need for cost-effective, patient-centred models of community-based care. Nursing in communities has a long history and roles have evolved over time in response to increasingly complex care required in home settings. Nursing roles in the community have proliferated and include nurse specialists, community matrons, district nursing teams, general practice nurses and advanced nurse practitioners. What does the Community Nurse Consultant (CNC) bring to this nursing team?

The role of the CNC aligns with, and derives from, the Multi-Professional Consultant-level Practice capability and impact framework (MPCP, see Box 1, below) (NHS England, 2023). The MPCP describes the capabilities required of a consultant practitioner, which is seen as the 'pinnacle of the practice career framework' across all health professions (Manley et al., 2022). This level of practice requires expert clinicians, systems leaders, researchers and innovators with a focus on continuous service quality improvement.

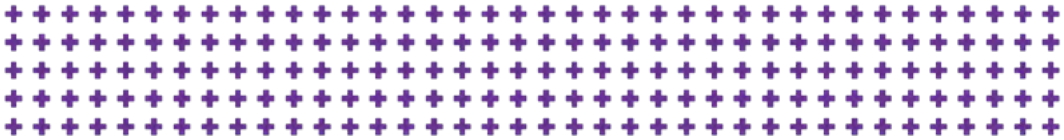
'It is possible to identify community nurse roles that require practitioners competent in many of the capabilities in the MPCP framework: for example, expert nurses will exemplify expert practice, and research nurses will produce research outputs that change practice.'

Box 1: The four domains of the Multi-professional Consultant Practitioner role

It is possible to identify community nurse roles that require practitioners competent in many of the capabilities in the MPCP framework: for example, expert nurses will exemplify expert practice, and research nurses will produce research outputs that change practice. This can lead to confusion within and outside the nursing profession about what is unique about a community nurse consultant.

This handbook sets out to address some of the critical issues in clearly defining the community nurse consultant role, including how to become one and why to employ one.

The Primary Care and General Practice Nursing Career and Core Capabilities Framework (Health Education England, 2021) was developed and based on The Career Framework for Health 2 and sets out six career pathways and capabilities for primary care and general practice nurses. It clarifies the nursing knowledge, skills and abilities required at each level of this framework.



The six levels are:

1. Support Work Level Practice
2. Nursing Associate Level/Assistant Practitioner Level Practice
3. Registered Nurse Level Practice
4. Registered Nurse: Enhanced Level Practice
5. Registered Nurse: Advanced Level Practice
6. Registered Nurse: Consultant Level Practice

While it identifies six career levels, it points out that progress through the six levels is not necessarily linear and roles may overlap in terms of the capabilities required to be a safe and effective practitioner.

The Primary Care and General Practice Nursing Career and Core Capabilities Framework (Health Education England, 2021) underpins much of what is included and expanded on in this handbook. It endorses the need for adaptability in community nursing roles, the increasing need for person centred care at home and the complexity of primary health care nursing in all its facets.

What is consultant level practice?

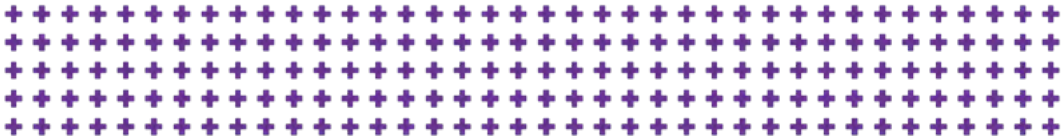
Consultants are characterised by their considerable experience and their ability to apply their expertise in advanced clinical practice and their leadership in dealing with complex situations. The pathway to consultant level practice requires a minimum of a master's degree with intention to progress to doctoral level and to have a teaching qualification. Perhaps more importantly, work at consultant level is recognised as a continuum of development rather than an end point in a career. It is the ability to apply their expertise to a variety of complex situations that sets apart consultant community nurses and brings into focus the contribution that they can make through being systems leaders. Alison Leary, Professor of Healthcare and Workforce Modelling at London South Bank University, recognised the complexity of district nursing when speaking about her research at a meeting of the Association of District Nurse Educators (ADNE) in May 2015. Professor Leary has observed nursing work in a wide variety of hospital-based environments as part of her research and she said, of the work she had seen in people's homes: "District Nursing work is easily the most complex nursing work I have ever observed.'" (Queen's Nursing Institute, 2015)

'For a community nurse consultant who is managing resources across teams, systems and different contexts, the ability to be a systems leader is essential.'

In the last two decades there has been much interest in using systems thinking to inform the ways that problems in delivering health services are analysed and solved. A systems thinking approach recognises that many problems are complex, having multiple stakeholders with different goals, taking actions that may conflict, have uncertain consequences in environments that could change unpredictably (Fischer et al., 2012). The need for a systems thinking approach in community nursing is arguably greater than any other area of nursing, because there are often so many stakeholders, not only from the health care arena but also from families and communities, and the social care and voluntary sectors too. Recognising that each of these stakeholders may have different interests, and the systems they are in may not be predictable, is a skill that community nurses develop, though often not explicitly. For a community nurse consultant who is managing resources across teams, systems and different contexts, the ability to be a systems leader is essential.

Three decades ago, Benner (1994) explored nursing competencies taking into account not only skills acquisition through education but also skills gained through experience. Benner noted that achieving the level she called 'expert' reflected a change in an essential aspect of skilled performance: moving away from using principles to solve problems to instead using past experiences to recognise patterns in problems and solutions. The recognition may be intuitive, based on rich experience. This is exactly what is required in taking a systems approach to tackling complex issues and it is what the community nurse consultant brings to practice. It is also why consultant level practice is based on both knowledge and experience and is constantly evolving as knowledge grows.

Simple, complicated, and complex systems are different complexity classes. A simple system is predictable and all the parts of it are already known. Protocols that can delegate work are usually within simple systems – for example, the process of giving an injection can be broken down into steps and the whole process – at least in the NHS – is predictable, where equipment and pharmaceuticals are in good supply and the injection recipients are known in advance. Training in each part of the process can be provided.



A complicated system can also be planned in advance, like a protocol, but has some unknowns. The wound dressing procedure is complicated. There are many steps that must be followed, such as aseptic techniques, and unpredictable events are possible, such as infection or bleeding. A high level of expertise is desirable to understand the optimal management of a wound, and the more dressings that have been done, the more predictable success is. There are critical similarities in all wound care (no matter the cause or site of the wound) that can help predict successful outcomes.

Complex systems have a persistent uncertainty of outcome, as system components may change unpredictably. Community nursing presents excellent examples of complexity in systems and problem solving. Take for example, planning care for someone being discharged home after surgical treatment for cancer and requiring ongoing chemotherapy – a situation known to many community nurses. The complexity of this situation is dense. The stakeholders are many – including patient, family and community – who might all influence what is acceptable in terms of home care; the health system that has to provide all the resources for clinical care, that will include post-surgical care, medication, equipment and people with appropriate skills level; and finding ways to meet the ongoing needs for emotional care for the patient and family. And any aspect of this picture might change in unpredictable ways (perhaps the patient's condition worsens quickly, or there is a breakdown of the family) and may have unintended consequences (such as medication side effects). Furthermore, caring for one such patient does not guarantee success in caring for another: care must be planned around individuals and unique circumstances.

A CNC is able to oversee such complex situations. They are experienced enough to understand that every situation like this one will be different because the patient and the family bring their own perspectives and expectations. There will be similar patterns in care, but there will be important and subtle differences too. The CNC's clinical expertise is sufficient to know what they do not know – they can call in specialist nurses as well as other health professionals. They know how to access resources and importantly how to monitor the situation so that changes are quickly identified and can be addressed. The focus of their work moves from the population level to the home, from service planning at decision making level, to service delivery support and from working with service users to participating in multi-professional meetings.

'A shift to patient-centred care and patient empowerment has been underway for some time, both nationally and internationally, driven by the realisation that there will be more people needing health care at home as they live for longer.'

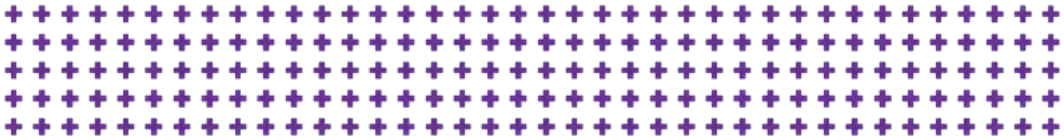
Why is the CNC role important?

The NHS Long Term plan (NHS, 2023) set out some clear reasons why the CNC role underpins a successful future for community health care delivery. The long-term NHS focus will be on care at home, more personalised care, integrated services to meet population health needs, promotion of health and better use of digital technologies to improve and manage care. The NHS plan exactly aligns with predictions of what future health care will look like (Schiavone and Ferretti, 2021) driven by a global trend to patient centred care and empowerment of people to create and manage their own health. Developments in genetics are personalising health care, so that treatments are individualized and increasingly moving outside the hospital setting (Schiavone and Ferretti, 2021). A shift to patient-centred care and patient empowerment has been underway for some time, both nationally and internationally (World Health Organization, 2015; DHSC, 2022) driven by the realisation that there will be more people needing health care at home as they live for longer, that there remain unacceptable disparities in health and health care between population groups and that closer working between primary and secondary care will ensure better managed care, reduction of risk and specialist support as needed. The traditional model of care is undergoing radical transformation and will need to change further to meet the many emerging challenges (Durrani, 2016).

The CNC role is becoming ever more essential to provide oversight of the complex systems that people must now navigate in accessing health care. Greenhalgh and Papoutsi (2018) point out that there may be 'multiple interacting influences' (p. 3) that account for a particular result and that it might not be possible to pinpoint one intervention that leads to success or failure. Community nurses (and indeed nurses in many settings) often adapt their way of working to what their patient needs and sometimes to system requirements. This was evident in the pandemic when health systems had to respond rapidly to the major disruptive event. Nurses met emerging needs by quickly adapting to new roles, teaching others who came into new roles, adopting increased safety measures and dealing with a vastly increased workload (Jackson et al., 2020). The way that nurses work in dealing with constantly changing systems is not recognised as key to success, but Greenhalgh and Papoutsi (2018) make the following point:

'People use their creativity and generate adaptive solutions that make sense locally. The articulations, workarounds and muddling-through that keep the show on the road are not footnotes in the story, but its central plot. They should be carefully studied and represented in all their richness'. (p. 2)

This points to the vital ability to take an overview of all that is happening. Working within systems that move and change, sometimes unpredictably, requires taking an adaptive leadership approach (Heifetz et al., 2009). Adaptive leadership requires



attention to the systems that are working to make something functional and to see how systems are working together (or not) it is necessary to take a 'balcony view' – which is like looking at the dance floor from above rather than being a dancer. In the MPCP the need for the ability to look across all health care systems comes through in each segment of the framework. For CNC practice, the emphasis is on ensuring expert practice with individuals, families, carers and communities as well as with systems and organizations, and, in addition, feeding back into the systems so that there is constant learning and improvement. This may be done through research or by quality monitoring and it is an important element of consultant practice.

The level of expertise that CNCs have is essential for the oversight function required to be a systems leader at this level. The CNC has to be able to understand population health and the context of interventions on individual care and care pathways. They must also perceive the likely impact of policies and programmes and be able to feed back relevant information to every system so that they are all constantly evolving and learning to meet new challenges.

Explaining the unique nature of the CNC role can be challenging, but understanding their essential contribution explains why employing a CNC will enhance the functions of Primary Care Networks. The CNC needs to have direct communication with Integrated Care Systems and Care Boards in order to feedback information on the effectiveness and efficiency of community systems. Learning systems evolve when there is a continuous feedback loop providing real time information on how well they are working and if they are achieving their goals (Manley et al., 2022; Greenhalgh and Papoutsi, 2018). The following case study illustrates the way in which CNCs work and their practical contribution. The remainder of the chapters in this handbook go into greater detail about career pathways that lead to nurse consultant level practice and how they can be supported by employers, how far the role can be standardised, and what systems leadership brings to improvements in community health and care.

Case study 1

Developed from several examples

In a deprived inner-city community, it is noted that there is a high prevalence of Type 2 diabetes across all age groups, and it is growing in children. The local authority and UK Health Security Agency (UKHSA) want to plan an intervention – a multi-component public health programme – to address this.

The community into which this programme is to be implemented is multi-

'The Consultant Nurse role is the golden thread that transcends the micro, meso and macro levels of the H@H service in Wiltshire.'

ethnic. The overall population is young with many adolescents and families, but there are also some older people and some that are currently not housed. The neighbourhood is characterized by having multiple fast food and street food outlets, and these serve as gathering places for young people especially. There are limited leisure facilities – only two local gyms and two public green spaces. There are several faith-based community support initiatives.

It is clear that taking the context of the neighbourhood into account is critical to the success of any public health programme there. A CNC will bring an overview of population health, demographics and the services available to this community and will have networks among the systems to gather information and to set up communications among all stakeholders. The CNC will note that there are many adolescents in the area and can talk with school nurses about education opportunities at school. The CNC will be familiar with local leisure facilities and can assess the possibilities for linking GP practices with gyms to provide some educational sessions, or other avenues of social prescribing. In other words, the CNC acts as a network node bringing together many networks within a community so that there is communication, minimal duplication of effort, smooth coordination and the focus of care remains with the person needing it.

Case study 2

Impact of Consultant level practice

Lucy Lewis, Hospital at Home Service, Wiltshire

The following account of the impact of consultant levels practice is an extract from a larger case study by Lucy Lewis that describes transformational leadership within the context of setting up a new Hospital at Home service in Wiltshire.

'We have often been asked *"What is the impact of employing Consultant Practitioners?" "How are you different to medics?" and "What do you do that Advanced Practitioners don't do?"*. Put simply, it is the difference between the four pillars of Advanced practice, with emphasis on clinical compared to the consultancy skills which we apply across our four (intentionally differently worded) domains, working at micro, meso and macro level. In only 20 months, our Consultant Practitioners within Hospital at Home have presented at National and European

conferences, contributed to national guidelines, blueprints and policy, published articles and supported the development of Advanced Practitioners across their four pillars, particularly in increasing clinical knowledge through supervision and also encouraging and mentoring to publish and disseminate their own service development and research projects. We have worked alongside our operational, quality team and transformation colleagues to influence what is required to deliver our service whilst collaborating with provider organisations across the system and NHS England Regional colleagues to ensure our model aligns with the national ask.'

Case study 3

Establishing expertise across systems

Mandy Waldon, Wiltshire

The Consultant Nurse role is the golden thread that transcends the micro, meso and macro levels of the H@H service in Wiltshire.

Micro (team) Level: Leading a diverse Multi-Disciplinary Team, creating a shared vision for a truly person-centred clinical pathway, empowering colleagues and fostering a sense of ownership and autonomy for working in new ways that focuses on patient experience and impact of the hospital at home service.

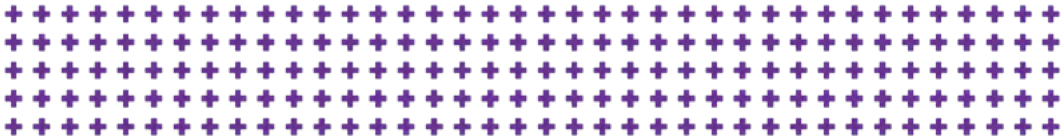
Meso (organisation) level: The key has been developing the diverse and honest relationships critical for integrating a new service with established, well managed community and primary care teams. Collective and inclusive leadership is essential for this as well as a culture for positive challenge and appreciative inquiry that recognises our strengths and identifies our aspirations. Demonstrating patience, tenacity and resilience is key for the longer-term view of transformational change in leading Wiltshire's hospital at home services.

Macro (system) level: Being the voice in the room that positively challenges entrenched clinical pathways/hierarchical structures to create a diversity of thinking has enabled the growth of a shared vision into a successful Consultant Practitioner led hospital at home service.

Commentary

These three case studies illustrate the way in which Community Nurse Consultants have to be able to take a high level view of nursing care at a macro level as well as understanding how high level policy applies to meso and micro levels – in other

'These case studies illustrate the way in which CNCs have to be able to take a high level view of nursing care at a macro level as well as understanding how high level policy applies to meso and micro levels – in other words from national to local policy and to the ways in which policy translates to reality for people in the care of community nursing teams.'



words from national to local policy and to the ways in which policy translates to reality for people in the care of community nursing teams.

This is a critical aspect of CNC work that is discussed and exemplified throughout this handbook. The second and third case studies describe the ways that CNCs contribute at all levels of care, illustrating the complexity of the CNC role that moves between policy and care, politics and compassion, expertise and negotiation.

References

Benner, P. (1982). From novice to expert. *American Journal of Nursing,* 82(3), 402-407.

Department of Health and Social Care (2022). *Health and social care integration: joining up care for people, places and populations*. Available at: (www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations). Last accessed 7/2024

Durrani, H. 2016. Healthcare and healthcare systems: inspiring progress and prospects. *Mhealth*, 2. https://pubmed.ncbi.nlm.nih.gov/28293581/ Last accessed 7/2024

Fischer A. Greiff S. Funke J. 2012. The Process of Solving Complex Problems The Journal of Problem Solving volume 4, no. 1 (Winter 2012) https://www.researchgate.net/publication/227943225_The_Process_of_Solving_Complex_Problems Last accessed 7/2024

Franks, H. (2014) The contribution of nurse consultants In England to the public health leadership agenda. *Journal of Clinical Nursing* 23 3434-3448

https://doi.org/10.1111/jocn.12593 Last accessed 7/2024

Greenhalgh T, Papoutsi C. (2018) Studying complexity in health services research: desperately seeking an overdue paradigm shift. BMC Med. 2018 Jun 20;16(1):95. https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-10 89-4 Last accessed 07/2024

Guest, DE. Peccei R. Rosenthal P. Redfern S. Wilson-Barnett J. Coster S. Evans A. and Sudbury A. (2004) An Evaluation of the Impact of Nurse, Midwife and Health Visitor Consultants, King's College, London, September. Available at: www.nursingleadership.org.uk/publications/NurseConsReport.pdf Last accessed 7/2024

Health Education England (2021) Primary Care and General Practice Nursing Career and Core Capabilities Framework https://www.skillsforhealth.org.uk/wp-content/uploads/2022/05/Primary-Care-and-GPN-Framework-May22.pdf

Heifetz R. Grashow A. Linsky M. 2009 The practice of Adaptive Leadership. Cambridge Leadership Association. USA Boston

Jackson C. Manley K. Webster J. and Hardy S. 2021 System wide learning from first wave Covid 19: A realist synthesis of what works? Research Square; 2020. DOI: https://doi.org/10.21203/rs.3.rs-115647/v1 Last accessed 7/24

Manley, K. and Titchen, A. 2016 Facilitation skills: the catalyst for increased effectiveness in consultant practice and clinical systems leadership, *Educational Action Research*, 24(2), pp. 1-24. DOI: http://www.tandfonline.com/doi/full/10.1080/09650792.2016.1158118 Last accessed 7/2024

Manley, K. Crouch, R. Ward, R. Clift, E. Jackson, C., Christie, J., Williams, H., & Harden, B. (2022). The role of the multi- professional consultant practitioner in supporting workforce transformation in the UK. AJPP, 3(2), 1-26. https://doi.org/10.22024/UniKent/03/ajpp.1057 Last accessed 7/2024

National Health Service England 2023 Multi-Professional Consultant-level Practice capability and impact framework. Centre for Advancing Practice https://advanced-practice.hee.nhs.uk/consultant/ Last accessed 7/2024

National Health Service 2023. *The NHS Long Term Plan* 2023/24. https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf Last accessed 7/2024

National Health Service (2019). *The NHS Long term Plan*. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ Last accessed 7/2024

NHS Executive (1999) *Health Service Circular 1999/217: Nurse, midwife and health visitor consultants.* Leeds: NHS Executive.

The Queen's Nursing Institute, 2015. The Value of the District Nurse Specialist Practitioner Qualification: A report by The Queen's Nursing Institute

'The CNC acts as a network node bringing together many networks within a community so that there is communication, minimal duplication of effort, smooth coordination and the focus of care remains with the person needing it.'

Redwood, S. Carr, E. C.J. and Graham, I. W., 2005. Perspectives on the Consultant Nurse Role. Project Report. Poole, England: Bournemouth University.

https://eprints.bournemouth.ac.uk/11689/ Last accessed 7/2024

Schiavone, F. Ferretti, M. 2021 The FutureS of healthcare. Futures, Volume 134, 102849, ISSN 0016-3287

https://www.sciencedirect.com/science/article/pii/S0016328721001580 Last accessed 7/2024

World Health Organization (WHO) (2015) *WHO global strategy on people-centred and integrated health services. Interim report.* Geneva, Switzerland: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_ SDS_2015.6_eng.pdf Last accessed 7/24

Career Pathways

Key points

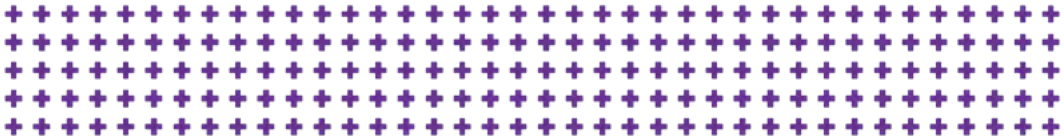
+ A CNC brings an ability to work at many systems levels, solving complex issues with people needing care
+ This capability comes from years of practice, broad and deep knowledge and the ability to reflect on practice and constantly improve
+ CNCs build a lifelong learning portfolio to support and deepen their practice across all skill areas.

Achieving the appropriate educational level

A Community Nurse Consultant (CNC) needs both knowledge and experience to achieve the level of practice required for this role. Testing and building knowledge through experience creates the ability to work through complex issues, recognising patterns and being able to find creative solutions. This is the value that a Community Nurse Consultant brings to a team, being able to discern a high-level view of issues but keep the individual, family or community at the centre of all interventions. This is the ability to work at macro, meso and micro levels of care: macro level will be national or regional, or maybe area wide, while meso will be the level of a community, local health board or large facility. Micro level work concerns that done with individuals or families. CNCs have to be able to move through these levels and this is illustrated in various case studies in this handbook.

The profession of nursing, in common with other health professions, requires lifelong learning and even when consultant level is reached, learning continues. Knowledge is constantly changing as new discoveries are made, showing that previously held beliefs were incorrect. In nursing, it is essential to take a learning and development approach to all practice, as research constantly adds new knowledge to practice. There are some astonishing descriptions of nursing treatments in the last century (Laurent 2020) including nursing children with pneumonia outside, even in the coldest weather (Laurent p. 40). Some medical schools teach students that, within a few years, half of what they have been taught will be wrong – they just don't know which half (Milton, 2018). Knowledge management as a discipline is now highly prized in industry: it is essential to keep ahead of competitors.

'A master's degree is required as a minimum qualification, though consultant level capabilities are commensurate with doctoral descriptors at Level 8.'



Evidence of consistently pursuing professional and educational qualifications is a core component of consultant roles. A master's degree is required as a minimum qualification, though consultant level capabilities are commensurate with doctoral descriptors at Level 8 (Royal College of Nursing, 2024). Scholarly activity, leadership programmes or specialist post graduate certificates can further demonstrate professional development; pursuing a doctoral degree can consolidate learning and enhance research skills. Establishing formal links with local universities is a good way to contribute to academic programmes and research activity while in practice. Nurse consultants benefit from a teaching qualification, along with experience of acting as an educator, mentor and coach. These roles evidence a commitment to helping colleagues to build their knowledge both formally and informally, which is an essential component of the consultant role.

Clinical credibility is also important for Community Nurse Consultants, as team members are likely to be experts in their clinical fields. This does not mean that the CNC has to be a clinical expert in all areas of practice – it is simply not possible – but CNCs should be aware of the limits of their knowledge and where to access 'just in time' information – whether from a colleague or a knowledge source. Building on clinical experience through reflection enables a practitioner to develop clinical judgement and build and apply knowledge to diverse situations. Research skills exercised within a learning and development framework equip practitioners to be curious about all their decisions and to seek evidence as it is needed. Evidence is now readily available, even through handheld devices, and seeking the latest evidence should be part of every decision.

Nurse consultant practice requires advanced level clinical decision making in complex situations. CNCs are required to understand the demands of providing advanced clinical care in situations which may change quickly and be impacted by many systems beyond health care. Clinical decisions may be constrained by factors beyond clinical considerations, so that a CNC requires enough clinical knowledge to support other members of a team in finding satisfactory solutions. For example, an older person who is having care at home for leg ulcers associated with diabetes may be vulnerable in several ways as well as their complicated physical condition. Isolation, loneliness, poor diet or unsuitable housing are all examples of factors that can impact the health of older adults, and each of these factors derives from different systems within which the person functions – economic circumstances, societal infrastructure and community norms. The CNC has to be aware of clinical need and the challenges that a nursing team might face in meeting clinical need in complex circumstances. This does not mean the CNC has to provide care, nor be the link between services, but may help to facilitate those links, or to call a multi-disciplinary team meeting (that includes the patient and family) to plan care appropriately. It is this ability to move from the individual and their need to the

bigger picture of systems – micro to meso to macro- that sets apart the work of the CNC.

Working with varied patient groups, service users and diverse communities supports the development of a deep understanding of the complex influence of demographics on service provision. Alongside this, it is important to be aware of key health policies and strategies that will influence the ways that care is organised and what can be provided. For example, if it is a local priority to provide hospital at home services, then budgets are likely to be directed to resourcing this type of care, which means that it may be easier to access equipment and supplies. Because local priorities can differ, it may be beneficial to seek experience in different localities and provide different care pathways. Collaborative working with a large range of clinical peers, leadership teams and professional groups can help build a diverse professional portfolio. This may include the voluntary sector and social prescribers. Ensuring integration of services with multidisciplinary teams through high degrees of collaboration are core components of consultant practice.

With the substantial professional experience that they bring to the role, nurse consultants will have built extensive networks throughout their career and will understand the importance of strong collaborations between professional groups. These connections encourage a broad view of issues from different professional viewpoints and require negotiation skills to find common ground for mutually agreeable strategy development. The ability to hear and understand many different views and to negotiate acceptable solutions to multi-faceted challenges are critical leadership skills for a CNC.

Actively contributing to service development, quality improvement, audit and research should be a visible thread throughout a clinical career journey for CNCs. This can be shown in many ways: identifying areas where services can be improved and bringing about that transformation or finding innovative practices through literature and networks and seeing if it can be applied in another area.

Taking initiatives, with accompanying critical evaluation, is the hallmark of a nurse consultant and this can influence the quality of care in a team, but also be motivational, as everyone is challenged to raise their practice standards. With appropriate dissemination and bridges to policy makers, such initiatives can (and should) influence practice development, workforce deployment and health policy locally, regionally and nationally in service and quality improvements.

‘Valuing the lived experience of individuals and families is at the heart of a person-centred approach to service provision and supports practitioners to design personalised care.’

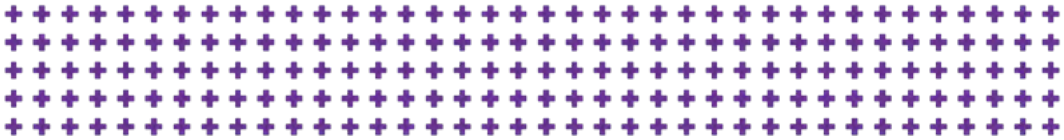
How to get to a Community Nursing Consultant Nurse role? Building a portfolio

A professional portfolio shows how expertise is built through formal and informal education, practice and experience. Essentially it records accomplishments and how they have been achieved. It is not the same as a curriculum vitae (CV), but a CV can be part of a portfolio. The portfolio should provide a comprehensive view of the path taken to arrive at the current career stage.

Showcasing and sharing best practices and innovation can be evidenced through a portfolio. This may be in the form of poster presentations, professional publications or presenting at conferences. Sharing specialist interests or research findings to peers contributes to the continuous learning and development of clinical practice. Valuing the lived experience of individuals and families is at the heart of a person-centred approach to service provision and supports practitioners to design personalised care. Being able to show how this is incorporated in practice is important.

Routinely inviting feedback from individuals, families and communities about the care they experience is a critical step in understanding their lived experiences and this may be done through individual or family conversations, and attending local community meetings or events. Keeping a record of doing this and how it is used will add depth to a portfolio. Receiving feedback from peers and colleagues is also essential, as part of a clinical leadership pathway, offering further awareness of leadership behaviours, strengths in practice and areas for development. Systematically including the views of colleagues on performance in annual assessments is a good way of doing this.

Case histories and examples that demonstrate competency, while subjective, are useful to have in a professional portfolio, as well as narratives reflecting on nursing practice and a personal philosophy of nursing. Detailed summaries of patient case histories where nursing played a significant role in positive clinical outcomes may



also be included. Planned professional growth activities can be included to show how long-term career goals can be achieved.

Preparing a portfolio forces self-reflection about capabilities and how they have been acquired in practice. At this stage of a career, as a senior practitioner considering CNC role it might be useful to prepare a portfolio with a close colleague or 'critical friend'3 who can help to make the links between education, practice and experience. A development needs assessment framework is available (NHSE, 2023) that explores elements of career and capabilities and shows how to find evidence of the impact of practice. Capabilities can be mapped alongside areas for learning and development. While this activity is an individual process, the Centre for Advancing Practice has enabled several pilot development programmes for consultant practice development; these are in learning disabilities and autism, cancer care and diagnostics. These programmes are providing practitioners with a specialty pathway, using the workplace as the main resource for learning, developing and improving, and facilitating development of their skills and experience as system leaders.

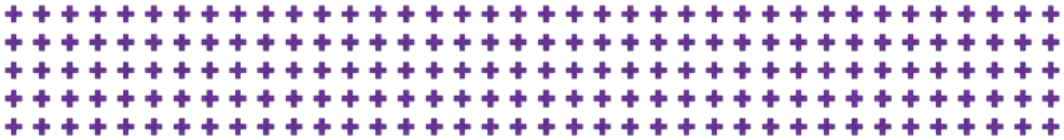
The importance of reflection and feedback

'Real knowledge is to know the extent of one's ignorance'. (Attributed to Confucius, 479 BC)

This quote from Confucius is a good place to start on a journey of reflection. Lifelong learning requires knowing how to learn from experiences, whether academic or clinical, routine practice or critical incidents. To learn from experience requires a deliberate effort to reflect on the experience, and become aware of personal feelings, assumptions and knowledge base for dealing with the situation. Exploring of all these factors promotes recognition of what has been learnt and what changes might be beneficial for future situations. The deepest and often hardest level of reflection is frequently this final piece, when changes are explored. This may challenge feelings about abilities and attitudes to change.

While not always comfortable, it is important to be aware of strengths and weaknesses to be able to take responsibility for improving performance. This is what makes an excellent advanced practitioner and consultant: the ability to look honestly at one's knowledge and identify where help or more information is required. As detailed earlier in this chapter, knowledge changes quickly in the 21st century and keeping up with change requires humility and curiosity.

'Reflection is one way to bring to the surface the tacit knowledge that we all use as nurses and can be reflection-in-action or on-action – that is, either during or after the event.'



There are many models of reflection that have been developed and used in nursing practice. It was an engineer – Donald Schon – who first captured the notion of 'reflection in action' which he did because he perceived that rapidly changing knowledge, together with increasingly complex systems in which we all function, meant that problems were rarely individual or simple. Rather they were likely to be dynamic, within complex systems and interacting with each other (Schon, 1982). Community nursing is indeed a world of complexity, as already discussed, with rapidly changing situations which are often uncertain and challenges which are interconnected. Schon believed that reflection-in-action was an essential process for the development and growth of knowledge and for realising that a different approach – or more knowledge – might be needed. He pointed out that much knowledge used in professional practice is tacit – that is, learned through experience – and often not put into words.

A decade later, Benner (1992) applied Schon's work to nursing and confirmed that nursing expertise is often embedded in tacit knowledge. Reflection is one way to bring to the surface the tacit knowledge that we all use as nurses and can be reflection-in-action or on-action – that is, either during or after the event. Using a reflective model can help to give structure to reflection, though reflection-in-action relies on asking questions during practice – which is also helpful. It may be thinking of possible interventions that might be necessary or as simple as questioning whether everything you are likely to need on a visit is available.

The takeaway message from this section is that all forms of reflection are important in a profession and role that is complex, uses tacit knowledge and addresses dynamic challenges. Reflecting is a way to identify patterns, to see what we know and do not know, how we put into action our own philosophy of nursing and life and how we can improve. Reflecting with your team, including encouraging feedback, encourages trust, collaboration and communication and underpins constant quality improvement. Feedback from others is also critical to develop trust, collaboration and communication in a team.

Clinical supervision

Clinical supervision is a structured process where clinicians are allowed protected time to reflect on their practice within a supportive environment and it is a learning method familiar to nurses. Clinical supervision has been shown to improve quality of care and to lower the risk of adverse patient outcomes (Ghaye and Lilliman, 2007). In the case of CNCs, it may be unrealistic to propose that a single supervisor can support the four advanced clinical practice pillars of clinical, research, education, leadership and management, while also supporting the developing practitioner/trainee with any competing workplace demands. An integrated multi-professional approach to supervision might be more effective for CNCs, where there is one coordinating supervisor and one or two more associated supervisors who have different areas of knowledge.

Supporting aspiring nurse consultants: why and how?

Nursing remains a key area of concern for all NHS trusts with around 34,000 nursing vacancies in England and nurse shortages in all the countries of the UK4. Nurse shortages lead to unsafe care and to services being curtailed. The levels of registered nurses in the community have been declining steeply – and missed care in patient homes may not be apparent. District nurse numbers in England have fallen by almost 50%, from 7,055 in September 2009 to 3,749 in December 2022, and the number of health visitors fell from 8,100 to 5,653 (Dean, 2024).

While more nurses are coming on to the register of qualified nurses, retention is falling, often in a cycle of low morale because of shortages. The NHS England Long Term Workforce Plan makes two notable commitments to improve nursing retention rates. Firstly, a pledge to fund continuous professional development (CPD) for nurses and secondly, the assurance to provide flexible working with career development and progression. Employers of community nurses are competing in a market in which there is a shortage of nurses, and evidence of commitment to community nurse career development can both attract and retain nurses.

To lead clinical care requires a clinical workforce that has skills across the four pillars of practice, which are defined by the Royal College of Nursing (2023) as clinical practice, education, research, and leadership. These domains apply to all registered and student nurses. The Nursing and Midwifery Council requires thirty-five hours CPD over a three-year period for revalidation. These hours can be used for study within a formal setting, but can also include informal education through coaching and mentoring in any area of nursing practice across the health system. Building a diverse portfolio strengthens the personal skills of system leadership and gives insights into a range of services.

Becoming a mentor to novice community nurses or to aspiring CNCs is one way to share knowledge and to share a reflective journey. A mentor provides support within a nurturing relationship and shares knowledge, provides emotional support, offers constructive feedback and opportunities for structured reflection. Nursing mentorship has been shown to enhance communication skills, increase self-confidence and job satisfaction, thus encouraging nurses to stay in the profession (Gulate-Rinaldo et al., 2023; Saletnik, 2018). Mentorship has also been shown to ease stress by offering support and camaraderie, and may protect against burnout (Gulate-Rinaldo et al., 2023; Temkar, 2020).

‘District nurse numbers in England have fallen by almost 50%, from 7,055 in September 2009 to 3,749 in December 2022, and the number of health visitors fell from 8,100 to 5,653 (Dean, 2024).’

Becoming a mentor to someone in another health profession can also be beneficial, because it encourages professional colleagueship and a shared understanding of roles. CNCs are able to show expertise in their own field of practice, demonstrating knowledge and skills beyond advanced decision making, and can guide other professionals to do the same in their own field. It is these human connections, founded on professional respect, that can transform team relationships. Once you are establishing networks, move on to help colleagues to make those connections too.

A CNC can also offer coaching to colleagues. Coaching is usually focused on a specific aspect of performance and has time limited goals. It is an important management style to keep colleagues motivated. A coach listens to what is seen as barriers to success and then works alongside the person being coached to overcome hurdles so that performance improves. It is an informal and friendly relationship.

Shadowing opportunities can also support personal development. Consider asking to shadow a senior decision maker as they attend strategic events, policy making or board meetings. CNCs have much to offer at high level policy and strategy events and becoming accustomed to them, and feeling comfortable to speak, can make you a valued participant.

Encouraging quality improvement projects and implementing service development through primary research participation are important contributions to growing a knowledge base as a CNC. It is not easy finding time for such activities, but getting protected time from employers can make it possible. For employers, it is worth noting that continuing professional development leads to better retention, recruitment and performance.

Conclusion

A Community Nurse Consultant brings richness to a community health care team through the depth and breadth of knowledge and experience. Community nursing is a complex, multi-layered discipline; it is often hard to describe, as it is highly adaptive to system changes both within and outside of nursing and health care. This chapter has described the pathways to consultant level practice: there are many and it is important to find the right one for you and your employer. We all learn in different ways but what is known is that achieving mastery in a discipline is a strong motivation to stay in that discipline (Pink, 2010). Education is multi-faceted and experience is essential to put education into practice so that it continually improves. It equips us all to provide the best care possible.

Case study 1

Career path to community nursing research and effectiveness lead role

Sarah Ellison, CNC in Congenital Heart Disease in Primary Care, Cheshire and Wirral Partnership

'After 30 plus years in nursing with the last 20 of these being in the community, I never expected to find myself in a research role. …My roles have centred very much on clinical nursing with positions as a community heart failure specialist nurse for many years and more recently that as a community matron and advanced nurse practitioner. During this time, I completed both BSc and MSc degrees along with non-medical prescribing.

Between these roles, I went into education as a senior lecturer at the University of Chester as part of the advanced practice programme. I was module leader for clinical examination and clinical diagnostics and teaching on the non-medical prescribing course. During this time, I was able to obtain a PGCE and higher education academy fellowship.

My clinical facing role changed almost overnight after the Covid 19 pandemic, and I am now working part time as a research and effectiveness lead for neighbourhood care community group in CWP. This role enables supporting and embedding research into practice, promoting quality improvement and innovation. I am involved with clinical academic opportunities, networking, teaching at university and supporting colleagues with research proposals, journal publications, posters, and presentations.

My research interests are with congenital heart disease, this is partly through my own lived experience as a patient and recognising the impact that patients face if

'My career has come full circle; I began my nurse training at Liverpool John Moores University as a project 2000 student and I'm now back there in my 4th year doing a PhD.'

they became ‘lost to follow up care’. I am the project lead for Cheshire congenital heart disease (CHD) in primary care group. This is a collaborative approach working closely with the integrated care board, specialist acute trust and NHS England. This work has led to digital innovations with the creation of a CHD dashboard which will help future service planning and delivery.

My career has come full circle; I began my nurse training at Liverpool John Moores University as a project 2000 student and I’m now back there in my 4th year doing a PhD. I feel that I am in a unique position as a patient, a nurse, and a researcher, to demonstrate how simple ideas can grow into amazing opportunities.’

Case study 2

Education for Consultant level practice

Lucy Lewis, Hospital at Home Service. Wiltshire

‘I have had several mentors who have seen my potential and helped me to reflect and through constructive and nurturing feedback to understand my personality type better and this has the potential to enhance situations where I lead but also how my “blind spots” can impact negatively. ‘Holding up the mirror’ is a great phrase if you are courageous enough to acknowledge and address your growth areas in order to become a better leader. Critical friendship and psychological safety with consultant peers I trust to be honest with me of where I can improve, reframe, rephrase, whilst still accepting me for who I am, has been empowering and invaluable to my continued consultant practice development.

I first undertook Myers Briggs in 2013 when I was completing the Transition to Advanced practice module as part of my MSc in Advanced Practice. I later repeated this with Health Education England (HEE) on the lead and be led programme. I am

an ESFJ (Extroversion, Sensing, Feeling, Judging) and as a trainee Advanced Clinical Practitioner (ACP), I learned about myself and what this personality type means for me. As a trainee Consultant practitioner, I reflected upon what this personality type means for colleagues I work with and me as a leader.

Now, as an established and experienced consultant practitioner I continue to see how I use my personality type as a strength as I am encouraging, charismatic and hard working however, my eagerness to take charge and meet goals in a structured and orderly way coupled with the high expectations I have for myself and our team can have a negative impact on productivity and team culture.

During the pandemic I was employed in my first consultant nurse post. I used this opportunity to consolidate all I had learned on the HEE programme in an established service which had been consultant practitioner led since its commencement in 2017. By January 2023, I was ready to take on the challenge of establishing a new Hospital at Home service with consultant practitioner colleagues in a county which did not have one in response to national policy directives.

Establishing a new service and building a team has brought challenges and opportunities. Many of our existing colleagues had change fatigue from adapting to role changes and ever-changing service needs in response to local, regional and national agendas.

Applying aspects of Appreciative Inquiry, an asset based approach to healthcare (and all walks of life) Appreciative inquiry | Knowledge and Library Services (hee.nhs.uk) has helped my colleagues and I recognise key achievements whilst acknowledging our learning of how we can do things differently in the future. influencing change in the workforce model, working with systems partner organisations to bring our 4 separate approaches to delivery to agree on a ‘One model’ Hospital at Home delivery.

I have reflected upon the last twenty months often. My enthusiasm for Hospital at Home, improving frailty services and being evangelical about Consultant Practice has been met with positivity form colleagues. However, I recognise that at times when things are not moving in the direction I would wish, I have become frustrated and vocal. Resorting back to the NHS comfort zone of deficit-based approach rather than practicing gratitude for all that has gone well since I arrived in our organisation and since we have set up our service. There is so much to rejoice about! We have come such a long way as a team, our co-ordinators, nursing associate, trainee and qualified Advanced practitioners, project leads, pharmacists, mental health practitioners and wider community system colleagues have all

‘Critical friendship and psychological safety with consultant peers has been empowering and invaluable to my continued consultant practice development.’

nursing associate, trainee and qualified Advanced practitioners, project leads, pharmacists, mental health practitioners and wider community system colleagues have all influenced our success. The expert practice and depth and breadth of all our consultant practitioners whose backgrounds are richly diverse has added to our leadership offer both internally and across the system'.

Commentary

The enthusiastic voices of the CNCs come through clearly in these case studies, as does their ability to weave clinical practice into research and education. Case study 2 makes it clear how reflection is a key part of learning with one notable phrase showing how important is the role of 'critical friend':

'Critical friendship and psychological safety with consultant peers I trust to be honest with me of where I can improve, reframe, rephrase, whilst still accepting me for who I am, has been empowering and invaluable to my continued consultant practice development.'

Both of these case studies show how the CNCs have taken opportunities as they have arisen sometimes not knowing where they might lead but always willing to deepen their learning. Sarah Ellison's graphic representation of her career journey shows how it is possible to build on knowledge for lifelong learning.

References

Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82(3), 402-407.

Dean, E. (2024). Patient safety fears and the normalisation of red flags. Nursing Standard volume 39 number 2 https://journals-rcni-com.rcn.idm.oclc.org/nursing-standard/analysis/patient-safety-fears-and-the-normalisation-of-red-flags-ns.39.2.8.s6/pdf Last accessed 7/24

Driscoll, J. (2007) *Practicing Clinical Supervision: A Reflective Approach for Healthcare Professionals*, 2nd edn. Baillière Tindall, London. https://scholar.google.com/scholar_lookup?hl=en&publication_

Ghaye, T. and Lillyman, S. (2007) *Effective clinical supervision*. 2nd ed. London: Quay.

Gibbs G (1988). Learning by Doing: A guide to teaching and learning methods. Further Education Unit. Oxford Polytechnic: Oxford. https://www.ed.ac.uk/reflection/reflectors-toolkit/reflecting-on-experience/gibbs-reflective-cycle Last accessed 7/2024

Gularte-Rinaldo, J. Baumgardner, R. Tilton, T. Brailoff, V. 2023. Mentorship ReSPeCT Study: A Nurse Mentorship Program's Impact on Transition to Practice and Decision to Remain in Nursing for Newly Graduated Nurses. Nurse Lead. 21(2):262-267. https://www.nurseleader.com/article/S1541-4612(22)00171-9/fulltext Last accessed 7/24

Laurent, C. (2020) Rituals and Myths in Nursing. A social history. Pen and Sword Publications. Barnsley England.

MacPhail, A. Tannehill, D. & Ataman, R. (2021). The role of the critical friend in supporting and enhancing professional learning and development. *Professional Development in Education*, 1–14. https://doi.org/10.1080/19415257.2021.1879235 Last accessed 7/2024

Milton N., (2018). The shrinking half life of knowledge https://www.nickmilton.com/2018/01/the-shrinking-half-life-of-knowledge.html Last accessed 7/2024

National Health Service England (2023) Multi-Professional Consultant-level Practice capability and impact framework. Centre for Advancing Practice https://healtheducationengland.sharepoint.com/:w:/s/APWC/EQUVCF1sUsRGtnO32vpZzvoBwVdrjlVnuom8jfm90MhXrA?rtime=LEWUBKSa3Eg Last accessed 7/2024

Royal College of Nursing, (2024). The levels of nursing May 2024. https://www.rcn.org.uk/news-and-events/news/uk-rcn-defines-levels-of-nursing-beyond-registration-100524 Last accessed 7/2024

Saletnik, L. (2018). The importance of mentoring. AORN J. 108(4):354-356. https://doi.org/10.1002/aorn.12386 Last accessed 7/2024

Schon, D. (1982) The Reflective Practitioner. Basic Books. USA

Temkar, A. 2020 Research: mentorship reduces nurse burnout. https://www.samuelmerritt.edu/news/research-mentorship-reduces-nurse-burnout Last accessed 7/24

'Professional identity in nursing is a sense of self, that is influenced by the characteristics, norms, and values held about nursing. This is what makes someone feel and act like a nurse and is established at the start of a nursing career.'

Professional Identity

Key points

+ Professional identity is the self-efficacy that has been developed over a career
+ The nursing profession has long struggled to communicate a professional identify that conveys its complex role in a changing healthcare landscape which may lead to CNC's capabilities being underestimated
+ Being able to articulate the CNC role, so that others understand it, is key to promoting the professional image that is deserved.

Who do you think you are?

This chapter is about your professional identify which may, at first glance, seem like an abstract concept. There was a time when nursing struggled even to be recognised as a profession, being seen as secondary to medicine – nurses assisted physicians who prescribed care (Stilwell and Newman, 2022). Happily, we have progressed, and nursing is now a graduate profession with a well-defined body of knowledge. Nevertheless, the old image of 'doctor's assistant' is hard to shake off, especially because nursing is a gendered profession dominated by women. Considering professional identify is therefore important, especially as CNCs, when teams will be multi-professional and the influence that a CNC has, may be affected by the way other team members view the profession of nursing.

Professional identity in nursing is a sense of self, that is influenced by the characteristics, norms, and values held about nursing. This is what makes someone feel and act like a nurse (Fitzgerald and Clukey, 2022) and is established at the start of a nursing career. This is another reason why nurturing early career nurses and providing role models is so critically important. Assertive and articulate nurses, who are not afraid to be in the lead and speak up, will coach and mentor others to be like them – this is how the profession grows and develops an identity of self-confidence and leadership.

The development of self-efficacy is linked with personal and professional identity, and includes such characteristics as self-confidence, self-respect, pride and commitment (Phillipa et al., 2021). Learning, working in a nursing role, and reflecting on nursing practice lead to self-efficacy and flourishing in nursing (Kristoffersen, 2021). For most people, professional identity changes across the course of a career and this affects the choice of career pathways. Confidence in practice is gained with time in the workforce, though, importantly, research has shown that professional identity may be negatively influenced (that is become

stifled or stagnant) when there is no opportunity to grow in work or that colleagues were impeding their development (Kristoffersen, 2021). Continuing professional development activities and mentoring have both been shown to strengthen role and professional identity.

Community Nurse Consultants are senior nurses with many years' experience in practice, including research and education, all of which will support a robust professional identity. But the routes to becoming a consultant will be different for everyone, so will professional identity differ and does this matter?

Identifying as a Community Nurse Consultant

The attributes of a CNC are discussed in earlier parts of this handbook and in the chapter on standardization. Consultant level nursing is underpinned by a comprehensive range of capabilities, together with experience in the four pillars of nursing, namely clinical practice, education, research, and leadership (RCN, 2024). These dimensions, coupled with critical reflection, enable the consultant level registered nurse to function to their full potential and the highest degree of autonomy possible within their context of employment (Manley and Crouch, 2020).

Personal perceptions and experiences – how we make sense of our identity as a nurse and why we take the career paths that we do – give us the map to navigate professional paths and find our destination. Professional identity evolves through the values perceived through engagement with learning and work and thus is influenced by, and also influences, career choices. A CNC has at some point chosen to work in the community rather than in a hospital setting, and in becoming a consultant has followed a broad path that has included academic and practice-based learning.

For many people, getting to the peak of their career can be accompanied by a sense of 'imposter phenomenon'. This is a term used to describe individuals who, despite substantial professional accomplishments, suffer from self-doubt. They imagine that their achievements are not due to their competence, but are down to luck, and somehow they have deceived colleagues into thinking they are more competent than they are (Ord et al., 2024). The transition to specialist roles has been shown to be stressful for nurses, as their roles are often not well-defined, and they may have less structured support and they are more likely to experience imposter phenomenon (Ord et al., 2024).

'For many people, getting to the peak of their career can be accompanied by a sense of 'imposter phenomenon'.'

Becoming a CNC may expose nurses to the same transitional vulnerability. Consultant is a title given to experienced nurses with broad and deep expertise and such professional identity may be daunting, especially if the role is not well defined and support structures are not in place. In their research study of specialist nurses and imposter phenomenon, Ord et al. (2024) noted that some nurses 'lacked the emotional resources required for their specialist roles' (p.142) and support the importance of building resilience through supervision and peer support (Hochman et al., 2023).

In an international study of nurse leadership carried out in 2020 through the Nursing Now campaign, the majority of nurse respondents reported that they felt uncomfortable speaking in a large meeting or in a group of senior managers and lacked self-confidence in the exercise of power when they assumed leadership roles (Newman et al. 2019). The lingering cultural perceptions of nursing as a 'semi-profession' are reinforced when nurses are not perceived as key decision-makers or important to policy.

Professional identity as a nurse consultant is far more important than often credited. It is the self-efficacy that has been developed over a career that gets consultants to these positions, and sometimes it is the lack of clarity and support for roles that can sap confidence. The practice of nursing at consultant level demands not only emotional intelligence (Por et al., 2011) but high-level complex problem-solving to determine priorities and actions with individuals, families and communities – a feature of nursing that is not often described and as discussed, is paramount in community nursing (Stilwell, 2020).

A robust professional identity as a nurse makes a positive contribution to the growth of the nursing profession as a whole; the image of nursing is strengthened and its contribution to health care articulated more powerfully. It is critical to model the values of nursing to more junior nurses in the team because this is

how they will develop their own professional identity. Furthermore, professional identity enhances the credibility and standing of the profession to all stakeholders, including employers and other senior team members.

Professional image

Nursing stereotypes are persistent. Nursing is viewed as a female dominated profession – which is true – and subordinate to medicine – which is not true. Nursing is a graduate profession, but studies show that nurses are not given due recognition for the skills they have by the public and often not by other professionals (Ten Hoeve, 2014). The essence of nursing is not always clear outside of nursing. An international systematic review of public perceptions of nursing found role incongruity among the public: they trusted nurses but did not necessarily respect them and did not understand their work (Girvin, 2016). Rather, the trust seemed to stem from the respect held for the traditional stereotypes of selfless, hardworking women. This image of the nursing profession that differs from reality has an impact on many contemporary issues, including earnings and professional satisfaction (Lopez-Verdugo et al., 2021) as well as who chooses nursing as a profession and how effective nurses are as leaders (Newman and Stilwell, 2025).

The nursing profession has long struggled to communicate a brand image that conveys its complex role in a changing healthcare landscape (Godsey et al., 2020). Nurses do not have a strong media profile and are seldom asked to give their views in health news stories, even though they may be germane to the topic and can add important perspectives (Mason et al., 2018). The US based study of Mason et al. found that nurses were identified as the source of only 2% of quotes in health-related stories, while physicians provided 21% of quotes. Journalists admitted to not understanding the roles or education of nurses, and said that they often have to justify to editors their use of nurses as sources for stories. While the COVID-19 pandemic made nurses and nursing highly visible, nurses were not consulted by the media for expert opinions (Mason, 2020). The absence of nurses from media briefings and interviews during the pandemic adds to the perception that the nursing profession lacks scientific knowledge and value.

Consultant nurses bring to a health care team a variety of skills and deep knowledge that may not be immediately appreciated, because of the outdated professional image of nursing described above. For any individual nurse consultant new into post, this lack of appreciation of their knowledge and skills may result in imposter phenomenon (Ord et al., 2024). This is a great point to reflect on, in a career portfolio. What are you bringing to this team? It is going to include

‘The absence of nurses from media briefings and interviews during the pandemic adds to the perception that the nursing profession lacks scientific knowledge and value.’

clinical expertise, leadership skills, management skills, communicating, teaching, mentoring, networking – all of these things. And pulling all of this knowledge and expertise together to care for individuals, families and communities is the art and essence of nursing.

As has been discussed previously, a CNC is a complex role, especially because it is placed in the community, which is a complex place, with many systems interacting. A CNC is a vital and equal team member. Being able to articulate the CNC role, so that others understand it, is key to promoting the professional image that is deserved. This may require additional communications or presentation training for those who are not confident in public speaking but that is an investment in continuous professional development that will pay dividends.

Conclusion

Professional identity and image in nursing suffers from outdated stereotypes which may leave nurses feeling undervalued and unconfident. Being able to role model professional strengths in nursing will chip away at these old stereotypes and bring nursing's image into alignment with its actual professional identity in this century. Being aware of and showcasing nursing's professional identity is part of the nurse consultant role, and it is important. Take a look at Box 1 below: it is the words used by 50 CNCs to describe themselves. Once all our stakeholders describe CNCs this way nursing will have the professional image it truly deserves.

References

Fitzgerald, A. Clukey, L. (2022) Factors influencing nursing professional identity development: A qualitative study. Nurs Forum. Nov;57(6):1346-1353. Last accessed 7/2024

https://pubmed.ncbi.nlm.nih.gov/36259223/

Godsey, J.A. Houghton, D.M. & Hayes, T. (2020). Registered nurse perceptions of factors contributing to the inconsistent brand image of the nursing profession. Nurs Outook 68(6), 808821. https://doi.org/10.1016/j.outlook.2020.06.005 Last accessed 7/2024

Girvin, J. Jackson, D., & Hutchinson, M. (2016). Contemporary public perceptions of nursing: a systematic review and narrative synthesis of the international research evidence. Journal of Nursing Management, 24(8), 994-1006. https://pubmed.ncbi.nlm.nih.gov/27406529/ Last accessed 7/2024

Hochman Y, Segev E, Shai O. 'Do you know the impostor syndrome?' Professional identity among early-career social workers, Social Work Education (2023); 42:(8): 1117-1133. https://doi.org/10.1080/02615479.20 22.2061945 Last accessed 7/2024

Ten Hoeve, Y. Jansen, G. & Roodbol, P. (2014) The nursing profession: Public image, self-concept and professional identity. A discussion paper. Journal of Advanced Nursing 70(2), 295–309. https://pubmed.ncbi.nlm.nih.gov/23711235/ Last accessed 7/2024

Kristoffersen M. Does professional identity play a critical role in the choice to remain in the nursing profession? Nurs Open. 2021 Jul;8(4):1928-1936. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8186704/ Last accessed 7/2024

López-Verdugo, M. Ponce-Blandón, JA. López-Narbona, FJ. Romero-Castillo, R. Guerra-Martín, MD. (2021). Social Image of Nursing. An Integrative Review about a Yet Unknown Profession. Nurs Rep. 2021 Jun 7;11(2):460-474. https://pubmed.ncbi.nlm.nih.gov/34968221/ Last accessed 7/2024

Manley, K. Crouch, R. Ward, R. Clift, E. Jackson, C. Christie, J. Williams, H., & Harden, B. (2022). The role of the multi- professional consultant practitioner in supporting workforce transformation in the UK. AJPP, 3(2), 1-26. https://doi.org/10.22024/UniKent/03/ajpp.1057 Last accessed 7/2024

Mason D., Nixon L., Glickstein B., Han S.,Westphaln K., Carter L. (2018) The Woodhull Study Revisited: Nurses' Representation on in Health News Media 20 Years Later. Journal of Nursing Scholarship, 50:6, 695–704 https://sigmapubs.onlinelibrary.wiley.com/doi/pdf/10.1111/jnu.12429
Last accessed 7/2024

Mason, D. (2020) Nurses lack representation in media: recognize them for the leaders that they are. Opinion USA Today https://eu.usatoday.com/story/opinion/2020/06/26/nurses-leaders-medicine-but-overshadowed-media-column/3223242001/ Last accessed 7/2024

Newman, C. Stilwell, B. (2025). Gender, Nursing And Global Health: Why Does Gender Matter? In Global Health and Nursing: a new narrative for the 21st century. Stilwell B. Ed. London UK. Elsevier

Newman, C. Stilwell, B. Rick, S. and Peterson, K. (2019). Investing in the Power of Nurse Leadership: what will it take? Chapel Hill: IntraHealth International. https://www.intrahealth.org/resources/investing-power-nurse-leadership-what-will-it-take Last accessed 7/2024

'Professional identity and image in nursing suffers from outdated stereotypes which may leave nurses feeling undervalued and unconfident.'

Ord, T. Metcalfe, D. Greaves, J. Hodgson, P. Unmasking impostor phenomenon: a study of nurses in specialist roles. Br J Nurs. 2024 Feb 8;33(3):139-143 https://www.magonlinelibrary.com/doi/abs/10.12968/bjon.2024.33.3.139 Last accessed 7/2024

Philippa, R. Ann, H. Jacqueline, M. Nicola, A. Professional identity in nursing: A mixed method research study. Nurse Educ Pract. 2021 Mar; 52:103039. https://pubmed.ncbi.nlm.nih.gov/33823376/ Last accessed 7/2024

Por, Jitna, Barriball, Louise, Fitzpatrick, Joanne. Roberts, Julia. (2011). Emotional intelligence: Its relationship to stress, coping, well-being and professional performance in nursing students. Nurse education today. 31. 855-60. https://www.researchgate.net/publication/49808854_Emotional_intelligence_Its_relationship_to_stress_coping_well-being_and_professional_performance_in_nursing_students Last accessed 7/2024

Royal College of Nursing, (2024). The levels of nursing May 2024. https://www.rcn.org.uk/news-and-events/news/uk-rcn-defines-levels-of-nursing-beyond-registration-100524 Last accessed 7/2024

Stilwell, B. (2020). A New Narrative of Nursing. In Nursing the World to Health, International Council of Nurses Toolkit for International Nurses' Day 2020. Pp18-19. International Council of Nurses www.icn.ch

Stilwell, B. & Newman, C. (2022) Nurses learning to be powerful leaders: What will it take? February. Creative Nursing Vol. 28 #1. Thematic series: Thinking Like a Nurse: Intent and Impact of Caring https://pubmed.ncbi.nlm.nih.gov/35173058/ Last accessed 7/2024

Standardising roles and practice: opportunities and challenges

Key points

+ Standardisation allows the generation of guidelines, rules, systems and processes that can be understood by all and are therefore a common language
+ The challenge of role standardisation may be the constant need to apply skills and knowledge to dynamic clinical and social situations
+ It is valuable to articulate the core standards to be expected of a CNC for workforce planning, job creation and employer understanding.

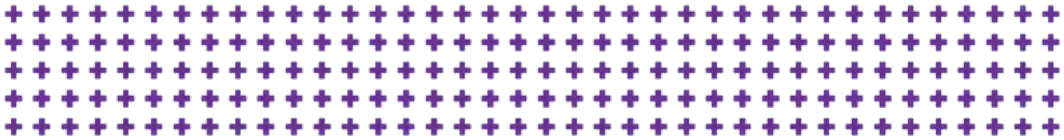
The need for standardisation

The Community Nurse Consultant (CNC) role has developed in response to changing health care demands and, more recently, the policy drive to provide home based care and care pathways that are planned around the individual needs of patients and their families (NHS 2023; NHS 2019).

The more general role of nurse consultant was also envisaged as a way to keep experienced nurses in clinical practice and improve nurse retention – which remains a priority for the NHS and for the community nursing workforce (Drennan and Goodman, 2011). Evans et al., (2021) point out that advanced roles in health care have evolved in response to the needs of health services rather than as part of an overarching national health workforce plan, and that may be a challenge to planning and sustainability.

Historically, all nursing roles have developed to meet the needs of a changing health landscape (Wootton and Davidson, 2025) and this was evident during the recent pandemic when nurses were required to work in new ways and often with great autonomy (Evans et al., 2021). As the largest group of front-line health workers, nurses use their problem-solving skills to find a pathway through the new challenges that they face every day, including in emergencies. This adaptability is largely overlooked as a skill of nursing, but it has been pointed out that it is this that 'keeps the show on the road' (Greenhalgh and Papoutsi, 2018). Understanding the need for adaptive solutions and knowing how to manage complex and dynamic demands in the community, marks out the expertise of all community nurses and especially CNCs who are able to oversee the complex health care landscape of community health care.

'Historically, all nursing roles have developed to meet the needs of a changing health landscape and this was evident during the recent pandemic when nurses were required to work in new ways and often with great autonomy.'



The organic development of nursing roles is a critical consideration when exploring issues of standardisation, because variability of roles may be evident through lack of consistency in job descriptions, or in a proliferation of titles (Daly and Carnwell, 2002: WHO, 2020). One of the main challenges reported for implementing the nurse consultant role has been a lack of clarity among organisations and stakeholders regarding role preparation, role definition and scope of practice (Evans et al., 2021; Drennan and Goodman, 2011; Daly and Carnwell, 2002). Understanding and articulating role boundaries and professional identity can be helpful in avoiding tensions around scope of practice and titles and can be supported through standardising roles and education.

The individual knowledge base for a CNC is of course influenced by the context of practice, but all CNCs will demonstrate the ability to use advanced problem-solving strategies to manage complex situations while operating at the highest clinical and leadership standards across all aspects of consultant level nursing. Because the practice of CNCs is applied to the context in which they are working, no two CNCs will have exactly the same scope of practice. Nevertheless, it is important to consider role consistency, and the part standardisation plays because it will strengthen safe practice, as well as avoid role confusion among stakeholders.

Standardisation allows the generation of guidelines, rules, systems and processes that can be understood by all and are therefore a common language. There are many examples of useful standardisation at different levels of the health system. At the macro level – which could be global or national – there are standards for a wide variety of health care processes such as patient safety, pharmaceuticals, vaccine regimes and the use of health data. At this level of health policy and planning, standards are vital for consistency and safety (Slemon, 2017).
At the mid-level of health care there are standards set or adapted by local trusts that guide disease diagnosis and management, care pathways and the management of people and facilities. Standardisation in nursing care is frequently prescriptive, with standards explicitly directing nursing actions (Slemon, 2017) but at the micro-level of care – where the focus is on the individual – nurses adapt their care to be a better fit for the patient. In a recent scoping review, Tsandila-Kalakou et al., (2023) found that clinical practice guidelines were adapted or disregarded if healthcare professionals (including nurses) perceived them to be detrimental to patient safety or to meeting patients' needs. In this study, patient needs included quality of communication, timely care, privacy or the need to customize care.

So, while standardisation of care is common, there is already a tension between strictly adhering to standards versus adapting them to the individualised needs of

patient centred care. It has been argued that standardisation of roles in nursing care may result in fragmentation of care and in the skills of critical thinking being lost or undervalued (Slemon, 2017), and this may be what is playing out in the adapting of standards to better meet patient needs. For CNCs, while the challenge of role standardisation may be the constant need to apply skills and knowledge to dynamic clinical and social situations, it is still valuable to articulate the core standards to be expected of a CNC. This allows prospective employers to appreciate the level of clinical and leadership skills they should expect to add to their health care teams with a CNC.

It may be helpful at this point to read The Primary Care and General Practice Nursing Career and Core Capabilities Framework (Health Education England, 2021) which sets out six levels of clinical practice linked to capabilities. It shows too that roles may not align perfectly with levels: it is important to be flexible in applying capabilities to situations of dynamic needs.

Implementing role standardisation

The CNC role has core functions that match other nurse consultant roles and these are:

- Expert practice in clinical care
- Strategic leadership with a systems perspective
- Learning and development across the health system
- Research and innovation.

The CNC works across all of these domains, bringing consultancy expertise with the goal of improving services for individuals, families, communities and populations. As discussed in Chapter 1, a consultant role is the pinnacle of a career and will be indicative of a skills level 8 or greater, with preparation at master's or doctoral degree level.

These pillars of nurse consultant practice provide the first step for standardizing the CNC role: all CNCs must be able to demonstrate competence in these domains of practice. Each domain has learning outcomes which have been specified in several workforce planning and community nursing documents (see for example RCN, 2024; NHS England, 2023; Department of Health, 2018). Individual role demands will, however, lead the CNC to spend different amounts of time in the work of each pillar. The ability to apply knowledge to a range of clinical and other situations is

'The entry requirements to be a CNC are well defined: a registered nurse with relevant post-graduate qualifications and experience; a master's degree and evidence of continuous scholarly and professional activity.'

captured in the consultancy capability which is integral to the CNC role.

In terms of standardisation, only those nurses who have achieved both entry requirements and core capabilities of the CNC role should use the title. Jobs for CNCs should align across all the capabilities with job descriptions that show how the capabilities will be applied.

The entry requirements to be a CNC are well defined: a registered nurse with relevant post-graduate qualifications and experience; a master's degree and evidence of continuous scholarly and professional activity. Building on the entry requirements, the core capabilities for each pillar of CNC practice are well described (NHS England, 2023) and will be achieved through learning and practice and demonstrated in a portfolio. Anyone wishing to employ a CNC can therefore map a job description against these capabilities, specifying minimum entry requirements for applicants. Standardising the role of CNC is achievable to this point.

Once the core capabilities are applied to the specific area of practice the role begins to adapt to the needs of the context of practice, so that each CNC's job, in practice, looks different. To illustrate this, two descriptions of a 'day in the life' of a CNC now follow. The similarities and differences will be an indicator of how far standardisation of the role is either possible or desirable.

Case study 1

Ann Palmer, Consultant Nurse, Solent NHS Trust - Day in the life of a Consultant Community Nurse

I am based in Southampton and work closely with community nurses, urgent response teams and long-term therapy. I generally work 9-5pm Monday to Friday but there is a level of flexibility in this to be able to attend meetings. This is an example of one of my working days.

Morning: 9-12 pm Clinical focus – Working in Urgent Response overseeing frailty virtual ward (VW). This involves reviewing each patient from the previous day and formulating a care plan; assessing the new patients referred to the service from the previous day; requesting diagnostic tests; formulating a care plan and deciding whether they should stay on VW. I have to approve any diagnostic tests, either that I or others have requested that day.

Afternoon: 12.30 – 2pm – Learning and development focus – Carrying out an appraisal of one of the Trainee Advanced Clinical Practitioners (TACP) which also involves reviewing their learning needs analysis, review their objectives for the next year and the discussion of the quality improvement project.

2-3 pm – Learning and development plus service development focus- Updating and discussing the progress of another TACP in another service line. Support and advising the supervisor of her roles and responsibility as this is the first time, they have completed this role. Planning for another TACP who will start later in the year.

3-4 pm – Practice and service development focus- Integrated Template update meeting – In January we launch an integrated template that is a data collection form that can be used by a multi-professional team to collect patient information and therefore avoids duplication of patient questioning. Each month we review how this is going and make any amendments to the template from feedback received from the teams.

4-5 pm – Professional leadership focus- Meeting with Consultant Geriatrician from acute hospital to discuss falls pathway in community setting.

5-5.30 pm – Clinical focus – Checking in to Urgent Response Service with outcome of diagnostic teams reviewed that day, updating clinical records.

Feedback from Operations Director:

"Coming into the organisation into a position that was new and developing must have been a real challenge. However, looking back on the impact of the Consultant Nurse role, but in particular the contribution to the development of the services within her portfolio, it is striking how much we have moved things on in terms

'The role provides the oversight over a wide range of services sometimes diving into the detail and providing expertise sometimes working more broadly at a system level to help shape and deliver strategic objectives working with the OD, CD and HQP.'

of quality, governance, efficiency and workforce. The Consultant position sitting alongside the operational senior manager for integrated care has brought clinical stability and oversight over a wide number of services but more importantly has helped support bridging those services so that the workforce has the tools to operate flexibly and fluidly putting the patient at the heart of the services.

"The role provides the oversight over a wide range of services sometimes diving into the detail and providing expertise sometimes working more broadly at a system level to help shape and deliver strategic objectives working with the OD, CD and HQP. In terms of this role and the success, that comes down to the individual drive and enthusiasm and interpersonal skills; she builds rapport and is able to get the most out of people and situations. Additionally, the CNC is getting more involved from a strategic point of view both regionally and nationally and this bodes well, particularly as we have wide ranging projects such as the new Rehab centre which will inevitably cut across many services."

Case study 2

Jane Mulcahy, Consultant Nurse for Children's Community Nursing & Complex Care

Specialist Practitioner in Community Children's Nursing, Sussex Community NHS Foundation Trust

What I love about my role is the ability to flex in to support a specific child or family in a particular situation, for example developing a plan for a young person with complex and fluctuating respiratory needs to access mainstream education, through to planning end of life care in a residential care home for children, whilst also being able to influence at strategic level using clinical experience and case examples from practice. I can work outside of standard service boundaries to support problem solving thorny issues and collaborate with colleagues both in and outside of the trust, for example supporting end of life planning for a 16-year-old young person where they fell between gaps in different service provisions. I was greatly supported here by a Consultant Nurse colleague for Palliative and End of Life Care and worked with both Children's and Adult hospice colleagues to create a bespoke plan. This type of system leadership is an essential element of my role.

Recent example day:

Event	Pillar of practice
9 am-10 am Finalising an application for potential charity funding for a Children's Medical Complexity Transition post – working on the clinical case study element	Leadership
10 am-11 am Advising on the contents of a new residential school trip/ holiday form for children with medically complex care where registered nurse support may be required	Leadership
11 am-12.30pm Attended a Community Children's Nursing Service senior nurse operational meeting to be connected with service updates and arising issues where I can offer support. I was able to: signpost to Easy Read templates; advise on forthcoming training events; identify a learning opportunity with the local ambulance service for escalation to the Trust Deteriorating Patient Steering Group. I also, feedback to colleagues on progress with my core projects: Palliative and End of Life Care; Healthcare Transition; Deteriorating Patient; Digital Personalised Care; Continence Products Quality Impact Assessment	Leadership Education/ professional development
12.30 -1.30pm Contacting the Designated Clinical officer for Special Educational needs and Disabilities (0-25 year) regarding 2 issues: 1. Clinical discussion regarding the medically complex health needs of an individual and plan to access education moving forward 2. Update on national guidance around delegation of clinical skills to un-registered staff in education	Clinical Leadership

'The CNC day moves between systems level leadership and clinical leadership with individuals, including patients in a virtual ward.'

2 - 3pm Finalising Healthcare Transition benchmarking report and slides to feedback to Adult services next week and plan next steps 'You're Welcome': establishing youth-friendly health and care services- GOV.UK)	Leadership
3 - 4pm Clinical case discussion to support medically complex discharge planning	Clinical
4 - 5pm Meeting with multi-professional colleagues to finalise an application for NIHR funding Research for Patient Benefit (RfPB)	Research

Whilst I have identified each section of the day under 1 or 2 pillars as the main focus of the event, in reality the work is interwoven between all 4 pillars most of the time, with an overarching element of systems leadership.

Commentary

The two roles described above are the same but different. They are embedded in different areas of practice, and have different responsibilities, yet they both require clinical, educational and leadership expertise to perform effectively. It is interesting to note that even in one day, the CNC spends time in each of the pillars of practice. Additionally, there is a 50% focus on clinical practice, which endorses a strategic aim of developing the consultant role, which was to keep experienced and expert nurses in clinical practice.

The CNC day moves between systems level leadership and clinical leadership with individuals, including patients in a virtual ward. This is a key characteristic of CNC practice and requires systems leadership where the whole system – from individual through health care system to social and environmental systems – are scrutinized and taken into account in planning and delivering care. The integrated template that is mentioned is an example of systems leadership and innovation to make data collection easier on staff and patients.

Formal support for CNCs has been cited as important for effective practice at this level, along with a clear job description and objectives for the role (Booth et al., 2006; Redwood et al., 2005). Given the importance attached to managerial and supervisory support, feedback was invited on the work of the CNC described above from her operations director. It is particularly significant that the feedback highlights the elements of systems leadership that is a defining characteristic of CNC practice. Note the phrase 'oversight over a wide number of services' and the consequences of that, which result in more patient-centred care.

Conclusion

The role of a CNC is that of an agile leader and this is one of the major contributions that they are able to bring to the healthcare workforce. They work as part of a multi-professional team and have systems oversight, which means that they use a wide range of information to plan and manage care in the community with the patient at the centre. Of necessity, their role is flexible in that it is shaped in response to the context of work as well as the changing needs of the service and the people being served. This flexibility is central to the effectiveness of the role, requires skill and experience and is captured in the role capabilities of system leader and consultant.

This role has been developing over 10 years and the core competencies and capabilities for the pillars of the role are all well described and evaluated. Knowledge is considered to be at level 8 (Skills for Health). While there is flexibility in the way the CNC applies knowledge, this does not detract from the core requirements, standards and expectations for the role.

'The role of a CNC is that of an agile leader and this is one of the major contributions that they are able to bring to the healthcare workforce. '

References

Booth, J. Hutchison C. Beech C. Robertson, K. (2006) Journal of Nursing Management 14, 83–89 https://pubmed.ncbi.nlm.nih.gov/16487419/ Last accessed 8/2024

Daly, W. Carnwell, R. (2003) Nursing roles and levels of practice: a framework for differentiating between elementary, specialist and advancing nursing practice. J Clin Nurs. Mar;12(2):158-67. doi: 10.1046/j.1365-2702.2003.00690.x. PMID: 12603547. Last accessed 8/2024

Department of Health, Northern Ireland. (2018) PROFESSIONAL GUIDANCE FOR CONSULTANT ROLES. Supporting Consultant Nurses & Consultant Midwives in Health and Social Care. https://www.health-ni.gov.uk/publications/professional-guidance-consultant-nurses-and-consultant-midwives Last accessed 8/2024

Drennan, V. Goodman, C. (2011) Sustaining innovation in the health care workforce: A case study of community nurse consultant posts in England. BMC Health Services Research 11:200 http://www.biomedcentral.com/1472-6963/11/200 Last accessed 8/2024

Evans, C. Poku, B. Pearce, R. Eldridge, J. Hendrick, P. Knaggs, R. Blake, H. Yogeswaran, G. McLuskey, J. Tomczak, P. Thow, R. Harris, P. Conway, J. Collier, R. (2021) Characterising the outcomes, impacts and implementation challenges of advanced clinical practice roles in the UK: a scoping review. BMJ Open 11:e048171. doi:10.1136/bmjopen-2020-048171 Last accessed 8/2024

Greenhalgh, T. Papoutsi, C. (2018) Studying complexity in health services research: desperately seeking an overdue paradigm shift. BMC Med. 2018 Jun 20;16(1):95. https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-10 89-4 Last accessed 07/2024

National Health Service England, (2023) Multi-Professional Consultant-level Practice capability and impact framework. Centre for Advancing Practice https://advanced-practice.hee.nhs.uk/consultant/ Last accessed 7/2024

National Health Service (2019). The NHS Long term Plan. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ Last accessed 7/2024

NHS Executive. (1999) Health Service Circular 1999/217: Nurse, midwife and health visitor consultants. Leeds: NHS Executive.

Redwood, S. Carr, E. Graham, I. (2005) Perspectives on the Consultant Nurse Role. Institute of Health and Community Studies. Bournemouth University https://api.semanticscholar.org/CorpusID:153750934 Last accessed 8/2024

Royal College of Nursing (2024). The levels of nursing May 2024. https://www.rcn.org.uk/news-and-events/news/uk-rcn-defines-levels-of-nursing-beyond-registration-100524 Last accessed 7/2024

Slemon, A. (2018) Embracing the wild profusion: A Foucauldian analysis of the impact of healthcare standardization on nursing knowledge and practice. Nursing Philosophy. 19:e12215. https://doi.org/10.1111/nup.12215 Last accessed 8/2024

Tsandila-Kalakou, F. Wiig, S. Aase, K. (2023) Factors contributing to healthcare professionals' adaptive capacity with hospital standardization: a scoping review. BMC Health Services Research (2023) 23:799 https://doi.org/10.1186/s12913-023-09698-9 Last accessed July 024

Wootton, M. Davison, L. (2025) Responding to global emergencies: what has the role of nurses been and what can it be in the future? In Global Health and Nursing: a new narrative for the 21st century. Stilwell B. Ed. London UK. Elsevier

World Health Organization (WHO) (2020). State of the world's nursing: Investing in education, jobs and leadership. https://www.who.int/publications/i/item/9789240003279

'Strategic leadership is about navigating the uncertainties and complexities of health systems and achieving objectives while constantly learning from feedback and interactions with stakeholders.'

Strategic Systems Leadership

Key points

+ Systems leadership involves working beyond organisational boundaries with multiple stakeholders on issues of common concerns that cannot be resolved by any one individual or organisation.
+ The person being cared for is at the heart of many systems and the CNC must be able to recognise and negotiate the domains of systems leadership.

What is strategic systems leadership?

Systems leadership derives from the concept of systems thinking which means seeking to understand the world as an interrelated whole. Understanding health systems in this way is important as there are many stakeholders in the various elements of health systems, that have complex interactions which may not be predictable. Strategic leadership, which is one of the pillars of consultant nurse practice, is about navigating the uncertainties and complexities of health systems and achieving objectives while constantly learning from feedback and interactions with stakeholders.

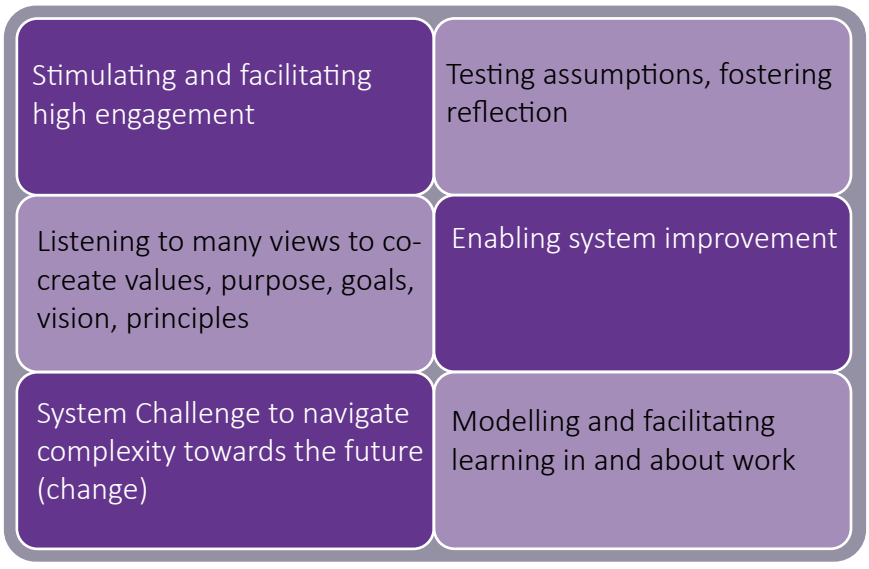
Manley et al., (2022) point out that systems leadership invites all stakeholders to participate in addressing issues, and systems leaders must facilitate cross boundary working, so that there is a shared vision of success with processes to support a shared goal.

This leadership perspective, based on systems thinking, is a required skill of consultant level practice because it can help organisations survive and thrive in today's uncertain and fast-changing times. The experience of the global pandemic made clear that rapid responses are essential to tackle system disruptions, as well as ways to include as many stakeholders as possible in planning and monitoring

what is happening so that approaches can be adjusted as needed. This is a vastly different style of leadership from the command and control, target-driven approach of that often-demoralised staff because it took away their voice and often authority in decision-making and there were many reported incidences of compassion fatigue (Ahmed, 2018). Lack of clinical engagement has led to failures in clinical governance which might have been avoided had the leaders of the organisation created an open environment in which staff felt valued and could learn from their mistakes – creating a culture of compassionate care (King's Fund, 2012).

Systems leadership involves working beyond organisational boundaries with multiple stakeholders on issues of common concerns that cannot be resolved by any one individual or organisation. This highlights the importance of listening to many views and being able to synthesise them to contribute to inclusive decision making. Not only does it involve working with multiple systems and cultures, but at the same time, acting as a change agent within systems to improve overall systems performance. Because systems are unpredictable and may have outcomes that have not been anticipated, one of the skills of system leadership is to test assumptions and learn from what has and has not worked – which encourages reflection in and on action. It is this reflection and continuous monitoring that leads to system improvement and innovation. Box 2 summarises the key components of systems leadership.

Box 2: Characteristics of systems leadership (NHSE 2023)



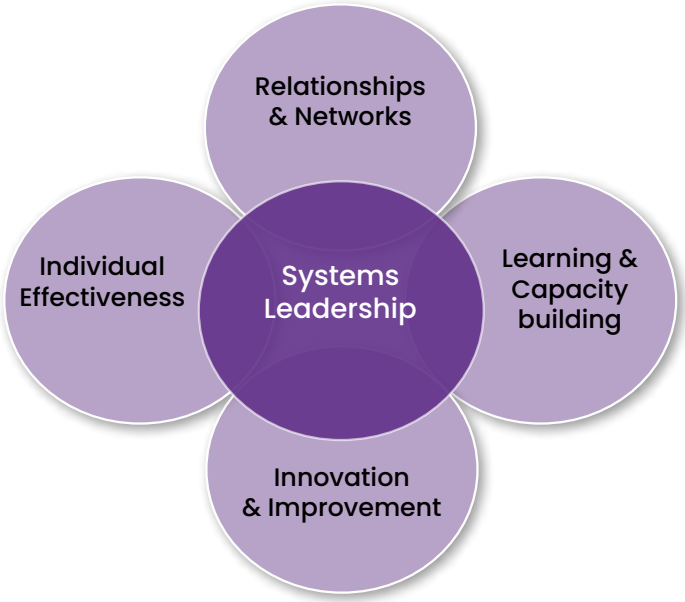
'Community Nurse Consultants are expected to use their skills in systems leadership to negotiate unified solutions for complex issues in healthcare with a multi-professional team.'

The Community Nurse Consultant's role in systems leadership

Manley et al.'s 2016 study of workforce enablers to improve urgent and emergency care found that a whole system approach was required to meet complex population healthcare needs, reduce duplication and waste and improve healthcare outcomes and patients' experiences. For this to be achieved emphasis was on holistic changes in structures, processes and patterns of the urgent and emergency care system. Systems leadership was found to be key to transformation because it drove integration across clinical boundaries so that there was shared purpose with the patient at the heart of care (Manley and Crouch, 2016). This study has clear relevance to the role of the CNC, whose work is equally, if not more complex because it involves many stakeholders beyond the professional arena, including patients, their families and communities.

Community Nurse Consultants are expected to use their skills in systems leadership to negotiate unified solutions for complex issues in healthcare with a multi-professional team. The NHS leadership academy (2017) developed a framework (shown in Box 3) to show the domains of system leadership.

Box 3: Domains of Systems leadership (adapted from NHS, 2017)



This framework has four domains which interconnect and together create the conditions for good systems leadership, including collaborative working across organisational boundaries. Each domain has roles that are necessary to build systems leadership and underpinning these roles are behavioural descriptors that are required for success (NHS, 2017). The behavioural descriptors are:

Individual effectiveness:

CNCs can demonstrate the effectiveness of their role within and outside the organisation and can promote system resilience and develop and encourage collaborative and innovative approaches to problem solving. For CNCs, the goal of their role effectiveness is to promote the health of individuals, families and communities.

Relationships and networks:

Critical to success is the ability to create and sustain relationships with the many stakeholders involved in community healthcare including community members. CNCs can lead the creation of a shared vision with the goal of developing a team-based approach to tackle complex issues together.

Innovation and Improvement:

Recognising patterns in systems and consistently seeking feedback on what works and what is unexpected leads to the creation of new ways of doing things. CNC systems leaders learn through constant quality improvement initiatives that test out new ways of practicing and thereby spread new knowledge.

Learning and capacity building:

CNCs can support organisations and teams to create learning systems modelling a culture of transparency and sharing, CNCs practice an inclusive leadership approach to develop talent at all levels. CNCs demonstrate clinical leadership to improve healthcare performance by positively influencing others to continuously improve the quality of care.

CNCs can operationalise the behaviours detailed above by using the menu of interventions outlined in Box 4. These interventions are readily available and are hallmarks of systems leadership.

Box 4 Menu of interventions (NHS Leadership Academy, 2017)

Individual Effectiveness	Relationships and Connectivity	Innovation and Improvement	Learning and Capacity Building
Leadership Development Programmes	Facilitated Group Conversations	Leading Complex Change	Talent Development Approaches and Interventions
Coaching and Mentoring	Action Learning Sets	Designing and Leading Agile and Lean Services	Developing Diverse Community Engagement/ Social Movements

Developing Inclusive Mindsets and Behaviours	Team and Group Coaching	Quality Improvement Skills	Systems Thinking and Collective Leadership
Skills Development Workshops	Holding Courageous Conversations	Innovation through Thinking Differently	Effective Knowledge Sharing
Shadowing, Buddying, Exposure to Different Roles and Environments	Conferences and Masterclasses		
Individual Diagnostics	Supporting Network Development Team and Group Diagnostics		

The impact of CNC systems leadership

To further develop the role of CNCs and to garner support for their role, it is imperative to demonstrate the impact that they can have through their skilled systems leadership. There have been several reviews of the impact of nurse consultants (Woodward et al., 2004, Coster et al., 2006, Kennedy et al., 2011). There is limited evidence that evaluates the impact of nurse consultants on patient and professional outcomes, though there is some evidence of the range of areas

that nurse consultants potentially influence. Many studies have so far been small scale and qualitative and although there are often positive results, these cannot easily be generalised across different settings or populations (Kennedy et al., 2011).

Importantly, there have been no studies that have captured the cost-effectiveness of nurse consultant roles generally, nor CNC roles in particular. In the current climate, where one needs to demonstrate value for money, and value to healthcare services of new nursing roles, this lack of research is a significant omission. Further research is also needed to measure the impact of CNC's work on patient outcomes, including measures of satisfaction with care.

To understand the full potential and impact of the CNC role, it is important for continuing evaluation to show how the role can drive change and innovation while improving patient and staff satisfaction, and the promotion of safe care. This comprehensive evaluation is not easy, and it is suggested that evaluations are planned at the start of employment of a CNC, to capture the role characteristics, and to use both quantitative and qualitative measures to show impact. In addition, it is helpful to workforce planners to show the barriers to implementing the role of CNC. Previous research has shown barriers to include clarity in the role description and resistance of colleagues (Taylor and Wiseman, 2020).

Conclusion

A CNC brings skills in systems leadership that enables them to negotiate the often-complicated process of working across boundaries and professional groups. To date, nurse consultants have introduced new services to meet discrete patient or community needs, using their leadership skills. (Redwood et al., 2007). Some of the difficulties identified in achieving change and using systems leadership skills were organisational barriers, such as lack of recognition of the role, and heavy workloads. CNCs need robust support mechanisms and organisational infrastructure to help them realise their full potential as systems leaders.

Case study 1

Dr Annie Cox, CAMHS Consultant Nurse and Approved Clinician, Derbyshire Healthcare NHS Foundation Trust

'I pride myself on my leadership element of my role. I am a local and national clinical leader and need to be to provide the care for my patients but to also develop nursing practice for Children and Young People (CYP) Mental Health

'By leading in these spaces, it enables me to be a conduit for the transfer of information from the proverbial shop floor to a national level and vice versa'.'

(MH). I am chair of the CAMHS Consultant Nurse Network and co-chair of the MH consultant nurse network, developing and progressing the MH consultant nurse voice across the health care system and beyond. I also sit on the RCN MH Forum steering committee developing and supporting work for CYP MH nursing. I am co-chair of the children and families significant interest group (CAFSIG) for the British Associate of Behavioural and Cognitive Psychotherapists (BABCP) which enables me and the SIG to develop best practice and develop training opportunities for therapists working with CYP. By leading in these spaces, it enables me to be a conduit for the transfer of information from the proverbial shop floor to a national level and vice versa'.

Case study 2

Jane Mulcahy, Consultant Nurse for Children's Community Nursing & Complex Care, Specialist Practitioner in Community Children's Nursing, Sussex Community NHS Foundation Trust

'My role was created 3 years ago to sit alongside the new organisational structure where Heads of Service became general managers with no requirement for a clinical registration. The Consultant Nurse role was therefore intended to provide a high level of clinical expertise and professional leadership. This spans two different services managed by different general managers, as well as offering professional advice to other services in the trust where children and young people are cared for e.g. Minor Injuries Unit and Child Development Services. I attend key strategic meetings to advocate and influence regarding the needs of children/young people and their families within the trust steering groups for; Deteriorating Patient and Resuscitation; End of Life Care; Tissue Viability; Healthcare Transition; Clinical Advisory Group; and Advanced Clinical Practice. I am also actively involved in national work including: QNI, CCN Network meetings and their associated subgroups; NHS England Clinical Skills in Education; CYPACP Collaborative Steering Group; Association of Chief Children's Nurses.'

Case study 3

Name TBC

I'm embedded in a regional cancer team. It's a unique role and has evolved out of a preprogramme of work in London where we've focused on primary care nursing as a key workforce to support people living with and after cancer.

At the moment I'm working with the national primary care nursing team and other primary care nurses to develop an education resource for General Practice Nurses (GPN). It's a complex piece of work as its based around the GPN core competency framework but we also need to ensure alignment with the core cancer capabilities framework within the aspirant cancer career and education development

programme (ACCEND.) This is due to be published next month so there are daily email exchanges and comments on our working draft.

Over the next month I have a series of education commitments through a collaboration with Central London Community Health Academy, providing cancer education to care home nurses and carers. It's an adaptation of a previous programme we delivered across London to community nurses, GPNs and AHPs. The care home sector has proved far more of a challenge to reach, and to deliver training to due to its fragmentation and multiple mostly private providers. We plan to evaluate our intervention and identify key learning and education needs for this sector in relation to cancer.

I'll also be working on planning for the London Regional Cancer Community of Practice events (CoP.) This CoP focuses on cancer in the context of out of hospital care, and opportunities for integration. Our members are GPNs, Community Nurses and AHPs, and secondary care based Clinical Nurse Specialists and AHPs and patients. We bring this diverse workforce together at face-to-face events and webinars. This takes about one day a week of my time as the clinical lead.

As a unique role in London and nationally I frequently am asked to be involved in strategic work and projects. I represent primary care nursing and cancer on a number of strategic groups such as the community nursing leaders group, personalised cancer care board for London and London lead cancer nurse forum.

Clinically I work a day a week in primary care as an advanced nurse practitioner. This is important for me to stay connected to the reality of clinical practice, and its opportunities and challenges, and I believe essential as a clinical leader to maintain clinical credibility.

Commentary

In all of these case studies – which are from diverse practice specialities – it is evident that relationships and networks have been fostered. In Case Study 1 the nurse chairs or co-chairs many committees and says of her work: 'By leading in these spaces it enables me to be a conduit for the transfer of information from the proverbial shop floor to a national level and vice versa'. This illustrates the strength of systems leadership: it highlights the nursing contribution and facilitates working at all levels of the health system. In Case Study 2, the emphasis is on information garnering and sharing between two services and advocating for a client group: 'I attend key strategic meetings to advocate and influence regarding the needs of

'CNCs have a particular role to play through raising awareness about the sustainability agenda with our colleagues across the health and social care system, as well as the communities we serve.'

children/young people and their families within the trust steering groups.'

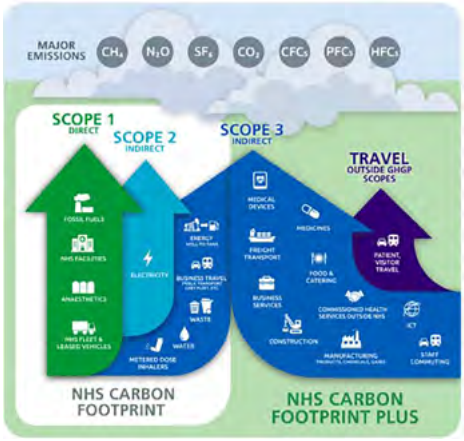
In Case Study 3, the networking is between education and practice for GPNs especially, but also involves links to regional groups: 'I represent primary care nursing and cancer on a number of strategic groups such as the community nursing leaders group, personalised cancer care board for London and London lead cancer nurse forum.' This CNC also continues clinical work 'to stay connected to the reality of clinical practice'.

These three case studies demonstrate the application of the systems leadership model to CNC leadership showing that it can be seen through innovation, education, relationships and networks and linking learning and practice.

The final system – planetary health: nursing's contribution to a sustainable planetary future

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the Health and Care Act 2022. The Delivering a Net Zero National Health Service report (NHS, 2022) is now issued as statutory guidance.

Figure 1: The Greenhouse Gas Protocol scopes in the context of the NHS (NHS, 2022)



CNCs have a particular role to play through raising awareness about the sustainability agenda with our colleagues across the health and social care system, as well as the communities we serve.

It is currently estimated that greenhouse gases attributable to the NHS in England account for 4% of the UK total; globally healthcare has a significant climate footprint of 5%. In England, the three key sources of carbon emissions in healthcare delivery come from prescribing, healthcare settings (as hospitals use considerably more energy and water than community-based care), and travel.

Climate change and global warming present many challenges to health, in particular the threat posed by the impact of poor air quality, extreme weather episodes, reduced biodiversity, emerging infectious and communicable diseases, which all directly influence the health of our communities (ICN, 2018). We know it is the most vulnerable groups in society who are disproportionally affected, increasing health inequalities across the UK. Nurses make up the biggest workforce group and yet a recent study showed that whilst there was some awareness of climate change and the impact on population health, nurses were not aware of the impact of nursing practice and healthcare on emissions and therefore climate change (Akore Yeboah, Rodrigues Amorim Adegboye et al., 2023).

The complex systems in which people live include social, personal and environmental – and this includes the impact of environmental changes on health. Nurse consultants, as system leaders, with an understanding of what most impacts people and communities, have an opportunity to contribute to implementing strategies that mitigate against environmental degradation. These may include recycling, introducing traffic free areas, or simply the realisation that a child living on a busy main road will be affected by traffic emissions and this has to be factored into any health assessment.

The International Council of Nurses (ICN, 2018) has stated that: ‘Nurses can make a powerful contribution to both mitigate climate change and to support people and communities around the world to adapt to its impacts. Leadership from nurses to take immediate action to build climate resilient health systems is necessary. This includes, but is not limited to, developing models of care to reduce unnecessary travel, developing climate-informed health programmes for emerging infectious and communicable diseases; engaging in sustainable practices in the health sector, building the response capacity of the health workforce; engaging in health

‘It is currently estimated that greenhouse gases attributable to the NHS in England account for 4% of the UK total; globally healthcare has a significant climate footprint of 5%.’

and climate research, and participating in intersectoral policy and governance responses.'

CNCs, through their systems leadership, can support colleagues to learn, innovate and embed sustainable development into everyday actions, recognising that everyone has a role to play. They can assist in fostering a shared vision and sense of joint responsibility in community teams for attention to planetary health and reaching the NHS net zero targets.

References

Ahmed, F. (2018).Leadership and management influences on personal and professional development and group dynamics: a student's experience. Nursing Children and Young People, 30(2), 40-45.doi:10.7748/ncyp.2018.e1027.

Akore Yeboah, E. Adegboye, ARA. Kneafsey, R. (2023) Perceptions, attitudes, awareness and perspectives towards sustainability practices and climate change among nurses: a systematic review protocol. BMJ Open. Oct 5;13(10):e071965. doi: 10.1136/bmjopen-2023-071965. PMID: 37798033; PMCID: PMC10565322.Last accessed January 2025

Heath Education England (2020) Multi-professional Consultant Level Practice Capability and Impact Framework available at URL Report template (hee.nhs.uk)

International Council of Nursing (2018) Nurses, Climate change and health. Position Statement https://www.icn.ch/sites/default/files/inline-files/ICN%20PS%20Nurses%252c%20climate%20change%20and%20health%20FINAL%20.pdf Last accessed January 2025

King's Fund (2012) Leadership and Engagement for Improvement in the NHS: Together We Can. The King's Fund, London.

Manley and Crouch (2020) Toward Multi-professional Consultant Practice: a potential career pathway for Advanced Practitioners. Health Education England Advanced Practice Conference November.

Manley, K. Crouch, R. Ward, R. Clift, E. Jackson, C. Christie, J. Williams, H. and Harden, B. (2022) The role of the multi-professional consultant practitioner in supporting workforce transformation in the UK. Advanced Journal of Professional Practice, 3(2), pp.1-26.

NHS England (2022) Delivering a 'Net Zero' National Health Service. https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/

NHS England, NHS impact (2023) Building a shared purpose and vision available at URL NHS England » Building a shared purpose and vision

NHS Leadership Academy (2017) Developing Systems Leadership Interventions, Options and Opportunities. www.leadershipacademy.nhs.uk Last accessed 9/2024

Rosser, E. Grey, R. Neal, D. Reeve, J., Smith, C. Valentine, J. & Brookman, K. 2017, "The consultant practitioner: an evolving role to meet changing NHS needs", British journal of nursing (Mark Allen Publishing), vol. 26, no. 19, pp. 1065-1069.

Conclusion

CNCs significantly enhance healthcare teams through their expertise, leadership, and ability to adapt to complex healthcare environments. Their role is crucial in improving healthcare accessibility, implementing policy at multiple levels, and advocating for sustainability in healthcare practices. However, for CNCs to realise their full potential, structural support, professional recognition, and clear career pathways must be prioritised. This handbook serves as a comprehensive resource for understanding, implementing, and advancing the CNC role in modern healthcare.

By strengthening the role of CNCs, healthcare systems can ensure high-quality, person-centred care that meets the needs of diverse populations while fostering innovation and sustainability in community health.

Acknowledgements

There were significant drivers after the Covid-19 pandemic to showcase the importance of community nurse consultants (CNC). During the pandemic, clinical nurses had stepped in to lead complex services and ensure high quality outcomes for patients and families. Nurse consultants led and provided safe and effective services, preventing admissions, across multiple complex situations and services to ensure patient's access to medicines, services and outcomes were maintained. A working group was developed to locate community nurse consultants, specifically those working in frailty services, children's services, but others too, across England. The purpose in bringing the group together was to create a handbook that set out the work of a CNC, with guiding principles for standardisation of the role. The chapters in this handbook grew out of learning and sharing together as a newly formed community nurse consultant group.

'By strengthening the role of CNCs, healthcare systems can ensure high-quality, person-centred care that meets the needs of diverse populations while fostering innovation and sustainability in community health.'

This handbook was produced with input from the CNC group, listed below. They worked over several months to create the concept for the first draft of

this handbook and their words resonate throughout. Thanks go to all of them for their invaluable work that breathed life into this important contribution to understanding the role of the community nurse consultant.

The author team included Barbara Stilwell, Crystal Oldman, Emma Shipley and Karen Storey. Agnes Fanning was a critical reader.

Abigail Barkham
Abigail Levison
Alexandra James
Alison Keizer
Ann Palmer
Anna Chainey
Anne Motley
Anwen Collard
Ayesha Marshall
Caroline Game
Caroline Jones
Catherine Evans
Catriona Logan
Claire Maidment
Clare Robertshaw
Cliff Kilgore
Deepa Devadas
Donna Little
Emma Hanrahan
Emma Matthews
Emma Neal
Erin Gallagher
Fiona Springham
Gary Cleeve
Georgina Littlejohn
Jacqueline Pollington
Jane Mulcahy
Jane Young
Joanne Holland
Kay Rumsey
Kerry Bareham
Lisa Kay
Liz Gilbert
Lucy Lewis
Lynn Macdiarmid
Lynn Salmon
Mandy Waldon
Matthew Morrissey
Natasha Dalton
Nicole Edwards
Paula Berridge
Philippa Nash
Rachel Mills
Rebecca Hyland
Sadie Campbell
Sam Sherrington
Samantha Head
Sarah O'Brien
Shelley Ripper
Theresa Maddison
Victoria Williams
Vivian Zinyemba

ANNEXE
Case studies from Community Nurse Consultants

Case Study 1

Becky Hyland, Heart Failure Nurse Consultant Practitioner, Wiltshire Health and Care

There are approximately 1 million people living with Heart Failure (HF) in the UK [1]. Wiltshire has an approximate population of 510,400 people [2], it is estimated that the prevalence of HF is 16.1 per 1000 population with the Banes Swindon and Wiltshire Integrated Care Service (BSW ICS) [3] and prior to 2022 only the southern third of the Wiltshire was supported by a community HF service.

To reduce health inequalities and ensure that all people living with HF receive evidence-based care that is evidenced to improve quality of life, reduce mortality and morbidity (ESC), my team was established.

I have been a cardiac nurse my entire career, working in tertiary, secondary and now community organisations. It was a research nurse role working on a cardiomyopathy clinical trial that honed my interest in HF specifically, specialising in 2015; and becoming a nurse consultant in 2022. Working with people living with HF, you have the privilege of supporting from diagnosis, treatment, through to palliative care and the chronic nature of this condition means you may know people and their families for many years, which is very special.

As I reflect on the consultant nurse role within the community heart failure service within Wiltshire Health and Care, the following themes emerge.

Strategic and Enabling Leadership- At a local level this role was crucial bringing together a group of new practitioners into a service and establish care pathways, ensure governance within the team, and develop competency. As a new service within the portfolio of care provided in the community, being a clinical leader, and advocating for the service and patients to ensure best practice was paramount. The chronic nature of HF means that often patients are shared with other specialist clinical teams, so establishing MDT and collaboration provides support and learning opportunities for others, and advocates for the patient. Regionally, I provide clinical supervision to neighbouring community HF nurses, developed an BSW ICS HF nurse forum which enables networking and educational opportunities throughout the care pathway, and collaborated with Dorothy House Hospice as they established a HF nurse within their organisation. Nationally, I have the privilege of being the Deputy Chair of the British Society for Heart Failure (BSH) Nurse Forum and an elected trustee on the BSH Board.

Research and Innovation – I have bought research opportunities to the organisation, working with NHS England and with research and development teams from the neighbouring hospitals. I am a member of a steering committee for a national NIHR and BHF funded HF registry study. This year I was asked to be one of two clinical leads for heart failure with Health Innovation Wessex, looking to bring evidenced based care and innovation to the region.

Learning, Development and Improving across the System – HF care is a highly evidence-based and ever-changing landscape and this role has led to educational opportunities across the ICS, with webinars and face to face educational opportunities from secondary through community and into primary care. I have also had the opportunity to present at conferences nationally and internationally on heart failure, promoting the role of HF specialist nurses in improving outcomes for people living with HF.

Expert Practice: establishing specialist diagnostic and clinical management HF services across a large county has ensured that people have early diagnosis local to their home. Consultancy with the three hospital trusts that surround the county has ensured good clinical governance and referral into and out of other specialist services when appropriate.

References:

1. BHF (2024) UK Factsheet BHF.org.uk
2. ONS (2024) https://www.ons.gov.uk
3. Fighting Failure (2020) (www.fightingfailure.org.uk)
4. McDonagh, T. (2021) ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: Developed by the Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC) With the special contribution of the Heart Failure Association (HFA) of the ESC, European Heart Journal, 42 (36): 3599–3726, https://doi.org/10.1093/eurheartj/ehab368

Case Study 2

Kay Rumsey, Consultant Nurse for Community Nursing, North East London and South West Essex, Organisation: NELFT

Introduction

The NELFT Nurse Consultant for Community (District) Nursing is a new role established in February 2024 for 12 months. This position covers all physical health community (district) nursing teams across North East London and South West Essex. My substantive role is Head of Service for two busy Integrated Care Teams (ICT) in South West Essex. I have been a registered nurse for over 30 years, with 22 of those at NELFT, working in Community (District) Nursing.

I'm passionate about community nursing and proud of my colleagues and the work they undertake on a daily basis. Throughout my 34-year career, I've thrived in both operational and leadership roles, using my experience to support nurses and lead complex teams. However, like many in healthcare, I've experienced burnout due to the growing demands and lack of clear processes and pathways. As nurses, we deeply care about the people we serve, making it difficult to step away even when exhausted. I knew change was necessary but found little time to reflect or innovate in my current role. When I saw the opportunity to apply for Nurse Consultant for Community Nursing, I seized it (once I quietened down my inner critic!).

This role was designed to improve service quality and reduce variation across North East London (NEL) and South West Essex, which is part of the Mid and South Essex Collaborative, (MSE). My aim is to maximise resources and align with our organisational strategy to deliver the best care possible for our patients and reduce the gap between strategic thinking and workforce capabilities.

Nurse Consultant Role Impact (1-9 months in post)

As a Nurse Consultant, I am a senior clinical expert in community nursing, though I'm still figuring out exactly what that means! I am responsible for supporting senior nurses and operational leads with complex case discussions. My work focuses on learning from patient safety issues identified through incident reports and investigations, such as equipment failures, dementia, frailty, continence, end-of-life care, diabetes, pressure ulcers, and more. I work to address these recurring themes and promote improvements in community care through strategic leadership and collaboration with district nursing teams and avoiding the trap of not listening to what our patients are telling us.

The role demands advanced clinical practice, leadership, education, and research, underpinned by education and experience. It's crucial to equip community nursing staff with the skills, knowledge, and behaviours to deliver safe, person-centred care, especially given the growing demand on services. Projections for North East London show a 72% increase in demand for community services over the next 17 years, highlighting the need for new approaches to manage this pressure effectively.

Key Initiatives

A major focus of my role in the first 9 months is addressing the rising demand for diabetes care, which remains one of the key priorities for NHS England. Many patients on District Nursing caseloads require frequent support, and this strains the capacity of Integrated Care Teams. One of the key initiatives I've led is a pilot project to recruit Specialist Nurses in diabetes, aiming to reduce caseloads by identifying patients who can self-manage their care. This initiative has already shown early promising results, with fewer patients needing daily District Nurse visits and more being empowered to manage their own conditions.

We're also working on a delegation of insulin administration policy for non-registered practitioners, to provide additional support in care homes. This will allow non-registered health and care workers to administer insulin to adults with stable Type 2 diabetes, expanding the scope of community care. Our efforts aim to:

- Reduce the number of patients requiring daily District Nurse visits
- Increase the number of patients able to self-manage their care
- Boost overall capacity within District Nursing services
- Decrease complications from long-term conditions.

By adopting a collective leadership approach aligned with NHS England priorities, including the Darzi review and the NHS 10-year plan, we can drive sustainable improvements in community services to better serve our expanding patient population. A key focus is on reducing health inequalities, a core NHS England goal, by leveraging the nurse consultant role to improve service access for underrepresented and vulnerable groups. Patient and user engagement will be central to these efforts, fostering a collaborative approach that shapes health services to be responsive to patients' needs, values, and preferences. Engaging patients not only enhances satisfaction and improves patient outcomes but also builds trust and transparency within the healthcare system.

One thing is clear: as a Consultant Nurse, boredom is never an issue! The variety and pace of the role keep me constantly engaged, and I'm excited about the opportunity to continue shaping the future of community nursing.

Watch this space for the next 12-18 months in the role.

Case study 3

Lucy Lewis, Consultant Practitioner (Registered Nurse), Frailty & Older People Hospital at Home Wiltshire Health and Care @WiltsHC_NHS

A case study of transformational leadership within the context of setting up a new Hospital at Home service in Wiltshire.

The Consultant Nurse in Hospital at Home

I am a Consultant Nurse specialising in Frailty and Older People. I completed three years with the Health Education England Consultant Practitioner Development Programme. (Nearly three years in Southwest Hampshire Frailty Support Team, before moving to Wiltshire Health and Care to work alongside Consultant practitioners, Advanced practitioners and operational colleagues to establish our Hospital at Home service.) The organisation embraced the concept of consultant practice from 2020 in Frailty, rehab (in patients), community Home First and heart failure. Other areas had led the way with consultant practitioner led Frailty virtual wards/Hospital at Home services and NHS England guidance advocated that clinical

leadership could be a Consultant Physician, e.g. Geriatrician/GP, Nurse or Allied Health Professional.

Expert practice filters into all that we do

It is a common misconception that Consultant practitioners should work 60% clinically, providing face-to-face 'hands on' assessment, diagnosis and person-centred care planning with the individuals we work with. Whilst our Advanced practice colleagues will often be specifically employed to be 80-90% clinically facing, the Multi-professional Consultant level practice framework uses the term 'Expert practice' as opposed to 'clinical pillar'.

Being a specialist in Frailty and older people, I can bring this knowledge and experience of working across numerous settings to all workstreams within our service, the organisation, wider system, regional and national groups. My expertise as a consultant nurse specialising in frailty and older people feeds into working with system partners when supporting individual people, and those closest to them, who are living with complex health and social needs. It informs how as system partners we work to meet the needs of the local population, helps shape service development and quality improvement projects, has given me insight into my own nurse-led research and how I interpret published evidence, ensures I share my knowledge with others in informal and formal education forums, and influences local guidelines, policy and national guidance I contribute to. It also gives me confidence in my own competence when approached to give expert opinion on subject matters such as acute care at home or vaccinations in the older population, and how I support others to grow as advanced and consultant practitioners.

Leadership learning

The Health Education England Consultant Practitioner development programme gave me the time, space and access to expert coaches to help me grow as a leader. I have had several mentors who have seen my potential and helped me reflect. Through constructive and nurturing feedback, I now understand my personality type better and this has the potential to enhance situations where I lead, but also how my 'blind spots' can impact negatively. "Holding up the mirror" is a great phrase if you are courageous enough to acknowledge and address your growth areas in order to become a better leader. Critical friendship and psychological safety with consultant peers whom I trust to be honest about where I can improve, reframe, rephrase, whilst still accepting me for who I am, has been empowering and invaluable to my continued consultant practice development.

I first undertook a Myers-Briggs exercise in 2013 when I was completing the Transition to Advanced Practice module as part of my MSc in Advanced Practice. I later repeated this with Health Education England on the Lead and be Led programme. I am an ESFJ (Extroversion, Sensing, Feeling, Judging) type, and as a trainee ACP, I learned about myself and what this means. As a trainee Consultant

practitioner, I reflected upon what this personality type means for me, colleagues I work with and me as a leader. Now, as an established and experienced consultant practitioner, I continue to see how I use my personality type as a strength. I am encouraging, charismatic and hard working; however, my eagerness to take charge and meet goals in a structured and orderly way, coupled with the high expectations I have for myself and our team, can have a negative impact on productivity and team culture.

During the pandemic I was employed in my first consultant nurse post. I used this opportunity to consolidate all I had learned on the HEE programme in an established service which had been consultant practitioner led since its commencement in 2017. By January 2023, I was ready to take on the challenge of establishing a new Hospital at Home service with consultant practitioner colleagues in a county which did not have one, in response to national policy directives. Establishing a new service and building a team has brought challenges and opportunities. Many of our existing colleagues had change fatigue from adapting to role changes and ever-changing service needs in response to local, regional and national agendas.

Applying aspects of Appreciative Inquiry, an asset based approach to healthcare (and all walks of life) Appreciative inquiry | Knowledge and Library Services (hee.nhs.uk) has helped my colleagues and I recognise key achievements whilst acknowledging our learning of how we can do things differently in the future. Influencing change in the workforce model, working with system partner organisations, to bring our four separate approaches to delivery, we agreed on a ‘one model’ Hospital at Home model.

I have reflected upon the last twenty months often. My enthusiasm for Hospital at Home, improving frailty services and being evangelical about Consultant Practice has been met with positivity from colleagues However, I recognise that at times, when things are not moving in the direction I would wish, I have become frustrated and vocal. This meant resorting back to the NHS comfort zone of a deficit-based approach, rather than practicing gratitude for all that has gone well since I arrived in our organisation and we have set up our service. There is so much to rejoice about! We have come such a long way as a team. Our co-ordinators, nursing associates, trainee and qualified Advanced practitioners, project leads, pharmacists, mental health practitioners and wider community system colleagues have all influenced our success. The expert practice, depth and breadth of all our consultant practitioners, whose backgrounds are richly diverse, has added to our leadership offer both internally and across the system.

Impact of Consultant level practice

We have often been asked, “What is the impact of employing Consultant Practitioners?” “How are you different to medics?” and “What do you do that

Advanced Practitioners don't do?". Put simply, it is the difference between the four pillars of Advanced practice, with emphasis on clinical compared to the consultancy skills which we apply across our four (intentionally differently worded) domains, working at micro, meso and macro level. In only 20 months, our Consultant Practitioners within Hospital at Home have presented at National and European conferences, contributed to national guidelines, blueprints and policy, published articles and supported the development of Advanced Practitioners across their four pillars., This has meant particularly increasing clinical knowledge through supervision and also encouraging and mentoring, to publish and disseminate their own service development and research projects. We have worked alongside our operational, quality and transformation colleagues to influence what is required to deliver our service, whilst collaborating with provider organisations across the system and NHS England Regional colleagues to ensure our model aligns with the national ask.

Designing a system-wide Frailty pathway and developing Frailty education within our organisation

Now that our fledgling Hospital at Home service is established, I have the opportunity to look beyond reactive, urgent and acute care at home. Alongside an Advanced practitioner colleague in another provider organisation within our system (a Hospital) and a Consultant Practitioner colleague working within NHS England regionally, we are seeking to work collaboratively with colleagues across health and social care in our Integrated Care System to develop a frailty pathway. This will include looking at primary, community, acute, proactive, reactive services and will include the voluntary sector, the ambulance and social services, in addition to hearing and amplifying the voice of the people who use these services and who are therefore most affected.

Within my organisation, I am working with colleagues to review, update and broaden our frailty education offer across the board, providing resources appropriate to the roles people have within the specific services they work in. This compliments the Associate Professor role I have with the University of Coventry where I teach Frailty/Comprehensive Geriatric Assessment and leadership How can identifying and grading frailty support older people in acute and community settings? (rcni.com) to post registration students. It builds on the work I have done previously with the Wessex Academic Health Science Network Acute Frailty Audit Wessex Acute Frailty Audit: applying quality improvement methodology to design and implement a regional frailty audit using a collaborative, multiprofessional approach | BMJ Open Quality and complements the workstreams I have influenced as former chair of the British Geriatrics Society Nurse and AHP Council, as BGS Policy and Communications rep, and as current Nurse and AHP rep on the BGS Frailty and Urgent Care Special Interest Committee Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society (bgs.org.uk).

Case Study 4

Dr Annie Cox, CAMHS Consultant Nurse & Approved Clinician, Derby City CAMHS

My work is in community CAMHS (Child and Adolescent Mental Health Services) and my role is quite varied. The mainstay of my work is providing the consultant level care for children and young people (CYP). This will involve the assessment and treatment of CYP and directing care provision. I also provide some individual CBT for CYP as I enjoy the more frequent support I can offer to CYP. When assessing and treating children outside of CBT, this may include undertaking and ordering physical health investigations such as blood tests or ECGs; it also involves prescribing medication and advising of therapeutic interventions to inform the care plan. I will also review children who have commenced medication and will be responsible for reducing and titrating the medication, alongside completing the necessary physical health reviews required for this.

Another part of my clinical role involves being the responsible clinician for children detained under the Mental Health Act (MHA) (1983) at our local hospital Trust. In the geography I work in, we do not have a local inpatient unit, so more often now CYP, when detained, are usually taken to the local hospital Trust before an inpatient bed can be requested from neighbouring areas. This role is distinct in the MHA 1983 and was made an option for Mental Health Nurses in the 2007 review of the Act. As a responsible clinician, I am responsible for the assessment and treatment of a CYP under the MHA and ensure that the right care for CYP is provided to reduce the Mental Health distress. All my clinical work requires me to work across the system; I work alongside CAMHS team members, pharmacists and paediatricians, staff on the ward and other local and regional organisations to ensure the right care is provided for the CYP and family. Ensuring the CYP and family is central to the care planning process is imperative to positive outcomes. For training and education, I have several inclusions: I am admin support for prescribing in the mental health team, which is a forum set up that prides itself on providing free half day webinars (once a quarter) offering continuing professional development for anyone with an interest in prescribing and associated topics. I teach at my local university undergraduate nursing programmes and the CBT course. I provide in-house training for staff and also undertake ad hoc training for a range of other organisations and teaching establishments.

I pride myself on my leadership element of my role. I am a local and national clinical leader and need to be, to provide care for my patients but to also develop nursing practice for CYP Mental Health. I am chair of the CAMHS Consultant Nurse Network and co-chair of the Mental Health consultant nurse network, developing and progressing the Mental Health consultant nurse voice across the health care system and beyond. I also sit on the RCN Mental Health Forum steering committee developing and supporting work for CYP MH nursing. I am co-chair of the children

and families significant interest group (CAFSIG) for the British Associate of Behavioural and Cognitive Psychotherapists (BABCP), which enables me and the SIG to develop best practice and develop training opportunities for therapists working with CYP. By leading in these spaces, it enables me to be a conduit for the transfer of information from the proverbial shop floor to national level and vice versa.
I consider myself a clinical academic, I am an active researcher and have a number of publications and even edited a book to help parents manage the anxieties of their children. (ORCID ID 0000-0002-8399-8050). My most recent research was afeasibility study around improving the diagnosis of social anxiety for young people by using 360 degree video and biometric feedback; this has recently been published and can be found here: https://onlinelibrary.wiley.com/doi/10.1111/inm.13499. By being involved in research and up to date with practice, this ensures that I am with the heartbeat of developing practice which informs my clinical care.

Case Study 5

Ann Palmer, Consultant Nurse, Solent NHS Trust

A Day in the life of a Consultant Community Nurse

I am based in Southampton and work closely with community nurses, urgent response teams and long-term therapy. I generally work 9 am – 5 pm Monday to Friday, but there is a level of flexibility in this to be able to attend meetings. This is an example of one of my working days.

Morning: 9 am – 12 pm Clinical focus – Working in Urgent Response overseeing frailty virtual ward (VW). This involves reviewing each patient from the previous day and formulating a care plan; assessing the new patients referred to the service from the previous day; requesting diagnostic tests; formulating a care plan and deciding whether they should stay on VW. I have to approve any diagnostic tests, that I or others have requested that day.

Afternoon: 12.30 – 2 pm Learning and development focus – Carrying out an appraisal of one of the Trainee Advanced Clinical Practitioners (TACP) which also involves reviewing their learning needs analysis, review their objectives for the next year and the discussion of the quality improvement project.

2 – 3 pm Learning and development plus service development focus – Updating and discussing the progress of another TACP in another service line. Support and advise the supervisor of her roles and responsibility, as this is the first time they have completed this role. Planning for another TACP who will start later in the year.

3 – 4 pm Practice and service development focus – Integrated Template update meeting. In January we launched an integrated template that is a data collection form that can be used by a multi-professional team to collect patient information and therefore avoid duplication of patient questioning. Each month we review how

this is going and make any amendments to the template from feedback received from the teams.

4 – 5 pm Professional leadership focus – Meeting with Consultant Geriatrician from acute hospital to discuss falls pathway in community setting.

5 – 5.30 pm Clinical focus – Checking in to Urgent Response Service with outcome of diagnostic teams reviewed that day, updating clinical records.

Feedback from Operations Director
Coming into the organisation into a position that was new and developing must have been a real challenge. However, looking back on the impact of the Consultant Nurse role, but in particular the contribution to the development of the services within her portfolio, it is striking how much we have moved things on in terms of quality, governance, efficiency and workforce. The Consultant position sitting alongside the operational senior manager for integrated care has brought clinical stability and oversight over a wide number of services. More importantly it has helped with bridging those services, so that the workforce has the tools to operate flexibly and fluidly putting the patient at the heart of the services.

The role provides oversight over a wide range of services, sometimes diving into the detail and providing expertise sometimes working more broadly at a system level to help shape and deliver strategic objectives working with the OD, CD and HQP. In terms of this role and the success, that comes down to the individual drive, enthusiasm and interpersonal skills; she builds rapport and is able to get the most out of people and situations. Additionally, the CNC is getting more involved from a strategic point of view, both regionally and nationally and this bodes well, particularly as we have wide ranging projects such as the new Rehab centre which will inevitably cut across many services.

Case Study 6

Jane Mulcahy, Consultant Nurse for Children's Community Nursing & Complex Care, Specialist Practitioner in Community Children's Nursing, Sussex Community NHS Foundation Trust

A Day in the Life of a Consultant Nurse

I am a Consultant Nurse for Children's Community Nursing and Complex Care in Sussex working in a community trust across a large geographic area that incorporates four Community Children's Nursing teams, a Children's Continence service, and Special School Nursing. The latter includes a specialist, residential school for children and young people up to the age of 25 years with neuro-disability and medically complex care, and a Children's Short Breaks Unit. Core elements of my role relate to system leadership for palliative and end of life care; healthcare transition to adult services; and the management of medically complex

care in the community setting including within education settings.

I work predominantly Monday-Friday, 9 am- 5 pm but with flex and across the different base sites of the teams involved, as well as using virtual meetings for trust wide and external meetings.

The pillars of practice allocated within my job description are:

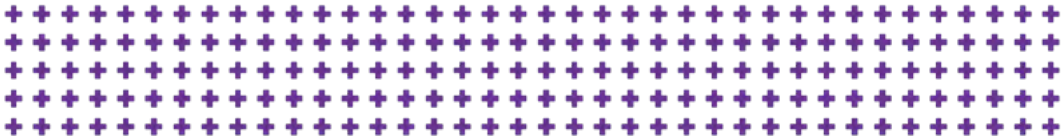
- Clinical practice 10-20%
- Professional leadership and consultancy 50%
- Education and Professional Development 20%
- Research and service development 10-20%.

My role was created three years ago to sit alongside the new organisational structure where Heads of Service became general managers with no requirement for a clinical registration. The Consultant Nurse role was therefore intended to provide a high level of clinical expertise and professional leadership. This spans two different services managed by different general managers, as well as offering professional advice to other services in the trust where children and young people are cared for, e.g. the Minor Injuries Unit and Child Development Services. I attend key strategic meetings to advocate and influence regarding the needs of children/ young people and their families within the trust steering groups for: Deteriorating Patient and Resuscitation; End of Life Care; Tissue Viability; Healthcare Transition; Clinical Advisory Group; and Advanced Clinical Practice

I am also actively involved in national work including: QNI Community Children's Nursing Network meetings and their associated subgroups; NHS England Clinical Skills in Education; CYPACP Collaborative Steering Group; Association of Chief Children's Nurses.

I am invited to present at the local University, regularly speaking about my caseload complexity tool. I have also presented recently at the QNI Conference regarding the Specialist Practice Qualification and SAPHNA regarding the Sussex Nursing Needs tool for use in Education settings. I have had work published this year, working in collaboration with colleagues, on at risk naso-gastic tube feeding in the community and am completing a project with my Critical Appraisal Topic (CAT Group) on the management of stoma granulomas.

What I love about my role is the ability to flex to support a specific child or family in a particular situation, for example developing a plan for a young person with complex and fluctuating respiratory needs to access mainstream education, through to planning end of life care in a residential care home for children, whilst also being able to influence at strategic level using clinical experience and case examples from practice. I can work outside of standard service boundaries, problem solving thorny issues and collaborate with colleagues both in and outside



of the trust, for example supporting end of life planning for a 16-year-old young person where they fell between gaps in different service provisions. I was greatly supported here by a Consultant Nurse colleague for Palliative and End of Life Care and worked with both Children's and Adult hospice colleagues to create a bespoke plan. This type of system leadership is an essential element of my role.

Recent example day:

Event	Pillar of practice
9 am-10 am Finalising an application for potential charity funding for a Children's Medical Complexity Transition post – working on the clinical case study element	Leadership
10 am-11 am Advising on the contents of a new residential school trip/ holiday form for children with medically complex care where registered nurse support may be required	Leadership
11 am-12.30pm Attended a Community Children's Nursing Service senior nurse operational meeting to be connected with service updates and arising issues where I can offer support. I was able to: signpost to Easy Read templates; advise on forthcoming training events; identify a learning opportunity with the local ambulance service for escalation to the Trust Deteriorating Patient Steering Group. I also, feedback to colleagues on progress with my core projects: Palliative and End of Life Care; Healthcare Transition; Deteriorating Patient; Digital Personalised Care; Continence Products Quality Impact Assessment	Leadership Education/ professional development
12.30pm-1.30pm Contacting the Designated Clinical officer for Special Educational needs and Disabilities (0-25 year) regarding 2 issues: 1. Clinical discussion regarding the medically complex health needs of an individual and plan to access education moving forward 2. Update on national guidance around delegation of clinical skills to un-registered staff in education	Clinical Leadership

2pm - 3pm Finalising Healthcare Transition benchmarking report and slides to feedback to Adult services next week and plan next steps 'You're Welcome': establishing youth-friendly health and care services- GOV.UK)	Leadership
3pm - 4pm Clinical case discussion to support medically complex discharge planning	Clinical
4pm - 5pm Meeting with multi-professional colleagues to finalise an application for NIHR funding Research for Patient Benefit (RfPB)	Research

Whilst I have identified each section of the day under one or two pillars as the main focus of the event, in reality the work is interwoven between all four pillars most of the time, with an overarching element of systems leadership.

Case Study 7

Author TBC

A day in the life of a primary care and cancer lead nurse

My workday starts with a coffee whilst I log on and take a look at my emails. I'm embedded in a regional cancer team. It's a unique role and has evolved out of a pre-programme of work in London where we've focused on primary care nursing as a key workforce to support people living with and after cancer.

At the moment I'm working with the national primary care nursing team and other primary care nurses to develop an education resource for GPNs. It's a complex piece of work as its based around the GPN core competency framework, but we also need to ensure alignment with the core cancer capabilities framework within the aspirant cancer career and education development programme (ACCEND.) This is due to be published next month, so there are daily email exchanges and comments on our working draft.

Over the next month I have a series of education commitments through a collaboration with Central London Community Health Academy, providing cancer education to care home nurses and carers. It's an adaptation of a previous programme we delivered across London to community nurses, GPNs and AHPs. The care home sector has proved far more of a challenge to reach and deliver training

to, due to its fragmentation and multiple, mostly private, providers. We plan to evaluate our intervention and identify key learning and education needs for this sector in relation to cancer.

I'll also be working on planning for the London Regional Cancer Community of Practice events (CoP). This CoP focuses on cancer in the context of out of hospital care and opportunities for integration. Our members are GPNs, Community Nurses and AHPs, and secondary care based Clinical Nurse Specialists and AHPs and patients. We bring this diverse workforce together at face-to-face events and webinars. This takes about one day a week of my time as the clinical lead.
As a unique role in London and nationally, I am frequently asked to be involved in strategic work and projects. I represent primary care nursing and cancer on a number of strategic groups, such as the community nursing leaders group, personalised cancer care board for London and London lead cancer nurse forum.
Clinically I work a day a week in primary care as an advanced nurse practitioner. This is important for me to stay connected to the reality of clinical practice, and its opportunities and challenges, and I believe it is essential as a clinical leader to maintain clinical credibility.

Having a robust evidence base to the work I do is important. The research pillar within advanced practice is practically the most difficult to progress, especially within primary care where clinical academic roles for nurses rarely have precedence. I've worked closely with colleagues at Keele University over the last couple of years to seek funding for my own research training, and am a member of Dr Andrew Finney's Primary, Community and District Nursing Research Forum.
Each day in my role is a little different, but I feel very fortunate to have had the opportunity to work in this role, which I have shaped to fit the needs of the workforce and opportunities to collaborate. Sadly, financial pressures within the entire NHS in London have resulted in a dramatic reduction in funding to my team this year and my role will be ending in the Autumn. Careful strategic planning will allow me to hand over some of the work to trusted colleagues in other organisations, but it is important to note that strategic consultant nursing roles are few in number and are vulnerable to the short term funding decisions made in a financially challenged NHS.

Case Study 8

Helen Donovan, Independent nurse consultant and immunisation specialist nurse Queen's Nursing Institute, lead for the Long Covid Nurse Expert Network

In 2023, I set up as a self-employed nurse consultant, prior to which I spent a long and varied career working in many areas of practice. The included: midwifery, general practice nursing, health visiting and heath protection. I then moved on to leadership executive roles and a UK role as the lead for Public Health nursing at the RCN.

Nurses are very often the key to supporting individuals and wider communities in navigating through sometime complex health and care systems. My diverse career enables me to have a clear overview of different parts of the health and care system, alongside the role that nursing and wider multi-disciplinary teams play in 'joining the dots' between various agencies to provide leadership across systems, to support better patient care and population health.

It is vital to achieve balance across the four pillars of advanced practice: clinical practice, education, research, and leadership.

My specialist area and passion has centred around vaccination- why wouldn't it, it works! Vaccination is described by the WHO as the most cost-effective medical intervention for saving lives. It is the ultimate public health measure, as it necessitates everyone being able to access the vaccines recommended and thereby requires clear strategies to facilitate this delivery but also clear and excellent interpersonal skills with individuals.

In this I have a leadership educational and clinical role. I provide education and webinars for nurses and other healthcare professionals delivering vaccines. I make sure I stay in contact with the individual challenges and questions from the people on the ground to understand their needs. I often feel one of the greatest supports I can give is to be on top of where to access and get good and reputable advice and guidance, which can be so challenging for people to keep up to date with. I keep abreast of vaccine research, particularly in improving access and understanding people's attitudes to vaccination. I maintain links with national policy teams and also with industry partners, working with them to support the dissemination of guidance.

I am grateful to be also able to continue with a portfolio of work across the wider system. I joined the Queen's Nursing Institute nursing team as a consultant to lead the Long Covid Network. This group incorporates mostly nurses, but also other allied health professionals, involved in the care of Long Covid and Chronic fatigue Syndrome (CFS). This legacy from the pandemic is sobering, with around two million people in the UK still living with symptoms. In this role, I work to keep the issues of Long Covid and CFS on the agenda at a national policy level and politically by working with the network and with other agencies.

I also work as an adviser in Nursing for the charity C3 Collaborating for Health, whose aim is to prevent non-communicable diseases. Their goals are to make it easier for people to stop using tobacco, improve what they eat and drink and to be more active physically. This requires a shift in mindset to think about promoting good health and wellbeing, rather than focusing on the management of ill health. As a nurse I appreciate that this is hard to do, both at an individual level, to change the way people act and behave, but also at a system level; switching the focus to

think up-stream requires a change in approach from health policy. I work to try and influence this.

This all dovetails with the work I do with the Self-Care Forum for which I am the Chair. We work to embed self-care into everyone's lives and support people to be better able and supported to help themselves.

I am involved in research to understand 'Why' people behave in the way they do and 'How' to support them adopt healthier lifestyles. Other research areas include understanding people's ability to self-care, what self-care means to people as individuals, and also to health care professionals.

I really enjoy the variety of work all this gives me and at the moment I juggle the various strands which further give me this overview of nursing in the community and public health arena.

Case Study 10

Rachel Thompson, Consultant Admiral Nurse, Lewy body dementia

A day in the life of a Consultant Admiral Nurse

Admiral Nurses are specialist dementia nurses who offer biopsychosocial support to families affected by dementia, by providing tailored information, advice and therapeutic interventions.

The Consultant Admiral Nurse for Lewy body dementia was established as a national role in 2020, the nurse employed by Dementia UK and funded by the Lewy Body Society.

Lewy body dementia (LBD) is the second most common cause of neurodegenerative dementia, accounting for approximately 10-15% of all dementias.

It is a complex and challenging condition characterised by hallucinations, fluctuations in cognition, sleep disturbance and Parkinsonism. However, it is often misdiagnosed and misunderstood (Kane et al., 2018). Both people with LBD and their family carers often experience poor mental and physical health, reduced quality of life and high levels of carer stress (Wu et al., 2018, Vatter et al., 2020, Bentley, 2022).

The aim of the role is to provide professional leadership and consultancy, education and training, involvement in research and expert clinical practice specifically for families affected by Lewy body dementia. Referrals are received via Dementia UK Admiral Nurse clinical services where complex needs are identified.

A feasibility study carried out in 2021-2022 concluded that the specialist knowledge and expertise of the LBD Consultant Admiral Nurse enabled family carers to better support the people they cared for, and to relieve some of the emotional stress associated with caring (Brown et al., 2022). 'It's just incredible the difference it has made': family carers' experiences of a specialist Lewy body dementia Admiral Nurse service- PubMed)

The following provides an example of a typical day:

Event	Pillar of practice
9 am – 10 am Check referrals/ inbox – review and triage any new referrals or requests for advice/ support. This may involve liaison with referring Admiral Nurses (Dementia UK) or Admiral Nurses employed in other areas including NHS, voluntary sector, care homes etc. Initial advice sent or arrangement to discuss in more detail	Clinical practice Leadership
10 am – 11 am Assessment with family seeking advice/ support following recent diagnosis of Dementia with Lewy bodies, involving person with diagnosis, partner and adult child. Assessment of needs carried out, including presenting symptoms, current treatment, understanding of condition, management, impact on all family members, support available and any risks identified. Psychoeducational advice and support offered and discussion re need for further interventions/ information.	Clinical practice
11 am – 11.30 am Recording notes/summary on clinical database	Clinical
11.30 am - 12.30 pm Attended an online planning meeting with other specialists in Lewy body dementia, regarding a Community of Practice for nurses and Allied health professionals Community of Practice- Lewy Body Discussed evaluation, planning next webinars and writing journal article	Leadership Research

1 pm – 1.30 pm Writing letter/ email for recent referral to share with GP including information about Lewy body dementia, recommending review of medication and referral to local services for assessment/ support.	Clinical Education Leadership
1.30 pm – 3.30 pm Co- facilitation of online psychoeducational/psychosocial group programme for family carers of people with LBD	Clinical
3.30 pm – 4 pm De-brief with junior colleague and recording notes	Clinical Leadership
4 – 5 pm Online education / training session for new Admiral Nurses working in services across the UK re understanding Lewy body dementia and supporting families.	Education
5 pm Onwards Check and respond to any new enquiries/ contact from existing caseload and send follow up information for new referral assessed today.	Clinical

Whilst this role has a national focus, it aims to influence practice and improve the experience of families across the UK through direct support and liaison with local services. Families often report there is limited understanding amongst professionals of how this condition differs from other dementias and tailored specialist support is still limited.

Following a successful evaluation in 2021, funding was agreed by Dementia UK to employ a Band 7 Admiral Nurse to support the service and as referrals increase, further support is being explored to expand the team.

The psychoeducational/ psychosocial group programme for family carers has been evaluated for feasibility and effectiveness and a poster submission has been accepted for an International Conference. Future plans include developing further resources, training and education in Lewy body dementia for families and health and social care professionals, alongside increased involvement in supporting research.

This is a varied and challenging role which has provided some fantastic opportunities to develop further knowledge and skills and link with specialists in the field, both nationally and internationally.

Five years of LBS funding UK's first LBD Consultant Admiral Nurse - Lewy Body

Case Study 11
The Nurse Consultant Role in establishing expertise across the system: A case study

Mandy Waldon, a Consultant Nurse specialising in older people and frailty. She leads a Hospital at Home service in Wiltshire that provides acute care for older adults. With nearly 30 years of nursing experience, Mandy has earned various qualifications, including a BA in Community Health Studies, a Post Graduate Certificate in Higher Education, Non-Medical Prescribing, and an MSc in Education and Development in Community Nursing Practice. She has worked at an Advanced Level for nine years, with her current role of Nurse Consultant being a long-term aspiration.

Mandy joined Wiltshire Health and Care to develop and lead a new H@H service in Wiltshire alongside other Consultant Practitioners and Advanced Clinical Practitioners.

Macro (system) level:
Being the voice in the room that positively challenges entrenched clinical pathways/hierarchical structures to create a diversity of thinking has enabled the growth of a shared vision into a successful Consultant Practitioner led H@H service.

Sharing learning through being open and honest about what is working and what isn't, nurturing a sense of shared ownership and risk in developing the solutions across the system #theartofimpossible.

Implementation of system-wide digital remote monitoring platforms to address the geography challenges in Wiltshire.

- Expert Practice
- Strategic and enabling leadership
- Learning, developing and improving across the system
- Research and innovation

The Consultant Nurse role is the golden thread that transcends the micro, meso and macro levels of the H@H service in Wiltshire.

Micro (team) Level:

Leading a diverse MDT, creating a shared vision for a truly person-centred clinical pathway, empowering colleagues and fostering a sense of ownership and autonomy for working in new ways that focuses on patient experience and impact of the H@H service.

Meso (organisation) level:

Key has been developing the diverse and honest relationships critical for integrating a new service with established, well-managed community and primary care teams.
Collective and inclusive leadership is essential for this as well as a culture for positive challenge and appreciative inquiry that recognises our strengths and identifies our aspirations. Demonstrating patience, tenacity and resilience is key for the longer-term view of transformational change in leading Wiltshire's H@H service.

Impact of Consultant Level Practice:

- New, innovative clinical care model in response to population changes and national drivers
- A committed, autonomous and highly skilled workforce within Wiltshire H@H
- Values-based, person-centred practice pathways with a focus on Quality Improvement through experimentation and discovery
- An ethos of collaboration and co-production in developing a H@H model with close partnership working across the systems to meet the needs of the local population

- Regional and National platforms to share the impact
- Networks both for H@H and Consultant Level Practice
- Articles published in Journals/Newsletters to maximise impact

The Queen's Institute of Community Nursing

www.qicn.org.uk
Founded 1887
Patron HM The Queen