

Maxi nurses. Advanced and specialist nursing roles

Results from a survey of
RCN members in
advanced and specialist nursing roles

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Employment Research Ltd

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Summary

In autumn 2004, 758 nurses in advanced-specialist roles were invited to take part in a survey asking them about their jobs – what their role entails, what gives them most satisfaction, and how the role fits in. After two reminders, nearly 70% returned completed questionnaires. The response rate alone demonstrates a key finding – that nurses in these roles feel passionate about their work and are keen to let others know more about what they are doing.

The term ‘advanced and/or specialist nursing roles’ encompasses a wide plethora of job titles, covering many different roles. This survey asked explicitly about the activities undertaken by nurse in these jobs in order to develop an activity based role typology. Further analysis looked at how the activities undertaken align with 5 commonly used role titles: nurse practitioner (NP), clinical nurse specialist (CNS), nurse consultant (NC), specialist nurse (SN), and advanced nurse practitioner (ANP).

Nurses in these roles spend the majority of their time (60% on average) in clinical activity, 17% of time in education, 14% in management activity and 4% in research. Certain ‘core’ activities (such as patient assessment/referrals, autonomous decision making and offering specialist advice) are undertaken by nine out of ten respondents.

Correlation between the different activities, and the way in which certain activities typically cluster, pointed to three main categories: ‘Case Management’ (eg. develop plans in collaboration with others, coordinate programmes of care, admit/discharge patients); ‘Diagnosis’ (eg. undertake physical examination, make diagnoses, screen patients, order investigations); and ‘Organisational activity’ (which includes leadership, educating staff and initiating research).

Interestingly, analysis revealed that there are four main job types that can be differentiated on the basis of the activities undertaken. Whilst the roles have much in common with one another – the level at which they practice and the prevalence of key activities such as making professionally autonomous decisions, making referrals and offering specialist advice to other staff – the main job titles refer to differences in the activities undertaken by different roles. For example overall CNS and SN undertake a similar range of activities (primarily case management related) and can be regarded as one group. Nurse consultants do a wide range of activities but it is the ‘diagnostic’ and ‘organisational’ elements of their job that distinguish them from others. Nurse practitioners see both the ‘diagnostic’ activity types and ‘case management’ activities as being what makes them different to other nurses. On the other hand advanced nurse practitioners do more of the diagnostic activities and see these activities as central to their role.

There is a wide mixture of people working in these roles. For example their ages ranged from 25 to 67 years (average age 46). Respondents typically have between 16 and 20 years nursing experience, 10 years of which is in the specialty they are now based. 91% are female, 9% male; 96% of respondents were white, with 4% minority ethnics. Just under half (46%) are educated to degree level or beyond.

Half of the nurses surveyed work in a hospital, primarily in a specialist unit of some sort, whilst one in ten work in a GP Practice and 18% in the community. But about a fifth (21%) describe their work setting as 'other'. Many of these are working across several different organisations. Interestingly, about a quarter (23%) do not see their role as fitting clearly in any one 'specialty', primarily because the role they are in crosses traditional speciality boundaries. 88% report that they refer patients/clients to other health care providers – most take clients from many different sources and also refer patients to a wide range of service providers.

Whilst 72% report that they work primarily on their own and 97% report that a high level of autonomy is required in their role, they are nonetheless operating as part of a wider team or teams, and the roles are characterised by interface with a wide variety of other staff and agencies. 85% either strongly agree or agree that they feel part of a team.

Regardless of which team/s they work within, respondents are virtually unanimous (98%) about the importance of nursing skills in their jobs. Just under a third (27%) refer specifically to the satisfaction they gain from being able to practice autonomously.

On average nurses in these roles express high levels of job satisfaction and are satisfied with their working hours and the level of control they have over their careers. For example, 84% say that most days they feel enthusiastic about their jobs. They are also significantly more likely to feel their work is valued than is reported by survey of a random cross section of RCN members – 62% compared with 54%.

The aspects of these roles that respondents find most satisfying – and all but 3% took the trouble to respond to this open ended question – are a mixture of what they do, how they do it, and the impact it has on patients. It's the last of these – having an impact or 'making a difference' – that respondents refer to most often. Others describe how having an opportunity to shape and influence service delivery is important to them.

But the way in which nurses' work in these roles is equally important – advanced-specialist nurses relish the level of patient/client contact they have and the chance to see cases through from beginning to end (93% of respondents report that they provide ongoing patient care as part or all of their job).

Other aspects of job satisfaction described, relate to the pivotal position that these posts have assumed in terms of liaising with other staff and other agencies to coordinate care and also as disseminators of good practice.

Nurses are virtually unanimous that their professional judgement is respected by nursing colleagues (94%), and by other health care staff (93%). But although their judgement is respected, a quarter report that their role is not understood by other nurses. Similarly although in the majority of cases patients regard them as nurses, 18% report that patients have difficulty understanding their role.

Lack of understanding of these roles is a potential source of frustration. 38% felt that the service is not getting the most out of their role for the benefit of patients. Failure to fully comprehend these newer ways of working has other knock on effects - 23% of those who make referrals, have had them refused because they are a nurse rather than a doctor. Similarly a third (33%) who order investigations had been refused on the same grounds.

Nurses in these roles have been heavily involved in shaping the role and the service they deliver. In 60% of cases respondents were in new posts and 79% of these nurses had been involved in establishing the role. The roles continue to grow and evolve - 90% say their role has expanded since they took the post, and that it is still evolving.

Despite the fact that many of the roles are growing (often beyond the post's job description) respondents are positive about role change. 93% said they were open to the idea of their role changing and 81% reported being happy with the way in their role has changed already. And more than half (58%) report that there are activities they would like to do more of, or to add to their role. The majority of nurses want to be able to be more actively involved in developing their role in order to expand and develop the service they provide.

The main constraint on role expansion is simply lack of time. A third of respondents felt that the volume of work meant they were too busy to be able to provide the level of service they would like. In many cases the posts are unique so post-holders are not able to share their workload with colleagues in order to allow them scope to continue to develop their own role/service in the way they would like. Whilst most are ready and willing to develop their roles further to benefit patients/services the infrastructure and support being offered by employers and in some case other colleagues sometimes lags behind the new modes of service delivery.

Most respondents reported that the best preparation for these roles is a combination of having the right experience and having suitable educational preparation. However a problem of being in highly specialised and often unique role, is that it is hard to be able to get appropriate cover to allow staff to have time out of their role to undertake professional development. Outside of resourcing, better access to training and professional development and more supervision or mentoring were two of the most frequently suggested forms of support needed. For example, 27% would welcome more clinical support/supervision or mentoring.

1. Introduction

1.1 Aims and objectives

The Department of Health and RCN have jointly funded this research to find out more about nurses in specialist and/or advanced roles. The project aims to describe the posts, the people in the posts, and the organisational infrastructure surrounding them, to be able to map the variety of roles that currently exists.

The project has been designed to address the following specific objectives:

- To describe the roles of these nurses and the work settings in which they are situated. Do the post-holders see the posts as being advanced and/or specialist? How is this evidenced in their roles?
- To examine the working relationships of nurses in this group. How do these roles 'fit' within their organisations and relative to other staff? What teams are they part of? Who accesses their expertise? Are these new roles understood by other staff and patients?
- To describe the career patterns and paths of nurses in these roles. Why did they take up this role? What were they doing before? What preparation have they had and what do they think is needed? What do they see as their next career step?
- To find out from nurses in these roles how patients and clients benefit from these roles;
- Consider the infrastructure, facilities and conditions required to make these roles as successful as possible, from both a post-holder and service perspective. What support can employers offer to nurses in these roles to ensure the service gets the most out of these roles? Is anything further needed?

1.2 Methods

Sample

The research is based on a postal survey of RCN members who are in advanced or specialist roles. These nurses were identified from the RCN Annual Employment Survey in 2003. The selection criteria used for inclusion in the survey were:

- Job title was given as 'Nurse Practitioner/Clinical Nurse Specialist/or Other Specialist';
- Nurses who reported they were employed and working;
- Nurses in posts that are F grade and above.

Using these criteria, generated a sample of 758 suitable nurses. The original sample (from the 2003 survey) had been stratified by country to allow cross UK analysis of the data. Hence the sample of advanced and specialist nurses drawn for the current survey (which is based on these respondents) covers all four countries. A weighting is applied to the data to rebalance the responses so that the mix between countries matches the typical geographical distribution of RCN members across the UK (see appendix for details).

Questionnaire design

The overall themes to be explored were identified in a meeting between the researcher and representatives from the RCN and Department of Health. Three other sources were used to help shape the design of the questionnaire – expert interviews, relevant documents and literature, and analysis of the responses given by these nurses in the original 2003 survey.

The questionnaire was piloted with a group of volunteers from the RCN interest group. Participants were invited to complete the questionnaire (which took about 40 minutes). It was then discussed question by question, before concluding with their views about the survey overall. A ‘thank you’ of £10 gift vouchers was given to participants.

Survey process and response

Late September 2004 an 8-page booklet style questionnaire was sent to each nurse’s home address with an accompanying letter explaining the purpose of the survey and a reply paid envelope. Two targeted reminders were sent – the first was a standardised letter, and the second a new questionnaire pack plus a personalised letter. The official close date was six weeks after the first mail-out on November 8th, but late returns up to the end of November have been included in the dataset.

A response of 60% was anticipated but the achieved useable response was 69%. In total 544 items of post (of the original 758 sent) were returned – 480 were useable responses, 38 indicated that the questionnaire was not applicable to them (not working in an advanced or specialist role) and 26 forms were post-office returns (ie. their address had changed since the last survey). In addition to the responses from the main sample, a further 27 forms were returned from nurses who had heard of the survey either from colleagues who had been sent a form or through the questionnaire pilot. These responses have also been included in the dataset, so that the total number of cases analysed is 507.

Answers to the majority of open-ended questions were content analysed to identify themes and the responses categorised. Numerical data were keyed and the data have been analysed using SPSS-12 software.

Despite the large number of open-ended questions, which made the questionnaires slow to complete (the typical time recorded in the pilot was 40 minutes), the questionnaires were completely very thoroughly. The overall impression from the volume and nature of the response is that these nurses are glad to have the opportunity to describe their roles. One respondent was so determined to ensure her response was received that she sent it recorded delivery. In 10 years of conducting over a 100 surveys, this is the first time Employment Research have had a recorded delivery response.

Analysis of the characteristics of respondents versus non-respondents, shows that response is related to age, with nurses over 50 being more likely to respond (74% compared with 64% across all ages groups). This pattern has been noted in other surveys of RCN members¹. There is no significant response variation by country, gender or ethnicity.

Ages ranged from 25 to 67 years, with an average age of 46 years. The divide between the sexes is identical to that of the membership population as a whole - 91% are female and 9% male. Just under one in twenty (4%) of the respondents are black or minority ethnics.

1.3 Report structure

The findings in the report are based on 506 respondents (weighted by country) and are presented as follows:

Chapter 2 – What is an Advanced or Specialist nurse? The whole issue of defining these roles and the people who undertake them is fraught with problems. What types of jobs do they do? The aim of chapter 2 is to use an activity driven approach to categorise the roles and then to see how these role typologies relate to common title for these roles.

Chapter 3 – How are these roles undertaken? We look at the way in which these nurses practice in terms of the teams they work within and autonomous nature of many of the roles, and the nature of contact with patients/clients.

Chapter 4 – Where do they fit in? This chapter maps where these nurses work, what grades they work at, and explores how they are placed in the organisations in which they work. Who manages them and where do they get professional support? A big question here is not just where these nurses see themselves fitting in, but what understanding other people have of their roles and where they fit.

Chapter 5 – Evolving roles. Two perspectives are taken in this chapter: the posts and how they were developed, and the way in which roles continue to evolve. Respondents were asked whether the post existed before they took it up, and about what involvement they had in establishing the post. We go on to look at how the roles have changed since they have been in post, and what changes they would like to make.

Chapter 6 – Becoming a specialist-advanced nurse. In this chapter we turn away from thinking at the posts, to look at what respondents have said from a career perspective. What preparation have they had, what experience is needed, how long have worked in their current field of practice, what were they doing before? Also look at what they see as their next career step.

Chapter 7 – Reaping the rewards – The aim of this chapter is to see what can be learnt from nurses already working in these roles about what is needed to make them a success. What are the benefits of these roles and what's needed to make sure these roles deliver to their full potential? Is the service getting the most out of what these roles offer? What's it like to be in these roles (in terms of job satisfaction, the best and worst aspects of the job)?

2. Roles of advanced and specialist nurses

We start the report by mapping out the roles of the nurses that have been covered by the survey. The plethora of job titles and variety of roles is well recognised and poses challenges to the profession and health service in terms of defining jobs and defining levels of practice. To avoid being caught in a complex tangle of definitions, job titles and terms relating to levels of practices, the survey included some explicit questions asking nurses which activities they do and how their time is divided between different types of activity. Analysis of these data allow us to conceptualise the roles on the basis of the activities these nurses actually do as part of their jobs, rather than relying on job titles to differentiate between roles. The first stage of analysis undertaken was to explore roles as defined by activity.

The next stage is to examine whether there is any alignment between the types of roles (as defined by activities), and the posts. The nurses covered in this survey had originally indicated (by ticking one box in the 2003 survey) that their job title was 'Clinical Nurse Specialist/Nurse Practitioner' or 'Other Specialist Nurse'. In this survey we asked respondents to firstly give their full job title (and each of these have been typed in full to ensure the range and variety of titles is not lost through coding), and then to indicate which of five main post 'types' best described the post they hold. The categories provided were: nurse practitioner (NP), clinical nurse specialist (CNS), nurse consultant (NC), specialist nurse (SN), and advanced nurse practitioner (ANP). If none of these were suitable, respondents were also offered an 'other' category and asked to give details.

To summarise, in this chapter we examine what people in advanced –specialist roles do and the way in which they practice. We also explore how the roles relate to different types of post.

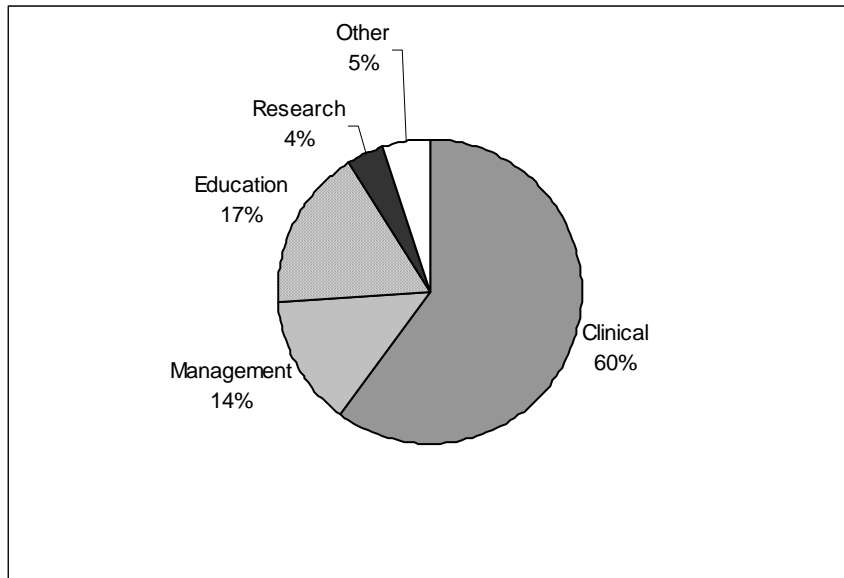
Key points in Chapter 2

- *Whilst nurses in these posts typically spend most of their time in clinical work, a feature of the roles is that many include education, research and management components as well.*
- *Certain 'core' activities such as patient assessment/referrals, autonomous decision making and offering specialist advice, are very prevalent and are undertaken by nine out of ten respondents.*
- *Other activities tend to cluster together – an individual doing one is likely to be doing others in the same group. The main themes are: 'Case Management', 'Diagnosis' and 'Organisational activity'.*
- *The post-types are differentiated by the activities they undertake. Nurse consultants, specialist nurses, nurse practitioners and advanced nurse practitioners do a slightly different mix of activities from one another and have different views about which activity types most central to their role.*
- *18% have undertaken a nurse prescribing course and 14% prescribe.*

2.1 Division of time

Before asking respondents in detail about which specific activities they do or do not do, we asked them to give an overall breakdown of the proportion of time they spend in each of five main activity areas – clinical work, management, education, research or other. The mean percentage of time spent in each activity type (for respondents whose answers totalled 100%) is shown in Figure 2.1.

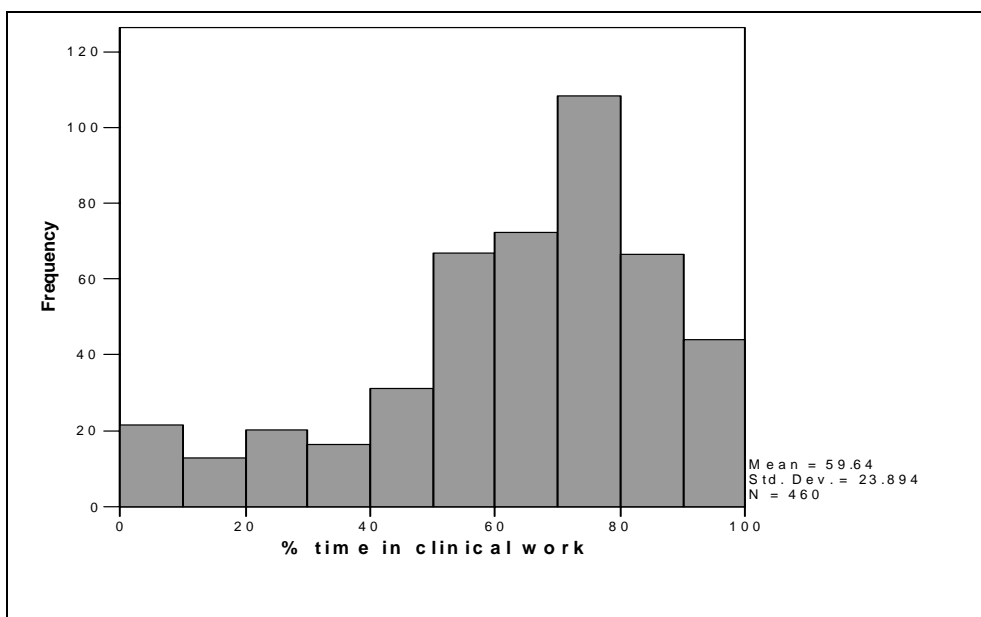
Figure 2.1 Division of time between main activity types (mean percentages)



Source: *Employment Research, 2005*

On average nurses in advanced or specialist roles spend most (60%) of their time in clinical work, although this varies, as Figure 2.2 shows.

Figure 2.2 Percentage of time spent in clinical work

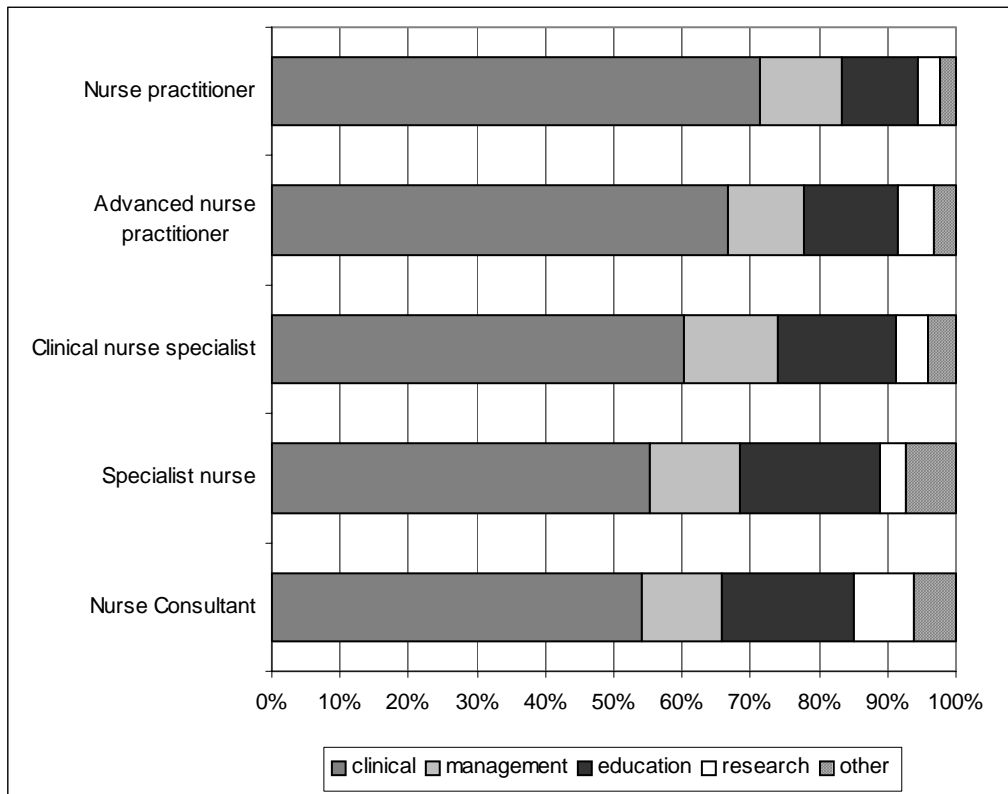


Source: *Employment Research 2005*

Whilst clinical work pre-dominates, a feature of these roles is that most do the other activities to some extent – 70% report some time spent on management, 86% on education and 53% spend at least some of their time on research.

Figure 2.3 shows how the overall division of the time by type of activity varies between the 5 main post types respondents report they are in.

Figure 2.3 Division of time by post type



Source: *Employment Research 2005*

2.2 Activities within role

Respondents were presented with a list of 19 activities and asked to tick which of these they do as part of their job. The results are presented in order of frequency (the letters indicate the order they appeared on the questionnaire) in Table 2.1.

Table 2.1 Activities undertaken as part of job

	%
r) Provide education/training to staff	95
q) Provide specialist advice/consultancy to other health care professionals	93
a) Assess health care needs of patients	90
p) Make professionally autonomous decisions	90
i) Refer patients/clients to other health care providers	88
k) Undertake health promotion and provide health education	84
b) Take a comprehensive history	81
g) Develop plans of care in collaboration with clients	78
o) Support people to enable them to manage/live with illness	78
e) Coordinate and manage care programmes for individual patients and carers	77
s) Provide leadership within and external to your organisation	77
j) Provide counselling	76
l) Admit/discharge patients from your caseload	74
h) Order investigations	64
n) Undertake specialist procedures	54
f) Screen patients for disease risk factor or signs of illness	51
c) Undertake physical examination	50
d) Make diagnoses	49
m) Initiate research	49
t) Other	11

Source: Employment Research 2005

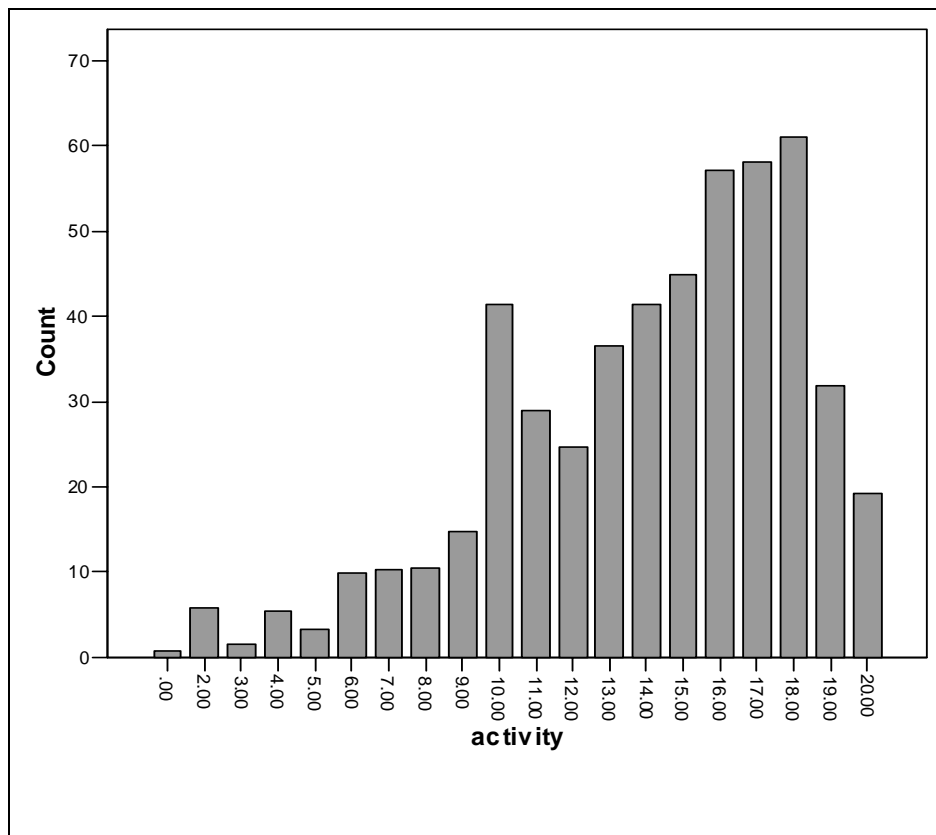
Clearly many of the nurses surveyed do many of these activities (Figure 2.4 shows the number of activities ticked). The number of activities undertaken varied according to the type of post held, as Table 2.2 shows. The fact that nurses in these roles typically do about 18 of these higher level activities, not just one or two, points to these roles providing ‘complete packages’ of care – not just undertaking one or two highly specialised techniques. This message emerges also from some of the qualitative data covered by the survey on sources of job satisfaction and impact on patients – having the authority to assess and act, is a feature valued by post-holders and the patients they treat.

The top four activities listed in table 2.1 are undertaken by at least 90% of the nurses surveyed – hence they are activities that these roles have in common with one another, despite variation in the job titles, setting or speciality worked in. The activities that are consistent across the roles are:

- Providing education/training to staff
- Providing specialist advice/consultancy to other health care professionals
- Assessing health care needs of patients
- Making professionally autonomous decisions

The activities undertaken exemplifies the level at which many of these nurses are working.

Figure 2.4 Number of activities ticked



Source: *Employment Research 2005*

Table 2.2 Number of activities by post type

	Mean	N	Std. Deviation
Nurse practitioner	15.6	74	3.30852
Clinical nurse specialist	13.8	174	3.66419
Nurse Consultant	17.2	45	2.35441
Specialist nurse	13.0	129	3.85890
Advanced nurse practitioner	15.2	36	4.83667
Other	12.2	37	5.09028
Total	14.1	496	4.01700

Source: *Employment Research 2005*

Anticipating that many of the activities would be encompassed by many of the roles, an additional question asked respondents to say which five (in rank order) activities they considered most central to their role, differentiating it from less advanced or specialist roles. The percentages (where over 2%) putting each activity as ranking first, second, third, fourth or fifth are given in Table 2.3, along with a mean score. This was calculated by giving activities that were ranked first, a score of 100, those ranked second a score of 80, and so on with those ranking fifth getting a score of 20. Activities that were not considered central to the role scored 0.

Table 2.3 Importance of activities in distinguishing role (where over 2%)

	First	Second	Third	Fourth	Fifth	Mean score
a) Assess health care needs of patients	18%	11%	4%	3%	2%	31
q) Provide specialist advice/consultancy to other health care professionals	12%	10%	9%	13%	13%	32
o) Support people to enable them to manage/live with illness	12%	5%	6%	6%	6%	22
p) Make professionally autonomous decisions	10%	13%	14%	8%	8%	33
b) Take a comprehensive history	9%	8%	3%	3%	3%	18
e) Coordinate and manage care programmes for individual patients and carers	7%	6%	6%	5%	5%	18
r) Provide education/training to staff	6%	7%	6%	11%	11%	22
n) Undertake specialist procedures	6%	4%	5%	6%	6%	16
s) Provide leadership within and external to your organisation	5%	4%	5%	7%	7%	16
c) Undertake physical examination	4%	9%	5%	3%	3%	16
d) Make diagnoses	5%	6%	8%	3%	4%	16
g) Develop plans of care in collaboration with clients	-	3%	5%	5%	5%	10
i) Refer patients/clients to other health care providers	-	-	7%	6%	6%	8
j) Provide counselling	-	3%	6%	5%	5%	10
f) Screen patients for disease risk factor or signs of illness	3%	-	-	3%	3%	6
h) Order investigations	-	-	-	5%	5%	5
k) Undertake health promotion and provide health education	-	3%	4%	5%	5%	9
l) Admit/discharge patients from your caseload	-	3%	-	-	-	5
m) Initiate research	-	-	-	-	-	3
N=	479	480	471	464	448	479

Source: *Employment Research 2005*

Three activities have high mean scores (reflecting the higher average level of importance associated with the activities across all respondents). These are professionally autonomous decision making, providing specialist advice to other staff, and assessing the health care needs of patients. The high mean scores reflect the high level of consensus across the variety of roles covered in the survey, that these features are critical in distinguishing these roles from less advanced or specialist nursing roles.

It is interesting to note that of these three, one relates to a clinical activity (assessment) that these nurses have in common, one relates to communication with other staff (providing advice) and the third relates to the way in which they work – with professional autonomy. One in ten (90%) report making professionally autonomous decisions and autonomy gets the highest mean score as a feature that differentiates these roles from other nurses.

2.3 Role Typology

To build up a better idea of the nature of roles, we looked to see if there are typical combinations of activities undertaken by different nurses. Can an activity typology be produced that encapsulates different role types?

The correlations between the activities were explored to identify where relationships between activities exist. Factor analysis was also undertaken to see which activities 'cluster' together. Three main groups of activities were identified amongst respondents that could be regarded as role types. These are:

1. 'Care Coordination'. The activities that cluster into this scale are connected with case management and coordination of care, starting from initial patient assessment through to planning care and liaising with other health care providers to enable clients to manage illness, and discharging or referring patients on to other services. The activities that correlate together within this 'factor' are:
 - g Develop plans of care in collaboration with clients;
 - a Assess health care needs of patients;
 - b Take a comprehensive history;
 - Support people to enable them to manage/live with illness;
 - i Refer patients/clients to other health care providers;
 - e Coordinate and manage care programmes for individual patients and carers;
 - l Admit/discharge patients from your caseload;
2. 'Diagnostic Activity'. These activities are less connected with a patient pathway and relate more specifically to diagnosis – through physical examination, investigations, screening or specialist procedures. The activities correlated in this factor are:
 - c Undertake physical examination
 - d Make diagnoses
 - h Order investigations
 - f Screen patients for disease risk factor or signs of illness
 - n Undertake specialist procedures

3. 'Organisational Level'. Three activities correlate into a third scale that is less directly patient care focussed and can be viewed as organisational level activity, that supports the development of services through leadership, education or research. The activities as listed on the questionnaire are:

- s Provide leadership within and external to your organisation
- r Provide education/training to staff
- m Initiate research

Four activities did not fall clearly into of these factors (nor did form a factor of their own). These are:

- j Provide counselling
- k Undertake health promotion and provide health education
- p Make professionally autonomous decisions
- q Provide specialist advice/consultancy to other health care professionals

Two of these activities – counselling and health promotion – are weakly correlated with each other, but did not come out as a separate factor in the analysis. Providing specialist advice did not correlate significantly within any other activity – note that this is something that 93% of respondents reported doing and so is not a likely to be a good discriminator.

Likewise making professionally autonomous decisions (indicated by 90%) was not clearly in one scale rather than another, but correlated weakly with activities in both the care coordinating scale and the diagnostic scale. Again emphasising autonomy as a universal trait of these roles.

2.4 Relationship between activities and post types

We then looked to see how the role types related to the types of posts respondents indicated best matched their job. Comparing the mean scores on each scale – i.e. the amount of each type of activities different post types do, we find that some of the posts have significantly higher scores on some of the role scales. Thus nurse practitioners and nurse consultants have higher mean scores on the 'care coordination' scales (showing they do more of these types of activities) compared with the other job titles. They, as well as advanced NPs, also have higher scores on the 'diagnostic' scale than their colleagues in other posts. Nurse consultants have highest scores on the 'organisational' scale. This gives us a sense of the amount of the different activities different nurses do. The fact that nurse consultants have high mean scores on all three scales, shows that they are more likely to have indicated that they do a large number of activities in each of the three main categories.

But to take this analysis one stage further, we looked at the top five activities that were considered to be 'most central to your role, differentiating it from other less advanced or specialist nursing roles'. As we saw earlier, a lot of respondents ticked a great many of the 19 activities so this question allows us to see which are the activities they see as differentiating their role from that of other nurses.

Some interesting differences emerge between the results to this analysis (where we look at key activities) and the results based on the full range of activities each respondent undertakes. The asterisked cells in Table 2.4 show which job types have highest activity scale scores, for the scales based on all activities undertaken, and a second set of scales based on the activities respondents regard as being most central to their role, differentiating it from that of less advanced or specialist nurses.

Table 2.4 Post types by activity scales – all activities and key activities

	Based on ALL activities undertaken			Based on 5 KEY activities (differentiating role from other nurses)		
	Coordinate	Diagnose	Organise	Coordinate	Diagnose	Organise
Nurse Practitioner (NP)	***	***		***	***	
Clinical Nurse Specialist (CNS)				***		
Nurse Consultant (NC)	***	***	***		***	***
Specialist Nurse (SN)				***		
Adv. Nurse Practitioner (ANP)		***			***	

Source: *Employment Research, 2005*

The results reveal that although CNS and SN report doing fewer activities off the list in general, (averaging 13.8 and 13.0 respectively out of 19), and hence also have lower scores on each of the scales (as they did fewer of the activities categorised into each), they had a higher average number of care coordination activities listed in their top 5. In other words, whilst on average they do a smaller number of care-coordination activities than, say, nurse consultants, they see these activities as central to their role, differentiating them from other nurses.

Nurse practitioners see both the diagnostic activity types and coordination activities as being what makes them different to other nurses. Meanwhile Nurse consultants, although they do a large number of activities overall, see the diagnostic and organisational elements of their job as the parts that distinguish them from others. Advanced nurse practitioners tend to do more of the diagnostic activities, and they see these activities as central to their role. Thus the difference in the responses of those who classify themselves to be in nurse practitioner posts as opposed to advanced nurse practitioner posts, is that they consider that they do diagnosis *and* care coordination activities, and both are central to the way they see their role.

Overall the findings suggest that there are similarities in the types of activities that clinical nurse specialists and specialist nurses do and that they see as central to their role. Outside of this overlap, the four main post types –specialist nurse/CNS, nurse practitioners, advanced nurse practitioners and nurse consultants – appear to relate to four slightly different roles.

Further analysis was undertaken to see if there was any significant difference in the activity scale scores (roles) between settings as classified into: acute/hospital, primary/community, and other settings (e.g. where work across several organisations). Results show that nurses working in primary/community settings have a higher score on the care coordination scores, although they are no more likely to see these activities as central to their role than their colleagues in other settings.

Those in primary/community have lower scores on the organisational scale, whilst those in ‘other’ settings score highest on this. Diagnostic activity is equally prevalent in community/primary and acute settings, but less so in the ‘other’ settings.

Looking in more detail at the proportions of each job type that undertook each specific activity (as opposed to the scales) shows up some key differences and similarities between the job types. A number of activities highlight the similarities between CNS and NS posts, and how these posts differ from NP, ANP and NC posts (Table 2.5). For example those in 'specialist nurse' posts are less likely (than the 3 other post types) to physically examine patients, make diagnoses, or order investigations but are more likely (than nurse practitioners) to provide advice to other health professionals. Making diagnoses would seem to be a critical differentiating activity. More than 90% of nurse consultants diagnose, compared with about a third of specialist nurses/CNS, and four-fifths of nurse practitioners and advanced nurse practitioners.

Table 2.5 Percentage undertaking each activity by job type

	NC	ANP	NP	CNS	SN	Signif.
CC a) Assess health care needs of patients	100	94	96	90	85	**
CC b) Take a comprehensive history	91	89	92	78	76	**
D c) Undertake physical examination	71	81	84	39	30	***
D d) Make diagnoses	93	83	77	32	33	***
CC e) Coordinate and manage care programmes for individual patients and carers	91	81	84	80	65	**
D f) Screen patients for disease risk factor or signs of illness	69	69	72	37	43	***
CC g) Develop plans of care in collaboration with clients						
D h) Order investigations	80	72	89	58	58	
CC i) Refer patients/clients to other health care providers	96	81	96	90	84	*
j) Provide counselling						
k) Undertake health promotion and provide health education						
CC l) Admit/discharge patients from your caseload	96	72	81	74	72	*
O m) Initiate research	85	54	41	50	40	***
D n) Undertake specialist procedures	78	81	59	49	46	***
CC o) Support people to enable them to manage/live with illness						
p) Make professionally autonomous decisions	100	94	96	87	92	*
q) Provide specialist advice/consultancy to other health care professionals	100	89	85	95	97	**
O r) Provide education/training to staff						
O s) Provide leadership within and external to your organisation	100	72	76	82	67	***
N=						

Source: *Employment Research 2005*

The relationship between the post type and activities undertaken and those considered central to role, suggests that the 'type of post' categorisation provided in the questionnaire has produced a usable typology of advanced and specialist nurses, which differentiates in a meaningful way between the variety of roles. The classification draws out differences and similarities between the post types. Based on the activities alone, there would seem to be some overlap the roles of CNS and NS, and also to a lesser extent between the roles of ANP and NP.

2.5 Prescribing

A few questions asked nurses specifically about what role they have with regard to providing drugs/medication for patients. Just under a third did not answer this question or said that this was not relevant to their role (see Table 2.6). CNS/SN were least likely to report that this was the case – i.e. a larger proportion of nurses in these roles were involved in some way with medication (Table 2.7). But they were least likely to have autonomy in prescribing – 19% said that medical colleagues dealt with prescribing, and 35% reported that although they made the prescribing decision, a medic signed the prescription or drugs chart. Nurse practitioners and nurse consultants were the groups most likely to prescribe from the extended nursing formulary (11% in both cases). Nurse practitioners were also the group most likely to use Patient Group Directions (PGD). Very few respondents used supplementary prescribing - just 2 out of 507.

Table 2.6 Role in providing drugs/medication - percentages

	Percent	N=
I prescribe from extended nursing formulary (ENF)	4	21
I use supplementary prescribing	<1	2
I use PGD (Patient Group Directions)	9	46
I make the decision, but a medical colleague signs prescript	30	152
Medical colleagues make prescribing decisions	17	87
Other	11	54
Missing (Not applicable)	29	145
Total	100	507

Source: *Employment Research 2005*

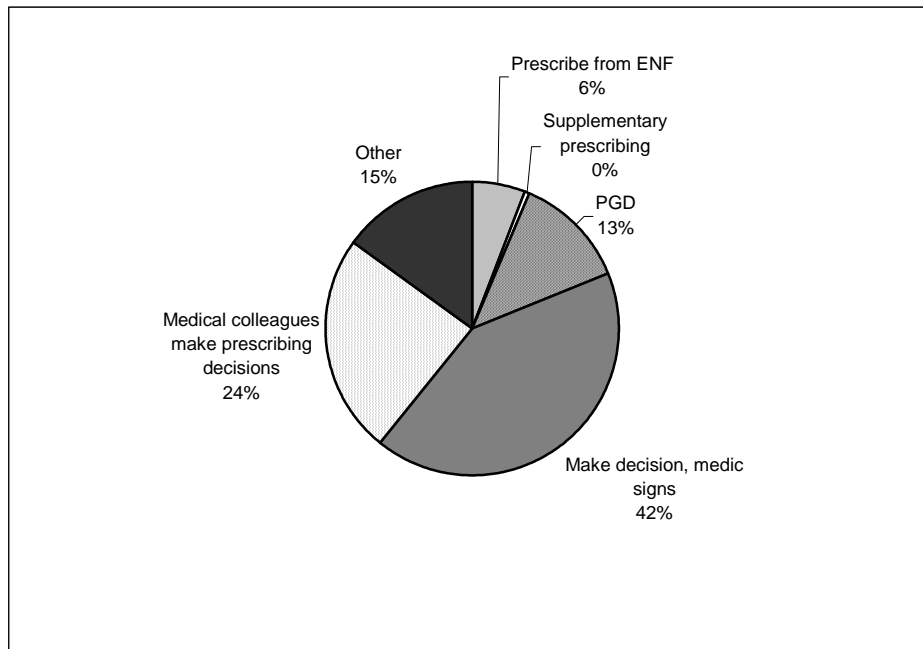
Table 2.7 Role in providing drugs/medication by post type - percentages

	NP	CNS/SN	NC	ANP
I prescribe from extended nursing formulary	11	2	11	
I use Supplementary prescribing	-	-	2	-
I use PGD (Patient Group Directions)	20	7	-	8
I make the decision, but a medical colleague signs	19	35	30	31
Medical colleagues make prescribing decisions	15	19	7	8
Other		10	11	11
N/A	36	27	39	42
N=	75	303	46	36

Source: *Employment Research 2005*

Figure 2.5 presents the proportion (of those who deal with drugs/medication) in each medication role across all post types.

Figure 2.5 Role in providing drugs/medication (of those that do)



Source: *Employment Research 2005*

Respondents were also asked whether they had done the ‘Extended Nurse Prescribing/Supplementary’ course. A few (6%) did not answer the question. Of those that did, 18% had done the course and 78% had not. This varied by post type with CNS/SN being least likely to have done the course (7%) and nurse consultants most likely (55%). Nurse practitioner and advanced nurse practitioners are between the two – both at 39%.

Staff that had not done the course were asked why they had not; two responses per respondent were coded into themed categories (Table 2.8).

Table 2.8 Reasons for not doing prescribing course

	% of cases	
<i>a) Will do</i>		14
Proposed for future	9	
Currently undertaking course/about to commence course	5	
<i>b) Not relevant/needed</i>		56
Not relevant to role/do not prescribe/not needed as part of role	51	
Job ending - Near retirement/maternity	3	
Not needed - other people in dept. qualified/qualifying	2	
<i>c) Not able to/Not supported</i>		32
Not available/Not been offered chance	11	
Not supported to do it by management/employers	5	
Lack of funding	3	
Cover/time for study is difficult (e.g. unique role)	8	
Not aware of opportunity	2	
Course not available (e.g. Trust has put course on "hold" at present)	1	
Not eligible (e.g. due to lack qualifications)	1	
Not able to get on course	<1	
Political reasons (eg. Welsh Assy/National policies)	<1	
<i>d) Don't want to</i>		13
Studying in other areas at present	8	
Do not wish to prescribe – end up doing routine prescribing/take away from main role.	3	
No financial incentive to complete course	1	
Not seen as good course	1	
<i>e) Other</i>	4	4
	Responses	450
	Cases	382

Source: Employment Research 2005

The most frequently cited (by 56%) reason for not doing the course was that it is not needed either because it is not relevant to the role being undertaken, or because other people have done it so its not needed. For those respondents who do see it as relevant, the main reason they have not done the course (and are not about to – 14%) is that they are not able to – 32% of all reasons cited related to this theme, and this would be double if we exclude those who are not doing it because its not relevant to them. More specifically, 19% of all respondents say that the course is either not available to them, or they are not supported by their employer/manager to do it, or else there is no funding for them to do it. In other cases the reason they are unable to do it is that being in relatively unique roles, it is difficult to get suitable cover to allow them to do the course. In 13% of cases respondents did not want to undertake the course – primarily because they already doing other studies, although for a few (9 people) its specifically because they do not wish to prescribe, saying that it will take way from other elements of their role.

3. Nature of the work

Having established the range of activities undertaken and how these relate to the different post types, this chapter moves on to look at the way in which these nurses practice. What teams do they work within and to what extent are nurses in these roles autonomous? Having established their working relationships in terms of colleagues and style of working, we then explore the nature of the roles in terms of the way in which they see patients/clients and how patients are referred to and from these nurses.

Key points in Chapter 3

- *Nurses in these roles work in a variety of different teams and 85% agree or strongly agree that they feel part of the team*
- *45% consider they are primarily in a nursing team whilst 38% see the multidisciplinary team as most central to their role.*
- *Regardless of which team they identify with, 98% report that nursing skills are important to their job.*
- *Although part of a team, the majority (72%) work primarily on their own and 97% report that a high degree of autonomy is required in their role.*
- *Continuity is a major feature of these roles – 93% have an ongoing relationship with their patients/clients.*
- *In many cases the roles seem to be the ‘hub’ of care coordination – nurses in these roles take referrals from a number of different sources (typically 5 are listed) and refer patients on to a range of other services.*

3.1 Team working and autonomy

Table 3.1 shows the proportion working in each type of team. Regardless of the fact that these nurses report a high level of autonomous working and 90% report making professionally autonomous decisions, working in a team is nonetheless the norm – only two cases (less than one percent) did not give a team they are working in². When asked ‘Which team/s do you work in?’ the most frequent response, given by just under three-quarters of nurses surveyed, is multidisciplinary. But many of these nurses see themselves as working in more than one team.

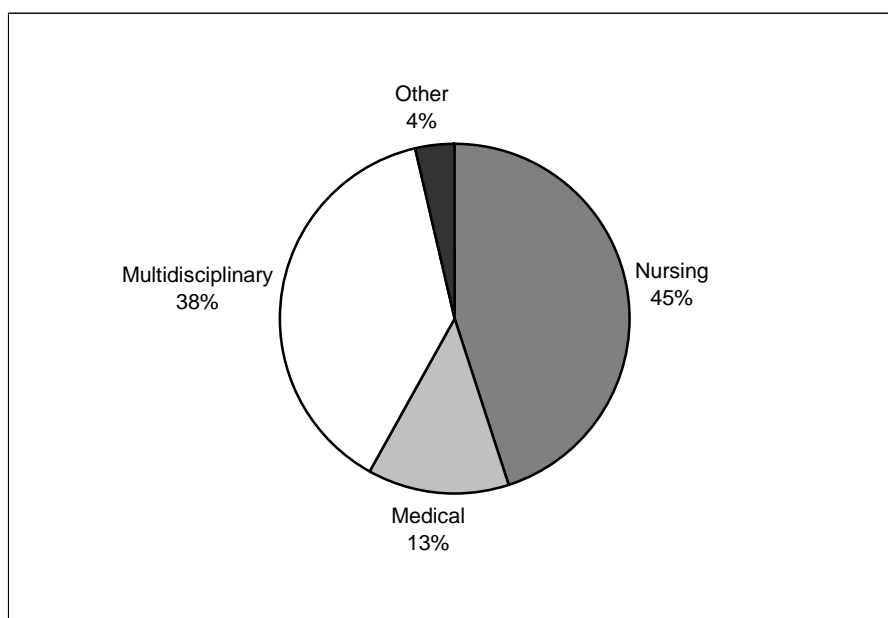
Table 3.1 Teams worked in - percentages

Nursing	62
Medical	37
Multidisciplinary	72
Other	9
Approximate total N	505

Source: *Employment Research 2005*

A further question asked respondents who work in more than one team to say which is the most central to their role. The results (including respondents who work in one team where the most central is taken as the only team they work in) are presented in Figure 3.1. Slightly larger proportions see themselves as primarily in a nursing team than in a multidisciplinary team – 45% compared to 38% in multidisciplinary. Just over one in ten see a medical team as most central to their role.

Figure 3.1 Which team is most central to your role?



Source: *Employment Research 2005*

² For exploration of professional autonomy and team working see: ref - Rafferty, Ball, Aiken

Table 3.2 Team central to role by post type - percentages

	% of all	NP	CNS/SN	NC	ANP
Nursing	45	45	46	44	37
Medical	13	30	7	9	34
Multidisciplinary	39	23	43	47	23
Other	3	3	3	-	6
Approximate total N	446	71	297	43	35

Source: *Employment Research 2005*

The importance of different teams varies between post types (Table 3.2) – nurse practitioners and advanced nurse practitioners are less likely to report that the multidisciplinary team is central to their role, but one in three report the medical team is central. Fairly similar proportions across the post types report the nursing team is central. Nurse consultants and specialist nurses/CNS are less likely to report the medical team is central (9% and 7% respectively).

Of the 9% (41 cases) who report working in some ‘other’ team, the sorts of teams referred to are: education, community, industry, management, social services and voluntary agencies.

All respondents were asked (as part of a series of attitude statements with agreement scales) to what extent they felt part of a team (Table 2.8). The vast majority (85%) either strongly agree (46%) or agree (39%) that they feel part of the team. Just 4% disagreed with this statement. Those in unique jobs (ie. where no-one else is employed with the same job-title where they work) were slightly less likely to feel part of a team (81% vs 89%), but there was no difference between post types or the sector worked in.

Interestingly, although virtually everyone is part of a wider team, a large proportion (72%) report that they work primarily on their own – highlighting the difference between belonging to a team and nonetheless working independently day to day.

Table 3.3 Views nursing autonomy and team working - percentages

	strongly agree	Agree	neither	disagree	strongly disagree	N=
2 A high level of autonomy is required in my role	74	23	2	0	0	502
15 I work primarily on my own	37	35	11	15	3	502
4 I feel part of a team	46	39	11	3	1	504
3 My nursing skills are important in my job	71	27	1	1	0	502

Source: *Employment Research 2005*

Another interesting finding, in terms of identity, is that whatever team nurses see as being most central to their role, 98% say their nursing skills are important in their job.

3.2 Patient contact & referrals

Overall, about 25% have clients that visit them, 20% go to clients/patients, and the remaining 45% do both. Tables 3.4 and 3.5 look at how the type of client contact varies between post types.

Most (93%) of nurses in these roles have an ongoing relationship with clients/patients – either in addition to having single episode contact (64%) or entirely (29%). Just 7% report that their client/patient contact comprises solely of single episodes.

Both these features varied according to post type. NPs and ANPs are more likely to have single episode contact than colleagues in other posts, whilst CNS are more likely to report that care provision is ongoing. Likewise NPs and ANPs are more likely to be visited by patients (71% and 69%), particularly in comparison with CNS (21%) and SNs (23%).

Table 3.4 Mode of seeing patients/clients by post type -%

	NP	CNS	NC	SN	ANP	Total %
Patients/clients visit me	71	21	39	23	69	35
I visit patients/clients	7	29	7	20	22	20
Both	22	50	54	57	9	45
N=	72	165	44	120	32	433

Source: Employment Research 2005

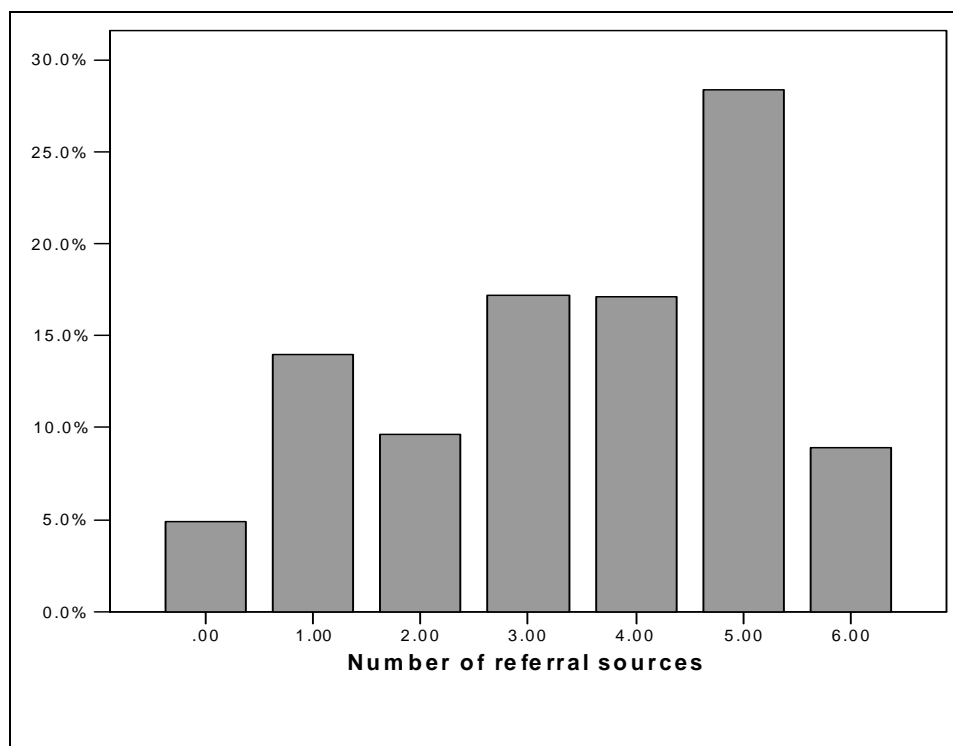
Table 3.5 Patient/client contact by post type - %

	NP	CNS	NC	SN	ANP	Total %
Provide ongoing care for patients	16	38	27	29	18	29
Contact is in single episodes	12	2	7	8	12	7
Mixture of ongoing & single episodes	72	60	67	63	71	64
N=	75	168	45	120	34	442

Source: Employment Research 2005

Overall, nine out of ten (88%) report that they refer patients/clients to other health care providers. The nature of referrals to and from these nurses was explored in greater detail, and the results are presented in Table 2.11, 2.12 and 2.13. The majority of these nurses take referrals from multiple sources – typically at least four different sources, as Figure 3.2 illustrates.

Figure 3.2 Number of referral sources per respondent



Source: *Employment Research 2005*

Referral routes varied between post types. The asterisks in the significance column of Table 3.6 give a measure of statistical significance of each result (asterisked cells indicate significant relationship, more asterisks indicate higher levels of significance).

Table 3.6 Referral sources - percentages

	% of all	NP	CNS/SN	NC	ANP	Sig
Self-referral	57	73	53	67	50	**
Referral by GP	61	71	63	65	53	-
Referral by consultant	68	39	80	82	42	***
Referral by nurse	66	64	70	83	47	**
Referral by other health professional	69	64	74	78	53	*
Other	28	24	26	36	31	-
Approximate total N	507	75	302	46	36	

Source: *Employment Research 2005*

ANPS generally have less referrals, hence have lower percentages from all 6 sources. Nurse Practitioners have higher proportions of self-referrals and GP referrals, whilst NCs and CNS/SN are more likely to have referrals from consultants or other nurses. 69% of all respondents say they have referrals from other health professionals, and this is 78% for Nurse Consultants.

Table 3.7 lists the other referral sources mentioned. It shows the mixture of agencies that some of these nurses liaise with, beyond the multi-disciplinary health team.

Table 3.7 Other referral sources - percentages

	%
Social services/social workers/Voluntary sector/other care agency	34
Other health service staff	30
On Special School roll/School/teachers	10
Families	10
From lab results/microbiology	4
Emergency/ambulance/arrest call	4
Industry	4
Not referred to directly	3
From looking at notes to see if meet criteria	3
Other	14
	126 cases
Total N	146 responses

Source: *Employment Research 2005*

Table 3.8 Referral destinations - percentages

	% of all	NP	CNS/SN	NC	ANP	Sig
Consultant	73	72	72	91	75	*
Other advanced/specialist nurse	64	57	67	65	68	-
Allied Health Professional	79	84	81	83	76	-
Other	30	28	29	38	31	-
Approximate total N	507	75	303	46	37	

Source: *Employment Research 2005*

A larger percentage of nurse consultants refer to consultants than do other advanced-specialist nurses (Table 3.8). Other than that, there is no significant difference in the pattern of referral destinations between post types, with about two-thirds referring patients on to consultants, other advanced specialist nurses, allied health professionals or other staff.

The referral patterns, taken in conjunction with the prevalence of coordination roles, build a picture of these nurses being at the centre of a web of services – they receive patients from a variety of sources and refer them on to a variety of destinations, whilst acting as sources of specialist advice to other staff.

4. Working situation

The aim of this chapter is to get a better understanding of where nurses in advanced and specialised roles ‘fit’ within health service organisations. We continue the analysis started in Chapter 3 on who these nurses work with and how they see clients, and go on to describe how the roles interface with other staff and services.

This chapter aims to do two things. Firstly to describe how nurses in these roles are positioned within organisations. Secondly, to find out more about how well understood these roles are by other staff and patients. In many cases, when advanced-specialist roles are first established there are strong drivers for its inception - the role and its purpose are clearly conceptualised by the originators. But further down the line, how much of this clarity remains? Do other staff and service users understand the remit of the role and where it fits within the range of service delivery? Chapter 4 addresses these questions, by looking first at the distribution of roles across organisations and how the posts are graded, before looking at where they fit in terms of colleagues with similar roles and line management. We finish the chapter by reviewing the extent to which respondents feel their role is understood.

Key points in Chapter 4

- CNS and Nurse Consultants are more likely to be working in acute/hospital settings. Across all role types about half work in acute/hospital settings and the rest are in primary/community or other settings.
- Disproportionately large number so these roles are in oncology/palliative care.
- Significant proportions of nurses in these roles are not able to give a single work place as their setting (21%) or define their role as fitting into single specialty (23%). In many of these cases nurses are working across organisational and specialty boundaries, providing a specialised-advanced service in a variety of settings to a variety of patients.
- Nurse consultant posts are typically graded higher than the other role types. Specialist nurses have the lowest proportion of H and above graded posts.
- A smaller proportion of respondents working in acute settings are in higher-grade posts.
- About half of these posts are unique within their organisations, in that no-one else has the same job title.
- Although confident that they are respected by their colleagues and other health care staff, the scope of the role is not always fully appreciated by others. A quarter have had referrals refused because they are a nurse not a doctor, and a third have had investigation request turned down on the same grounds.

4.1 Employer, work setting & specialty

Table 4.1 shows the distribution of posts by employer and Table 4.2 shows the split between hospital and community settings. The NHS or GP Practices employs 90% of respondents. Within the independent sector the most prevalent post types are specialist nurses and clinical nurse specialist, who together account for 63% of all independent sector respondents.

CNS and nurse consultants are more likely to be working in an acute setting, whilst nurses in nurse practitioner posts are in fairly equally divided between hospital and community/primary care settings. Looking within the acute setting, 46% describe their posts as CNS and a further 22% are in SN posts.

Table 4.1 Employer by post type - %

	NP	CNS	NC	SN	ANP	Total %
NHS	56	92	88	83	67	81
GP Practice	36	1	-	2	25	9
Independent	7	5	9	9	8	7
Other	-	2	2	6	-	3
N=	72	166	43	125	36	442

Source: *Employment Research 2005*

Table 4.2 Setting by post type - %

	NP	CNS	NC	SN	ANP	Total %
Acute/Hospital	41	64	65	43	53	54
Primary/Community	43	19	21	31	31	28
Other	16	17	14	25	17	19
N=	74	168	43	118	36	439

Source: *Employment Research 2005*

The proportion of respondents in each type of setting is described more detail in Table 4.3, along with a breakdown by post types. Half of all respondents who gave a work setting were based in a hospital, primarily in a specialist unit of some sort. 10% report working in GP Practice and 18% in the community. About a fifth (21%) work in some other setting.

Table 4.3 Setting where respondents work - percentages

	Percent (of all)	NP	CNS/SN	NC	ANP	N=
Hospital unit	33	21	34	47	39	146
Minor injury unit	2	7	1	-	-	8
Medical assessment unit	0	-	-	-	-	1
Hospital ward (one)	1	1	-	-	-	1
Hospital wards (many)	8	4	10	12	3	37
Hospital outpatients	6	7	7	2	8	28
Community	18	3	23	21	-	76
GP Practice	10	41	1	-	31	
Out of hours provider	0	3	-	-	-	2
Walk in centre	1	4	-	-	6	5
Other/Many settings	21	7	25	19	11	21
Total (100%) N=	488	73	287	43	36	439

Source: *Employment Research 2005*

About half (46% or 55 cases) of those who ticked 'other' as place of work, are working across several different organisations. Another 20 cases (17% of other) were working across a hospital site in a variety of settings, and 13 cases (11% of other) were working in occupational health/industry. Table 4.4 describe the specialty respondents work in.

The speciality that stands out as having a particularly large share of advanced or specialist nursing roles, outside of the big areas like adult acute (11%) and primary/community (16%), is oncology and palliative care – 15% of respondents report working in this speciality. One in ten respondents indicated they worked in paediatrics. The other striking finding is the large proportion – 23% - that do not see their role as fitting in any of these specialties, but instead have circled 'other'. Although respondents who ticked 'other' gave details of their specialty, their responses were hard to classify, since they were using the other category either because their role crossed speciality boundaries (e.g. infection control, pain management), or because it is so highly specialised that traditional ideas of specialty do not easily apply.

Table 4.4 Specialty where respondents work - percentages

	% of advanced and /specialist nurses	<i>N</i>	% across all staff groups ³	<i>N</i>
Primary Care / Community	16%	82	19%	
Older peoples nursing	0%	2	10%	
Mental Health	5%	25	6%	
Adult Critical Care	5%	26	13%	
Adult general/medical/surgical	11%	54	21%	
Rehabilitation/Longer term care	1%	5	2%	
Paediatric Critical Care	2%	10	3%	
Paediatric	7%	36	5%	
Women's Health/Midwifery	3%	16	2%	
Learning disabilities	0%	2	2%	
Oncology/Palliative care	15%	76	4%	
Education/Research	1%	5	2%	
Several specialties, across the organisation	9%	44	3%	
Other	23%	114	9%	
Total	100	498	100	9,336

Source: *Employment Research 2005*

The figures in the third column in Table 4.4 show how a random sample of RCN members divides between the specialties, based on all grades of nurses in every type of nursing post. This gives us a proxy for the general distribution by specialty in the nursing workforce. The biggest difference is in the number working in 'other' specialties or working across several specialties (discussed above). But this aside, several other differences stand out. Most noticeably, the paucity of these roles in older peoples nursing compared with the workforce at large, and the disproportionately large numbers in oncology/palliative care, and paediatrics.

Possible explanations for this are that:

- Nature of different specialties lend themselves to these sorts of roles
- History of development of these roles – started in certain specialties and have become established but has not 'taken off' to the same extent in other fields of practice.

³ Ball J & Pike G 'Stepping stones: Results from the RCN membership survey 2003' (see page 21). RCN London.

4.2 How the posts are graded

Looking at pay/grade gives some indication of where these roles fit in relative to other nursing posts, and from a career ladder perspective. The majority of these posts are H grade positions, but a significant proportion (37%) are G grades.

Table 4.5 Grade by post type

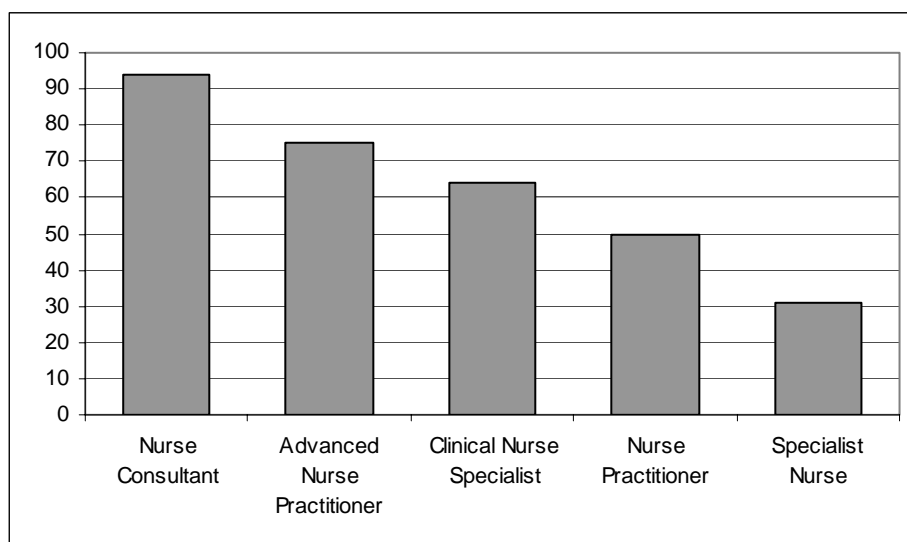
	NP	CNS	NC	SN	ANP	Total %
F	11	3	-	15	-	7
G	38	33	6	55	25	37
H	27	54	44	29	56	41
I	12	8	11	-	8	7
Other	11	2	39	2	11	8
N=	73	170	46	126	36	451

Source: Employment Research 2005

Table 4.5 gives the grade distribution of respondents and within each post type. The majority of respondents (78%) are in G or H grade posts. Note that the sample surveyed was restricted to those in F grade positions and above. In the 2003 RCN AES, a few (3.5%) were in lower graded positions.

None of the nurses in nurse consultant or advanced nurse practitioner posts, and very few CNS are working at F grades. Meanwhile one in ten of those in ‘nurse practitioner’ posts and one in six of those in specialist nurse posts are being paid at F grade (or its equivalent). The relationship between post types and grade is more apparent when we look at the proportion of each post type who are in H/I or ‘other’ graded posts. (Figure 4.1).

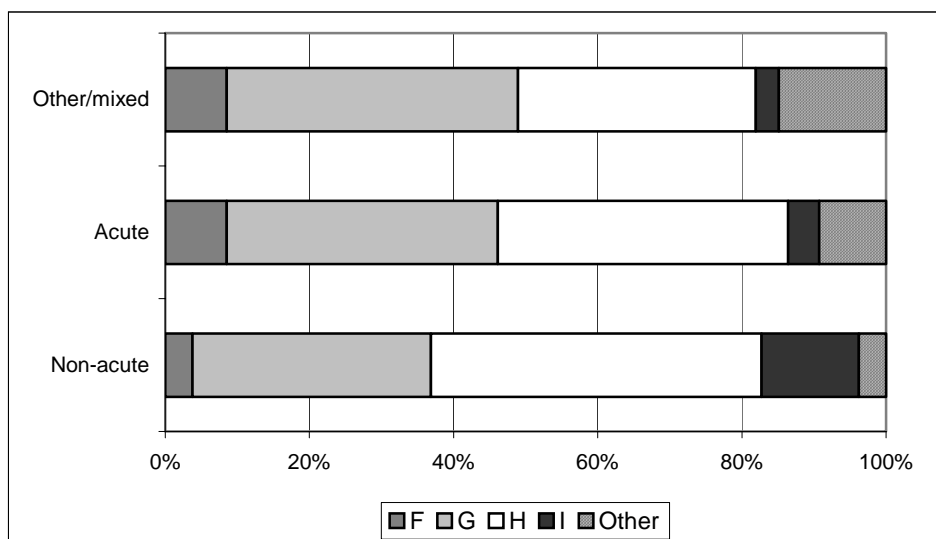
Figure 4.1 Percentage who are H/I or Other grades



Source: Employment Research 2005

Significant differences exist between the grade profiles of nurses in different settings (Figure 4.2). Comparing acute and non-acute settings, those in non-acute (primary/community care) are less likely to be in F or G graded posts, and are more likely to be on H or I grades (or their equivalent). Just under one in ten (9%) of those working in a hospital environment are on describe their grade as 'other' compared with 4% of those in primary/community care settings.

Figure 4.2 Grade by setting



Employment Research 2005

Source:

4.3 Organisational position

In this section we address the following questions:

- To what extent are these roles unique/one-offs?
- Who manages these staff?
- Who provides professional support?

Responses are split down the middle in terms of how many are in unique roles, and how many have colleagues doing the same job (with the same job title) within their organisations – 53% say there are others with same job, 47% report that there are not. Having colleagues doing the same job varied significantly according to the post type - just one in five (22%) nurse consultants have colleagues with the same job compared with 47% of ANPs, 58% of CNS/SN, and 63% of nurse practitioners.

There is little difference between those based in hospitals compared with those based in the community, but perhaps reflecting the smaller size of organisations worked in, a smaller proportion of those working in GP Practice (40%) had colleagues in the same job. The average number with the same job is 2.5 across all respondents (including those who have no commensurate colleagues), or 4.6 of those that have colleagues in the same role.

The degree of perceived autonomy required in the role, is related to whether they are working in unique roles. Respondents were virtually unanimous (97% agreed) that a high level of autonomy is required in their roles. But whilst there was general agreement, about three-quarters agreed strongly (74%) with this statement whilst a quarter (23%) simply agreed. A larger proportion of those in unique roles agreed strongly – 80% compared with 69% of those with colleagues in the same role.

Four out of 5 respondents are managed (i.e. their immediate line manager) by a nurse. About half (51%) have another manager who is responsible for providing professional support. This is the case even for those nurses whose line manager is a nurse (49%), but more frequently so if the line manager is a non-nurse (62%).

4.4 Understanding and utilising the roles

As well as getting an understanding of the roles themselves, the survey aimed to explore how other people respond to these roles. As an indicator of the degree to which the authority of these roles is recognised, two questions asked whether respondents had ever had a referral or investigation request refused because of being a nurse (not a doctor). Almost one in four (23%) of those who refer patients (N=428) have had their referrals refused because they are a nurse rather than a doctor. Similarly a third (33%) of the 315 respondents who order investigations had been refused on the same grounds.

The likelihood of having referrals refused depends on both job title and sector. Those in nurse practitioner (37%) and advanced nurse practitioner (45%) posts are more likely to have had their referral refused, compared with specialist nurses/CNS (17%) and nurse consultants (24%). Some but not all of this variation would seem to relate to the different distribution of posts between the sectors, and the fact that community/primary care based nurses were twice as likely to have had referrals refused compared with their hospital based colleagues (33% vs 16%). But even within the same sector, those in specialist nurses are least likely to have had refusals (13% in acute and 16% in community/primary).

Nurses' views about the way in which their roles are understood sheds some light on this area (Table 4.6).

Table 4.6 Views re roles being understood – percentages

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	N=
11 My professional judgement is respected by nursing colleagues	46	49	5	1	0	506
12 My professional judgement is respected by other healthcare staff	38	56	6	1	0	507
13 Patients generally regard me as a nurse	33	52	9	6	0	505
14 My role is understood by other nurses	13	45	19	21	2	504
16 Patients have difficulty understanding my role	3	15	23	50	9	506
17 Other staff make appropriate use of the services in my role	12	63	15	9	1	506

Source: Employment Research 2005

Nurses are virtually unanimous that their professional judgement is respected by nursing colleagues, and by other health care staff – although fewer agree strongly with the latter. Whilst they believe their professional judgement is respected, they are less convinced that other staff actually understand the roles they are in. A quarter report that their role is not understood by other nurses, and although patients generally regard them as nurses, so their professional identity is clear, 18% say that patients have difficulty understanding their role. Perhaps related to this, one in ten find that other staff are not making appropriate use on the services provided by their role.

There is a significant difference between nurse consultants' and nurse practitioners' views, with 87% of NC agreeing that other staff make appropriate use of their services compared with 66% of NPS.

5. Evolution of extended practice posts

So far we have looked at what these roles are, who is in them and where these roles fit (in terms of identity and management structures) in organisations. In this chapter we look at the data on how the posts were developed; the people and the way in which the roles continue to evolve. Respondents were asked whether the post existed before they took it up, and about what involvement they had in establishing the post. We then look at how the roles have changed since respondents have been in post and how they ideally would like the role to be reshaped.

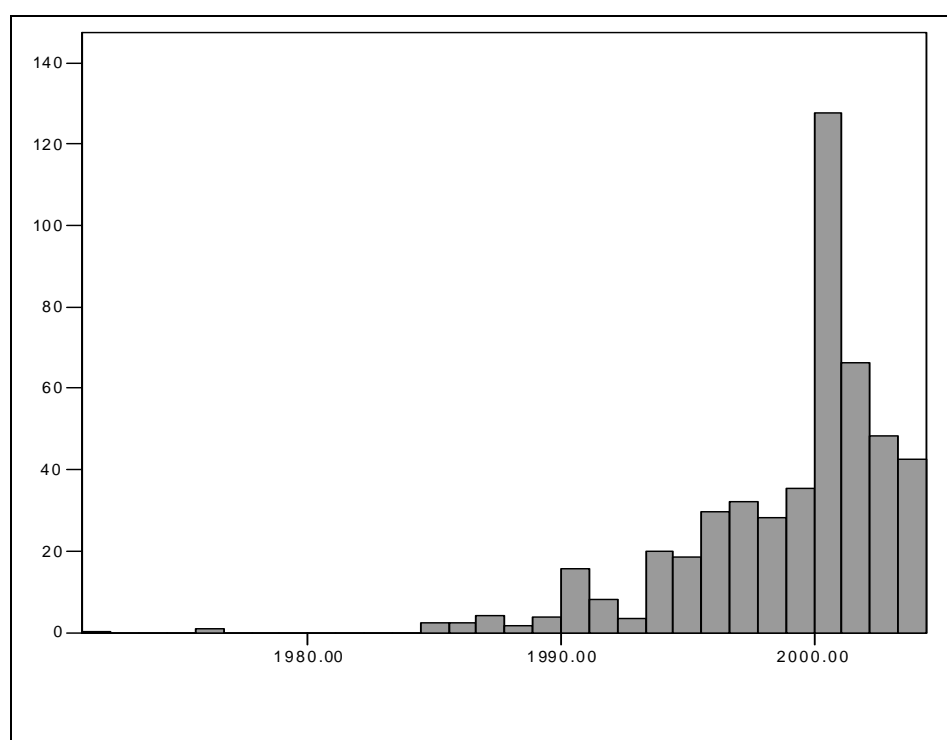
Key points in Chapter 5

- *Many of these nurses are in new posts that did not exist before they took up the job, particularly those in nurse consultant or advanced nurse practitioner post.*
- *Nurses have been involved in the development and establishment of many of these posts.*
- *The roles continue to change and evolve – 90% report the roles they are in have expanded, but this expansion is welcomed by post-holders who are keen to add activities (such as prescribing or other clinical activities) to their roles.*
- *Lack of time and funding are the main constraints on nurses preventing them from expanding/developing the role in the way they would like.*
- *Respondents identify activities that could usefully be delegated to allow the role to retain its focus – the most frequent area identified is administrative and clerical work.*

5.1 History/development of the post

We start this analysis by looking at when the respondents themselves first took up their current post (Figure 5.1). The results show that most respondents had taken up their current post in the last 4 years, with 2001 being the most frequently given year. In 60% of cases the post did not exist previously, i.e. they were new posts at that time – giving some indication of the rapidity of growth of these sorts of roles. The proportion of ‘new’ posts varied according to the type of post with larger proportions of those currently in nurse consultant jobs or advanced nurse practitioner posts saying that they were the first post-holders in these jobs (91% and 86% respectively, compared with 47% of specialist nurses).

Figure 5.1 Year took up current post - numbers

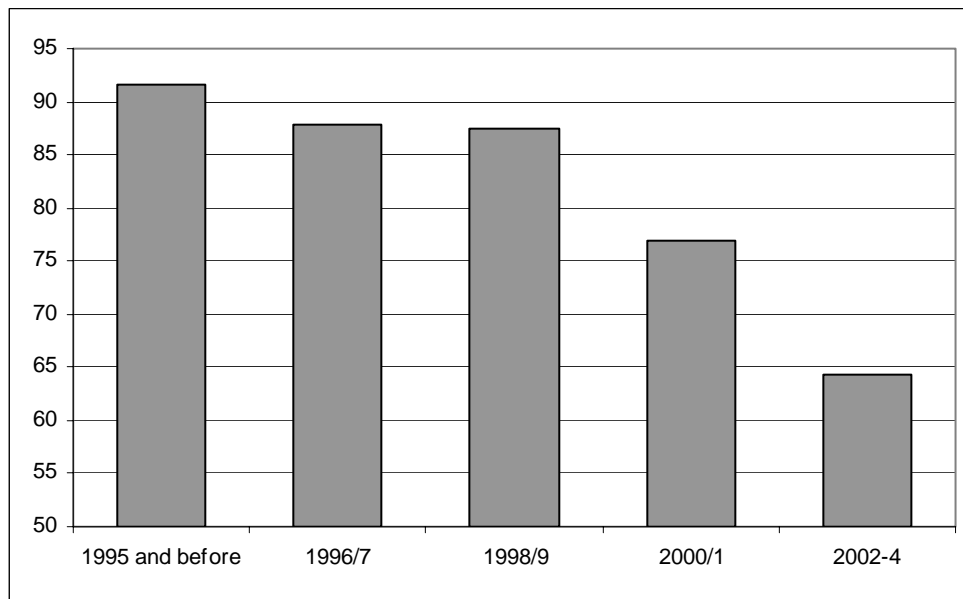


Source: *Employment Research 2005*

In four out of five cases (79%), nurses who were taking up new posts had been involved in establishing the role. Those working in primary and community care were more likely to have been involved in establishing the post than staff in other settings.

There also appears to be a change over the years (see Figure 5.2). Those who have taken up new posts recently are less likely to report they have been involved in setting them up compared to those who took up new posts during the 90's and before. But it is the people in the ‘newest’ roles (i.e. those roles in which highest proportion of posts did not exist before the post-holder took them up), that have been most involved – 90% of nurse consultants and 91% of advanced nurse practitioners going into posts that did not previously exist, were involved in setting up their new posts.

Figure 5.2 Involvement in establishing new post by year started



Source: *Employment Research 2005*

5.2 Ongoing change - how the roles have evolved

Although many of these posts have only been in existence for a short while, the roles covered by them have changed. Nine out of ten respondents say that their role has expanded since they took the post, with just 8% saying it has stayed the same and 2% reporting a contraction. Likewise 90% agreed or strongly agreed that their 'role is evolving'.

With many of these posts evolving and new posts being created, how well defined are the posts? The vast majority (95%) report that they have a job description and 71% of these respondents consider that it provides an accurate description of their role. Over a quarter (27%) did not feel it was accurate and 2% were not sure. This compares to data collected from a cross section of RCN members in 2001 that found that 10% of RCN members did not have a job description at all (and 2% didn't know). Of those with a job description, 43% said that it was not an accurate description of their role.

One of the attitude statements in the current survey was: 'My role has expanded beyond my job description'. Just over half (55%) agreed that this was the case (see Table 5.1).

Table 5.1 Views of role change – percentages

	strongly agree	Agree	neither	disagree	strongly disagree	N=
7 My role is evolving	46	44	6	2	1	500
8 I'm open to the idea of my role changing	43	50	7	1	0	505
9 My role has expanded beyond my job description	30	25	30	20	4	494
5 I sometimes feel I am expected to work beyond my level of competency	7	17	15	49	11	507
10 I am happy with the way my role has changed	31	50	14	5	1	492

Source: *Employment Research 2005*

Despite the fact that many of the roles are growing, often beyond the post's job description, respondents were positive about role change. 93% said they were open to the idea of their role changing and 81% reported being happy with the way in their role has changed already.

Overall then they are positive about the way in which their role is evolving. We do not know about the drivers and motivations for change, or locus of control, but other questions point to how respondents themselves would like to see their roles reshaped. The survey asked if there were any activities that they do not currently do, that they would like to add to their role. More than half (58%) said there was. The following questions explore what these activities would be, and what was stopping respondents from doing them at the moment. A final question asked what, if anything, they would like to be dropped from their role and why.

Table 5.2 Activities would like to add to role

	% of cases
06 More specific clinical duties/roles (e.g. nurse led clinics)	29
02 Prescribing (more fully)	25
01 Research; Audit	21; 4
03 More pro-active roles/work	10
12 Educate staff/university links	8
08 Assessment/Physical Examination	7
05 Expand role/service; Enriching/Improving the service	6; 5
13 Patient/Family/Client group education	5
17 Order investigations	5
15 Professional development/education for self	4
07 Counselling/Support	3
04 Chronic disease management	1
09 More involved in strategies and Trust policies	1
11 Support/Supervise/Manage staff/Leadership	1
16 Make diagnosis	1
88 Other	5
N=	Cases = 290
	Responses = 403

Source: Employment Research 2005

The first finding to note, is the fact that so many respondents – well over half – gave details of activities they would like to add to their role. We do not have any data to compare this finding with, but such a strong response does raise the question: what proportion of staff in other walks of life - accountants, lawyers or dentists - would want to expand their jobs? Just under a third referred to specific clinical activities or roles, and quarter referred to prescribing developments and another quarter wanted to be able to do more research or audit work.

The main reason given for not currently doing the activity that they would like to have added into their role (Table 5.3), is that they simply do not have enough time. In many cases this is because they are in unique posts, and so cannot share their workload with colleagues to enable them to continue developing their role. The overall impression from looking down the list of most cited activities, is that the majority of nurses want to be able to be more actively involved in developing their role in order to expand and develop the service they provide. It is as if nurses in these roles are in some cases victims of their own success. The qualitative data points to the fact that in many cases these ‘new’ roles were originally developed by setting up a single post, to ‘test the waters’. But due to the success of these roles, they have become a pivotal component in care delivery - interfacing with a wide variety of other staff/agencies and providing clients access through many different routes.

Table 5.3 Reasons that activities are not currently undertaken

	% of cases
01 Time – too busy (sole post holder)	47
04 Resources/funding	19
06 Qualification/s or training (suitable course not available)	16
09 Hospital/National policy restricts	12
11 Staff numbers/cover/lack of skilled staff	10
03 Lack of recognition by management – medical lead	9
05 Trust/Medical restrictive culture	9
02 Not been offered (training/opportunity) as part of role	8
08 Lack of management support	8
12 Job boundaries of other staff (e.g. radiologists, consultants etc.)	5
10 Lack admin/clerical; too much paperwork	1
13 New Service – need to assess	1
14 Lack financial reward/grade	1
07 Not high priority by Trust	<1
88 Other	3
N=	Cases = 286 (56%) Responses = 421

Source: Employment Research 2005

To allow services to continue to develop requires an increase in the number of posts, so that the original post-holder can continue to lead service development. Virtually all the factors hampering respondents from expanding their roles, are in the employers’ sphere of control: too little time/sole post-holder, resources, restrictive culture, lack of managerial or medical recognition or support, or difficulty accessing appropriate training. It seems as if the majority of these nurses are ready and willing to develop their roles for the benefit of patients/services but that the infrastructure and support being offered by employers, and other colleagues is lagging behind the new modes of service delivery. This point is returned to in chapter 7, ‘Reaping the Benefits’.

Table 5.4 lists (in rank order) the activities that respondents said they would like to drop from their role if they could. Note that 244 people answered this question – thus the majority (52%) did not consider that there was anything they would like to see dropped from their role.

Table 5.4 Activities would like to drop from role

		% of cases
01	Secretarial/admin/clerical work	35
03	Nothing	33
02	Basic clinical jobs could be undertaken by LESS specialised staff (not using nursing skills fully); Make role less broad, hone down to more specific	17 & 4
08	Managerial activities that others could do more easily (e.g. Business planning, budgets, etc.)	8
09	Specific activity related to specialisms	3
11	IT	2
04	Social Work/advocacy ref. DLA Social services	1
07	Providing cover elsewhere (e.g. because lack funds/staff)	1
05	Home visits	<1
06	Less clinical work to increase time on education & research	<1
88	Other e.g. training medical students, meetings	8
N=		Cases = 244 (48%)
		Responses = 275

Source: *Employment Research 2005*

The most frequently cited activity that advanced-specialist nurses would like to see dropped from their roles, is administrative/clerical work. The next most frequent response given by a third of cases, is that there is actually *nothing* that they would like to remove from their role. Adding this to the number that did not answer the question, we see that only a third of all cases put forward activities they would like to see dropped. This suggests a high degree of overall job satisfaction amongst these nurses – an aspect of work-life that is explored more fully in Chapter 7.

Looking across these responses, the picture that emerges is that advanced and specialist nurses are either happy with the role as it is, or else want to drop things from the role that dilute it. The changes most wanted, are those that enable them to keep the focus on their area of expertise. Hence they would like to reduce the general admin/clerical work, and reassign activities that other less specialised staff could easily. The activities that they would like to hand over to other staff that do not make best use of the skills, are not just clinical activities, but also management type activities such as business planning and budgets.

6. Career paths

The previous chapter focused on how the posts themselves have evolved, but in this chapter the focus shifts away from the posts to take a more personal perspective – how have the people come to these posts and where does being an advanced-specialist nurse fit in to the rest of their careers? Thus we start by describing what they were doing before and how long they have worked in their current field of practice. We also look at what preparation they have had, and what preparation or experience they think is needed to do these sorts of roles. The final part of this chapter describes the data on respondents' next career steps. Is this a temporary stepping-stone for nurses who are likely to move on to other types of role, or do many see these roles as their future as well as their present?

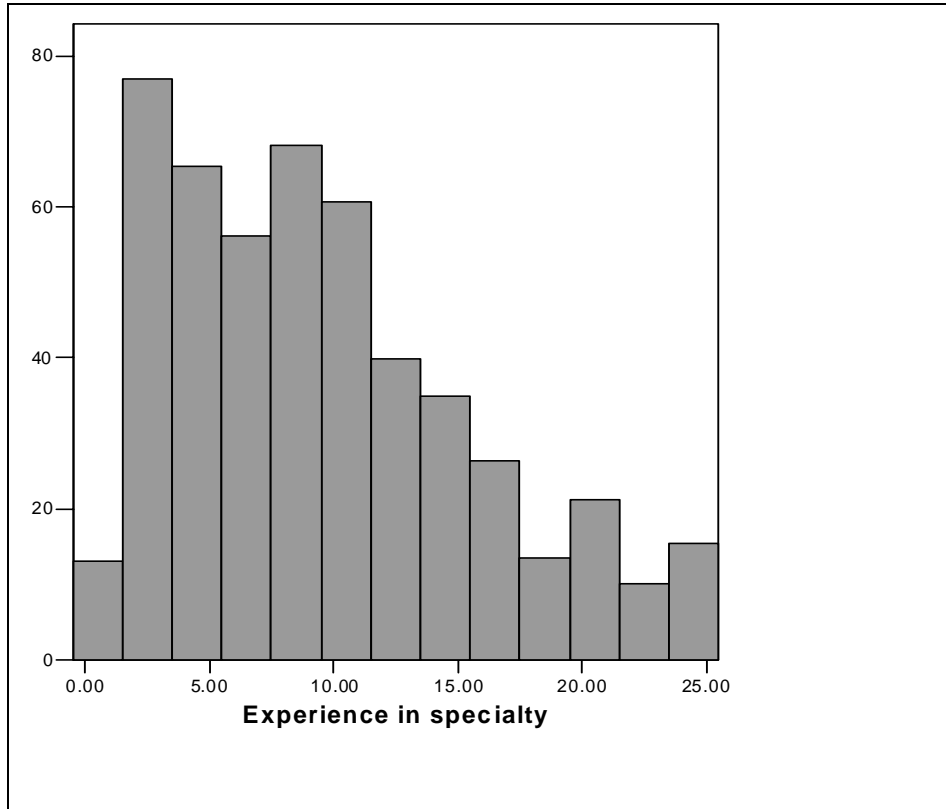
Key points in Chapter 6

- *Respondents had typically been in post about 5 years and had come from a range of different backgrounds.*
- *Most have at least ten years experience of the speciality/field of practice they are working within.*
- *Respondents report that they took up these posts in order to further their professional development, for the stimulation of new 'challenges', to become more specialised in their chosen field of practice and to develop services for patients/set up new services.*
- *46% are educated to degree level or beyond.*
- *Education and training are seen as important means of preparing for these roles, although specific academic qualifications are less frequently referred to. A breadth and depth of experience is also seen as good preparation.*
- *Two-thirds plan to continue working within the same specialty, either in roughly the same job or else specialising further or going up the career ladder within the same field.*

6.1 Previous experience

The average length of time that respondents had been in their current post was 5 years, although typically they had had about 10 years experience in the specialty they are now based. Figure 6.1 illustrates the range in experience in specialty. There was a significant difference in specialty experience by post type, with nurse consultants having the longest in-specialty experience (average 11.4 years) and nurse practitioners the shortest time (average 8.22 years).

Figure 6.1 Years worked in current specialty - numbers



Source: *Employment Research 2005*

Table 6.1 presents the data on respondents' previous jobs in terms of the type of post held, whilst tables 6.2 & 6.3 give previous employer and work setting. This data comes from responses to an open question asking respondents to give their previous job and organisation. The responses were then coded according to a set of job titles, employer types and setting codes that had been used in a previous large scale survey of nurses. For about a quarter of respondents, the job title they gave for their previous job suggests that this is their second advanced or specialist post that they have held. The most frequently cited job held before the current one, was as a sister or charge nurse, although a fifth had previously been working as a staff nurse.

Table 6.1 Previous job

	%
Sister/Charge Nurse/Ward Manager (F/G Grades)	26
Advanced/Specialist nursing post	24
Staff Nurse/Community Nurse (D/E)	20
Senior Nurse/Matron/Nurse Manager/Care Manager	5
District Nurse	5
Practice Nurse	5
Research/Education	3
Non-nursing job/work	2
Midwife	2
Health Visitor	1
Manager/Director	1
School Nurse	1
Telephone adviser/help line	0
Other – Level not clear/specified	5
Total N= (100%)	496

Source: Employment Research 2005

Table 6.2 Previous employer

	%
NHS	65
GP Practice	12
PCT – Primary Care trust	7
Independent/Private Healthcare	3
Non-nursing employer	3
Other Nursing Bank	2
NHS Professionals	2
University	2
Charity/Voluntary Group	1
Health Auth/NHS Exec.	1
Health Care Trust	1
School/LEA	0
Bank in NHS Trust	0
Other	2
Total N= (100%)	489

Source: Employment Research 2005

Table 6.3 Previous work setting

	%
Hospital	37
Hospital Unit	24
GP Practice	16
Community	8
Non health-sector employer	3
Hospital outpatients/clinics/day care	2
Hospice	2
University	1
Nursing/care home	1
School	1
Other health-sector employer	0
Other	4
Total N= (100%)	236

Source: Employment Research 2005

Respondents were also asked to say why they had taken up their current post. Again this was an open-ended question where up to 3 answers were coded. The results (Table 6.4) show that for 31% of respondents the current post represented career advancement. But almost the same proportion took up their current position because of their interest in the specific work area. A further 20% were looking for the challenge and stimulus that comes from working in a specialised-advanced nursing role. One in ten report that they needed the change that the post offered them. Two of the response categories – wanting to make a difference and to develop/establish a new service – demonstrate the keenness of these nurses to be involved in developing and improving services through their roles (26% of cases referred to one or other of these).

Table 6.4 Reasons respondents took up their current job

	% all cases	%
Promotion/career move/professional development	31	
Natural progression, developed from previous role	10	
Better grade/financial reward	5	Career progression
Needed change	11	
Unique opportunity	1	
Well matched to post (felt able/encouraged to take up post)	7	
Interest in specific area/role	29	
Have experience in area/Utilise skills	9	Specialisation
Challenge/want to be specialised/specialist status	20	
Patient contact (wanted to remain clinical, not purely managerial)	9	
To get mixed role (e.g. mgt & clinical, clinical & ed)	<1	
Wanted responsibility	2	Way of working
To be part of a team	1	
Development of professional relationships (eg. with managers/consultants, etc.)	<1	
Wanted autonomy	6	
Make a difference (eg. felt service could be improved)	15	Service development
To set up/develop the service	11	
Location/childcare	5	
Changed hours (e.g. to get part-time work, less unsocial shifts, increase hours)	4	
Availability	3	Personal
Had to give up “heavy” duties due to illness/condition	2	
Opportunity to move to another Health Board	1	
Bad relationship/past experience	1	
Other	3	Other
	Responses	912
	Cases	492

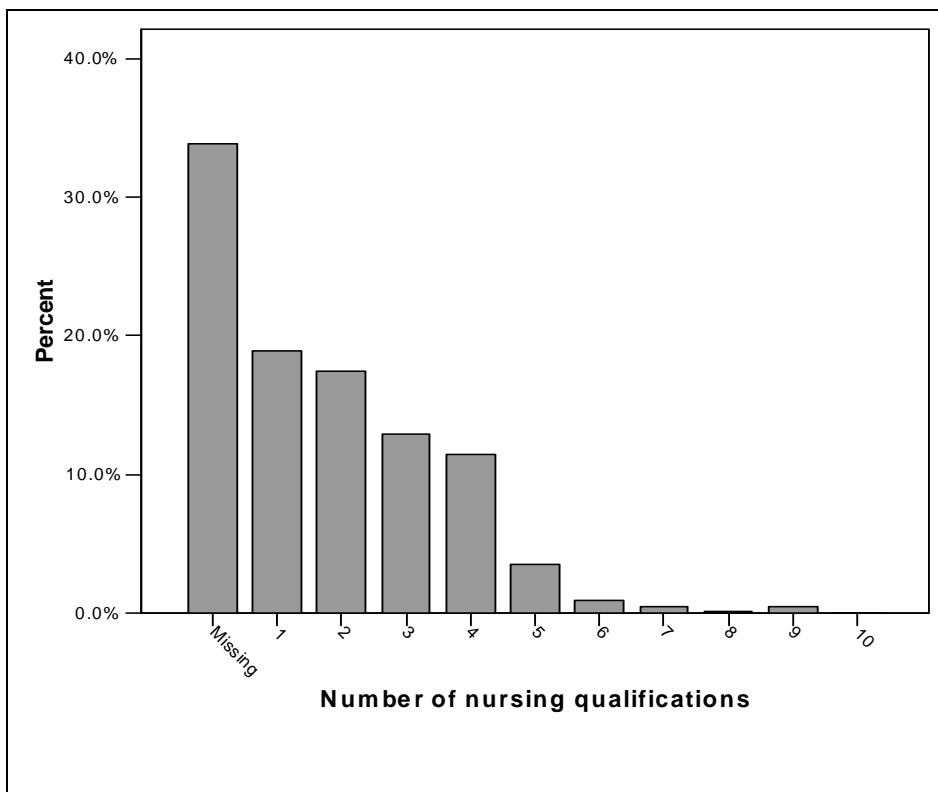
Source: *Employment Research 2005*

6.2 Nursing qualifications & preparation

Respondents were asked (in 2003) which of the following qualifications they held: First level registration, second level registration, nursing diploma, nursing degree, masters/PhD. About 40% held nursing diplomas, 39% held a nursing degree, and 15% held a higher degree (masters or PhD). Of course some of those holding a diploma may also hold a degree or higher degree, so the highest qualifications held were computed to establish the proportion holding at least a degree. In 31% of cases a degree was the highest qualification held and in 15% of cases a higher degree. Thus just under half (46%) are educated to degree level or beyond.

In the 2003 survey respondents were asked how many other nursing qualifications they held. Figure 6.2 shows that a large proportion of respondents did not answer this question. Of those that did, the average number of additional nursing qualifications held was between two and three.

Figure 6.2 Other nursing qualifications (2003)



Source: *Employment Research 2005*

Table 6.5 Best way to prepare for a specialist-advanced nursing role

		% all cases	
04	Professional qualification; specialist qualifications (e.g. degree)	35	Education/ qualifications
06	Education/on-spot training/clinical training/national training	62	
01	Type of Experience (in general)	32	Experience
08	Range of roles/experience/responsibilities.	17	
02	Length of Experience	3	
09	Have "General Nursing" experience/background	2	
10	SENIOR level experience/expertise	2	
12	Managerial experience	4	
07	Mentoring/job trial/supervision by specialist	35	Structured role related
14	Read/research about role	10	
15	Role Development programme	6	
05	Previous skills	3	Specific skills
17	Leadership skills	1	
16	Have love/passion for specialty	4	
03	Personality	2	Personal/team working
13	Interpersonal skills/confidence	4	
11	Networking/Team working skills	4	
18	Support/encouragement from colleagues	3	
88	Other	3	Other
	Responses	1092	
	Cases	474	

Source: *Employment Research 2005*

Table 6.5 presents the results to an open-ended question asking respondents what they see as the best preparation for a specialist-advanced nursing post. The 18 response codes fall into 5 main themes. The question was well answered with 93% responding. The three most important types of preparation cited were: education, experience, and some form of supervised 'job trial'. Most respondents reported that the best preparation is a combination of having the right experience (and views differed here about what is the best experience, as can be seen in the table) and having suitable educational preparation. The majority referred to experience in general, or having a wide range of experience, but a few felt that it was specifically managerial or senior level experiences that was needed.

6.3 Next steps

A final question in this section, looked to get some sense of where their current posts fits with the rest of their career, by asking what they see as their next career step. How many plan to continue in posts similar to their current one? The results are presented in Table 6.5. Two-thirds (67%) plan to continue working in the same specialty. These are split between those who see themselves continuing in roughly the same role, those who will stay in the same field but hope to get a higher-grade post, and those who want to become more specialised still within their current field of practice. Very few (1%) are considering returning to a more generalist role. Fitting the age profile of this group, 15% see their next career step as retirement.

Table 6.6 Career plans of all respondents and by post type (percentages)

	% all cases	NP	CNS/SN	NC	ANP
Continue in same or similar role as this	30	37	30	20	37
Move to a higher grade post, in same field	19	17	16	41	23
Become more specialised in this field	18	17	20	5	13
Return to more generalist area of practice	1	0	1	0	0
Sideways step to different area of specialisms/expertise	5	6	5	0	7
Move into a more managerial role	4	3	4	0	0
Move into nurse education	3	6	3	0	0
Retire	15	13	17	10	20
Other	5	1	4	24	0
Total	466	70	281	41	30

Source: Employment Research 2005

There is a clear relationship between career plans and age. Not surprisingly, the average age of those who plan to retire is older than the rest - at 56 years. But another age difference emerges, which is that those planning to return to more generalist areas of practice have a much younger mean age of 34, although numbers here are very small. The average age of each of the other categories is fairly constant at about 43/44 years old. Some of the differences between post types with regard to career plans are likely to be due to age differences – remembering that advanced nurse practitioners had the highest mean age and hence are most likely to be considering retirement.

Nurse consultants would seem to be the most career ambitious in terms of grade progression – with 41% wanting their next post to be a higher-grade post in the same field.

7. Reaping the benefits

The aim of this final chapter is to build up a picture of what is good about these roles – not just from the perspective of post-holders in terms of job satisfaction, but also from a client view point. What evidence is there of the benefits to patients? What's good about these posts and what do post-holders find most satisfying about their jobs? We also use attitudinal data from the 2003 RCN AES to explore in general terms what aspects of their working lives' these respondents view positively, compared with nurses in other roles. Several questions go on to explore what support is needed to reduce job frustrations and enable these posts to be as effective as possible.

Key points in Chapter 7

- *95% of respondents described the benefits of these roles to patients/clients. Continuity of care, easy access to expertise and the relationship with patients were frequently cited benefits.*
- *Typically the evidence available on the benefits of these roles involved audits (30%), patient satisfaction surveys (22%), or other research (13%)*
- *The aspect of their jobs that gives respondents most satisfaction, is being able to make a difference to patients' lives and seeing the impact that the service they provide has.*
- *They also value highly the nature of the relationship they have with clients/patients, and the style of working – level of autonomy and having the authority to act.*
- *Overall the morale and motivation of these nurses is good and compares favourably with nurses in other roles. The areas they are particularly positive about (relative to other nurses) are: enthusiasm for the job, feeling valued and having control over working hours and careers.*
- *But there are frustrations of being in these roles – respondents often feel they are stretched too thinly and are thus unable to develop the services in the way that they think it needs to be, or that lack of understanding about their role leads to unrealistic expectations or inappropriate deployment.*
- *Over a third feel that the service is not getting the most out their role, primarily due to under-resourcing.*

7.1 Benefit to Patients

Respondents were asked to describe in their own words in what way patients/clients benefit from the role they undertake. The responses were coded into themes and the percentage of cases giving answers falling into each category, are presented in Table 7.1.

Table 7.1 Benefits to Patients -percentages

<i>Role/Relationship with patient</i>	
Expertise (Specialist care/experience/knowledge)	32
Continuity of care; One-to-one; Known face/always see me/same team	24
Offer counselling/emotional support etc.	22
Offer patient education/information; Health promotion advice/guidance	19
Nature of relationship with nurse (more comfortable, reassured, trust/confide)	17
Home treatments/visits	4
Understanding Patient Needs	4
Able to act as patient advocate	4
Combine caring role of nurse with advanced skills	2
<i>Service</i>	
Access - direct/easy/equal eg. by telephone, self-refer, open 24 hours.	19
Standard of care/ better quality of care/pain management	14
More time to give care/longer appointments, etc.	13
Speed of delivery of service – e.g. diagnosis, treatment, referrals.	10
Whole package of care; Holistic/one-stop shop; authority to act	10
Evidence based care/practice	6
Shorter waiting times/list	5
Better patient choice/flexibility	5
Service would not otherwise be available – i.e. Filling gap/meeting need	3
Up-to-date practice/development/skills/equipment	2
Cost effective	1
<i>Links with others</i>	
Liaison/coordination/communication with other staff/agencies/GPs	12
Strategic/policy/service/guideline development and shaping	2
Staff morale improved	<1
<i>Impact on Health</i>	
Patient Quality of Life – being independent/empowered/self-care, etc.	12
Reduced infection rates/better infection/symptom control	5
Reduced hospital admissions	4
Better patient outcomes	3
Training	3
Reduced length of stay	1
Prevention	1
Other	<1
	Responses 1228
	Cases 482

Source: *Employment Research 2005*

Perhaps the most obvious benefit of these roles that one would expect to see, is a positive impact on health and well-being of patients/clients – responses related to improved outcomes were made by 29% of respondents. But the area that drew most responses relates to the quality of the relationship/contact offered to patients due to the level of expertise. About a third referred to the fact that their role allows patients to access their expertise and one in four refer to the continuity of care that the role provides. They report that patients value being able to see the same face, and having an ongoing relationship with the nurses/team.

Another major area of benefit identified by respondents, was the accessibility and completeness of the services provided. Patients are able to access the services quickly and because nurses have the authority to act, they are often diagnosed and treated more quickly than would otherwise have been the case, receiving a ‘whole package of care’ rather than having to be referred on. Patients thus spend less time on a waiting list and in many cases have longer appointments with a health professional who many feel ‘more comfortable’ with. A major benefit of these roles is the opportunity to offer patients education and guidance (19%) and provide emotional/psychological support (22%).

A further question asked what evidence there is to demonstrate the benefits of the role to clients/patients. The results are presented in Table 7.2. 30% refer to an evaluation or audit that had been undertaken, and a further 13% cite research. Feedback from patients features frequently – either formally through patient satisfaction surveys (22%) or more informally through thanks and feedback offered.

Another mark of success given was the level of uptake of services provided – one in ten made reference to service uptake and the fact that patients in many cases are choosing to access the services by self-referring.

There are some differences in the types of patient benefits and evidence referred to by the different post types. Nurse practitioners were more likely than the other post types to refer to patient satisfaction surveys, the uptake of services and the ‘complete package of care’ being provided. Meanwhile larger proportions of nurse consultants referred to the continuity of care and ‘one to one’ relationship with clients, and to the level of expertise. Nurse consultants are more likely to have referred to audits and evaluations that have been undertaken. Specialist nurses were less likely to refer to providing a ‘whole package of care’ but were more likely than their colleagues in other posts to refer to the counselling/emotional support aspect of their role. The nature of the relationship between nurse and patient was a theme referred to be of advanced nurse practitioners.

Table 7.2 Evidence of impact - percentages

<i>Audits/Research</i>	
Audits/evaluations	30
Research/reports	13
Specific clinical trial results/increased participation in trials, RCT	1
Meeting national targets/audit default rates	1
Staff surveys/Good staff morale/Less sickness absence	1
<i>Patient satisfaction</i>	
Patient satisfaction – surveys	22
Positive patient feedback	12
Patient satisfaction – general	7
Thank you notes/cards	7
Verbal thanks/appreciation from patients	6
Donations – money left in will, etc.	1
<i>Uptake of service</i>	
Services well used; Patients choose service/self-refer; low DNA, good compliance	10
Feedback/comments from HCPs/GPs/Agency-staff/Medical/hospital/staff	6
<i>Quicker service delivery</i>	
Less time in hospital/better home care/length of stay/quicker rehabilitation	4
Quicker/better diagnosis/assessment	3
Quicker/better treatments/procedures	2
Waiting times reduced/shorter waiting lists/same day appointments	5
<i>Better health outcomes measured</i>	
Better symptom control/management	3
Better patient outcomes	6
Reduced infection rates	2
Less complications e.g. post surgery care/bed-sores, etc.	2
Improved Quality of Life	2
Patient education/patients more independent/better understanding of health	5
<i>Quality of service delivered</i>	
Holistic care/care by those with expertise field	2
Patient involvement in care/care plans/decisions/self-care	2
Continuity of care/1:1 care/relationship with patient/known face - point of contact	2
Implementation/development of better standards/guidelines/policies/procedures	2
Patients receive more emotional/psychological care/counselling support	2
Specific clinical procedure – improved	1
Risk Factor Management; Safe Systems - less Accidents/incidents	3
Few/no complaints	3
<i>Coordination</i>	
Good co-ordination/communication with others	2
Better referrals/Less inappropriate referrals/Reduction in further referrals	2
Successful/Better discharge/planning/info	1
Less GP call out	1
Reduced re-admissions/reduced hospital admission rate	7
<i>Unmeasured</i>	
Don't know/ Very little/none/no written or personal evidence/no audits done yet	7
Anecdotal	5
<i>Other</i>	
	3
	Responses 900
	Cases 464

Source: Employment Research 2005

7.2 Sources of job satisfaction and frustration

Respondents were asked what they personally find most satisfying about being in this type of post and what causes them the most frustration. The results are presented in tables 7.3 and 7.4.

The aspects of these roles that respondents find most satisfying – and all but 3% took the trouble to respond to this open ended question – are a mixture of what they do, how they do it, and the impact it has on patients. It’s the last of these – having an impact or ‘making a difference’ – that is most frequently referred to. Others describe how having an opportunity to shape and influence service delivery is important to them. But the way in which nurses work in these roles is equally important – they relish the level of patient/client contact they have and the chance to see cases through from beginning to end (remember that 93% of respondents report that they provide ongoing patient care as part or all of their job). Just under a third (27%) refer specifically to the satisfaction they gain from being able to practice autonomously.

Many of the other aspects of job satisfaction that respondents describe, relate to the pivotal position that these posts have assumed, in terms of liaising with other staff and other agencies to coordinate care and also as disseminators of good practice. 18% refer specifically to training or sharing knowledge with other staff as a source of job-satisfaction.

Table 7.3 Most satisfying aspects of being in this type of post

	% all cases	%
10 Maintaining and improving patient care – “Making a difference”	52	
02 Have responsibility/influence in policy/operational management	6	Impact
18 Develop/shape services	5	
01 Hands-on practice	2	
03 Relationship/contact with clients; continuity	31	How its done
05 Autonomy/ Authority to act	27	
09 Variety of work/jobs within role	8	
04 Teaching/training staff in specialised areas; sharing knowledge; development of staff	18	Interface
13 Gaining professional respect	5	
17 Part of wider team (multi agency, multi-disciplinary - MDT)	3	
15 Patient/family education	10	What they do
08 Using expert knowledge/skills	7	
16 Work with specific clients/specialty	1	
11 Knowledge/experience gained/ Professional development	6	
12 Appreciation/Positive Feedback	7	Personal development
06 Job satisfaction	6	
07 Challenge	4	
14 Commitment	1	
88 Other	3	
	Responses	989
	Cases	491

Source: *Employment Research 2005*

How do nurses in these positions compare to other nurses in terms of their morale and overall job satisfaction? The average scores for nurses in advanced -specialist posts on a series of attitude statements were compared with those for nurses with other job-titles (using RCN AES 2003 data). On average they express greater satisfaction with their jobs overall, their working hours and choice over them, and with control over careers. For example, 84% say that most days they feel enthusiastic about their jobs, compared with 78% of other nurses. They are also significantly more likely to feel their work is valued – 62% compared with 54%.

They are slightly more positive about pay, workloads and job security and progress opportunities. But they are no more or less likely than other nurses to recommend nursing as a career or to be positive about the environment in which they work. Whilst the overall impression is that these nurses have higher levels of morale than their colleagues (of 37 items in total, on 22 items they score higher and on 12 items there is no difference), there are three items upon which they are less positive than the average respondents to the 2003 survey.

- 67% feel it will be difficult to progress from their current grade (vs. 58%)
- 80% agree that the quality of care where they work is good (vs. 86%)
- 25% say there are is staff to provide a good standard of care (vs. 31%)

Table 7.4 Job frustrations of being in this type of post

		% all cases	Theme
03	Time constraints – too busy to give good care	21	
27	Volume of work (too much to do well)	12	Too
24	Lack of time for education/training opportunities	3	Stretched
35	Travel time/covering many areas	2	(Funding/
19	Lack of staff/cover (dedicated role)	11	Time)
01	Lack of funding	16	
11	Lack of understanding of role	13	
17	Lack of appreciation/recognition/respect	13	Role
25	Poor or unclear guidelines/procedures for working	1	Boundaries
28	Inappropriate grade/remuneration	4	
34	Unrealistic expectations	1	
32	Poor working relationships with colleagues/ with consultants etc.	11	
12	Lack of managerial support	7	Cultural
33	Resistance to/slow to bring about change	6	Context
23	Lack of action by Trust/Poor management	2	
20	Lack of communication/updates	<1	
07	Incomplete/inaccurate paperwork	<1	
08	Amount of paperwork, bureaucracy	3	
09	Lack of clerical support	5	Supporting
30	ICT	2	Staff
16	Inexperience of team/colleagues	2	
29	Poor communication/coordination between services etc.	3	
15	Not being able to provide particular treatment/care, or unable to see care through to end	7	
02	Difficulties of dual management/clinical role	5	
04	Working alone – isolation	5	
06	Emotional issues (related to nature of work)	3	Role
14	Limited to speciality	1	Specifics
21	Awaiting GP's response – time	<1	
26	Referral times/procedure; inappropriate referrals	3	
31	Repetition e.g. of prescription signing	1	
5/10	Role/service funded by one area but accountable to other.	1	
13	Government/National policies/priorities 'Legislation vs practice'	4	National
18	Political structure	4	Context
22	NONE	2	
36	Inflexible working hours/on-call	1	
88	Other e.g. impact on other staff- potentially deskilling	8	
	Responses	866	
	Cases	476	

Source: Employment Research 2005

Table 7.4 describe the frustrations of working in these types of posts. Resourcing and time constraints are the most frequently referred to problems. A third of respondents (and 476 out of 507 answered the question) felt that the volume of work meant they were too busy to be able to provide the level of service they would like. Just under one in five (16%) refer specifically to funding and some point specifically to the fact that their post needs funding full-time or the number of posts needs to be increased so that they are not sole service providers. The problem of being in highly specialised and often unique roles is that it is hard to be able to get appropriate cover to allow staff to have time out of their role to undertake professional development.

Another frustration of these jobs, is the lack of clear understanding about what these roles are about – an issue raised in Chapter 4. Other staff not fully understanding the roles has numerous consequences: people expect too much or not enough from the post-holders, so that in some situations they are expected to work beyond their role (and occasionally asked to do things that are outside of the competence) whilst in other they are not given recognition for what they do, and staff do not make full use of the service they provide.

7.3 Fulfilling the potential

A further question took up this point, by asking respondents directly: ‘Is the service getting the most out of your role for the benefit of patients? And if not, in what way is it not?’ Over a third of respondents (38%) felt that the service is not getting the most out of their role for the benefit of patients. In what way are the roles not being fully utilised? The answers have again been coded into categories, and are presented in Table 7.5.

Table 7.5 Ways in which the service is not getting the most out of the role

	%	Theme
05 Workloads/Time (too busy/stressed to give quality of care I would like)	25	
01 Post needs to be full time/dedicated, not part-time.	<1	
03 Role/Service needs to be expanded/enlarged	15	
16 Lack of space	1	Under resourced
15 Lack of staff (general)	12	
06 Cannot address development issues due to lack of time	6	
07 Insufficient time to supervise/educate staff	6	
10 Need more time for OWN education.	2	
09 Insufficient funding/general	12	
02 Insufficient Admin and Clerical support	16	
13 Misuse/mismanagement of time/skills	11	Skills not fully utilised
04 Not given enough authority/responsibility (e.g. due to org. culture)	5	
11 Poor collaboration/communication between departments/agencies/staff	7	
08 Too much time resolving management problems	4	Lack support
17 Lack of support	1	
14 Lack of qualified/experienced staff to provide high level care	4	
88 Other	20	
	Responses	269
	Cases	184

Source: *Employment Research 2005*

The results echo the answers to the question on job frustrations – lack of resourcing and the resultant workloads are major obstacles. Many of these roles would appear to be stretched too thinly, they want to have more time to do their current role more fully and to develop and expand the service they provide to benefit more patients. In some cases this is about increasing the funded establishment but others see the obstacles as lack of support from other areas, which have a knock on effect on the time they have available – e.g. 16% refer to lack of clerical and administrative support. Resourcing/funding accounts for 65% of all the reasons given and was referred to by nine out of ten who answered this question.

So what are the most important types of support needed to help people in these roles to do their jobs better? The answers to precisely that question are presented in Table 7.6.

Table 7.6 Most important type of support needed to help you do job better

	% all cases	%
01 Team/peer support	34	
02 Support/respect from management; less constraining/more open to new ideas	34	
14 Consultant support/access – respect and confidence	9	
10 Clerical/admin support	19	
15 Support from other areas/team members (labs, research, etc.) /access to other peoples skills/knowledge	7	Sources of support
18 Support from Community services/voluntary agencies	3	
03 Support from industry/commercial companies	<1	
20 Effective contribution from management e.g. help with budgeting, project management	2	
21 Multi-disciplinary working	2	
13 Funding/Finances/Better resources	16	
04 Dedicated post – post needs to be full-time/constant on-site care	2	
11 Equipment	2	Time
16 More staff/cover	12	Resources
09 Time	5	
12 Clinical support/supervision/mentoring	27	Mentoring
17 Better understanding and awareness of role/job definitions	5	
07 Being kept up to date/Communication/debriefs/meetings	2	
24 Better communication (from other professionals/staff/agencies)	2	Communication
05 Access to information	1	
19 Feedback from service users	1	
06 ICT systems/e-mail	3	
08 Education opportunities/Skills updates/Training	23	Professional
23 National/international programmes/conferences	<1	Development
22 Emotional support	2	
25 Legislation/regulation/accreditation/national recognition	1	Other
88 Other	3	
	Responses	993
	Cases	460

Source: *Employment Research 2005*

The results show that to enhance the contribution that these nurses are able to make, they want support from their colleagues and be given the freedom to carry out their roles fully. More than a third (37%) also referred to funding/resources/time as being the support they most need to help them do their jobs better. Two other types of support stand out as being frequently cited – better access to training and professional development, and more supervision or mentoring. Earlier in the report we have seen that about half of the nurses in these posts are holding in unique position and a great many work on their own.

Table 7.7 Views about support – percentages

	strongly agree	Agree	neither	disagree	strongly disagree	N=
¹ I have access to the professional training and development I need	30	51	6	12	2	501
¹⁵ I work primarily on my own	37	35	11	15	3	502
⁵ I sometimes feel I am expected to work beyond my level of competence	7	17	15	49	11	507
⁶ I am given the support I need to do my job well	18	43	21	15	3	505

Source: Employment Research 2005

Given this context, and the fact that the roles are constantly evolving with a quarter feeling they are expected to work beyond their level of competence (Table 7.7), it is perhaps not surprising that 27% would welcome more clinical support/supervision or mentoring. On the other hand, most (61%) feel they are given the support they need to do their job well.

8. Conclusions

Nurses in these roles have responded enthusiastically and comprehensively to the survey – they are clearly keen to tell

people about the work they do and way in which they practice. Although there are a huge number of different job titles, the range of activities undertaken can be categorised into three main areas: ‘Care Coordination’, ‘Diagnosis’, and ‘Organisational level’ activity.

The notional post titles of ‘Nurse Practitioner’, ‘Advanced Nurse Practitioner’, ‘Nurse Consultant’ discriminate between posts on the basis of what nurses do (types of activity most central to their role), as well as where and how they work, and their grades. The differences between ‘Clinical Nurse Specialists’ and ‘Specialist Nurse’, are so slight that for much of the analysis they are treated as one group.

What many advanced and specialist nurses have in common with one another is that they are frequently at the centre of a web of services, practising autonomously to coordinate care. They are part of a number of teams, refer patients from and to several different sources and liaise with other staff (within and beyond health services) to provide expert knowledge and advice.

About half see the nursing team they work in as being most central to their job, but for two-fifths, it is the multidisciplinary team that is most central. Again emphasising the extent to which these nurses are integrated with other services and staff. Regardless of which teams they work in, they are virtually unanimous about the importance of their nursing skills in the work they do.

These nurses play an important role in developing services – many were involved in setting their own (new) post up, and have been proactive in developing the role/services since. The constantly changing nature of the roles is not regarded as a problem by post-holders – they are keen to see the roles evolve and services develop to better meet patient needs.

The results to this, the largest survey of its kind, suggest that these roles have huge potential to contribute positively to service delivery. But two main things hold these roles back. The first is time/funding constraints. In about half of the cases, they are in unique posts and there is simply not enough time or colleague support to get the job done to the standard they would like and lack of time/funds impinges on their ability to get suitable training and develop the service further. The second constraint relates to others' understanding of the roles. These types of post are relatively new, and in some cases the infrastructure and organisational culture has lagged behind the new ways of working, and is not providing the support needed to make the roles as successful as they could be.

Appendix A: Sample & weighting

The sample for the current survey was derived from a previous survey of RCN members that established the job-title of respondents. The 2003 RCN Annual Employment Survey covered 15,917 RCN members. At the time when the survey closed at the end of August 2003, an overall response rate of just under 62% was achieved. The sample included ‘top-up’ samples for Wales, Scotland and Northern Ireland to ensure adequate numbers to present the survey results separately for each country. Table A1 shows the responses to each part of the stratified sample.

Table A1: Overall response rates by sample

	Total mailed	Post Office returns	Inappropriate	Number Responses	Response rate
Main sample	7817	100	15	4626	60%
Northern Ireland top up	2700	10	5	1709	63%
Scotland top up	2700	24	4	1695	63%
Wales top up	2700	15	5	1670	62%

Source: Employment Research/RCN 2003

In order to incorporate the national top up samples and balance the data set so that it represents the normal country distribution of the membership, the data have been weighted. Each case is given a ‘weight’ to make up for the fact that they are over/under represented. The weighting factor was calculated by dividing the proportion found in the population by the proportion in the dataset (see Table A2). Hence as the data set included twice as many nurses from Scotland as are in the population as a whole, a weighting factor of a half is applied to case from Scotland.

Table A2: Country weighting factors

Country	% of Respondents	% of Membership	Weight applied
	(Dataset)	(Population)	
England	38.6	81.2	2.101384615
Scotland	20.6	10.2	0.495278351
Wales	25.1	5.3	0.211550847
Northern Ireland	15.7	3.3	0.210040541

Source: Employment Research 2005

Appendix B: Profile of respondents

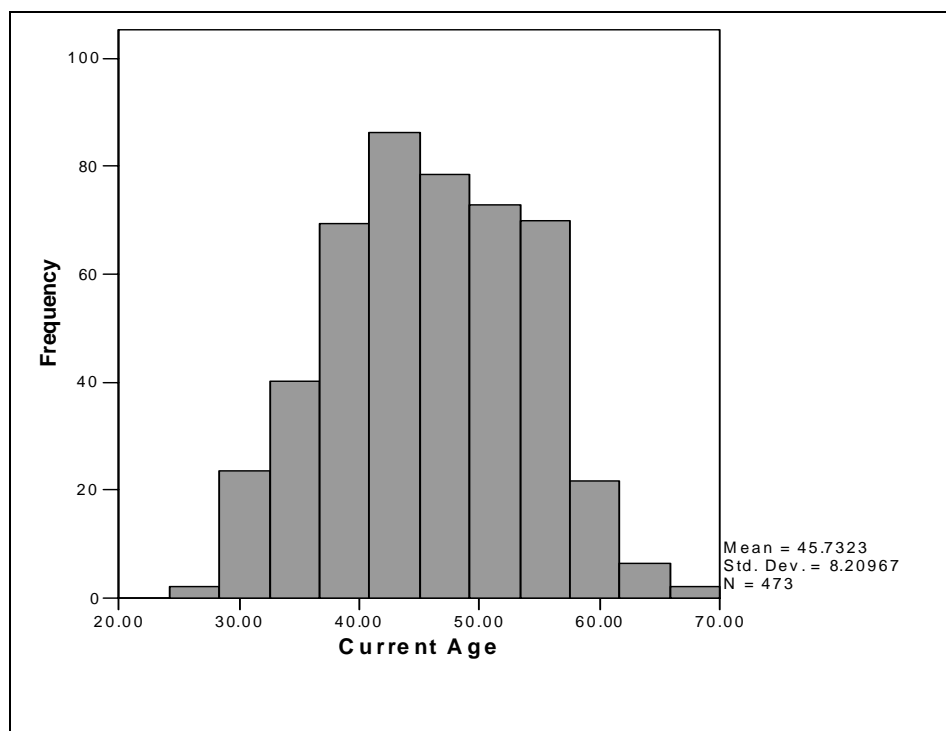
One advantage of using a sample that have already been surveyed is that we already have data on nurses' demographic profile from the original data set (which allowed more space on the questionnaire to be used to ask questions related specifically to their roles). Hence data from the RCN Annual Employment Survey 2003 was used for this analysis (so 27 cases are not included as they did not complete the original form).

B1. Age and time since qualification

Figure B.1 shows the age profile of respondents – this is the age they were in the summer of 2003 (first survey) plus a year as they completed the recent survey in summer 2004. The average age of respondents was 46 years old (ranging from 25 to 67). Hence the average age of these respondents in 2003 was 45. Three-quarters (74%) are forty or over.

The average age of respondents varied between the post types, with advanced nurse practitioners having the oldest mean age (52 years), whilst the other posts averaged between 44 and 46. Interestingly it is nurse practitioners that have youngest mean age of 44.

Figure B.1 Age profile of respondents



Source: *Employment Research 2005*

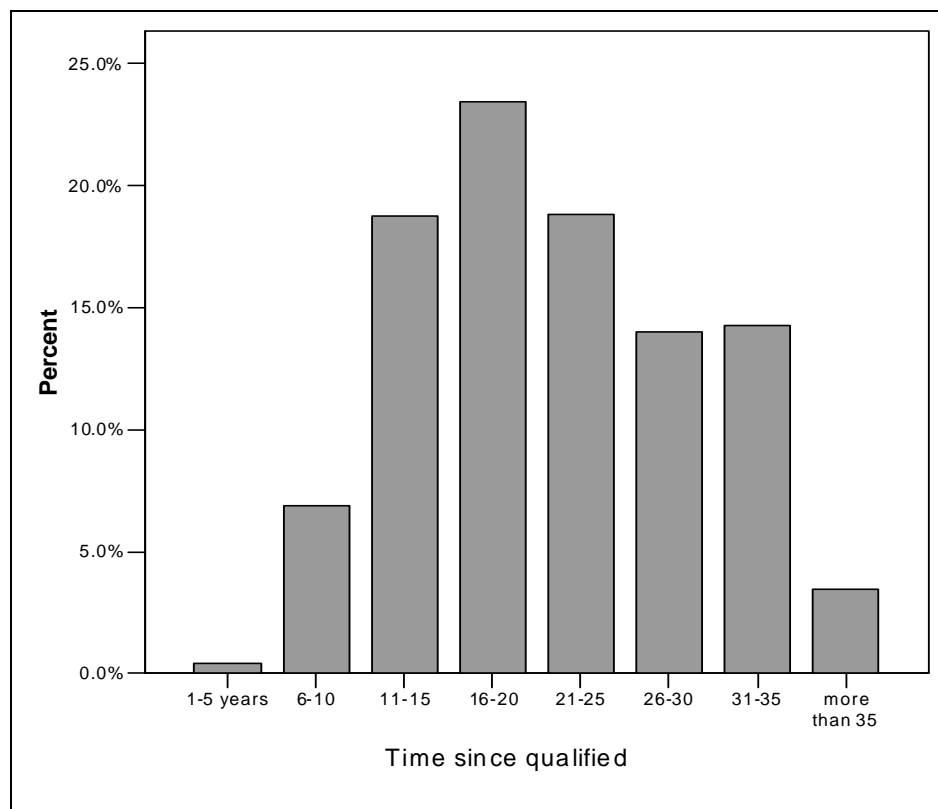
To compare the age of these nurses with the average nurse in RCN membership, we look at the profiles when the data was collected in 2003. The average age of nurses across the whole population in that survey was 41 years. Whilst on average across the entire sample of advanced or specialist posts in F grade or above posts, the average age was just 2 years greater at 43. This varied by job title - the average age of staff nurses was 38, ward managers 43, district nurses 46 and practice nurses 44.

The older mean age amongst respondents to the current survey (45 at 2003, compared to 43 across all nurses who formed the sample for the current survey) is likely to be a product of the age response bias described in the first chapter.

Figure B.2 shows that these nurses typically qualified as a registered nurse between 16 and 20 years ago. The vast majority (97%) qualified in the UK (the equivalent proportion across all nurses in the 2003 survey was 94%).

In chapter six we go on to look at the length of experience in current specialities and at how respondents have arrived in these posts – what preparation have they had and what were they doing before.

Figure B.2 Time since qualification (2003)



Source: *Employment Research 2005*

B.2 Gender & ethnicity & family circumstances

91% of respondents are female, 9% male. Men are fractionally better represented in these posts than was the case across the respondents to the 2003 annual employment survey, where the proportion of male nurse was 8%. The numbers of men are too few to identify differences with any certainty, but at first glance it would appear that men are more likely to be in other posts or nurse consultant posts (12% compared with 8% of women) and more describe their work settings as 'other'. A higher proportion of men (18% vs 8%) give their grade as 'other'.

More than nine out of ten (96%) of respondents are white, with 4% minority ethnics – this contrasts with 9% of all respondents to the 2003 survey.

Over half (52%) have children and 22% have regular caring responsibilities for an elderly relative or other adult with care needs. The cross section of nurses surveyed in 2003 elicited 55% of respondents with children and 18% with other caring responsibilities. About half (49%) of the respondents are partnered with children, 3% are single with children, about a third (32%) are partnered without children, and 16% are single and do not have children.

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