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# EVALUATION OF THE SUCCESSION PLANNING AND DEVELOPMENT PATHWAY FOR CONSULTANT NURSES, MIDWIVES AND ALLIED HEALTH PROFESSIONALS

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| CONTENTS | PAGE NUMBER |
|---|---|
| **EXECUTIVE SUMMARY** | **5** |
| **Section One** | |
| INTRODUCTION | |
| LITERATURE REVIEW | 16 |
| Role definition and confusion | 16 |
| Supporting ‘new’ roles | 17 |
| Preparation for the role | 18 |
| Succession planning | 19 |
| Limitations of existing research | 19 |
| Summary of the literature | 19 |
| AIMS AND OBJECTIVES OF THE EVALUATION | 21 |
| **Section Two** | |
| METHODS | 22 |
| Summary of approach | 22 |
| Ethics and governance | 22 |
| Sampling | 23 |
| Data collection and analysis | 24 |
| Matching the aims and objectives to the methods/stage | 26 |
| **Section Three** | |
| RESULTS | 27 |
| Stage 1: Stakeholder interviews and pathway participants’ questionnaire responses | 27 |
| Selection process (information, application and selection) | 27 |
| The pathway and mentorship | 41 |
| The consultant NMAHP role: enhancing the pool | 57 |
| Summary of Stage 1: stakeholder interviews and pathway participants’ questionnaire responses | 62 |
| Stage 2: Case studies | 63 |
| Commonalities across the cases | 64 |
| DNAT and matching activities | 64 |
| The domains of practice: current and expected | 67 |
| Summary of Stage 2: case studies | 67 |
| Limitations of the evaluation | 68 |
| **Section Four** | |
| CONCLUSION | 68 |
| RECOMMENDATIONS | 70 |

| **Section Five** | | |
|---|---|---|
| | | |
| APPENDICES | | |
| I | Strategic leads briefing paper | 73 |
| II | Consent Form | 74 |
| III | Questionnaire | 75 |
| IV | Semi-structured Interview Guide | 90 |
| V | Case study data | 91 |
| VI | Case studies | 92 |
| VII | Conditional matrix | 93 |
| VIII | Answered aims and objectives | 94 |
| IX | Additional statistical data | 96 |
| | | |
| REFERENCES | | 97 |

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**Disclaimer**

The views expressed in this report are those of the research team and not necessarily those of the funding body: National Health Service Education Scotland [NES].

# EXECUTIVE SUMMARY

## Introduction

This report provides an evaluation of the NHS Education Scotland (NES) Succession Planning Development Pathway for Consultant Nurses, Midwives and Allied Health Professions The evaluation was undertaken by a team led by Nursing Studies at the University of Edinburgh and was commissioned by NES in November 2007 and carried out over the following 12 months.

The Scottish Government commissioned NES to develop the Succession Planning Development Pathway (the Pathway / SPDP) as part of the Partnership Agreement to treble the number of Consultant NMAHP posts. The pathway was launched in November 2005 with the overall aim to enhance the potential pool of Consultant NMAHPs. The objectives of the evaluation tender specified particular aspects of the process and outcomes such as selection, pathway, DNAT, mentorship and confidence levels.

## Context

Consultant NMAHP[2]s are becoming integral to health care delivery. These posts are perceived as providing new career opportunities for clinical experts, strengthening clinical leadership and research and improving patient outcomes and service quality. The literature on Consultant Nurse/NMAHP role evaluation and impact is limited, but suggests a number of challenges associated with the role including succession planning.

The following are the aims and objectives of the evaluation specified by the funders (NES) and addressed by the research team. [See Appendix VIII]

## Aims

The overall aims of the project were:

- To identify the extent to which the succession planning development pathway for consultant nurses, midwives and allied health professions has contributed to an increase in numbers to the recruitment pool for these senior posts across NHS Scotland;

- To ascertain the usefulness of the process (particularly the Development Needs Analysis Tool as a mechanism to identify personal strengths and areas of potential development); and

- To identify the potential of transferability of this model to other staff groups.

## Objectives

The objectives of the project were:

1. To analyse and review the selection process of how potential participants to the pathway were selected – both by NHS Board employers and the NES Selection Panel

[2] Nurses, Midwives and Allied Health Professions

2. To examine the range of activities undertaken by participants in order to ascertain if these activities met the identified needs

3. To gather information from participants, sponsors and strategic mentors with regard to :
   - -patterns of mentorship
   - -appropriateness of mentorship arrangements
   - -usefulness of mentorship arrangements in helping to meet identified needs
   - -usefulness of coaching / work shadowing / other support and development mechanisms
   - -level of sponsor support
   - -identification of other elements which would have helped in meeting identified needs

4. To ascertain the level of impact the pathway has had on changing / influencing career development practices across NHS Scotland

5. To examine the extent to which the pathway has increased confidence levels and developed the skills profile in those considering applying for a Consultant post

6. To examine the extent to which the pathway had increased the confidence, skills and effectiveness of those who already hold Consultant posts

7. To produce interim and final reports.

**Methods**

The evaluation comprised a qualitative and quantitative mixed methods approach in two stages. Descriptive statistics were applied to the questionnaire and a constant comparison approach to the interview data. A scoring frame using the domains of practice and the Development Needs Assessment Tool (DNAT) ratings was applied to the case studies.

| Stage | | Subjects | Method of data collection |
|---|---|---|---|
| Stage 1 | (a) | Pathway participants (n=30) | Postal questionnaire and review of DNAT |
| | (b) | Stakeholders (n=20) (selection panel, sponsors [strategic leads] and mentors) | In depth qualitative interviews |
| Stage 2 | | Pathway participants (n=3) | Case studies |

**Findings**

Two issues emerged from the data overall that provide some context to the findings which are presented under three main headings. First there was the tension between service needs, individual needs (and capabilities) and short term funding. Second was the absence of a strong profile and understanding of the Consultant NMAHP role within the NHS. The latter issue may, in part, have been exacerbated by the rush to develop Consultant NMAHP posts

and the potential 'dilution' of the role via the appointment of some postholders without the necessary academic preparation. According to the literature, this complex and challenging role is poorly understood, defined and supported within organisations. Consequently, less well-prepared individual post holders may appear less able in such exposed situations. This underlines the importance of robust ongoing personal development and review for Consultant NMAHPs.

The findings (incorporating all data sources) and recommendations are presented under three headings which correspond with the objectives in the evaluation brief.

(1) The selection process (Objectives 1 and 2)

The selection process comprised three key aspects: information, application and selection.

Information was reportedly controlled and filtered by NHS boards at a local level therefore, not all potential applicants may have been privy to information relating to the pathway. Stakeholders[3] perceived there to be a lack of suitable candidates at the outset. Further, some suitable candidates reportedly chose not to apply for the pathway. The patronage evident in the process via sponsorship may also have excluded other potentially suitable candidates outwith the NHS from applying. The initial pool of potential candidates for the pathway was therefore somewhat limited.

The application included the DNAT and identification of activities to meet identified need. Three quarters of participants[4] sought help to complete their application although not necessarily in partnership with their sponsor/mentor. 88% of pathway participants strongly agreed/agreed that the DNAT was useful at the time of application. Participants welcomed the funding and focus that the DNAT/pathway provided. Stakeholders were less supportive of the DNAT and pathway with the lack of a conceivable outcome and the need for protected time highlighted as limitations.

76% of the activities pathway participants undertook comprised educational activities and shadowing. The activities were relatively broad ranging.

The selection information was incomplete and therefore, certain aspects of the pathway could not be fully evaluated (e.g. pre pathway DNATs). There was an absence of explicit documentation for participants, mentors and sponsors in relation to both process and outcome.

**RECOMMENDATIONS: the evaluation**

- Future NES interventions/initiatives involving evaluation should seek to obtain consent as a condition of anonymised participation.

- Evaluation tenders should be contracted out prior to the commencement of the intervention.

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[3] Stakeholders: sponsors (strategic leads), sponsors/mentors, selection panel and mentors

[4] Participants = pathway participants (existing and aspiring Consultant NMAHPs)

**Selection process**

Should the pathway remain in any form, the selection process may benefit from the following:

- A specific and explicitly limiting (paper) application to the pathway
- Appropriate documentation highlighting the aim, method and expected outcomes of the pathway.
- Clear defined administrative support at the point of central selection / organisation (i.e. NES).
- Consideration of whether sponsor support is appropriate or necessary, specifically whether it may be more appropriate to encourage individuals to apply independently of their employing organization.
- Consideration of opening up the pathway to non-NHS employees e.g. a wider pool of applicants.
- Consideration of providing a concrete outcome in order to encourage applicants.

The DNAT is a useful tool that may be transferable depending upon the proposed context. However, it needs to be completed with mentors with the appropriate expertise and attend to all domains as part of an appropriate and explicit mentorship programme.

(2). Mentoring and the pathway (Objectives 2, 3, 5 and 6)

The mentor role and function would have benefited from explicit documentation. Nonetheless, 73% of pathway participants strongly agreed/agreed that mentorship was useful with 20% undecided. 70% of mentorship sessions lasted between 30 – 60 minutes with 61% being relatively structured using the DNAT. 20% were unstructured and did not refer to the DNAT.

Mentors perceived the purpose of mentorship as raising or encouraging political awareness, signposting, ‘prodding’ or ‘toughening up’ the mentee for the rigours of a post at a perceptibly more strategic level.

Mentors reported that participants grew in confidence during the process. Retrospectively measured confidence levels suggest that although participants identified ‘strategic development’ (leadership/consultation) as an area of need other domains - audit and research plus staff and patient education - required more development.

The Consultant NMAHP role exists across four or five domains, of which strategic development (leadership/consultation) is but one. Mentorship should therefore reflect all of the domains of practice e.g. a matrix of mentorship.

The pathway was generally well received by participants and stakeholders.

The pathway overall was considered to be bespoke and flexible, legitimising opportunities for the individual to 'chap on doors'. The centrally driven nature of the pathway and the networks it engendered was welcomed as was the resources it provided. Paradoxically, the bespoke nature of the pathway also highlighted its perceived frailties, e.g. vague, too flexible, no outcome.

There were no obvious benefits in terms of explicit commitment and/or remuneration for stakeholders or organisations in terms of money, recognition or backfill. Equally, participants considered that the pathway had been undertaken in conjunction with their day-to-day responsibilities. Participants and stakeholders commented on the need for dedicated time to properly utilise the opportunities offered by the pathway.

88% of pathway participants strongly agreed/agreed with that the pathway was a worthwhile development experience. 64% reported gaining the competencies required for a Consultant NMAHP role while 25% were undecided and 10% disagreed.

47% were undecided or disagreed that their prospects of acquiring a Consultant NMAHP post had increased as a consequence of the pathway.

The pathway is unique. However, several respondents considered that there were better options available such as political or clinical leadership courses.

The complexity and challenges of succession planning in the NHS generally was noted. The need for strategic vision and sustainability of initiatives particularly in relation to these critical roles was also highlighted by several stakeholders and mentors.

There is insufficient evidence to support the pathway being transferable in its current form. However, modified forms of the DNAT and mentorship may be transferable aspects of this initiative, depending upon the proposed context.

**RECOMMENDATIONS: Mentorship and the pathway**

It is arguable as to what extent a pathway can prepare individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, especially when it is aimed at such a diverse group, e.g aspiring and existing Consultants.

- Serious consideration should be given to developing structured, coherent and fully funded succession planning opportunities that account for the broad variance in abilities and needs, matched with a strategic vision for these posts.

- Other models should be considered such as clinical fellowships and/or internships at several levels (masters, doctoral, post-doctoral) e.g. ESRC/Leverhulme schemes. Such fellowships could explicitly prepare and support individuals for aspiring or existing Consultant NMAHP posts using existing academic provision with a matrix of mentorship as appropriate and in collaboration with HEIs. This could dovetail with the clinical careers fellowships initiative.

- Such fellowships could operate on an 'open' call for individuals with specific expertise and capability wishing to apply independently and a 'closed' call strategically supporting identified NHS service need e.g a meritocratic approach.

- A matrix of mentorship is required for a role that encompasses 4 or 5 domains to ensure that it develops equitably across all domains.

- Develop existing consultant NMAHPs as mentors to the next generation of Consultants.

- Provide support (organisational and financial) to existing consultants to develop relevant individuals within their specialty to address succession planning for existing posts. DNAT or Consultant KSF[5] outlines could be used as part of this process.

<u>(3). Enhancing the pool of Consultant NMAHPs (objectives 4,5 and 6)</u>
The answer to the question as to whether the pathway enhanced the pool of Consultant NMAHPs is equivocal at best. Most respondents offered no view on this aspect. Others, while circumspect, gave qualified responses. 8 existing Consultant NMAHPs commenced the pathway and two participants became Consultants during or following completion of the pathway.

The view that the pathway had not enhanced the pool of Consultant NMAHPs was juxtaposed with the notion that there is a very limited and potentially reluctant pool of potential applicants in the first place. Conversely, the view that the pathway had enhanced the Consultant NMAHP pool was tempered with the proviso that those *individuals* would have emerged without the pathway.

The uniqueness of the Consultant NMAHP role as a clinical leader as opposed to a line manager is wholly appreciated by stakeholders, specifically the research/clinical expert function. The challenges of the role were also acknowledged.

A rush to invest in visible Consultant NMAHP posts may have led to a dilution of the role via the appointment in some instances of less able and/or qualified individuals. Consequently, the roles (and the post holder) arguably become more vulnerable and less visible.

The decision to develop the pathway was based on the notion that there was no appropriate academic preparation available. However, a number of Consultant NMAHPs are reportedly currently in posts without the required masters degree (or a record of scholarship). There is therefore, a need to ensure that existing Consultants are appropriately prepared, qualified and supported.

A scoping exercise reviewing the provision of masters and doctoral level preparation in Scotland, mapping existing provision to the domains of practice in the Consultant NMAHP role and other developed roles may assist future succession planning initiatives.

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[5] Knowledge Skills Framework

**RECOMMENDATIONS: Consultant NMAHP role: enhancing the pool**
There is insufficient evidence to support the pathway being transferable in its current form. A more strategic and sustainable commitment to providing succession planning should be considered – one that addresses all the domains of the role and supports them appropriately e.g. fellowships/internships. The following actions would be required to support this:

- Scope and review the existing provision of masters and doctoral level preparation in Scotland.
- Map existing provision to the domains of the Consultant NMAHP role and other posts.
- Develop a strategic vision of what HEIs should offer in relation to fitness for practice across all domains and roles (clinical education, research, management).
- Review the existing Consultant NMAHPs cohort and consider how best to integrate and support their role.
- Support and encourage existing postholders to undertake Masters level study if they have not already done so.
- Any interventions or activities aimed at developing or enhancing Consultant NMAHPs should be explicitly mapped to intended outcomes via the domains of practice.
- There is a need to ensure that aspiring and existing Consultants develop appropriately in all 4/5domains of practice.
- The research/audit domain of the Consultant NMAHP is integral to the role, *the clinical leadership function and the professions*. This aspect of the Consultant NMAHP role should be highlighted in any future initiative and/or intervention in collaboration with HEIs.

**Conclusion**
The pathway did not significantly enhance the pool of Consultant NMAHPs. There is however, a limited pool of individuals for these posts in the first instance. It is arguable as to what extent a pathway could have prepared individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, aimed at such a diverse group, e.g aspiring and existing Consultants.
.
There is insufficient evidence to conclude that the pathway per se is transferable. However, the DNAT and mentorship could be transferable if modified appropriately for the proposed context. Any evolved initiative however, would need to recognise the four/five domains of the role and address them appropriately, specifically the research domain.

Succession planning for the Consultant NMAHP role needs to encourage and develop *individuals* and their capabilities as opposed to 'pools'. The difficulties of marrying the exigencies of service need, short term funding and individual capability need to be highlighted. It may be that this can only be addressed by more substantial and sustainable means such as fellowships or internships allied to a matrix of mentorship incorporating HEIs and experienced Consultant NMAHPs.

Finally, the existing cohort of Consultant NMAHPs need to be appropriately supported to ensure the role does not become more vulnerable and invisible. Consultant NMAHPs could be key individuals in developing succession planning in their area through developing and supporting individuals locally.

# INTRODUCTION

The Succession Planning Development Pathway (SPDP) arose from discussions with the Minister for Health and Community Care around the delivery of the Partnership Agreement commitment to treble the number of Consultant Nurses, Midwives and Allied Health Professionals (NMAHPs) within the context of the challenge of recruiting to some of these posts. Developing Consultant NMAHP posts was perceived as a commitment to retaining clinical experts, providing a new career opportunity, strengthening clinical leadership, improving patient outcomes and service quality, and maximizing these professionals' contribution to the delivery and implementation of Delivering for Health (2002). The following are the 5 domains of the role:

*1.Expert practice*
*2.Practice and service development*
*3.Professional leadership and consultancy*
*4.Research and audit*
*5.Education and development.*

The Scottish Executive commissioned NHS Education Scotland (NES) to develop a Succession Planning Development Pathway (SPDP) and this was launched in November 2005. The evaluation contract was awarded to a team led by Nursing Studies, University of Edinburgh and commenced in November 2007. This report focuses on the evaluation of the SPDP which was carried out over the subsequent 12 months.

## Context and process

The SPDP initiative was developed to enhance the recruitment pool for Consultant NMAHP posts across NHS Scotland. To inform the development of this initiative NES undertook a scoping exercise with strategic leads. The scoping exercise reportedly collated strategic leads'[6] experiences of recruiting to Consultant NMAHP posts at that juncture, specifically what they considered were the areas of potential development for prospective consultants. The following are the key themes that reportedly emerged from that exercise:

- Problems in obtaining candidates with strengths in all four (or five) areas or domains. Clinical practice considerably outweighed strengths in education and research, professional leadership and consultancy, service development and 'other'.

- There was a perceived need for leadership, political/corporate/strategic awareness development for postholders.

- There was no 'pool' at required level, specifically a lack of Master level preparation. Potential candidates may lack a strategic overview and have narrow experience.

- The funding (of consultant NMAHP) posts was raised as an issue.

[6] Principally executive nurse directors

- The need to retain a high threshold for these posts with regards to appropriate preparation, experience and remit in order to keep the role distinct from Clinical Nurse Specialists (Nursing and Midwifery specific).

Based upon the above exercise the concept of a pathway was developed: '*a flexible pathway to enable tailoring to meet individual needs and designed to complement the Clinical Leadership Programme'* with associated funding (September 2005). The target group was identified as being *existing consultants* and those *almost at that stage* in their career development. Moreover, the pathway's stated aim was to *'build confidence, effectiveness and big picture awareness and clarification of career aspirations and options'* with the outcome being to enhance the Consultant NMAHP recruitment pool.

A Development Needs Analysis Tool (DNAT) designed to cover five domains of (consultant) practice was commissioned and developed at this juncture. A briefing paper on the proposed pathway (September 2005: appendix I) asked strategic leads to suggest the how to best identify or select potential candidates and the results of this apparently demonstrated support for candidates being identified at a local level. Thus, '*a strong partnership approach between the sponsor and potential applicants (was) encouraged in the preparation of applications to NES'* (NES circular November 2005). The closing date for the first round of applications was 9th January 2006.

Guidance notes for applicants and sponsors dated February 2006 noted that the: *'pathway is designed to support the professional development of existing and aspiring NMAHP Consultants. It is designed to be used in conjunction with local systems and processes that support role development through the personal development planning and review process which is explicitly linked to the NHS Knowledge and Skills Framework'.*

Thus, the SPDP was intended to complement not supplant existing NHS staff development and succession planning: Hirsh[7] (2000) being the definition of succession planning used in this instance. Guidance notes (February 2006) specified that *'the pathway consists of a flexible but rigorous pathway with learning outcomes to be achieved in* ***five***[8] *key areas of the consultant role.'*

Prospective pathway participants were required to have completed the application 'in partnership' with their sponsor whose support was a pre-requisite. The application consisted of a completed DNAT and the identification and costings of associated activities (e.g. courses, clinical visits, shadowing, coaching) that would best address the participant's identified needs. The closing dates were 9th January 2006 (first round) and 15th September 2006 (second round). A sub-group of the NES SPDP Steering group (the selection panel) reviewed and selected successful applications on the basis of an explicit 8-point criteria. Thereafter, NES provided funding for the activities identified by successful applicants. The timelines of the SPDP development are summarized in figure 1.

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[7] 'a process by which one or more successors are identified for key posts (or groups of similar key posts), and career moves and /or development activities are planned for these successors. Successors may be fairly ready to do the job (short term successors) or seen as having longer term potential (long term successors).'
[8] Emphasis as per original document.

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Minister of Health and Community Care and discussion to treble Consultant roles within context of recruitment retention issue (2003)

SEHD commissions NES to develop pathway

NES undertakes scoping exercise of strategic leads re areas of development.
Results: leadership skills, political awareness, masters level preparation, breadth of experience

Concept of pathway developed including DNAT

September 2005 (Appendix I)

- Briefing paper to Strategic leads:
- Asked how best to identify or select potential candidates

November/December 2005

- Letter announcing pathway and funding inviting sponsor supported candidates to apply by January 2006 with 8 criteria to be considered when applying.
- Director of Nursing/AHP as sponsor to identify candidates
- Sponsor and candidate complete DNAT to ensure pathway appropriate route
- Sponsor selects and then submits template and DNAT of candidates.

Closing date for 1st round 9th January 2006 and selection

Guidance notes (February 2006)
June/July 2006: 2 briefing workshops held for 2nd round
Applications invited in July/August 2006 for 2nd round
closing date 15th September 2006

Pathway runs from March 2006 – June 2007
Evaluation commissioned in November 2007 – November 2008

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*Figure 1: Timelines of SPDP development*

## LITERATURE REVIEW

The following databases: AMED, Anthrosource, ASSIA, CINAHL, IBSS, PsycINFO, Medline PubMed, Social Sciences Citation Index were searched utilising key terms (and relevant combinations) such as nurse consultants, NMAHP, role development, succession planning, education, training, expert practice, advanced practice, role. It should be noted that the following review refers primarily to consultant nurse (and midwife) roles given that they are the originators of what is now referred to as a consultant Nursing, Midwifery, Allied Health Professional or NMAHP. The majority of the articles reviewed here refer almost exclusively to consultant nurse or midwife roles given that they predate the current moniker of "consultant NMAHP" and the tendency to view all such roles as part of a broader group.

New consultant nurse and midwife posts were first announced in Scotland in September 1999. The primary aim in establishing the consultant post was, arguably, to retain expert nurses in clinical practice. The post provided expert nurses with a clinically-based alternative in their career development. Thus, rather than expert nurses electing to opt for management or academia in order to advance their careers, both professionally and financially, they could elect to remain in clinical practice. Further initiatives including Caring for Scotland (2001), Choices and Challenges (2002), Delivering for Health (2005) and Modernising Nursing Careers (2006) continued to champion the post of consultant nurse as a legitimate and necessary addition to nursing and healthcare development.

Currently consultant nurses are considered to contribute to better patient outcomes and services as well as providing a visible and assertive nursing leadership which contributes to research-based practice (Coster et al 2006, HSS&PS 2005, Shuldham et al 2004). Such a visible and all-encompassing role however, presents considerable challenges. Data emerging thus far suggests that nurse consultants may be struggling to meet and fulfil their remit which is often poorly defined and therefore inadequately supported (Coster et al 2006).

### Role definition and confusion

There have been sporadic, relatively non-structured attempts to evaluate the role of the consultant nurse thus far. This may be partly to do with the ad hoc manner in which these roles have emerged in Scotland and across the UK. In addition, the roles appear to have been highly dependent upon local drivers and as such, a fairly loose overall template for the role has been interpreted differently across a variety of locations (Booth et al 2006). Woodward et al 2006 [n=10] suggests that the relevant NHS organisations have a lack of understanding of and support for the role, and consequently fail to fully comprehend the equal importance of all domains of the role (expert practice, practice and service development, professional leadership and consultancy, research and audit, education and development). Consultant nurses also appear to hold varying notions of their role requirements (Fairley and Closs 2006, Dawson and McEwen 2005).

Fairly and Closs (2006) describe the role of the consultant nurse in critical care linked to patient outcomes in a case study. This case study reports the consultant nurse as being something more akin to a 'troubleshooter', raising doubts for this reviewer as to firstly the

actual level of expert practice and secondly, as to whether the post-holder is operating effectively within any of the other domains. Conversely, a national postal study of consultant nurses and critical care outreach in England [n=52] by Dawson and McEwen (2005) challenge the legitimacy of this type of work (e.g. outreach) and contend that consultant nurse should develop research and contribute to evidence-based practice. Further, a mixed method review of the consultant nurse in Northern Ireland placed the worth and benefit of the role within the context of an individual or organisational understanding of the role (HSS&PS 2005). In effect, role definition is key to how the success or otherwise of the role is measured. The diversity and scope of these roles is manifold and encompasses a broad spectrum of health and illness. Emerging data suggests that consultant nurses in certain fields of practice e.g. mental health, may find the role more difficult to operationalise.

*Mental health*

The small number of available evaluation studies all comment on mental health nurses having most difficulty in attempting to define and operationalise the role. Woodward et al's small sample (2005) identified that consultant nurses from a mental health background appeared to have most difficulty whilst Coster et al (2006) in an evaluative study of 419 consultants stated that consultant nurses in mental health reported having less of an impact than other specialities.

Hayes and Harrison (2004) suggest that policy directives from 'Government', specifically consultant nurses and modern matrons, have tended to focus on physical care. They suggest that mental health nursing is in something of a flux with regard to boundaries and inter-disciplinary working and that mental health nursing perhaps, in some way needs to re-assert its identity. Guest et al (2001), in the initial (DoH) evaluation of the consultant nurse role also identified role confusion among mental health nurse consultants and suggested that this was partly due to the socialisation, practice and development of psychiatric nursing as opposed to the more definitive and visible aspects of physical care.

*Strategic versus local*

There are notable differences in way that consultant nurse roles have been operationalised in Scotland and England, with the latter having had consultant nurses prior to 1999 (Manley 2000a 2000b, 1997). The role of the consultant nurse in Scotland is viewed perhaps as being more strategic than that of their English counterparts. Thus, Scottish consultant nurses tend to lead at a national level in their area of expertise e.g. cancer or perinatal mental health (HPS 2004). The geographical spread and populus of both countries demonstrably influences the numbers of consultant nurses and therefore, the availability and subsequent opportunity for individuals to lead at a national level. This will inevitably impact upon the individual consultant nurse's domains of practice, ability to influence practice at local level and the required level of preparation and support for the role.

<u>Supporting 'new' roles</u>

Previous studies looking at developed roles in the NHS have identified the importance of 'new' or 'innovative' roles being recognised and valued within the organisation and the concomitant provision of support and guidance (McGillis Hall 2007, Lloyd Jones 2005 Levinson and Vaughan 2001, Read et al 1999, Roberts-Davis et al 1998). Booth et al

(2006), Woodward et al (2006) and Coster et al (2006) all comment on the need for mentorship, organisational support and appropriate line management for consultant nurses. Similarly, various authors promote the need for support from doctors and line managers suggesting that support is integral to job satisfaction for the post holder (McDougall 2005, Sturdy 2004, Collins et al 2000)

The issues raised are not surprising and not dissimilar to many of the challenges faced by other innovative and newly developed posts such as Clinical Nurse Specialists (Hill 2005, McCreaddie and Hutchison 2002, McCreaddie 2001). As nursing struggles with the differences between advanced and specialist practice and the political drivers of reducing doctors working hours and service re-design, so Clinical Nurse Specialists toil with developing and maintaining innovative nursing roles in an ever-changing and demanding context. The discussion about what actually constitutes advanced practice along with the necessity to justify such roles via specified evaluation frameworks remains a potent and contemporary debate (Bryant-Lukosius et al 2004, Bryant-Lukosius and Di Censo 2004) Ironically, many Clinical Nurse Specialist are now consultant nurses, their input having been integral to the development of the post in the first instance (Costa, 2003). The consultant nurse post-holder is, however, expected to operate at a higher clinical, research and academic level than that of a Clinical Nurse Specialist and it is a concern that some individuals may not be properly qualified, nor prepared for the role. A better definition of the difference between advanced and specialist practice for NMAHPs is currently being proposed by the CNO Directorate of the Scottish Government as part of the Advanced Practice Toolkit. (Ref: Supporting the Development of Advanced Nursing Practice, A Toolkit Approach, Scottish Government 2008)

Preparation for the role

Woodward et al (2005) assert that the background characteristics and past experience of the individual most certainly influence the degree to which the post holder can achieve the domains of the role. Caring for Scotland (2001) suggested that nurse consultants would make a significant contribution to the research agenda and therefore, consultant nurses should have, or be working toward a masters' degree, have research experience *and a record of scholarship and publication.* This edict is somewhat paradoxical however, given that someone working towards the former is probably unlikely to have both, or certainly either, of the latter.

Recent studies evaluating the role suggest that the aspiring consultant nurse would be best prepared for the role if they had a masters degree, experience in all domains of practice and experience of change management (Booth et al 2006, Coster et al, 2006, Woodward et al, 2005,2006,). In Woodward et al's study (2005) those less likely to achieve their aims did not have a masters degree or experience in change management and certain domains, specifically research.

A further study by Charter et al (2005) noted that 80% [n=20/25] of the consultant nurses in emergency care identified at least one aspect or domain of their role for which they were under-prepared. Guest et al (2001) however, suggested that nearly 65% of the consultants surveyed had either a Phd[9] or a Masters.

[9] Doctoral degree – usually Doctor of Philosophy if obtained via the traditional model

*Academic preparation?*

There are anecdotal reports that aspiring or new consultant nurses are electing to undertake Professional Doctorates. Professional Doctorates have been relatively well established internationally since the first Doctorate of Education (EdD) at Harvard University in 1921 (Scott et al, 2004). It was not until the 1990s however, that the first EdDs emerged in the UK, with numerous others now being widely available (Ellis, 2005). The traditional PhD is considered to be ideologically focussed, very specific utilising one research method only (Rafferty et al 2000, McKenna, 1997). Thus, it has also been suggested that the 'traditional PhD' is perhaps not best suited to a career in a non-academic arena or research field (Scott et al, 2004).

There are a number of difficulties in developing nursing research in both academic and clinical environments (Fyffe and Hanley 2002), however, consultant nurses should, theoretically, be well-placed to make the most of these challenges (Fyffe 2006). Interestingly, the role of consultant nurse in research has emerged in England although not, as yet, elsewhere (Smy 2003). Nonetheless, research is a key domain of the consultant role and it remains to be seen how this aspect can be best operationalised.

Ellis (2006), in a scoping exercise undertaken in Australia, cites the emerging role of the consultant nurse and the need to be familiar with multiple research methodologies, with the perception that the traditional PhD is limited in practical terms, as being the main factors in developing professional doctorates. No mention is made within this study or elsewhere of the potential 'third route', namely a PhD by publication (or letters).

Succession planning

Preparing aspirant and new consultant nurses appropriately for the role is central to any notion of succession planning. Numerous authors agree that succession planning is a key aspect of any developing industry (e.g. McConnell 2006, Redman 2006, Charter et al 2005 Bolton and Ray 2004). Yet, healthcare generally and nursing specifically, is noted to fall some way short of what is nominally required (Scott Blouin et al 2006). Two aspects are highlighted as integral to successful succession planning, namely: planning including the appropriate identification of candidates and relevant competencies (McConnell 2006, Bolton and Ray 2004) and appropriate mentorship (Cadmus 2006, Redman 2006). Resources are also identified as a key issue (Bolton and Ray 2004, Watkins 2002). Others caution against unmatched expectations with regards to identified candidates failing to secure relevant positions (Bonczek and Woodard 2006, Watkins 2002).

Limitations of existing research

The limitations apparent in the literature on role evaluation and the preparation of consultant nurses available within the public domain make for an interesting discussion and debate. There is one large Department of Health funded study in England and Wales (Coster et al 2006, Guest et al 2003, Redfern et al 2003, Guest et al 2001) which provides a largely circumspect and muted account of the roles' success thus far. A further review in Northern Ireland has a poor return rate of 35% but does emphasis the importance of viewing the success or otherwise of the role in context.

Other studies are largely either personal descriptive accounts (Fairley and Closs 2006, Shuldham et al 2004, HPS 2002) or small qualitative studies (Woodward 2006, 2005). To their credit consultant nurses have also undertaken research, normally descriptive surveys of their immediate peers, in a bid to illuminate their role (Booth et al 2006, Dawson and McEwen 2006, Charter et al 2005) Authors have also cited the difficulties in maintaining confidentiality in these studies both due to the specific nature of some of the roles and small samples making anonymity almost impossible. Indeed, the initial review of the first three consultant nurse/midwife posts in Scotland remains unpublished in the wider arena, presumably for that reason (McIntosh et al 2002).

Most of the evaluative studies concentrate almost solely on the individual postholder rather than including those on, or with whom they might have an impact. One recent study (Redwood et al 2007) however, does follow up colleagues of individual nurse consultants, although the consultant nurse identifies which colleagues to interview. No studies have been undertaken which include either users in the design of the project, or patients as consumers of the role. None of the studies have involved consultant allied health professionals. Lathlean (2007) emphasizes the need for longitudinal studies to fully comprehend the vagaries of the role with regards to sustainability, achievements and measurement of same.

Summary of the literature

The data on consultant role evaluation and impact is, therefore, somewhat diverse, cautious and omitting key features with regards to design (contextual, longitudinal) or in capturing the increasing numbers of AHPs in these posts. What is clear, however, is that these highly visible, expert and dynamic posts require support and understanding for the individual and would benefit considerably from opportunities that appropriately develop and support existing and aspirant post-holders. There are reports of work-based learning and programmes committed to preparing consultants for their roles however, the reports of these initiatives are not yet fully in the public domain (Sturridge and Lathlean 2006, Lathlean and Masterson 2004, Lathlean and Masterson 2002).

Nursing patently has to ‘grow its own’ (Higgins 2003) in order to ensure the future of the role of the consultant nurse in tandem with AHP colleagues. NHS Education Scotland (NES), at the behest of the Scottish Executive Health Department (now Scottish Government), initiated a succession planning pathway for *existing and aspiring* consultant NMAHPs. The following outlines the aims and objectives of the evaluation of the NES Succession Planning Development Pathway for Consultant Nurses, Midwives and Allied Health Professionals which was carried out by a team led by Nursing Studies at the University of Edinburgh.

AIM

The overall aims of the project were:

- To identify the extent to which the succession planning development pathway for consultant nurses, midwives and allied health professions has contributed to an increase in numbers to the recruitment pool for these senior posts across NHS Scotland;
- To ascertain the usefulness of the process (particularly the Development Needs Analysis Tool as a mechanism to identify personal strengths and areas of potential development); and
- To identify the potential of transferability of this model to other staff groups.

OBJECTIVES

The objectives of the project were:

1) To analyse and review the selection process of how potential participants to the pathway were selected – both by NHS Board employers and the NES Selection Panel
2) To examine the range of activities undertaken by participants in order to ascertain if these activities met the identified needs
3) To gather information from participants, sponsors and strategic mentors with regard
    a. to :
    b. -patterns of mentorship
    c. -appropriateness of mentorship arrangements
    d. -usefulness of mentorship arrangements in helping to meet identified needs
    e. -usefulness of coaching / work shadowing / other support and development mechanisms
    f. -level of sponsor support
    g. -identification of other elements which would have helped in meeting identified needs
4) To ascertain the level of impact the pathway has had on changing / influencing career development practices across NHS Scotland
5) To examine the extent to which the pathway has increased confidence levels and developed the skills profile in those considering applying for a Consultant post
6) To examine the extent to which the pathway had increased the confidence, skills
7) and effectiveness of those who already hold Consultant posts
8) To produce interim and final reports.

# METHODS

## Summary of approach

This project required mixed methods incorporating both quantitative and qualitative approaches in order to fully capture the diversity in the available data and data sources (Cresswell 2003). The design was therefore, a graduated linear exploration of the relevant data sources with data collection and analyses methods that best fitted the challenges of the tender specification e.g. a project requiring evaluation of process and outcome, diverse geographical spread and accessibility of key informants/participants.

Stage 1 (a) was a scoping exercise to provide a quantitative descriptive survey of the SPDP participants in conjunction with a thorough review of individual participants' DNAT/PDPs[1] and activities logs involving content analysis. Stage 1 (b) involved in-depth qualitative interviewing of key individuals or stakeholders (i.e. NHS sponsors, mentors and the NES selection panel) to capture the processes involved in potentially diverse local and national procedures. Stage 2 utilises an embedded case study design to examine in further depth any standard, unique or revelatory cases (n=3) that may provide additional contextual and explanatory data. Table 1 outlines the stages, participants and data.

*Table 1: Stages, participants and data*

| Stage | | Subjects | Method of data collection |
|---|---|---|---|
| Stage 1 | (a) | Pathway participants (n=30) | Postal questionnaire and review of DNAT |
| | (b) | Stakeholders (n=20[10]) (selection panel, sponsors [strategic leads] and mentors) | In depth qualitative interviews |
| Stage 2 | | Pathway participants (n=3) | Case studies |

## Ethics and Governance

Relevant COREC/NRES and Research and Development submissions were made. Ethical approval was obtained via Fife, Forth Valley and Tayside Research Ethics Service specifically Tayside Committee on Medical Research Ethics B (07/S1402/95). Individual Local Research Ethics permissions were also obtained. Multi-Centre Research and Development Research (MRAD) permissions were requested and received via NHS Lothian Research and Development (2008/R/UO/03). Sponsorship and quality assurance mechanisms were lodged via ACCORD[11] the collaboration between NHS Lothian and University of Edinburgh. The principles of research governance were observed (SEHD, 2001) and all data stored securely in accordance with the provisions of the Data Protection Act (1998).

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[10] 21 interviews were undertaken. 1 interview was excluded due to data integrity being potentially compromised.

[11] Academic and Clinical Central Office for Research and Development

Information sheets were provided for all participants. Written consent was obtained for all questionnaire, interview and embedded case study data (Appendix II). All data was stripped and anonymised. Selection panel members, mentors and sponsors have all been denoted as stakeholders to further preserve anonymity where possible.

Sampling

Stage 1 (a) sought to recruit all SPDP participants (n=42) for the completion of a quantitative descriptive survey. A database of pathway participants and stakeholders held by NES was used to contact the relevant participants. Initially, contact addresses were reviewed individually either by email or telephone contact to ensure accuracy. It was not possible to contact a number of participants at this juncture as the database information was not up-to-date since participants had changed designations or moved health boards (n=3). An information sheet, questionnaire and stamped addressed envelope (SAE) was posted to the remaining participants n=39. One follow-up (postal) reminder only was sent out as per ethical permission. The Consultant NMAHP Network also agreed to produce an aggregate email encouraging participants to reply. The postal questionnaire response rate was 77% (n=30). Of the questionnaire respondents, one third were existing Consultants. The professions breakdown is as follows:

- 21 nurses,
- 7 AHPs
- 2 midwives.

The questionnaire is shown at Appendix III.

Stage 1(b) purposively then theoretically sampled the NES selection panel, NHS board sponsors and mentors until saturation (n=21) or theoretical sufficiency (Day 1999). This type of sampling looks to data sources that can best answer the questions under investigation (Charmaz 2006). Purposive sampling commences by attempting to limit variation in the sample. The first stakeholders recruited were stakeholders from the two participants who provided pilot data for the initial development of the questionnaire (see data collection). Thereafter variation in the sample was increased as specified in Table 2 in an attempt to provide depth to the emerging results. Sampling concluded once no new information or theoretical insights emerged (Glaser and Strauss 1967).

*Table 2: Stage 1(b) sample*

| **Stakeholder Designation(s)** | **n=21**[12] |
|---|---|
| Selection panel | 4 |
| Sponsor and mentor | 4 |
| Sponsor only | 6 |
| Mentor only | 7 |

[12] One stakeholder interview was omitted from the final analysis as there were doubts regarding the integrity of the data obtained. Thus, the final number of stakeholders included in the sample was n=20

*Table 3: Stakeholder selection criteria*

| | |
|---|---|
| 1 | Change in job circumstances of participant/ No change |
| 2 | Mentorship experience good/ poor |
| 3 | DNAT/ SPDP experience generally good/ poor,<br>Unusual activities chosen to meet DNAT |
| 4 | Mix of nurses, midwives, AHPs (not necessarily representative) |
| 5 | Confidence/ DNAT profile |
| 6 | Geography (particularly rural stakeholders) |
| 7 | NES Selection Panel |

Stage 2 reviewed the data from stage one (a) and (b) and extracted 3 cases of pathway participants who could be said to 'explain' the process and outcomes in context (Gray 1998) as potentially unique, revelatory or standard. The case studies were descriptive, exploratory and explanatory (Pegram 2000). The case studies used an embedded design (Yin 1994) that comprised pathway participant and relevant others. To preserve anonymity the case studies are presented as a composite case as far as possible and this is reviewed in detail (page 63).

Data collection and analysis

Stage 1(a) utilised a structured questionnaire (SQ) derived from the literature and project objectives. Two pilot telephone field note interviews were carried out with two pathway participants. These participants were from the one Health Board area; one had accessed the pathway at round one, the other at round two. One participant was an AHP and the other a nurse. Based upon the literature, project objectives and the pilot field note interviews, a questionnaire was derived, refined and further tested on both pilot interviewees. A range of question styles was used including open, fixed response and rating style options (Appendix III). The questionnaire responses were entered into an excel database and coded.

It was intended to compare and contrast the pathway participants' initial DNAT ratings on confidence in the consultant NMAHP domains of practice with post pathway scores via the postal questionnaire. However, the research team was unable to obtain the original DNATs from NES without seeking additional ethical approval since the pathway participants had not given their explicit consent as part of a pathway participation contract.

Descriptive statistics (mean and standard deviation for continuous variables which are normally distributed, median and interquartile range for non-normal data) were calculated for the responses generating quantitative data. The frequency of uptake of differing educational development opportunities were analysed in addition to percentages of practitioners engaging in the new programme and other modes of mentoring/learning to support their role. Differences in practices between individual practitioners and other relevant influential variables were tested using the appropriate tests.

Stage 1(b) developed and implemented a semi-structured interview guide (SSIG) based on the literature, the initial results of the SQ and initial discussions with stakeholders (Appendix IV). Data from the SSIG was analysed in conjunction with data collection using the constant comparison approach (Strauss and Corbin 1998).

Stage 2 adopted an embedded case study design with SPDP participants and relevant others (sponsors, peers, managers, patients) as data sources. Data was collected by various means including taped interviews, relevant documents and field notes or observation where appropriate. Thematic Content Analysis was applied. Thematic Content Analysis involves the identification of common threads that extended throughout the entire set of interviews. Themes have been described as concepts instigated by the data rather than concrete entities directly described by the participants (Morse and Field, 1996). The case studies were originally intended to explore transferability of the model of the SPDP. However, findings from Stage 1suggested the pathway was unlikely to be transferable in its current form. This allied to being unable to review existing DNATs with regard to confidence levels led to a change of emphasis in the case studies at Stage 2. Consequently, the case studies were used as an opportunity to explore individuals in context, and illustrate the individual's pre and post (current) position in relation to their self-assessment via the DNAT.

Mapping the aims and objectives to the methods/stage

| Objective | Method/Stage |
| --- | --- |
| 1. To analyse and review the selection process of how potential participants to the pathway were selected (NHS board and NES selection panel) | Stage 1(b) scoping:<br>-Taped interviews with NES panel and key NHS board informants<br>-Relevant documents relating to selection and NES and local level where appropriate. |
| 2. To examine the range of activities undertaken by participants in order to ascertain if these activities met the identified needs | Stage 1(a) scoping:<br>-Specifically content analysis of participants DNAT, PDP and Activities log.<br>-Additional data within structured questionnaire.<br>-Further clarification provided on identified cases in Stage 2 (case studies) |
| 3. To gather information from participants, sponsors and strategic mentors with regard to:<br>-Patterns of mentorship<br>-Appropriateness of mentorship arrangements<br>-Usefulness of mentorship arrangements in helping to meet identified needs<br>-Level of sponsor support<br>-Identification of other elements which would have helped in meeting identified needs | Stage 1(a) scoping:<br>-Structured questionnaires to participants of SPDP<br>Stage 1(b) scoping:<br>-Taped interviews with sponsors and mentors<br>Stage 2: case studies<br>-In-depth interviews with relevant participants, sponsors, mentors and relevant others |
| 4. To ascertain the level of impact the pathway has had on changing/influencing career development practices across NHS Scotland | Stage 1(a) scoping:<br>-Structured questionnaires to SPDP participants<br>Stage 1(b) scoping:<br>-Taped interviews with sponsors and mentors<br>Stage 2: case studies<br>-with in-depth interviews with participants, sponsors, mentors and relevant others |
| 5. To examine the extent to which the pathway has increased confidence levels and developed the skills profile in those considering applying for a Consultant post | Stage 1(a) scoping:<br>-Structured questionnaires of SPDP participants<br>Stage 1(b) scoping:<br>-Taped interviews of sponsors and mentors<br>Stage 2: case studies<br>-With in-depth interviews with participants, sponsors, mentors and relevant others |
| 6. To examine the extent to which the pathway had increased the confidence, skills and effectiveness of those who already hold Consultant posts. | Stage 1(a) scoping:<br>-Structured questionnaires of SPDP participants<br>Stage 2: case studies<br>-With in-depth interviews with participants, sponsors, mentors and relevant others |

*Figure 2: Schema mapping aims/objectives to method/stage*

RESULTS

The following section will briefly review the pathway and participants to provide some context for the results that follow. The results will then be presented according to the themes that emerged. This section is therefore organised into two parts. The first part (Stage 1) is primarily based upon the stakeholder interviews (Stage 1b) with data from the questionnaire responses (Stage 1a) integrated as appropriate. The second part (Stage 2) reviews the case studies as a composite case to further illuminate pertinent issues. A conditions, context, processes and outcome – a conditional matrix – is provided at Appendix VII.

**Stage 1: stakeholder interviews and pathway participants' questionnaire responses**

The Succession Planning Development Pathway (SPDP) was launched by NES in November 2005. Table 4 details the numbers of participants on the pathway.

*Table 4: Cumulative number of Pathway Participants by Health Board*

| Health Board | Existing Consultants[13] | Aspiring | Total |
|---|---|---|---|
| Ayrshire and Arran | - | 7 | 7 |
| Borders | 1 | 2 | 3 |
| Grampian | 2 | - | 2 |
| Fife | - | 6 | 6 |
| Forth Valley | 1 | 1 | 2 |
| Greater Glasgow and Clyde[14] | | 5 | 5 |
| Highland | 2 | - | 2 |
| Lanarkshire | - | 3 | 3 |
| Lothian | 2 | 5 | 7 |
| Tayside | - | 3 | 3 |
| The State Hospital | - | 2 | 2 |
| | **8** | **34** | **42** |

The findings from Stage 1 are reported under the following headings:

- Selection process (including DNAT)
- Pathway (including mentorship)
- The Consultant NMAHP role: enhancing the pool

**Selection process**

The process for selection of participants on the pathway was as follows. Selection to the pathway was carried out in two rounds (December/January 2005/6 and August/September 2006). Information on the pathway was circulated to strategic leads and others via the usual comprehensive dissemination channels of NES. The (same) information was made

[13] These are individuals who were in Consultant NMAHP posts prior to the pathway.

[14] During the timeframe of the pathway commencing to completing Greater Glasgow NHS and Argyll and Clyde NHS merged to form one Health Board Greater Glasgow and Clyde.

available to prospective candidates. The onus however, was on the strategic leads or sponsors to identify potential candidates at a local level. This was identified as the most appropriate process by the strategic leads in response to NES's briefing paper in September 2005. Strategic leads were also perceived as being best placed to develop Consultant NMAHP posts for pathway participants. Further, criteria 3 of the 8 available to the selection panel identifies '*demonstration of the applicant's fit with wider organisation plans*' as being important.

Once the sponsor[15] had identified suitable candidates, they were required to complete the DNAT[16] in partnership with the individual as a means to determining whether the pathway was the '*most appropriate route to best meet their needs'*. The sponsor was then required to identify which applications to support. There was an inference that more individuals would be identified and complete the DNAT (with the sponsor) than were likely to be sponsored. Theoretically there were no set limits on the number of candidates the sponsor could support as potential participants on the pathway. NES make this explicit in the information sent to Boards. There were however, limitations with regards to available funding from NES. Applications (DNAT and application template) were forwarded to NES by the closing date via the sponsor. A selection panel of three (a sub committee of the steering group) made the final decision regarding which candidates to support on the pathway from the joint submissions made by the sponsor and candidate.

The interviews with the stakeholders: sponsors, selection panel and mentors enhanced with relevant data from the pathway participants questionnaire responses, revealed that the selection process comprised three key elements: information, application and selection. These will now be reviewed in turn.

<u>Information</u>

There were two aspects to this part of the selection process;

(a) the dissemination of information to potential candidates
(b) the information the candidates were required to submit.

*Dissemination of information to potential candidates*

Once NES disseminated the relevant information via their usual channels and the strategic leads, the onus on that information reaching potential candidates clearly lay with individual Boards. The interviews suggested there was a diverse approach to disseminating information at a local level, if indeed the information was disseminated beyond strategic leads. Nonetheless, nearly three quarters of pathway participants (e.g. candidates who applied and were successful) saw the original NES circular regarding the programme according to questionnaire responses. Moreover, 50% (15) of the cohort had more than 14 days to complete their application [see figure 3].

[15] A sponsor is effectively a strategic lead: an executive level Director of Nursing and/or AHPs.
[16] Development Needs Assessment Tool (see appendix III for DNAT included in questionnaire)

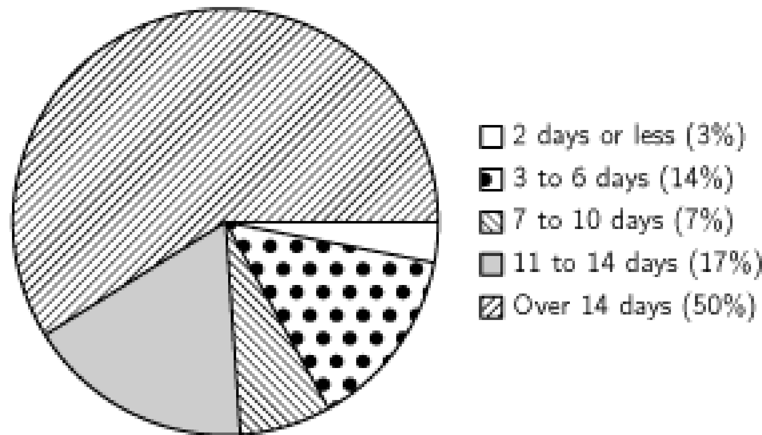


*Figure 3: length of time participants had in which to submit an application*

The reasons for the reported diversity in dissemination across the boards are difficult to ascertain. One reason may be inadequate distribution mechanisms within Boards. Another reason was the role of strategic leads and sponsors in selecting candidates. This role was not entirely clear, and presented a range of dilemmas in terms of selection. A certain control by strategic leads in this respect made sense in view of the intention that the sponsors may wish to develop a suitable post or outcome for the successful candidate.

The evaluation notes however, that some individuals did receive information from professional networks. It is debatable as to whether it was appropriate for information to be disseminated to a wider audience when strategic leads were patently charged with identifying and (locally) selecting candidates for the pathway as they, themselves, had apparently requested. Further, candidates could not be supported without sponsor support.

Some sponsors reported making this information broadly available within their organisation, thereby inviting individuals to present themselves for sponsorship on the pathway. This approach seemed to be most evident in the smaller health boards. Somewhat ironically it was the sponsors from these boards who claimed to have most knowledge of potentially suitable candidates and hence, it was perhaps less important they made the effort to ensure the information was widely available. How well this information was made available in all boards was difficult to gauge and is perhaps irrelevant given the key role of the sponsor.

There was evidence that a wider dissemination of information (e.g. beyond sponsors) was expected:

*I think that was one of the weaknesses eh because we were dependant on the communication trickles, rivers whatever you call it, in the Boards. And now the consultant network itself asked us whether we could do it in a different way, but we didn't know who the people are out there (yeah). We couldn't send it out to every single registered person in Scotland. Erm we also, - we did ask the consultant network themselves to disseminate it. (P4)*

There is evidently a need to accommodate the tension arising from recognising the position of strategic leads, requiring their explicit support for the initiative via sponsorship of individuals *and* making the pathway potentially accessible to a wider audience. The patronage of sponsors was important however, it may also have arguably compromised the potential pool of applicants from the outset as in some boards only certain individuals would have been privy to the information. Indeed, one mentor noted they received information regarding the pathway from a professional network as opposed to via their line manager (e.g. a sponsor/strategic lead). In that instance, it was *that* individual (a subsequent named mentor) who encouraged and supported individuals to apply as opposed to the strategic lead/sponsor.

Funds made available to facilitate the pathway was NHS monies and patently required strategic leads support therefore managing the information in this manner is entirely understandable. Patronage from within the NHS was integral to the process and potential applicants also had to come from *within* the NHS. Potential applicants from non-NHS agencies were unable to apply (e.g. HEIs, pharmaceutical agencies, independent sector). Hence other possible candidates were excluded from accessing this initiative and consequently from the recruitment ‘pool’ for Consultant NMAHPs.

*The information the candidates were required to submit*

There was acknowledgement of the considerable information generated by the selection process:

*There was a, you know, there was a lot of information to supply. There was a lot of information that was required and I think in actual fact it was a bit bureaucratic.*
*→And knowing AHPs that’s enough to put some really the good staff off. It’s enough to put me off. So I think it was bit bureaucratic and I think probably what had happened, I think it was because it was the first time we’d done it. I think what had happened is, people provided too much information. Then it probably made it very difficult to actually select from that because sometimes your message is lost in all the papers (P20).*

The information relating to the pathway; specifically the applications, reportedly filled 9 large cardboard boxes. The amount and nature of supporting evidence submitted varied and some applicants were also noted to supply information that was not requested e.g. Masters degree theses.

*It (the application: DNAT) was very in-depth yeah, even, I was struggling with it (laugh) (P15)*

*The recollection of the application was that it enabled that kind of spray and pray scattergun approach. Let’s get everything in and see what you know what I’ll get and all the rest of that (I- uhumm) without really using the tools that are around. (P16).*

However, there was a view that the elaborate nature and amount of information requested and received was integral to siphoning out inappropriate applicants:

*I think the process made people do, the applicants do an element of self weeding out (uhumm) it was so demanding to actually do that and to do it well that they were already halfway down (uhumm) the route of becoming a consultant if they'd really taken it seriously to fill in the DNAT (P4).*

*The usefulness of the DNAT and subsequently the pathway*

Nevertheless the DNAT was viewed positively by virtually all of the (successful) participants in this cohort as a means of focussing and reflecting upon their abilities and needs initially. 88% of participants strongly agreed/agreed that the DNAT was useful at the time of application with the remaining participants undecided. The usefulness of the DNAT during the SPDP was slightly less positive with those who strongly agreed/agreed falling to 77%, 13% being undecided and 10% either strongly disagreeing/disagreeing. Asked to comment on the usefulness of the DNAT post-SPDP, 40% declined to comment, 47% strongly agreed/agreed with 13% undecided/disagreed.

Participants found the DNAT useful initially, with its perceived usefulness reducing intra and post SPDP. This may be a reflection of the participants becoming more attuned to the required areas of development. In effect, the DNAT simply 'outlived' its usefulness or alternatively, had served its purpose. Notably, participants cited 'funding' and 'focus' - the latter specifically in relation to the DNAT - when asked to comment on the *strengths* of the SPDP within the questionnaire. Thus, the DNAT was, as one participant suggested, 'crucial' to the pathway overall and therefore, participants' perception of the pathway. Equally the DNAT's reducing perceived usefulness may similarly reflect a small number of participants emerging disenchantment with the pathway. For example specific limitations cited by several participants (n=4) were the perceived lack of a viable outcome i.e, a Consultant post. Numerous participants also commented on the lack of (protected) time in which to undertake the pathway as a specific limitation with the pathway invariably being 'fitted in' around work commitments. This need for 'protected time' for this kind of initiative was also raised by stakeholders.

Application:DNAT and activities

Three issues emerged;

(a) the process of completing the applications
(b) the candidates who applied (and did not apply)
(c) marrying short term availability of applicants with longer term service needs

*The process of completing the applications*

The extent to which sponsors and candidates completed the application *in partnership* - specifically *the DNAT* - is uncertain. 63% of pathway participants sought help to complete the DNAT from at least one other individual. Just over a fifth of participants sought help from their mentor:

*I don't think anybody could have just filled the form in (I- uhumm) themselves because there was a lot of reflection required and em… a lot of em create direction and support to actually look at the future. (I- uhumm) and that really needed a mentor type person to discuss that with the individual and em… look at their strengths look at their weaknesses, look at the kind of training needs that obviously for the, as part of the programme (P15).*

The DNAT was welcomed by the pathway participants and the activities denoted by the DNAT were relatively broad ranging encompassing shadowing, coaching, courses and training. 53% of pathway participants developed these activities in collaboration with another individual with a further 20% accessing the help of two or more others. 27% of pathway participants identified and developed the activities required to meet the DNAT *on their own*. This latter point, in conjunction with the fact that only a fifth of respondents sought help from their mentor, rather negates NES's stated aim that the application (DNAT and activities) should seek to decide whether the pathway is appropriate, assess relevant needs and identify related activities *in partnership.*

Educational activities were undertaken by 43% of respondents and 33% undertook shadowing. A broad range of leadership courses were also undertaken by participants e.g. Kings Fund, Liberating Leadership course, Windsor Leadership course. Thus, the majority of activities focused upon funded courses with shadowing and attendance at meetings/conferences the other preferred activities. A list of the activities undertaken is outlined in figure 4 with 3 sample participants and their respective activities in figure 5. All participants considered that the activities met either 'all' of their needs or 'some' of their needs. One stakeholder considered that a 'directory of activities' may have been useful.

- Leadership courses (varied)
- MPhil/MSc modules/other qualification e.g. CBT
- Study tour
- Shadowing: Consultant Nurse, Director, other
- Coaching
- Motivational course
- Develop links with HEI – curriculum planning
  e.g. development of honorary lecturer contract
- Attendance at conferences
- Attendance at strategy meetings/senior meetings
- Service re-design work/conferences
- Visiting other centres/individuals

*Figure 4: examples of activities undertaken by participants*

Sample (a): 2 day leadership programme and 1 week shadowing: all needs met

Sample (b): 2 visits to specialist centre in UK and 1 MSc module: all needs met

Sample (c): 6 sessions of coaching, MSc module, participation
in national group, submitted research bid (unsuccessful): some needs met

*Figure 5: sample participants*

The participants (questionnaire and cases studies) perceived the DNAT to provide a framework and focus to the pathway that may have otherwise been absent particularly given the bespoke nature of the programme. The DNAT therefore provided the participant with an awareness of the breadth of the role and provided the basis for selecting appropriate activities.

However, the view of the DNAT from the perspective of stakeholders was less encouraging and a significant number were unable to recall the DNAT in any detail despite having allegedly taken part in its completion or use via mentorship. Others were less than convinced of its general use:

*I thought it was very personal and very, because it was self assessment. (I- uhumm, uhumm) I'm not sure that it was the best way to do it. (I- uhumm) I'm not actually sure how it could be better (I- uhumm, uhumm) but there were some areas where I thought that they either over estimated their ability or under estimated their ability (P17).*

Conversely, others welcomed the applicability of the DNAT:

*(Participants) might be holding a masters degree so they have already proven that they can think and work at that kind of level so they don't, but, but it's maybe the application of some of that thinking in the work context, probably thinking about the bigger picture rather than just the area of clinical focus (P2).*

The DNAT therefore, drew praise primarily from the participants who applied it. Stakeholders generally struggled to articulate the DNAT, its use of properties or had relatively ambivalent responses.

Importantly, the DNAT was also an attempt to ascertain the applicant's potential suitability as a Consultant NMAHP. If the DNAT was not completed in conjunction with the sponsor how otherwise could the sponsor have assessed the applicant's potential and therefore, supported (or not) their application?[17]

*Who is this person? Is this somebody we would want to support, how do we see- you know what have they done, what would be their career trajectory, is this somebody we would want to invest in? (I- uhumm) Em…and of course I think the first people were actually the people who were already in NMAHP Consultant posts as apposed to truly being Succession Planning people. And it was it seemed to me pretty obvious if they are already in post and they were identifying skills and knowledge deficits in development needs that they were appropriate people to put through the programme. (P7)*

[17] There was no evidence that sponsors refused to support candidates for the pathway of those who presented themselves or were invited to apply in the first instance. Most sponsors indicated a very limited number of individuals applied. However, the criteria for unsuccessful candidates in the second round highlighted that some applicants did not appear to have sponsor support.

*The candidates who applied (and did not apply)*

Notably, there were eight existing as opposed to aspiring Consultant NMAHPs on the programme overall [8 out of 42]. Five of these individuals applied at the first round [5 out of 17]. There were 64 existing Consultant NMAHPs at the time of the pathway and therefore, few of those Consultants decided to access the pathway. The Consultants who did access the pathway were, in the main, well-qualified and experienced in the role. There were therefore newer, less experienced existing Consultants who chose not to access the pathway from among the total cohort of 64, assuming they knew of the initiative.

It would have been useful to have had discussions with the Consultant NMAHPs who did not access the pathway: to compare and contrast pathway participants (existing and aspiring Consultants) with non-pathway participants (existing Consultants). Of particular interest in the latter cohort would be their reasons for not accessing the pathway in conjunction with their ongoing or subsequent development and experience. This discussion can be undertaken retrospectively as part of the dissemination of the evaluation.

A key aspect of assessing the worth of an initiative such as the pathway is in ascertaining if those who could have applied did apply. However, this study is tasked with evaluating the pathway and by definition that means those participating in the pathway rather than those not participating. Nonetheless, in order to review whether the pathway has enhanced the pool of Consultant NMAHPs there needs to be some consideration about the potential *population* of Consultant NMAHPs. Is this a potentially large or limited group in the first instance from which to recruit from?

There were different views expressed by stakeholders. Some felt that the selection process failed to capture the appropriate candidates

*Q* *You mentioned there about the selection process. Are there other's that you might be aware aware of who possibly didn't (apply)?*

*P16* *Yeah there are and I would have thought they would have been further up my ranking in terms of who the organisation would be sponsoring.*

Others thought the potential was tapped:

*They were the ones who put themselves forward and applied so there wasn't another seventeen at their back who were refused you know (P10).*

*We only have a few people that put their hands up when the initiative comes 'round so I have never had to make difficult choices. (P11)*

*Marrying short term supply of candidates with long term service needs*

There were also difficulties in marrying the exigencies of service need with available candidates within a short-term initiative:

*An example would be em… (a Consultant NMAHP post in a particular speciality) but we, we've interviewed twice you know we've interviewed once and been out to advert twice and*

*could not get anyone for that post and actually now we said well we'll probably just do without that post. We will use the money in another way. So that's a lost opportunity (I- yeah) and the thing is kind of knowing that we could now target some people and encourage them to go the Succession Planning but by the time they come out the other side we will you now have spent the money (P7).*

The difficulties in marrying the exigencies of service need with available candidates also need to be balanced with cognizance of the potentially unrealistic expectations of candidates *and* the appropriate use of scarce resources.

Sponsors appeared to be supportive of the potential of those individuals who did present themselves for the pathway:

*(I) valued both of them. I knew that academically they had good credentials (I- Uhumm) and knew that professionally they had credibility on the floor and had no problem at all sponsoring them (P10).*

*Certainly the individuals are, they are motivated and they are enthusiastic and they are recognised in their field being good clinical leaders as well as practitioners (I – uhumm, uhumm) which I think is really important (P21).*

While sponsors were notably supportive of those individuals who did apply there were numerous stakeholders who felt there was simply a dearth of suitable candidates. Alternatively, several respondents noted that potential applicants simply chose not to apply:

*I suppose really there were probably two or three people at the time (I- uhumm) that I thought em… were more likely to go Nurse Consultant Pathway rather than Management Pathway and I kind of approached them (I- uhumm) and I said "have a look at this and see what you think". (I- uhumm) em… Two of them felt that the actual eh… the book that they had to fill in, the application (I- uhumm) em… put them off basically, they said I can't it's far too in-depth, I'm not interested. (I- uhumm) And I suppose that at the end of the day the other comments were around well you know em…"what value is it for me, I hadn't really thought about Nurse Consultant and actually there is nothing it's you know it's a lot of hard work in a sense we might not get something at the end of the day". (I- uhumm) So that was the kind of comments back (I- uhumm, uhu, uhu) from the two that decided not to eh.* (P15)

The lack of a conceivable outcome for pathway participants was noted by a number of stakeholders and several participants (n=4) and commented on specifically by mentors who were somewhat discomfited by this non-conclusive arrangement. Nonetheless, it is likely that some potential participants were dissuaded from applying due to lack of tangible reward. Equally however, several mentors and stakeholders suggested potential participants reported feeling 'obliged' to apply for fear that a non-application may discredit their claim or application for any future Consultant NMAHP position. Hence, one respondent undertook the pathway whilst undertaking a professional doctorate. Similarly, it is likely that others chose not to apply for the pathway because they were undertaking further development, albeit one with a tangible 'reward'.

Succession planning is arguably a long-game but service need and funding demand more expedient actions. Thus, the role as a sponsor is crucial to the success of the initiative yet the success of the initiative has to marry relatively incompatible or unachievable demands. Hence, the SPDP may develop a pool of Consultant NMAHPs but they may not be appropriate to the area of (local) service need. Another respondent cited similar concerns in terms of the impossibility of 'predicting the future' within those parameters and expectations. Consequently, these kinds of concerns suggest a need for some kind of strategic direction as well as local initiative.

The funders may wish to consider ways in which individual capability and service need with regard to Consultant NMAHP posts can be best addressed in the future. It may be that facilitating both is possible. Hence, the door is always open for capable individuals to develop and create Consultant NMAHP posts and similarly, service need is facilitated via more closed and focused initiatives to support succession planning for existing consultant posts (see recommendations).

Finally, there was a suggestion that NMAHPs are notoriously reticent at putting themselves forward and this was in some way to blame for the limited pool of applicants:

*I'm not sure that we've got the right people but I think that's as much people like us putting their hands into the system and saying– we need to do more. I think it's the Scottish trait, I think it's the Scottish female trait that we are very poor about putting ourselves forward for these kind of things. (Laughs) I'm not sure that we've got the visibility of the approach and that our Chief Nurses and other Nurse Leaders are really tapping into where we're going next (P8).*

Certainly visibility and being prepared to consider a Consultant NMAHP (or other) position as a viable career path was discussed in some detail. This will be addressed in the concluding section 'Consultant NMAHP post: enhancing the pool.'

<u>Selection</u>

The selection panel of three had eight criteria with which to assess applications and this was disseminated to NHS Boards as part of the SPDP briefing information (November/December 2005 and July/August 2006) (see Table 5).

*Table 5: NES selection panel criteria*

| | |
|---|---|
| 1 | Confirmation that the applicant is an existing consultant or almost at that stage in their career development |
| 2 | Assurance that appropriate line management support for the applicant by way of a named senior person as "mentor" and/or line manager is in place. |
| 3 | Demonstration of the applicant's fit with wider organisation plans. |
| 4 | Provision of evidence that funding will be used for educational development activities such as coaching, mentoring, work shadowing, formal education / learning, specific project work, travel costs for national groups, etc. |
| 5 | Provision of a detailed plan outlining activities (including rationale for those activities), associated timescales and costs. |

| 6 | Provision of evidence that clear links exist between planned activities and the applicant's personal development plan. |
|---|---|
| 7 | Confirmation that a mechanism to report to NES will be established in terms of financial spend and progress of applicant(s). |
| 8 | Confirmation that successful applicant(s) will provide a report to NES following completion of the pathway. |

The reasons for rejecting applications were reported by the relevant stakeholders as being as follows:

- Poor quality of applications
- Limited information provided
- Poor understanding of the role of the Consultant NMAHP
- Disproportionate emphasis on clinical skills (training)
- Overestimation of abilities (e.g. high confidence ranking in DNAT)
- Request to undertake courses without proper recourse to DNAT
  -specifically doctorate funding

Selection: first round (January 2006)
There was no information available to the research team to specify which criterion was most relevant to the candidates selected (or rejected) at the first round of applications. The number of applicants applying in the first round is provided in Table 6.

*Table 6: 1st Round (n = 17 successful, n = 15 unsuccessful)*

| Health Board | n= | Successful | Unsuccessful | Existing Consultants |
|---|---|---|---|---|
| Argyll & Clyde | 6 | 1 | 5 | - |
| Ayrshire and Arran | 2 | 2 | - | 1 |
| Fife | 7 | 3 | 4 | - |
| Grampian | 2 | 2 | - | 2 |
| Greater Glasgow | 3 | 1 | 2 | 1 (unsuccessful) |
| Lanarkshire | 2 | 1 | 1 | - |
| The State Hospital | 4 | 2 | 2 | - |
| Tayside | 1 | 1 | - | - |
| Lothian | 5 | 4 | 1 | 2 |
| **TOTAL** | **32** | **17** | **15** | **6 (1 unsuccessful** |

Selection: second round (September 2006)
Six candidates rejected at the second round did not meet criterion 2, 4 and 5 as shaded in Table 5. No information was available on successful candidates.

There are three issues worth highlighting at this juncture relating to the selection process overall: administration, application of criteria and sponsor recommendation.

*Administration*
First, the application process generated considerable information that filled nine large cardboard boxes. This made the selection panel's job somewhat onerous. There were also

reported difficulties with the administration of the project. Documentation that would have been useful to the research team was therefore, unavailable.

Moreover, it is also difficult to ascertain the completeness of the documentation provided (e.g. 2nd round unsuccessful candidates' criterion available, but 1st round unsuccessful candidates' criterion not available). For example, in Table 6 it is noted that one of the unsuccessful candidates from Greater Glasgow is an existing Consultant NMAHP who was on long term leave at the time of application. It may have been that her line manager put her forward for the course in her absence but as the documentation was incomplete she was therefore, denoted as being unsuccessful.

It is the view of the research team that evaluation should be built-in to any project from the outset e.g. prospective not retrospective. We would therefore, strongly recommend that the funders consider commissioning evaluation *at the outset* of any future initiatives. Moreover, consent to participate in an (anonymised) evaluation should also be a pre-requisite of participants accessing future initiatives.

*Application of criteria*
There is an incomplete audit trail with regards to the selection process at the point when applications were submitted. Particular individuals may have held considerable sway over decisions made in selecting candidates that were profession-specific. This was reportedly due to those stakeholders' apparent knowledge of the candidates applying. Whether this additional 'knowledge' was useful or not, without an accessible audit trail it leaves the process open to claims that it was not as objective as it could have been, or should have been seen to be.

*Sponsor recommendation*
Finally, it is notable from Table 6 that not all of the individuals supported by sponsors were accepted on to the pathway. Again, it is impossible to triangulate the views of the selection panels with relevant documentation and therefore, present contextualized information as to why sponsor-supported individuals were not selected. Notably, only two of the individuals supported in round two were unsupported candidates from round one. Thus on paper, 13 individuals (12 if you exclude the 'unsuccessful' Consultant NMAHP) did not re-apply despite being initially supported. Were these individuals 'lost' to the potential pool of Consultant NMAHPs for good, or did they simply access other initiatives? One stakeholder (sponsor) admitted there had been an administration mix up (locally) which caused the potential candidate from being excluded from the pathway. That candidate was subsequently supported to undertake a masters' degree.

Of six candidates supported by the stakeholder in Argyll and Clyde (at the first round), only one candidate was considered suitable for selection on to the pathway. This therefore, arguably raises either issues about the sponsor and candidates and/or or the selection panel's processes. It is also possible given the administrative difficulties that this may simply be inaccurate – an administrative error rather than an issue of note.

Summary

The following points should be noted:

- There were no applicants from Western Isles, Dumfries and Galloway, Orkney and Shetlands.
- Out of 17 successful candidates at the first round, 3 did not appear to start the pathway as they are not on the final database. No information is available on why this is the case.
- There were 26 candidates successful in $2^{nd}$ round with 6 candidates identified as unsuccessful
- 2 of the successful candidates from the $2^{nd}$ round were noted to have been unsuccessful from the $1^{st}$ round.
- Three of the 26 successful candidates at the $2^{nd}$ round were existing Consultant NMAHPs at the time of application.

**RECOMMENDATIONS: the evaluation**

- Future NES interventions/initiatives involving evaluation should seek to obtain consent as a condition of anonymised participation.

- Evaluation tenders should be contracted out prior to the commencement of the intervention.

**Selection process**

Should the pathway remain in any form, the selection process may benefit from the following:

- A specific and explicitly limiting (paper) application to the pathway

- Appropriate documentation highlighting the aim, method and expected outcomes of the pathway.

- Clear defined administrative support at the point of central selection / organisation (i.e. NES).

- Consideration of whether sponsor support is appropriate or necessary, specifically whether it may be more appropriate to encourage individuals to apply independently of their employing organization.

- Consideration of opening up the pathway to non-NHS employees e.g. a wider pool of applicants.

- Consideration of providing a concrete outcome in order to encourage applicants.

- The DNAT is a useful tool that may be transferable depending upon the proposed context. However, it needs to be completed with mentors with the appropriate expertise and attend to all domains as part of an appropriate and explicit mentorship programme.

**The pathway and mentorship**
Stakeholders suggested the issue of succession planning was a 'huge problem' (P12) in general in the NHS as well as in relation to the Consultant NMAHP role. Nevertheless, stakeholders professed a commitment to, and appreciation, of the Consultant NMAHP role suggesting they were likely to be supportive of mentorship in this particular initiative.

*The mentor*
Pathway participants were generally (verbally) advised (77%) to choose someone who was at a significant level within the organization – someone who could 'open doors' and facilitate access to relevant individuals and meetings. This was presumably in line with NES's original scoping exercise where strategic leads expressed the view that 'political awareness' and 'strategic thinking or influencing' should be key aspects of any development pathway.

There was no specific written guidance on choosing a mentor, or documentation for the mentor explaining their role, the pathway, the DNAT, outcomes or 'sign off'. The role of mentor; purpose and function was not explicit. The relatively loose nature of the purpose, pattern and outcome of mentorship was identified as being something that could be improved upon:

→ *Yes I think it is that bit about having an understanding of what's expected of you as a mentor ( I- uhumm) and to, so to really support the person that's on the pathway ( I- uhumm) yeah you know it's that bit about supporting those that are mentoring. Not supporting as such, but actually having eh… "this is what we*
→ *would be looking for you know even a check-list to say these are the kind of key things we think". You know and it may well be some people might say I don't need that but I would welcome that. I think it would have been beneficial for me ( I-uhumm) to sort of say okay what's expected of me and I can go, and I can sit and I can talk and I can say yes I think you would benefit from doing this, this and*
→ *this. But you know how do I then make sure that, that input is there and get that kind of feed back from whoever that's running the pathway (P12)*

In the first round it appeared that participants selected an executive person from their own profession such as a Director of Nursing or an executive level AHP, or even a general manager. There were particular difficulties noted when mentors were managers:

*Well em, recently, difficult to be honest. I think. I'm a manager first and foremost and that I think, probably does actually cause some issues between somebody who mentors and somebody who manages. So, the difficulties that arose from that is, when we met we would be talking specifically about management areas and I sometimes wonder if a mentor should rather be out of the operational aspects of day to day work with a member of staff, to be able to do that role effectively (P18).*

The definition of an effective mentor is one of a trusted friend or counsellor who may be older, can provide some guidance and has some knowledge or experience of the situation of the mentee. An effective mentor should perhaps be someone outwith the operational aspects associated with the day to day working relationship with the mentee. There is

arguably a dichotomous relationship between manager and mentor. Clearly, there may be some tension between the notion of 'trusted friend', a line manager and their associated accountability and operational responsibility. One mentor - a very senior manager - noted that she/he met the mentee once and never heard from the individual again and consequently assumed that the individual had chosen another mentor. The mentor offered the opinion that the mentee may have felt 'intimated' by the mentor.

In the second round of applications participants were apparently encouraged to go outwith line management or hierarchy. The reasons for this are not explicit but may allude to the input required by the respective mentors (who were at that time also sponsors) and the corresponding demands on their time. Thus, second round participants selected an individual not necessarily within their own occupational group, but at an executive level. While encouraging participants to go outwith operational line management was a positive move given the above, it may also have compromised the aspect of mentorship that requires the mentor to have some knowledge and/or experience of the mentee's situation. It appeared that AHPs had particular difficulty in accessing appropriate mentorship in either the 1st or 2nd round and this may simply reflect the dearth of AHPs in executive level positions. However, despite commitment to the pathway and the Consultant role it was clear that some individuals become mentors simply by default:

*I mean I got an email from someone to say that my name had been given to them and would I be prepared to do (it) and you know it is very easy again to say no to these things, but clearly my view is that development and personal investment in the development of others is important. So I said 'yes' without really knowing what I was saying 'yes' to, to be honest(P1).*

P1s experience was not necessarily common to all. However, the move from a hierarchical mentor such as Director of Nursing to an executive/operational mentor clearly involved the delegation of this function to individuals who were less likely to be familiar with the purpose and process of the pathway, than the original sponsor/mentor. Nevertheless, mentors had a relatively clear view of the purpose of mentorship:

*The approach I've taken is there's a rub in there about being a critical friend too which is more than just being positive, supportive, developmental, which is a wee bit about the 'grit in the oyster'. It is a wee bit about challenge and prodding and influence as well (P8).*

P8 contended that the sooner the mentee accepted the challenge and constructive criticism and responded appropriately to this then the more positive the outcome (of mentorship) was likely to be for both parties. Terms such as 'prodding' and 'toughening up' were also used by respondents to illustrate their perception of the purpose of mentorship. Other mentors also described mentorship in relatively prosaic terms that tended towards the language of battle:

> *Part of the things we looked at em was more involvement at strategic meetings em… there is a bit of an eye opener for the candidate because you know within*
> → *the kind of cocoon of where they work they've never been exposed to that (P15).*

> *Working with them (mentors) finding out a little bit about what they find are good sort of tools and techniques to make things work. I mean dealing with a group of*
> → *Dr's is often described as herding cats, well that's well that's quite a polite term (I- laugh)em… being able to muster a consensus out of a varied group of Clinicians is quite important in a Consultant role whether it's Medicine, Nursing or Allied Health professionals. You have got to be able to get to that point in working with colleagues and you have got to be the vehicle at times for that*
> → *negotiation.(I uhumm) em… And times it can be confrontational it can be difficult so preparing people for the fact that's it's sometimes going to be difficult (P11).*

There was an inference that perhaps NMAHPs were not 'naturally' good at either confrontation or 'political awareness' and this tended to corroborate P8 and others clarion call regarding the necessity for individuals to 'toughen up'. While the language of battle was evident in asserting the purpose of mentorship, there was also recognition of softer issues of guidance and 'signposting' (P9) as being key aspects of the process.

*Quantity and quality of mentorship.*
43% of pathway participants (mentees) found the mentorship aspect of the SPDP to be very useful with a further 30% agreeing that it was useful. 20% were undecided while 3% disagreed/strongly disagreed. All pathway participants met with their mentor at least once with 7% meeting only once. 17% met with their mentor twice, 42% between 3 – 5 times with 17% meeting on 6 or more occasions. A fifth of sessions lasted approximately 30 minutes with most (50%) lasting an hour or longer. The remainder (30%) lasted 90 minutes plus.

Pathway participants reported that approximately 11% of mentors provided structured sessions and 50% fairly structured sessions with both focussing on the DNAT and activities to some extent. 18% reported unstructured sessions with some focus on the DNAT and associated activities. 21% considered that mentors conducted sessions that were unstructured *and* had no particular focus on the DNAT and related activities. However, over three quarters of pathway participants strongly agreed/agreed that their mentorship experience matched their expectations. Nonetheless, 7% were undecided about their mentorship experience while 14% strongly disagreed/disagreed that their experience matched their expectations.

> *I think again because my involvement was a lot less than I had anticipated it would be and to be honest, em… I had about two maybe three meetings early, early on with (SPDP Participant) ( I- uhumm) and really - I spoke to her after you had contacted me and said "Emm… obviously you were going to come and speak with me, and you know, I felt I really didn't have much to contribute (I- yeah, yeah) to it because we hadn't met as often as I would have liked to (P12).*

There were a number of specific examples of mentorship that were less than satisfactory for both parties. This may have been due, in part, to a lack of clear and specific guidance on mentorship purpose and function. The mentor noted that after the initial *'flurry'* regarding the pathway there had been no obvious process to or closure of the relationship: it (and the pathway) had '*fizzled out'* (P12). There was a consensus among stakeholders regarding the

latter point of lack of closure - particularly no obvious signing off or outcome to the initiative.

The concept of leaving the process and outcome of the mentorship relationship open and flexible at the behest of the individuals concerned is an important part of mentorship. However, it arguably does tend to fly in the face of normal NHS practice and NMAHP working practices where an audit trail and appropriate documentation denote explicit accountability to all parties. The provision of such documentation and explicit guidance may have provided assurances to both mentee and mentor that the process was appropriate, progress was being achieved and outcomes acknowledged. Coherence in terms of appropriate and explicit documentation regarding mentorship made available to both mentor and mentee was missing for many and perhaps prevented both parties from attaining a clear sense of achievement. Nonetheless there were examples of mentorship relationships where both parties clearly thrived:

*In actual fact, I must admit, at the very beginning it was even about behaviours and influencing peoples' behaviours. So you know, it was whole, a whole barrage of things in a sense. (specific issue deleted) And so, at the end of the day (the mentee) has totally changed the behaviours around the working area and the way the mentee works with people and gets them to do what the mentee wants them to do. ( ).But the mentee has redesigned the service [ ] redesigned the staffing around the service. (additional list of a variety of very specific changes in a specific area). So, you know, it's had a huge impact on the service. And whether or not it's regarded as a consultant succession or not, it's, the mentee's in a different place from where (they were), and so is the service (P20).*

There was a view that, aside from the mentor's style and skills, the personality and motivation of the mentee was a necessary ingredient in a mentoring arrangement that brought results:

*She's always been particular, she's always been excellent, she's always had great ideas, she's always been able to know what she wants to do, (I- uhumm) and do it well. She has struggled with her confidence levels to portray that, for example her presentation skills (I- uhumm) were dreadful. (laugh) em… her interview skills were dreadful. Em… and the difference is phenomenal (I- Uhumm) and she recognises that herself (I- Uhumm) and that's through coaching and mentoring at a strategic level (P10).*

*I think a lot of (names mentee) where she is because of her personality (I- uhumm) she's a bit like a dog with a bone. If she's got an idea (I- uhu) she'll just keep banging her head against that wall until somebody listens to her. Em…the others are much more sedate (I- uhumm, uhumm) em…so there is something there about em…resilience (P21).*

The view that some individuals are more resilient than others also implied that certain candidates are therefore, perhaps more suitable for a Consultant NMAHP role/post.

Despite explicit aims, outcomes and processes not being made available to mentors and mentees, mentorship was considered a positive experience by most mentees and mentors. There were clear successes from some mentorship relationships that may have subsequently

enhanced the Consultant NMAHP pool. These benefits were reportedly the increased confidence of the mentee (by the stakeholder), further development via DNAT activities as well as practical service benefits (e.g. reported improvements to service organisation). It may also be the case that the opportunity brought the (developed) abilities of the mentee to the attention of the relevant individuals. This in turn may have increased the potential for considering whether the individual may be suitable for a Consultant NMAHP post. However, it is also likely that some candidates had particular attributes that would have stood them in good stead for Consultant NMAHP posts, whether the pathway had been available or not. Thus, one group of pathway participants appeared to derive particular benefit from the pathway and/or were brought to the attention of the relevant sponsor. A second group of pathway participants were perceived to be individuals who would have developed without the pathway. Of concern are the third group of individuals who did not derive any perceived benefit from the relationship and in fact, for whom, it may have been a negative experience (e.g. 20% undecided, 3% disagreed/strongly disagreed).

Several pathway participants and stakeholders also suggested coaching as an alternative to mentorship. A number of participants sourced external coaching as part of their DNAT and associated activities and rated the experience very highly. Notably, several stakeholders felt the mentees and the pathway may also have benefited from an explicit link with HEIs[18].

*Other models – addressing ALL domains and increasing confidence*
The Consultant NMAHP role exists across four or five domains and this was evident and explicit within the DNAT. Influencing, policy and strategy are but one aspect of this multi-faceted role. Although leadership/strategy/influencing may be an area in which aspiring or existing Consultant NMAHPs require significant development as suggested by the results of NES's initial scoping exercise (of strategic leads). While political awareness and strategic thinking linked to toughening up the candidate could be addressed to some extent through an NHS mentor it was suggested that perhaps other domains of practice would be better developed through HEIs e.g. education and research.

> *You need a matrix of mentorship (I- uhumm) for consultant posts and therefore I think you need a matrix approach to mentorship for the Succession Planning (P7).*

P7 considered that perhaps simply addressing one domain at the expense of others may be relatively short-sighted, particularly when any future posts were likely to be or should be linked in to HEIs.

*Confidence levels*
A key objective of the evaluation as outlined by the funder was to review whether the pathway increased the skills, confidence and effectiveness of the existing and aspiring Consultant NMAHPs. As noted previously this was difficult to ascertain as (a) there were no existing baseline measures and (b) the research team were unable to access pathway participants' DNAT applications which may have provided such measures. However, DNAT domains of practice were included in a re-ordered format within the postal questionnaire. The analysis of this provided statistically significant results specifically

[18] Higher Education Institution

within two domains with regard to confidence levels – 'patient and staff education' and 'audit and research'. Those two domains in conjunction with other *domains* and their *respective confidence levels compared* with the *participants' perceived areas of development need* perhaps provide the most illuminating aspect of the evaluation.

Pathway participants were asked (retrospectively via the postal questionnaire) to identify the areas of development need and respective learning outcomes they had specified in their DNAT [figure 6]. This is important given that there was no access to the original DNATs. This was an open question in a list format (Appendix III, question 4.10). Participants clearly identified strategic development ahead of all other possible areas or domains which concurs with the views of the strategic leads expressed to NES in the original scoping exercise. However, the domains identified by the participants are not a complete match for the domains within the DNAT with the exception perhaps of 'research and audit'.

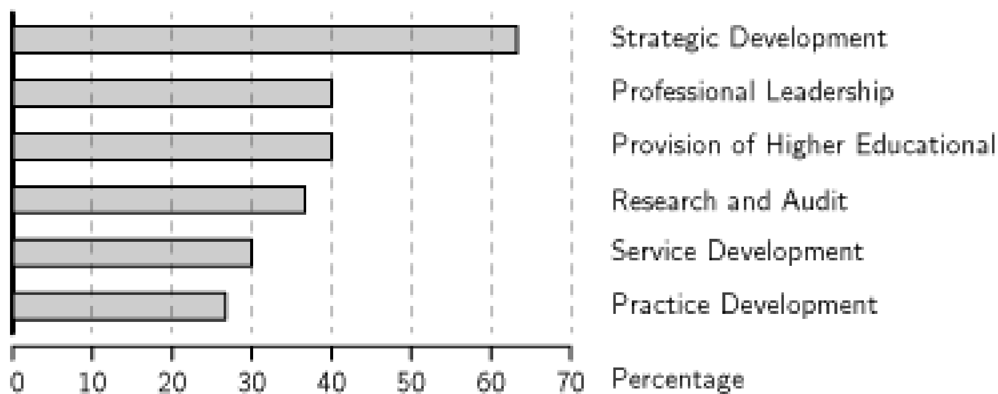


*Figure 6:*
*Areas of development need identified by the participants (question 4.10)*

The re-ordered DNAT (section three in the postal questionnaire) asked respondents to rate their confidence levels in their *current practice post-SPDP.* We will now briefly review each of those areas in turn starting with the most statistically significant domain. You should refer to section three of the postal questionnaire in appendix III to appreciate the full remit of each field of the domain. Additional statistical data related to the following domains ca be found at Appendix IX (e.g. student t-test, p –values).

*Audit and research*
The primary result for the domain of audit and research [figure 7] is that confidence in the identification of research questions is distributed differently from that of the other fields within this domain. Thus, RQs – identify appropriate research questions relevant to daily practice and lead in the commissioning, design, implementation and reporting of these projects – is significantly identified as being an area requiring development as opposed to some development. The ability to formulate research questions is statistically distinct from three of the domains (evaluation and audit ($p=0.0002$), dissemination ($p=0.002$), scholarly activity ($p=0.01$). Consequently this field of the domain (RQs) is highlighted as being statistically significant even within such a small sample ($n=30$).

For the remaining measures of confidence the ability to influence standards of evaluation/audit (eval/audit p=0.0002) and the ability to disseminate findings of evaluation/audit (dissem) are similar. Likewise, the ability to present evidence to influence policy (evid pd) and the ability to exhibit scholarship (scholar) are not different.

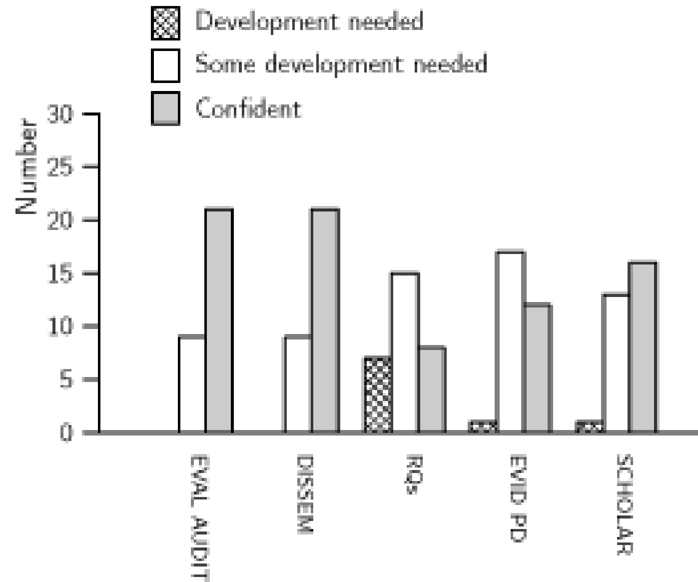


*Figure 7:*
*Levels of confidence and need for development in the domain of* ***audit and research*** *(question 3.5)*

*Patient and staff education*
In this domain confidence was measured in terms of training needs (t needs), ability to deliver courses for HEIs (hei cours), ability to develop courses for HEIs (lecture), ability to develop innovative learning for HEIs (opt learn), leadership skills in education (lead ed), level of collaboration with HEIs (hei coll) and supervision skills (superv). The distribution of confidence levels for each field is illustrated in figure 8. Statistical analysis of measures of confidence demonstrated that there was no difference across the fields of this domain with the exception of supervision skills (superv) – initiate and provide skilled supervision for members of team and peers - which has a statistically different profile of confidence from the other components of this domain (p=0.0100, P=0.0091, P=0.0049, P=0.0023, P=0.0468, P=0.0021). The majority of participants were most confident in this field and this was statistically significant.

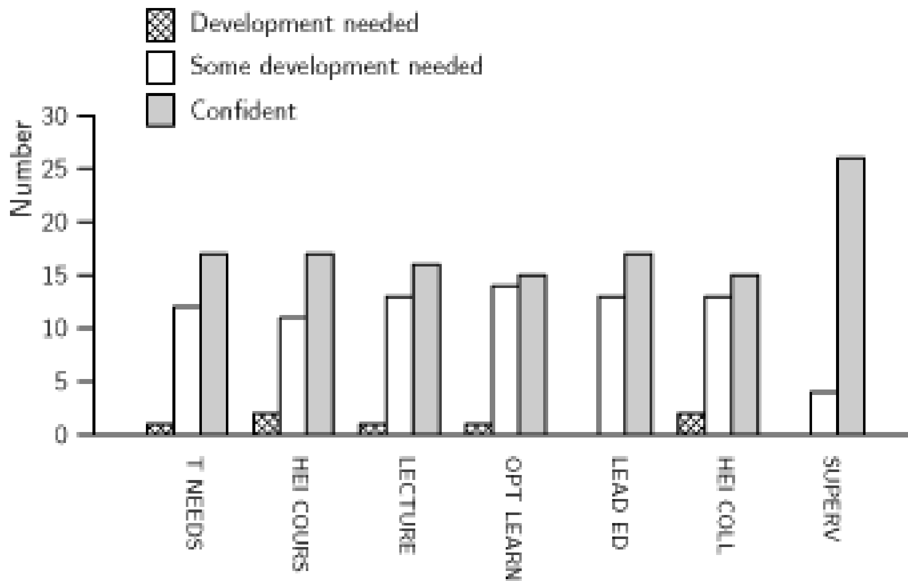


*Figure 8: Levels of confidence and need for development in the domain of* ***patient and staff education*** *(question 3.3)*

*Leadership and consultation skills*

Within this domain four fields of confidence were measured, namely provide leadership locally, regionally and nationally (lead lrn), use leadership and consultancy skills to make a difference to patient care (lead con), think creatively and work collaboratively to overcome obstacles to change (obstacles) and provide strong and effective clinical leadership across professional boundaries focusing on service excellence (clin lead). Figure 9 illustrates the distribution of confidence levels within the sample for each of these variables.

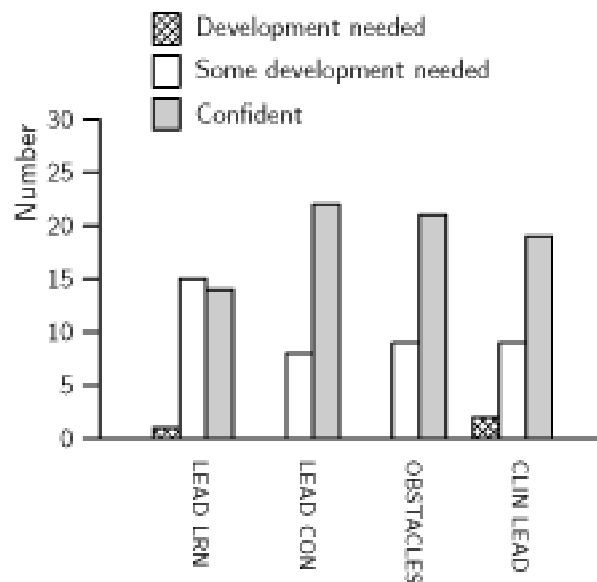


*Figure 9*

*Levels of confidence and need for development in the domain of* ***leadership and consultation skills*** *(question 3.1)*

Comparison of the distribution of confidence levels using the Mann-Whitney[19] rank test indicates that there was no difference across these four fields. It is clear that there is no difference in confidence in *lead con*, *obstacles* and *clin lead*. However, this is less clear in *lead lrn* – provide leadership locally, regionally and nationally - although this is not statistically significant (p=0.068).

*Expert practice*

There are no differences in measures of confidence in this domain [figure 10] with the exception of *exp resou* – act as an expert resource internally, rationally and nationally, on the care of clients and their families - which has a statistically different confidence level across four of the five domains. (p=0.004, p=0.014, p=0024, p=0.06), with the exception of *exp analysis* where more development needs were indicated. This therefore, resonates to some extent with the less equivocal confidence measures in providing leadership locally, regionally and nationally as above.

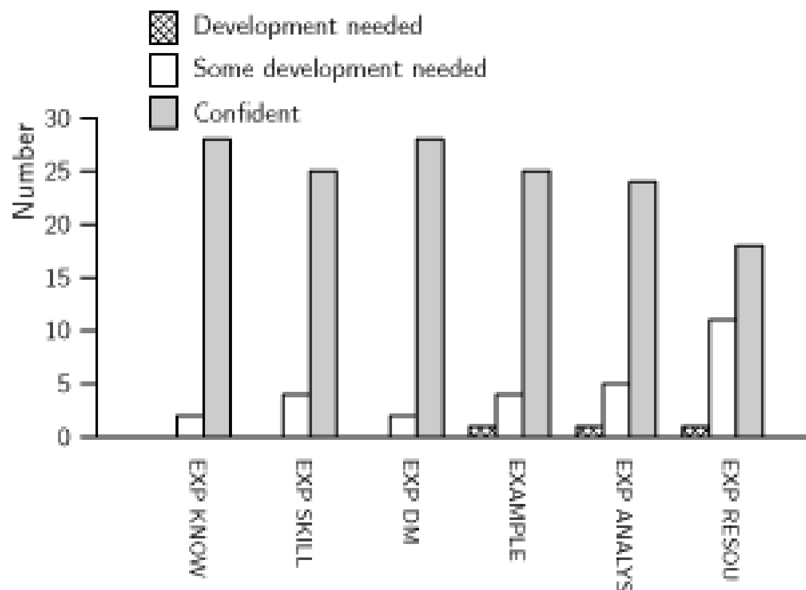


*Figure 10*
*Levels of confidence and need for development in the domain of* ***expert practice*** *(question 3.2)*

*Practice and service development*

For the domains of policy learning (policy lrn: influence the national, regional and local policies and strategies for own area of practice), innovation (innovate: to influence practice development by supporting and developing innovative and lateral thinking in self and others) and interagency working (interag: promote collaborative across boundary and

[19] The Mann-Whitney Rank Test is used to compare differences in magnitude of categorical data (such as percentages) and test if any differences are statistically significant.

interagency working that reflects local health planning, national policies and strategies) approximately 50% of respondents reported to be confident. The remainder reported some development needs except one responder who indicated developmental needs in the domain of interagency working. In the domains of health policy (health pol: interpret implications of health policy in the management of change and the development of practice p=0.039), strategic thinking (stra think: strategic thinking in developing own role, practice of others and across a service, p=0.03), new developments (new dev: o initiate, influence and lead new developments and services P=0.002, and articulating the risks and benefits of new developments in their own area of practice (RBNewDev, P=0.006) a greater proportion of the group reported to be confident (55-80%). The remaining 20-45% reported some development was needed. None of the differences in this section were statistically significant.

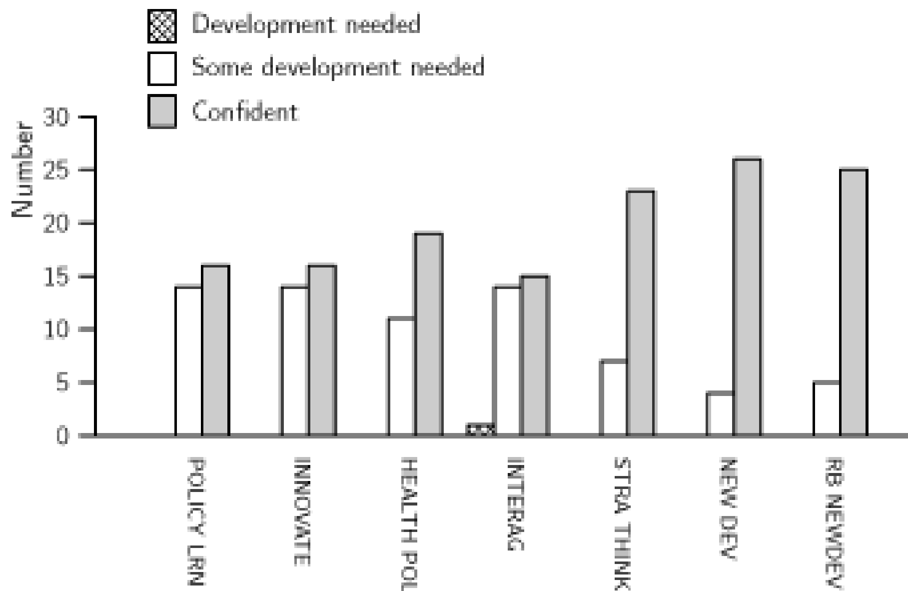


*Figure 11:*
*Levels of confidence and need for development in domain of practice and service development (question 3.4)*

*Summary of confidence levels data*
Several points need to be highlighted as emerging from the data thus far. First, participants noted 'strategic development' as a development need, yet audit and research was clearly the domain requiring most development (retrospectively or post-pathway) followed by patient and staff education. It could be argued that the pathway met the participants' needs and this was subsequently evidenced in their confidence levels in this domain. However, if this is the case then there is a corollary of this.

First, these confidence levels could be evidence of one domain (strategic development e.g. leadership/service development) being developed at the expense of another e.g. audit and research. Second, the domains of leadership and consultation skills specifically, *lead lrn* – providing leadership locally, regionally and nationally and expert practice, specifically *exp*

*resou* – act as an expert resource internally, regionally and nationally - are clearly less well developed or confident although they are not statistically significant. If participants benefited specifically from the apparent leadership/strategic focus of the pathway then it may be reasonable to assume that these domains and fields would have reflected this vis a vis their confidence levels. Arguably that is because the consultant NMAHP post exists across all domains. Consequently, the confidence or more appropriately self-efficacy of the existing or aspiring consultant NMAHP is based upon the arguably interdependent relationship between the domains. Thus, it is posited that it is not possible to be a clinical expert or a leader without being well developed within all five fields of the domain of audit and research as there is arguably a synergistic relationship.

Nonetheless, participants claimed to be most confident in 3.2 – expert practice. Further, those areas highlighted outwith audit and research e.g. *lead lrn (leadership)* and *exp resou (clinical expert)* with *interag – promote collaborative across boundary and interagency working that reflects local health planning, national policies and strategies (practice and service development)* – may also hint at the lack of 'visibility' of the individuals and the consultant NMAHP role. This is discussed in more detail later.
W*hat is understood by 'expertise' in a consultant NMAHP role?*
In summary therefore, the confidence levels data suggests that there may be a need to review what is *understood* by expertise in the consultant NMAHP role and to ensure that the role is attended to equitably across *all* domains. The emphasis on leadership/strategic development prompted by the scoping exercise involving strategic leads and the focus on mentors being at a strategic level within the organization – although understandable – may have inadvertently led to a disproportionate emphasis on one domain at the expense of others, despite the usefulness of the DNAT. A key theme of NES's original scoping exercise of strategic leads noted the need for strengths in all domains and the February 2006 guidance notes highlighted learning outcomes for *all five domains*. A matrix of mentorship as suggested by P7 involving HEIs –specifically with regard to the audit and research domain – may have provided more scope and depth to the development of the domains.

Finally, it is important to note that it is perhaps entirely unreasonable to expect aspiring (and to a lesser extent existing) consultant NMAHPs to be confident in all domains, or not require some development in some areas.

*The pathway*
The pathway was generally well received by the stakeholders and participants and the 'blue sky' ambition of the intervention noted. There was however, a tension between the perceived positive and negative aspects according to stakeholders as highlighted in Table 7.

*Table 7: The stakeholders perspectives on the pathway*

| Perceived positive aspects | Perceived negative aspects |
|---|---|
| Bespoke, individually focused, flexible (n=7: 2 selection panel) | Too flexible or vague: professional anathema (n=7: 1 selection panel) |
| Legitimised chapping on doors<br>Centrally driven = 'gets done'<br>Provides networks (n=4) | No outcome, guarantee or purpose (n=5) |
| Money, Time (n=2) | Time, backfill, money (mentors) (n=3) |

*Bespoke/focussed - legitimised*

The pathway overall was considered to be 'bespoke' and flexible, legitimising opportunities for the individual to 'chap on doors'. The centrally driven nature of the pathway and the networks it engendered was welcomed as were the resources it provided. Indeed one stakeholder and mentor considered it a 'godsend' (P9) in terms of providing appropriate induction to a newly appointed Consultant NMAHP. Given the absence of succession planning generally, a central driver such as the pathway was, in the main, warmly welcomed:

*I think what's really useful about having a centrally driven model is the fact hat it makes you focus on it. It's like targets isn't it? if you've got a central driver behind a target you are gonna focus on it. Whereas if it's a chosen target I think, you know, or a local target, I think there is always a risk that if something else came along, you'd perhaps focus on something else (P19).*

*It was almost legitimising the application. It was flagging up to senior people in the board that the applicants meant business and it was giving them a very high profile (Uhumm) em and it was showing that it was about em it wasn't just for individual development, but, actually marrying up with the service development and service needs (Uhumm) so that was em the main thrust behind having the joint application (P4)*

Part of the thinking behind having a sponsor/candidate joint application was to provide an opportunity for the sponsor and candidate to consider the potential for developing a Consultant post for the service. However, the absence of a specific outcome was a significant issue for participants and mentors alike.

*No outcome - vague*

The bespoke nature of the pathway, somewhat paradoxically, also highlighted its perceived frailties. As the mentorship arrangements and outcomes were vague and flexible so too was the pathway processes and outcomes. The 'flurry' of activity followed by a perceived 'fizzing out' of the initiative was highlighted by mentors, stakeholders and participants.

> *The whole programme process was vague and certainly if somebody were to say I want to do it now I would say I probably would say 'don't bother'. (I- uhumm) em…just because It was very vague and I don't know that there was actually a lot of*

> *benefit (I- uhumm, yeah) em… I think it could have been done a lot better (I-uhumm) em… (later). So again it's about communication and outputs (I- uhumm)*
> → *and you know even the person who has done it she doesn't know if it's finished now or not (P15).*

The pathway generally did not have specific aims, processes or outcomes that were identifiable to those taking part. Allied to the absence of specific outcomes vis a vis closure, a guaranteed post (or academic accreditation), the imprecise nature of the pathway arguably discomfited mentors and participants alike.

*P2: I mean I take my hat off to people who apply and go forward for it. But I think it's quite difficult and quite challenging when it's to be fair it's ill defined. There isn't a promise of a job or a role at the end of it. Nor is there a promise of a qualification. So there has to be a bit of faith that this is the kind of approach that I want to do (I-Uhmm) and em…but I don't know what it will do for me.*

There was a concern about the 'impact' upon individual participants committed to undertaking the pathway but with no obvious reward.

*Part of the problem with succession pathways, and stuff like that is that, obviously it doesn't always fit in with the operation and the way of an organisation works and that. A good example of that is that despite the fact that, a lot of time and a lot of stress that member of staff actually had to do, - to fulfill you know in the activities that (the mentee had to undertake) for succession planning - actually there was an obstruction, a real obstruction to be able to go for a (Consultant NMAHP) post. And given that the fact that (Consultant NMAHP) posts are actually like, a bit like hen's teeth really, you know, it must have been very difficult for (the mentee) (P18).*

While the ambition behind the joint application of sponsor/candidate was to initiate a potential post for the individual, realising this ambition is more problematic. P7 highlights the difficulties in marrying service need with individual capability and short term funding suggesting that bringing all three factors together at the same time was problematic:

*An example would be em… HAI but we, we've interviewed twice you know we've interviewed once and been out to advert twice and could not get anyone for that post and actually now we said well we'll probably just do without that post we will use the money in another way. So that's a lost opportunity (I-yeah) and the thing is kind of knowing that we could now target some people and encourage them to go the Succession Planning but by the time they come out the other side we will you now have spent the money (P7).*

External factors to the pathway, for example AfC[20] classification and rebanding could *reduce* as opposed to enhance the pool of Consultant NMAHPs. One pathway participant recently completed her Masters' degree *and* had undertaken the pathway. A Consultant NMAHP post was advertised within the Board specific to the candidate's speciality. An essential criterion for the Consultant NMAHP post was denoted as an existing band 7. However, the candidate had been 'reduced' to a band 6 under AfC. The pathway

[20] Agenda for Change – grading scale for NMAHPs

participant, having undertaken the pathway and recently completed a Masters' degree, was therefore not eligible to apply for the advertised post.

In other circumstances the pathway provided opportunity for focussed reflection and further development for individuals to varying degrees, with or without an outcome:

*I mean this individual was in a service which had gone through quite a lot of change (I- uhumm) and there was a lot of angst associated with that at the time. However, I think [what] the programme has done is enabled that person to analyse that and reflect on it and make sense of it and move forward (I- uhumm) Em...... and be much more positive about what's going on (p16).*

*The pathway helps people to see that it might be possible and I think people who are in a clinical role will look to the nurse consultant and think, 'Gosh' I could never do all those domains, but the pathway helps to demystify it and break it down into more manageable bits, so it will encourage more people to consider it (P9).*

While P9 makes a salient point about breaking down the pathway into 'manageable bits' the previous discussion on confidence levels related to the domains of the role emphasizes the need to attain a balance between 'demystifying' the role and underplaying its complexities and challenges. This aspect is further explored within the case studies.

*Resources*

Resources such as money and opportunities were welcomed by all. However, there was no obvious benefit in terms of explicit commitment and/or remuneration for mentors or organisations in terms of money, or backfill. Equally, participants considered the pathway had been undertaken in conjunction with their day-to-day responsibilities. As indicated previously by some pathway participants, stakeholders (specifically mentors) commented on the need for dedicated time to properly utilise the opportunities offered by the pathway.

*My sense says that the day job got in the road at times and that they didn't kind of push that aside albeit temporarily just to articulate what it is that they wanted and then manage that time out in a pro-active way (P9)*

*Other models?*

The pathway is patently unique. The extent to which it is as good as, if not better than other interventions is debatable. Some individuals did flourish and good mentor – mentee relationships were formed. However, several respondents considered that there were better, more established options available particularly for domains such as strategic leadership/policy.

*If anything I think the RCN Leadership one was more supportive. (I- uhumm) Em… there were clear outputs eh… they had support groups, supervision etc (P15)*

Stakeholders – although generally supportive of the concept of the pathway if not the implementation - proffered the perception that it was 'better than nothing' or that the alternative was 'queer street' and as such it was important in terms of maintaining the visibility of the role. Hence, the need for 'something' was clear. Visibility and the concept

of keeping the issue of succession planning *specifically* for Consultant NMAHPs on the agenda were considered important:

*I think it's been different so its prompted us into thinking differently because as a consequence of that we have done is develop a what would you call it a network a support network (I- uhumm)for aspiring Consultants. (I- uhumm) So and eh… the [Consultant NMAHPs] are also part of that so it's, it's as a starter has forced us to think about (I- uhumm) internally what we need to develop (I- uhumm) so that's helpful itself (P17).*

P17 refers to establishing an internal (Health Board) network while others also appreciated the opportunity to establish networks outwith the health board. The pathway therefore, had an effect to some extent in encouraging individuals and organisations to consider how to support the role locally.

*The participants' view on the pathway*

88% of the participants strongly agreed/agreed that the pathway was a worthwhile development experience with the remainder disagreeing or being undecided. Notably, 87% of pathway participants cited the opportunity for general development as opposed to career enhancement (70%) as the motivating factors in their application (see table 8). Nearly two thirds (64%) of pathway participants considered that the pathway had enabled them to gain competencies for a Consultant NMAHP role. One quarter were undecided about this and the remainder disagreed (10%). Over half of the aspiring Consultant NMAHPs (53%) strongly agreed/agreed that the pathway had increased their chances of gaining a Consultant NMAHP post with nearly a third undecided. 20% disagreed/strongly disagreed with this statement.

This relative split in the cohort with regard to the potential for the aspiring Consultant NMAHPs to actually obtain posts is interesting. The majority of the cohort considered that they had gained the competencies (64%) to obtain such a post yet, 47% were undecided or disagreed with their prospects of actually obtaining such a post. The reasons for this can only be hypothesized. However, it is perhaps reasonable to suggest that any initiative aimed at enhancing a role or workforce pool should be conjoined with a strategic vision on the future of the role and therefore, the likelihood of such posts being accessible to a suitably prepared cohort (or individuals).

*Table 8: participants motivation for application to SPDP*

| **Factors motivation application to SPDP** | | **Fraction with n reasons driving application to SPDP** | |
|---|---|---|---|
| Opportunity for general development | 87% | 1 Reason | 13% |
| Opportunity for career enhancement | 70% | 2 Reasons | 40% |
| Funding opportunity | 50% | 3 Reasons | 17% |
| Educational opportunity | 43% | 4 Reasons | 30% |
| Other | 13% | | |

**RECOMMENDATIONS: Mentorship and the pathway**

It is arguable as to what extent a pathway can prepare individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, especially when it is aimed at such a diverse group, e.g aspiring and existing Consultants.

- Serious consideration should be given to developing structured, coherent and fully funded succession planning opportunities that account for the broad variance in abilities and needs, matched with a strategic vision for these posts.

- Other models should be considered such as clinical fellowships and/or internships at several levels (masters, doctoral, post-doctoral) e.g. ESRC/Leverhulme schemes. Such fellowships could explicitly prepare and support individuals for aspiring or existing Consultant NMAHP posts using existing academic provision with a matrix of mentorship as appropriate and in collaboration with HEIs. This could dovetail with the clinical careers fellowships initiative.

- Such fellowships could operate on an ‘open’ call for individuals with specific expertise and capability wishing to apply independently and a ‘closed’ call strategically supporting identified NHS service need e.g a meritocratic approach.

- A matrix of mentorship is required for a role that encompasses 4 or 5 domains to ensure that it develops equitably across all domains.

- Develop existing consultant NMAHPs as mentors to the next generation of Consultants.

- Provide support (organisational and financial) to existing consultants to develop relevant individuals within their specialty to address succession planning for existing posts. DNAT or Consultant KSF[21] outlines could be used as part of this process.

[21] Knowledge Skills Framework

**The Consultant NMAHP role: enhancing the pool**

Four themes emerged:

- The need to establish the value and profile of the role
- The SPDP candidates' suitability as ambassadors for the role
- Higher education qualifications
- Mapping and development of existing training opportunities

*The need to establish the value and profile of the role*

Sponsors and mentors alike perceived the Consultant NMAHP role as being integral to both professional development and service delivery. Specifically, the Consultant NMAHP role is viewed as being significant in terms of leading research, developing clinical practice and service re-design. The uniqueness of the role as a clinical leader as opposed to a line manager was wholly appreciated by stakeholders and mentors.

*People who are absolutely skilled, knowledgeable and authoritative in relation to evidence based practice. You know, these are people who don't tell us let's do it because I think it will work. These are people who say let's do it because here's the evidence base that tells me it will work or alternatively, let's do this because you know, we think it will work and let's put a proper research base behind it (P1).*

Nonetheless, there was recognition of a number of difficulties that had emerged in the relatively short lifespan of the role. It was suggested that it was important to be circumspect about whether developing a Consultant NMAHP was an appropriate undertaking in the first place. This was compared to the exponential rise in Clinical Nurse Specialists' posts where they emerged across every speciality. Stakeholders suggested there was a need not to just 'jump on the bandwagon' (P12) and assert a particular agenda: be it managerial or medical-led, but to carefully consider the appropriateness or otherwise of the Consultant NMAHP as an intervention.

The adversarial reactions of medics and managers to the role and the challenges this reportedly presented to the individual Consultant NMAHP, professions and the NHS was a recurring theme in the interviews with stakeholders. It was also an issue that was often discussed by mentors:

*Interestingly for one of those individuals the whole conversation has been about acceptance of the role by medical leadership and service management (P8).*

Given the preponderance of 'tough' talk in relation to mentorship it was perhaps unsurprising the Consultant NMAHP role was not universally appreciated.

*You know when they're (managers) faced with a whole lot of operational delivery, and they're kind of thinking, you know all that money I could have had, you know a big hitting manager in there just sorting stuff. Instead I've got this person who at worst seems to be floating around at the minute you know and actually not recognising this is somebody who could actually be helping me very significantly and there's stuff that I need to be doing.*

*In the last few months actually which would lead me to suggest that in some parts of this organisation the benefits and understanding of the NMAHP Consultant role is not as good as I →would have liked it to be. (I- uhumm) and that therefore I think leaves us vulnerable in terms of actually bringing people forward (P7).*

Irrespective of stakeholders' positive perceptions of the role there was a clear concern that the role was vulnerable in its present form. This may have, in part, prompted their alleged 'tough' talk and 'prodding':

*I think that while I have spent quite a lot of time with successful (Consultant NMAHPs) →to talk that through with them and say your post is vulnerable (uhumm uhumm ) if you cannot articulate the added value that you have brought to your organisation, (uhumm) to your patients, and to eh…the service as a whole. (uhumm) em… and beyond that to the development of practice at a national level (P5).*

There was an imperative for existing Consultant NMAHPs to demonstrate their worth. However, there was also a steadfast and robust defence of the role generally, and specifically when compared with what was (or was not) expected of medical colleagues in similar roles:

*I don't hear any other medical Consultant for example eh... coming to the board and saying this is how I have added value (I- uhumm) Em...... so I think we have got a long way to go on mindsets around that you know (I- uhumm) (P16).*

There were varying mentions of 'getting behind them' (P9) and 'collective responsibility' (P11, 7) with regard to the importance of providing appropriate support to this allegedly vulnerable post, particularly in the face of such adversity. Several respondents noted the need for a 'strategic vision.' There was also a need to integrate the post within specified boundaries and not to overstretch it despite its strategic potential which may extend to national or regional responsibilities. In addition, there was acknowledgement of a general reluctance at senior (NMAHP) level to 'putting your head about the parapet' (P8) or in being 'not keen to pick up the gauntlets' (P10) in yet another warring analogy. Hence, Consultant NMAHP posts may be viewed as simply too problematic with easier options reportedly being education or management. This may also have contributed to the reluctance of reportedly able individual s in committing to the pathway. As P7 asserted above: *I think [it] leaves us vulnerable in terms of actually bringing people forward (P7).*

*The candidates' suitability as ambassadors for the role*

Expediency with regard to the need to invest in visible Consultant NMAHP posts was noted and this was suggested as leading to a dilution of the role via the appointment of less able individuals. Thus, the role (and the postholder) becomes more vulnerable as the role is potentially discredited.

*P7* *If I'm honest about the function of some of the NMAHP Consultants who are already in post. (I- uhumm) and actually (the) there's a danger that the nature of the post becomes discredited because of the capabilities of some of the individuals who occupy those posts. (I- so I think there's a bit in terms of us collectively when I say us I mean you know NMAHP leaders across Scotland ensuring that we don't*

*put people into post with that title who aren't able to fulfill those functions. (I- uhumm)*

*Q* *Uhumm and of the ones who are not quite at the level yet do you think with time and support they'll reach the –*

*P7* *I think some of them will need quite a lot. (I- uhumm) I mean I very interestingly I discovered this week that [deleted ] hadn't even got a Masters or working towards it. (I- uhumm) How on earth did [deleted….]. I actually said somebody has to tell me[deleted ] (I- uhumm) I suspect [this happened] in the days when everybody had a target[22].*

*Higher education qualification*
Master level preparation (or a record of scholarship) – a fundamental requirement for the Consultant Nurse role made explicit in Caring for Scotland (2001) has, according to P7, patently been ignored in the case of two appointees. This admission is interesting particularly when the pathway was developed on the back of an a priori assumption that there was no specific course *available* or *suitable* with which to prepare Consultant NMAHPs. Meanwhile, some existing Consultant NMAHPs do not evidently have the explicit minimum level required. This is in contrast to the already cited example of the mentee who had recently completed a masters degree (and the pathway) but as a Grade 6 was precluded from applying for a Consultant NMAHP position.

15 of the pathway participants in this cohort had a masters degree while 3 had doctoral degrees. In addition 9 were currently studying for a masters degree - some masters degree modules being funded by those individuals participation on the pathway - while 5 others were currently studying for a doctoral degree. The majority of this cohort (22/30) was at a minimum of masters' degree level. The concern however, would be the remainder who may consider that they can obtain (or who may already have) a Consultant NMAHP position without fundamental academic preparation.

The decision to develop an individual pathway was made on the back of a declaration of there being no appropriate academic courses that could adequately prepare potential Consultant NMAHPs. The reasoning behind this decision is not made explicit within the study and is beyond the scope of the evaluation. However, the importance of Masters' degree preparation and a record of scholarship with regards to these roles is well established. There is arguably a pressing need to scope the provision of masters and doctoral level education in Scotland in order to address this key assumption. A review of the associated function and relevant fit in terms of preparation for professional roles such as the Consultant NMAHP is surely needed if succession planning is to be attained.

The key issue of whether the pathway has enhanced the pool of Consultant NMAHPs prompted a generally ambivalent response from the stakeholders. Instances where stakeholders considered the pathway had not increased the pool were qualified by stating there was no-one to recruit in the first place (e.g. P19). Stakeholders who considered the pathway had increased the pool of potential Consultant NMAHPs highlighted individual

[22] Aspects of this quote have been deleted to further preserve anonymity

abilities over the impact of the pathway (e.g. P5, 20). According to participants' responses no-one obtained a developed role *as a consequence* of the pathway even although the majority of the cohort changed their role/designation during or following completion of the pathway. There is however, at least one individual who has obtained a Consultant NMAHP post since. In summary therefore, the pathway has minimally increased the pool of Consultant NMAHPs but these individuals may arguably have attained posts via other means.

*Mapping and development of existing training opportunities*

One issue that was raised as being important to incorporate in any Consultant NMAHP endeavour were the equality and diversity, patient focus and public involvement agendas (P8). While this may be an added burden upon an already vulnerable role it may also be an opportunity for the role to become more visible and more linked into established and vocal networks. Arguably there is no greater support than that of vociferous patients.

Finally, there needs to be careful consideration of how best to develop and prepare the next generation of Consultant NMAHPs. Given the sentiments expressed herein however, there is also a pressing need to support and protect the *existing* pool of Consultant NMAHPs:

*I tell you what I would like to see. I would like to see some mapping in the future, over the next 10 years. Perhaps this could be a research study, around where the nurse consultant's going next (P19).*

**RECOMMENDATIONS: Consultant NMAHP role: enhancing the pool**

There is insufficient evidence to support the pathway being transferable in its current form. A more strategic and sustainable commitment to providing succession planning should be considered – one that addresses all the domains of the role and supports them appropriately e.g. fellowships/internships. The following actions would be required to support this:

- Scope and review the existing provision of masters and doctoral level preparation in Scotland.
- Map existing provision to the domains of the Consultant NMAHP role and other posts.
- Develop a strategic vision of what HEIs should offer in relation to fitness for practice across all domains and roles (clinical education, research, management).
- Review the existing Consultant NMAHPs cohort and consider how best to integrate and support their role.
- Support and encourage existing postholders to undertake Masters level study if they have not already done so.
- Any interventions or activities aimed at developing or enhancing Consultant NMAHPs should be explicitly mapped to intended outcomes via the domains of practice.
- There is a need to ensure that aspiring and existing Consultants develop appropriately in all 4/5domains of practice.
- The research/audit domain of the Consultant NMAHP is integral to the role, *the clinical leadership function and the professions*. This aspect of the Consultant NMAHP role should be highlighted in any future initiative and/or intervention in collaboration with HEIs.

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**Summary Stage One: Stakeholder interviews and pathway participants' questionnaire responses**

The pathway did not significantly enhance the pool of Consultant NMAHPs. There is however, a limited pool of individuals for these posts in the first instance. It is arguable as to what extent a pathway could have prepared individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, aimed at such a diverse group, e.g aspiring and existing Consultants.

.
There is insufficient evidence to conclude that the pathway per se is transferable. However, the DNAT and mentorship could be transferable if modified appropriately for the proposed context. Any evolved initiative however, would need to recognise the four/five domains of the role and address them appropriately, specifically the research domain.

Succession planning for the Consultant NMAHP role needs to encourage and develop *individuals* and their capabilities as opposed to 'pools'. The difficulties of marrying the exigencies of service need, short term funding and individual capability need to be highlighted. It may be that this can only be addressed by more substantial and sustainable means such as fellowships or internships allied to a matrix of mentorship incorporating HEIs and experienced Consultant NMAHPs.

Finally, the existing cohort of Consultant NMAHPs need to be appropriately supported to ensure the role does not become more vulnerable and invisible. Consultant NMAHPs could be key individuals in developing succession planning in their area through developing and supporting individuals locally.

RESULTS

**Stage Two: case studies**

The case studies were intended to provide context to hitherto unknown settings and dynamics (Yin 2003). In the context of this evaluation the case studies were specifically intended to review the potential transferability of the pathway. However, findings from stage one suggest that there is insufficient evidence to support the pathway being transferable in its current form. However, the DNAT and mentorship could be transferable if modified appropriately for the proposed context.. Moreover, one question remained relatively unanswered. To what extent did the DNAT and pathway contribute to increasing the confidence of existing and aspiring consultants?

The aggregate data of the pathway participants' questionnaire attests to post-pathway (self-report) confidence levels. However, due to the research team being unable to access the original DNATs of the pathway participants the findings cannot report *increased* confidence levels from aggregate data. Moreover, the findings from Stage 1 did not fully illuminate or illustrate the issue of DNAT assessment, activities undertaken and the subsequent outcome for *individual participants*. NMAHPs work in very varied and diverse speciality areas and there is therefore a need to appropriately reflect context in any reported findings. The aim of the case studies presented was therefore, to assess the pathway's impact upon individuals and their career plans as opposed to the transferability of the pathway. The case studies' (original) DNATs and the five domains of (Consultant) practice provided a frame of reference for analysis.

Methods

Each case study was intended to represent a unique, standard or revelatory case. An existing consultant and two emerging or aspiring consultants, one of whom subsequently elected to focus on a non-consultant career path, are included. A deliberate mix of demographics, specialities and professions are also accounted for within the case studies. However, the three case studies will be presented as a composite case as far as possible due to the difficulties in preserving the anonymity of the individuals in such specific settings, areas and roles. Thus, the particulars of each case and what constitutes their individual claim to being unique, standard or revelatory cannot be made more explicit within the report. Nonetheless, the commonalities of the cases will be reviewed with appropriate reference to differences where possible.

All three cases were observed and reviewed in their current work settings following a two week diary review. The cases were asked to provide any documents (e.g. research reports, policies, guidelines, best practice statements) they had been involved with recently. The data comprising the case studies included (Appendix V):

- a 2 week diary review participant completed prior to visit
- interview with participant and one other (peer, line manager, other)[23] [24]

[23] One telephone interview was undertaken with the line manager of C1. Informal (field note) discussions were also undertaken other members of staff/peers (C1, C2, C3).

- observation sessions (one day:to include 1 meeting, one clinical session plus one)
- documentary 'evidence'(e.g. research reports, policies, guidelines, best practice statements)
- telephone follow-up if appropriate

The above data provided the opportunity to review the participants' (current) work in the five domains of practice as identified *by the DNAT.* Hence, the DNAT was used as a frame of reference and analysis for the observations, documents and interviews collected via the case studies. One researcher reviewed the data: documentation (including the original DNAT), interviews and observation notes. The initial observations of the researcher were discussed with the research assistant who undertook the case studies and reviewed in relation to the domains of practice. The individual cases were then 'rated' using the DNAT according to the data collected (Table 8).

It is important to note the case studies provided their *original* DNAT. This comprised ratings of whether the individual needed training in most or all of the domains, some development, or carried out the domain confidently. These were expressed as a corresponding degree of confidence (3:most, 2: some,1: confident). A re-ordered version of this was included in the pathway participants' questionnaire sent to the participants post pathway (Appendix III: section 3). Those versions; original and re-ordered DNAT, are not compared directly, rather the original DNAT is used for comparison with empirical data.

<u>Commonalities across the cases</u>

Each case had experienced either significant changes in their existing post or had moved post during the past 2 years. One participant was an existing, although relatively new, consultant. A further participant had taken on additional responsibilities within their role during the time of the pathway while another had moved from a specialist position to a senior management position. All of the cases viewed their mentorship experience positively and one of the three cases had more than one mentor. Mentorship was perceived as being useful and welcomed as in 'someone taking an interest in you' and in terms of the 'legitimacy' it gave to the individual. Equally, the DNAT was perceived to be a useful undertaking although it was also viewed as being 'difficult' to complete. The DNAT was identified as raising individuals' awareness of the extent and breadth of the four/five domains and in encouraging reflection. It also allowed the cases to consider their career options and in one instance this resulted in a move from a more clinical post into a senior management position [see Appendix VI].

<u>DNAT and matching activities</u>

There was one common denominator among the case study participants. All participants identified 'audit and research' as being the area requiring most development with '2's being attributed as opposed to '1's in all or most other domains *within the original DNAT*. This is consistent with the aggregate responses of the pathway participants to the *re-ordered DNAT* in the questionnaire overall (Appendix III: section 3). Although 'audit and research' was identified as being an area requiring most development in comparison to other domains the

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[24] The interviews/field notes undertaken with stakeholders/others are not explicitly reported here as they repeat some of the issues raised within the stakeholder interviews and do not significantly contribute to the review of domains of practice/current activity issue.

activities subsequently identified *did not* address this need directly *or* were not followed through.

Leadership or 'strategic awareness' however, were also identified as being areas of need. Aggregate pathway participants' questionnaire responses suggest the cases appeared more likely to identify leadership or strategic activities (e.g. shadowing or leadership courses) than a research-oriented activity. All three participants undertook leadership courses or shadowing. One case identified an academic research activity and subsequently changed this to a leadership course. A further case did not identify any research activity at all despite identifying this as an area of need. This case identified a particular clinically-oriented course despite the individual's clinical expertise being rated relatively highly (1's) within the DNAT. However, another case identified and undertook an academic research activity in addition to a leadership activity e.g. shadowing. Somewhat ironically, it was the case that subsequently moved into a senior management position who undertook the structured research activity as a means of addressing the identified deficiencies in this domain.

The domains of practice: current and expected

A key issue that arose within Stage 1 was the focus on the leadership domain in the pathway to the potential detriment of other important domains. As discussed previously the Consultant NMAHP role should encompass all four/five domains. Table 9 outlines the rating scale applied in comparison with the rating scale of the DNAT. Table 10 reviews the individual empirical case studies with the domains of practice and the applied rating. Composite ratings for the domains are also offered.

The extent to which each case is operating within the domains of practice currently is an approximation only, based upon limited and temporal observation and documentary evidence as denoted above. Nevertheless it is a *rough guide* as to the cases' current activity within the Consultant domains of practice.

*Table 9: Rating of data in comparison with DNAT*

| Rating | DNAT |
|---|---|
| + minimally operating | I require training in most or all = 3 |
| ++ moderately operating | I require training in some = 2 |
| +++ maximally operating | I am confident I do this competently = 1 |

*Table 10: Domains of practice and observed case study activity*

| **No** | **Domains** | **C1** | **C2** | **C3** | **Composite case domain Totals** |
|---|---|---|---|---|---|
| 1 | Expert Practice | + | ++ | ++ | 5/9 |
| 2 | Service Development | ++ | ++ | +++ | 7/9 |
| 3 | Professional Leadership and Consultancy | ++ | ++ | +++ | 7/9 |

| 4 | Research and Audit | + | + | ++ | 4/9 |
|---|---|---|---|---|---|
| 5 | Education and Development | + | ++ | + | 4/9 |
| **Totals** | **All domains** | **7/15** | **9/15** | **11/15** | |

According to Table 9 the cases are participating relatively well in domains 2 and 3 (the leadership/strategic domains) and less so in domain 1 (expert practice). The latter domain however, may be partly influenced by the changes in roles experienced by all 3 cases and by one case in particular. Expert practice is also arguably a domain that has a ceiling for each individual case. There is however, minimal activity in domains 4 (research and audit) and 5 (education and development) for all three cases. All three cases identified Domains 3 and 4 as areas of need. While domain 3 apparently 'improved' in terms of activity, (e.g. from DNAT pre-pathway to post-pathway) domain 4 did not. Domain 4 however, was only addressed by one of the cases via an appropriate activity. That case did address domain 4 via an appropriate activity however, is currently working in a role that arguably has less of an emphasis on research/audit per se than that of an existing or aspiring consultant.

The above mapping of DNAT activities to domains is a rough and temporal approximation of participation by the case study participants currently. Nonetheless, it highlights important issues regarding the importance of mapping assessment to activities and subsequent impact with regard to enhancing the pool of Consultant NMAHPs.

Notably all three cases' highest academic qualification level was a degree. One was currently undertaking academic study while another claimed ambitions to undertake further study post pathway. However, one case had no such ambitions or intentions:

> *This is going to sound really awful you have came from the University. Em, and from an academic background but I really, I really didn't want to go down the Masters Degree route. Em… I went to down the Degree route to tick a box and to be able to apply for a similar job to that I was already doing now I thought no, I am not doing that again. You know people need to take me for what I am and the experience and skills that I have got. Em… these pieces of paper are very important (I-uhu) but I felt that I needed something different. (I- uhu, uhu) I hope that doesn't sound (I- no, no) sound disrespectful.*

This case further rationalised the above view with the interesting claim that there was little or no benefit in undertaking further study. The proviso being that the individual felt that they were already operating at a 'high level' and would not gain a 'better' position from doing so. Hence, the fact that this case was already in a developed position dissuaded her/him from enhancing their academic portfolio and associated domains of practice. This is one individual's perception. However, given P7's comments in the stage one results regarding individuals being appointed at consultant level without the requisite masters degree it is a view that should be accorded some respect. Appointing individuals to positions for which they are not appropriately prepared or qualified may infer confidence and competence that has not been properly attained. This subsequently dis-incentivises

those individuals to obtain the required development and arguably further reduces the efficacy of the role and the visibility of that particular post.

**Stage 2 Summary: case studies**

The case studies were originally intended to explore transferability of the model of the SPDP. However, stage one suggested that there was insufficient evidence to support the pathway as being transferable in its current form. The participants' original DNATs were unavailable to the evaluation team and therefore, the opportunity to compare and contrast pre and post pathway was lost. Therefore, a key aspect of the evaluation namely reviewing the confidence/competence levels and the changes that could be ascribed to the pathway was difficult to gauge. The case studies were therefore, used as an opportunity to explore individuals in context, and illustrate the individual's pre and post (current) position in relation to their self-assessment via the DNAT.

The above case studies corroborate the data presented in stage one that the focus of the pathway on leadership/strategic awareness may have inadvertently compromised the other three/four domains, specifically the research/audit function. The research/audit function is arguably foundational to the role – without which the Consultant post and the individuals operating in those positions may become ineffective, invisible and more vulnerable (personally and professionally). Consequently the future of the professions vis a vis leadership may also be compromised.

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**Recommendations**

*The following recommendations have already been made in stage one however, the case studies highlight the following:*

- Any interventions or activities aimed at developing or enhancing Consultant NMAHPs should be explicitly mapped to intended outcomes via the domains of practice.

- There is a need to ensure that aspiring and existing Consultants develop appropriately in all 4/5 domains of practice.

- The research/audit domain of the Consultant NMAHP is integral to the role, *the clinical leadership function and the professions*. This aspect of the Consultant NMAHP role should be highlighted in any future initiative and/or intervention in collaboration with HEIs.

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**Limitations of the evaluation**

With all research there are limitations (Burns and Grove 2001) and there are three of note in this study. The first and most significant limitation is the initiative being developed without evaluation being made integral and explicit. Evaluation is most effective when 'built-in,' allowing processes and outcomes to be made explicit at the outset and thereby accounted for. Baseline measures can then be reviewed and followed up intra and post intervention.

The re-ordering of the DNAT within the questionnaire represented the research team's attempt to compare and contrast original DNATs with the post-intervention questionnaire. However, the original DNATs were not available to the research team and this therefore left this aspect of the questionnaire accounting for self-report assessment post-intervention only. This 'pre and post' dilemma was addressed to a limited extent by the case studies being developed with a review of the domains of practice, the original and questionnaire DNAT.

A second limitation of the evaluation related to issues of anonymity and confidentiality and according due sensitivity to the participants, particularly in relation to the reporting of the case studies. The case studies provide data that could have corroborated further the findings made in Stage 1. The decision to present a composite case study therefore, potentially weakened the data and arguably reduced the aim of the case study to provide context. Nonetheless, the research team consider that individual sensitivities and 'interactional reciprocities' (Charmaz 2006) are an essential aspect of this kind of research and make no apologies for protecting individuals' rights to anonymity.

The final limitation of particular note is the pathway participants' questionnaire. Although extremely detailed this was undertaken on a small sample (n=30/42) out of necessity which inevitably compromised statistical power. However, triangulated with stakeholder interviews and the composite case study, it provides a powerful account of the pathway and the need for a more substantial and strategic commitment to the issue of succession planning.

**CONCLUSION**

The pathway did not significantly enhance the pool of Consultant NMAHPs. There is however, a limited pool of individuals for these posts in the first instance. It is arguable as to what extent a pathway could have prepared individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, aimed at such a diverse group, e.g aspiring and existing Consultants.

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There is insufficient evidence to conclude that the pathway per se is transferable. However, the DNAT and mentorship could be transferable if modified appropriately for the proposed context. Any evolved initiative however, would need to recognise the four/five domains of the role and address them appropriately, specifically the research domain.

Succession planning for the Consultant NMAHP role needs to encourage and develop *individuals* and their capabilities as opposed to 'pools'. The difficulties of marrying the exigencies of service need, short term funding and individual capability need to be

highlighted. It may be that this can only be addressed by more substantial and sustainable means such as fellowships or internships allied to a matrix of mentorship incorporating HEIs and experienced Consultant NMAHPs.

Finally, the existing cohort of Consultant NMAHPs need to be appropriately supported to ensure the role does not become more vulnerable and invisible. Consultant NMAHPs could be key individuals in developing succession planning in their area through developing and supporting individuals locally.

## RECOMMENDATIONS

### 1. The evaluation

1.1 Future NES interventions/initiatives involving evaluation should seek to obtain consent as a condition of anonymised participation.

1.2 Evaluation tenders should be contracted out prior to the commencement of the intervention.

### 2. Selection process

Should the pathway remain in any form, the selection process may benefit from the following:

2.1. A specific and explicitly limiting (paper) application to the pathway

2.2 Appropriate documentation highlighting the aim, method and expected outcomes of the pathway.

2.3 Clear defined administrative support at the point of central selection / organisation (i.e. NES).

2.4 Consideration of whether sponsor support is appropriate or necessary, specifically whether it may be more appropriate to encourage individuals to apply independently of their employing organization.

2.5 Consideration of opening up the pathway to non-NHS employees e.g. a wider pool of applicants.

2.6 Consideration of providing a concrete outcome in order to encourage applicants.

### 3. Mentorship and the pathway

It is arguable as to what extent a pathway can prepare individuals for such a complex and dynamic role and do so in such a short time frame with limited resources, especially when it is aimed at such a diverse group, e.g aspiring and existing Consultants.

3.1 Serious consideration should be given to developing structured, coherent and fully funded succession planning opportunities that account for the broad variance in abilities and needs, matched with a strategic vision for these posts.

3.2. Other models should be considered such as clinical fellowships and/or internships at several levels (masters, doctoral, post-doctoral) e.g. ESRC/Leverhulme schemes. Such fellowships could explicitly prepare and support individuals for aspiring or existing Consultant NMAHP posts using existing academic provision with a matrix of mentorship as appropriate and in collaboration with HEIs. This could dovetail with the clinical careers fellowships initiative.

3.3 Such fellowships could operate on an 'open' call for individuals with specific expertise and capability wishing to apply independently and a 'closed' call strategically supporting identified NHS service need e.g a meritocratic approach.

3.4 A matrix of mentorship is required for a role that encompasses 4 or 5 domains to ensure that it develops equitably across all domains.

3.5 Develop existing consultant NMAHPs as mentors to the next generation of Consultants.

3.6 Provide support (organisational and financial) to existing consultants to develop relevant individuals within their specialty to address succession planning for existing posts. DNAT or Consultant KSF[25] outlines could be used as part of this process.

**4. Consultant NMAHP role: enhancing the pool**

There is insufficient evidence to support the pathway being transferable in its current form. A more strategic and sustainable commitment to providing succession planning should be considered – one that addresses all the domains of the role and supports them appropriately e.g. fellowships/internships. The following actions would be required to support this:

4.1 Scope and review the existing provision of masters and doctoral level preparation in Scotland.

4.2 Map existing provision to the domains of the Consultant NMAHP role and other posts.

4.3 Develop a strategic vision of what HEIs should offer in relation to fitness for practice across all domains and roles (clinical education, research, management).

4.4 Review the existing Consultant NMAHPs cohort and consider how best to integrate and support their role.

4.5 Support and encourage existing postholders to undertake Masters level study if they have not already done so.

4.6 Any interventions or activities aimed at developing or enhancing Consultant NMAHPs should be explicitly mapped to intended outcomes via the domains of practice.

4.7 There is a need to ensure that aspiring and existing Consultants develop appropriately in all 4/5domains of practice.

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[25] Knowledge Skills Framework

4.8 The research/audit domain of the Consultant NMAHP is integral to the role, *the clinical leadership function and the professions*. This aspect of the Consultant NMAHP role should be highlighted in any future initiative and/or intervention in collaboration with HEIs.

**Appendix I:**
*briefing paper to strategic leads requesting advice on how best to select/identify potential applicants.*

### INTRODUCTION

- NHS Education for Scotland (NES) has been commissioned by the Scottish Executive Health Department (SEHD) to develop a succession planning development pathway for consultant nurses, midwives and allied health professions.

- As key strategic leads, NES is keen to engage with you both to keep you informed of developments and to gather your thoughts on planned next steps.

### AIM

- To develop a flexible pathway to enable tailoring to meet individual needs, and designed to complement the Clinical Leadership Programme.

- To provide funding to support identified NHSScotland staff to undertake the pathway in 2005/06.

### TARGET GROUP

- Existing consultants and those almost at that stage in their career development.

### PROJECTED BENEFITS

- For the service : supporting growth and succession planning through the development of capable NMAHP clinical leaders a quality recruitment pool, and retention of this expertise within the service.

- For the selected individuals : building confidence, effectiveness and big picture awareness, and clarification of career aspirations and options.

### NEXT STEPS

- You may already have responded to an earlier scoping exercise in which we sought views on the key development needs of those applying for consultant posts. The identified areas were :
  - Leadership skills
  - Political/corporate/strategic awareness
  - Masters level preparation
  - Breadth of experience

- We are interested in hearing your thoughts on how best to identify / select potential applicants and on how best to consult and keep yourself informed of developments. We would welcome all feedback to Miss Leigh Willocks, Programme Manager, NES (leigh.willocks@nes.scot.nhs.uk) by **Friday 30 September 2005**.

**Appendix II: Consent Form**

[logos deleted]

Centre Number: 6498 NES

Study Number: 07/S1302/95

Participant Identification Number for this study:

**CONSENT FORM**

Title of Project: **EVALUATION OF THE CONSULTANT NMAHP SPDP**

Name of Researcher: Dr Margaret Coulter

Please initial box

1. I confirm that I have read and understood the information sheet dated ………. (version …..) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any medical care or legal rights being affected ☐
3. I understand that the relevant data collected (e.g. questionnaire, tape recordings, field notes) may be listened to/looked at by the researcher and research team. ☐

   I give permission for those individuals to have access to these materials and for anonymised data to be presented in research reports and/or publications.

4. Pathway participants ONLY: ☐

   I understand that I *may* be selected as a case study

5. I agree to take part in the above study. ☐

Name of participant    Date    Signature

Name of person taking consent    Date    Signature

*When complete, 1 for participant; 1 for researcher to file*

**Appendix III: Questionnaire**

**Project title**
**EVALUATION OF THE SUCCESSION PLANNING DEVELOPMENT PATHWAY FOR CONSULTANT NURSES, MIDWIVES AND ALLIED HEALTH PROFESSIONALS**

**QUESTIONNAIRE**

**Project funder**
NHS Education Scotland

**Project sponsor**
University of Edinburgh

**Information for respondents**
This evaluation has two phases. The first phase comprises the attached questionnaire for completion by succession planning development pathway (SPDP) participants or former participants. The information obtained from questionnaires will be coded to protect identities and all respondent information will remain anonymous. Contact details will be used to select mentors and stakeholders for interview but any information you give in the questionnaire will not be exchanged with them or other participants. In the second phase three case studies will be undertaken.

Please answer all the questions and follow the filter questions as appropriate. The questionnaire is double sided with questions on both sides of each sheet. There is also a page at the back of the questionnaire where you are invited to add any further comments. The questionnaire will take approximately 20-30 minutes to complete.

WE ARE VERY GRATEFUL FOR YOUR TIME AND EFFORT IN COMPLETING THIS QUESTIONNAIRE AND SHALL ENDEAVOUR TO FEEDBACK THE RESULTS OF THE EVALUATION TO ALL PATHWAY PARTICIPANTS

The research team

**SECTION ONE: Profile of SPDP participant** **Code ☐☐☐**

**1.1 Name**[1] ______________________________

**1.2 Current designation**[1] ______________________________

**1.3 Current grade/ pay scale** ______________________________

**1.4 Profession** *(please tick)*

*Nurse* ☐ *Midwife* ☐ *AHP* ☐ ____________________ *(please specify)*

**1.5 Who are you employed by?** *(please tick all that apply)*

*NHS Board* ☐ *University/* ☐ *Other* ☐ ____________________ *(please specify)*

**1.6 Contact details**[2]

Telephone: ______________________________

Email: ______________________________

First part of home post code ______________________________

**1.7 Age** (years) *(please tick)*

*24-35* ☐

*36-45* ☐

*46-55* ☐

*56-65* ☐

**1.8 Gender** *(please tick)*

Male ☐ Female ☐

**1.9 Ethnic background** *(please tick as applicable)*

Black Caribbean ☐ Indian ☐

Black African ☐ Pakistani ☐

Black Other ☐ White ☐

Bangladeshi ☐ Other *(please specify)* ☐

Chinese ☐

**1.10 Country of origin** *(please tick as applicable)*

UK: Scotland ☐ England ☐ Wales ☐ Northern Ireland ☐

Republic of Ireland ☐ Other*: (please specify)* ______________________________

[1] Name is for contact purposes only, and current designation will be coded to protect anonymity

[2] Contact details are required for selecting mentors and stakeholders for interview but the comments you make will not be discussed with them

## SECTION TWO: Academic and professional background

*Please insert the information requested in the following two tables*

**2.1 What professional qualification/s do you currently hold?** **e.g. RN, RNT, MCSP, State Registered Physiotherapist**

| **Type of Qualification** | **Awarding institution** | **Year completed or commenced (approximately)** |
|---|---|---|
| | | |
| | | |
| | | |

**2.2 What academic qualification/s do you hold, and what if any, are you currently undertaking?**

| **Level** | **Awarding institution** | **Subject** | **Year obtained or due to complete (approximately)** |
|---|---|---|---|
| Doctorate | | | |
| Master's degree | | | |
| Degree | | | |
| Post graduate diploma/ post graduate certificate | | | |
| Other (please specify) | | | |

***2.3 What is your specialist area?*** e.g. Lung cancer nurse, stroke rehabilitation

(please specify) ______________________________________

**2.4 How many years have you worked in the above speciality?**

*(please state)* ______________________________________

SECTION THREE: Self-rating of levels of confidence in CURRENT practice

***Please tick your CURRENT level of confidence applying the rating scale shown:***

***Rating Scale***

Confident = Confident and already do this competently
Some development = Development needed in some aspects
Development = Development needed in most aspects, or all of this area

| **COMPETENCE STATEMENT** | Confident | Some Development | Development |
|---|---|---|---|
| **3.1 Leadership and consultation skills** | | | |
| Provide leadership locally, regionally and nationally | | | |
| Use leadership and consultancy skills to make a difference to patient care | | | |
| Think creatively and work collaboratively to overcome obstacles to change | | | |
| Provide strong and effective clinical leadership across professional boundaries focusing on service excellence | | | |
| **3.2 Expert practice** | | | |
| Demonstrate broad knowledge in own sphere of practice | | | |
| Demonstrate advanced specialist skills in own sphere of practice | | | |
| Demonstrate autonomy of practice and expert decision making in meeting the needs of patients in own practice | | | |
| Is visible within own expert practice area and acts as a positive professional example to other staff | | | |
| Analyse, synthesise and evaluate expert practice in own area | | | |
| Act as an expert resource internally, regionally and nationally, on the care of clients and their families | | | |
| **3.3 Patient and staff education** | | | |
| Use a whole system approach to identify the educational and training needs of core health professionals to meet the needs of the service user | | | |
| Work in partnership to develop, deliver and evaluate local and regional higher education courses in own area of practice | | | |
| Develop skills lecturing and facilitation for a range of education programmes | | | |
| Promote innovative ways to influence and optimise learning | | | |
| Lead the development of educational initiatives for patients, a range of staff and the wider service | | | |
| Work collaboratively with academic departments to establish educational and development opportunities and to deliver education in practice | | | |

| COMPETENCE STATEMENT | Confident | Some Development | Development |
|---|---|---|---|
| Initiate and provide skilled supervision for members of team and peers | | | |
| **3.4 Practice and service development** | | | |
| Influence the national, regional and local policies and strategies for own area of practice | | | |
| Influence practice development by supporting and developing innovative and lateral thinking in self and others | | | |
| Interpret implications of health policy in the management of change and the development of practice | | | |
| Promote collaborative across boundary and interagency working that reflects local health planning, national policies and strategies | | | |
| Demonstrate strategic thinking in developing own role, practice of others and across a service | | | |
| Initiate, influence and lead new developments and services | | | |
| Articulate the risks and benefits of new developments in own area of practice | | | |
| **3.5 Audit and research** | | | |
| Work collaboratively to influence the development and utilisation of evaluation and audit methods to review practice standards and guidelines | | | |
| Ensure dissemination of evaluation/ audit results and take necessary action to support practice change | | | |
| Identify appropriate research questions relevant to daily practice and lead in the commissioning, design, implementation and reporting of these projects | | | |
| Influence policy at local, regional and national levels by highlighting evidence in support of proposed service and practice developments in own area of practice | | | |
| Use scholarly activities and research to promote and evaluate the integration of evidence based practice in care for clients and their families and influence the development of the learning environment | | | |

## SECTION FOUR: The SPDP Application Process, the DNAT and Activities

**4.1 When did you successfully apply to undertake the SPDP?**

*(please tick as applicable)*

1st round (09/1/2006) ☐ 2nd round (15/9/2007) ☐

**4.1a If successful in the 2nd round, was this your first application?**

Yes ☐ *[If 'yes' go to 4.1c]* No ☐ *[If 'no' go to 4.1b]*

**4.1b Do you know why your 1st application was unsuccessful?**

Yes ☐ No ☐ Don't know ☐

*Please briefly outline why you think your first application was unsuccessful?*

| |
|---|
| |

**4.1c Whom and/ or what were your main sources of information about the SPDP?**

| **Sources of information: individuals** *(please tick)* | | **Sources of information: other** *(please tick)* | |
|---|---|---|---|
| Manager | ☐ | NHS Education Scotland website | ☐ |
| Peer/ colleague | ☐ | NHS Education Scotland circular/ letter | ☐ |
| Higher education contact | ☐ | | |
| Other *(please specify)* ____________________ | ☐ | Other *(please specify)* ____________________ | ☐ |

**4.2 Please give the name and contact details[2] of your SPDP sponsor for follow-up**

Name of sponsor[3] ________________________________________

Workplace address ________________________________________

________________________________________

Telephone ________________________________________

Email ________________________________________

**4.3 How long did you have to submit an application, from hearing about it to the submission date?**

2 days or less ☐ 3 to 6 days ☐ 7 to 10 days ☐ 11 to 14 days ☐ Over 14 days ☐

**4.4 What was your motivation in applying for the SPDP?**

(please tick all options that apply)

1. funding opportunity ☐
2. opportunity for general development ☐
3. educational opportunity ☐
4. opportunity for career enhancement ☐
5. Other ☐

(Please specify) ______________________________

**4.5 Briefly what did you hope to achieve by successfully completing the SPDP?**

[2] Contact details are required for selecting mentors and stakeholders for interview but the comments you make will not be discussed with them

[3] Sponsor's contact details are required for follow up interviews, please see information for respondents on page 1

**4.6 Did you attend a workshop to gain information about the SPDP?**

*(please tick as applicable)*

Yes ☐ *[If 'Yes' go to 4.7]* No ☐ *[If 'no' go to 4.7a]*

**4.7 The workshop provided me with useful information for my application for the SPDP**

*(please tick)*

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**4.7a Please give the reason(s) why you were unable to attend?**

____________________________________________________________________

**4.8 Please list your sources of information about the SPDP in their order of usefulness with 1 being the most useful**

1. 4.

2. 5.

3. 6.

**4.9 Did you seek guidance prior to completing the Development Needs Assessment Tool (DNAT)?**

*(please tick as relevant)*

Yes ☐ *[if yes go to 4.9a]* No ☐ *[if 'no' carry on to 4.10]*

**4.9a From whom did you seek guidance to complete your DNAT?**

(please tick all that apply)

Manager ☐ NHS Education Scotland ☐

Director ☐ Other ☐

Mentor ☐ *(please specify)* ___________________

HEI contact ☐

**4.10 Please list the areas of need identified and the respective learning outcomes specified in your Development Needs Tool?**

| **Areas of Need** | **Learning Outcomes** |
|---|---|
| Eg. Lecturing and facilitation skills. | Eg. Undertake systematic assessment of education/ training needs of healthcare staff to meet the needs of service users in own practice area. Lead educational initiatives for patients and a range of staff in own practice area, and demonstrate effective facilitation skills. Contribute to relevant higher education module/s by regularly giving lectures. |
| 1 | 1. |
| 2. | 2.. |
| 3. | 3. |
| 4. | 4. |

*Please read the following statements and tick the option that most closely matches your opinion*

***Prior to the SPDP***

**4.11 I consider that completion of the DNAT was useful at the time of application**

Strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

***During the SPDP***

**4.12 I consider that completion of the DNAT was a useful activity during the SPDP**

Strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

***Following completion of the SPDP***

**4.13 When I consider it retrospectively completion of the DNAT was a useful activity**

Strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**4.13a <u>Or</u>** Not applicable (as still undergoing SPDP) ☐

**4.14 Who developed the plan of activities to meet the needs identified in the DNAT?**

1. I developed them alone ☐
2. I developed them with one other ☐ *(specify)* ________________________
3. I developed them with more than one other ☐ *(specify)* ________________________

**4.15 In the following boxes, please**

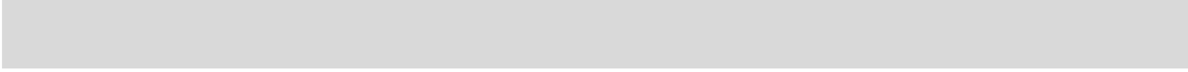
1) *List the activities (including training) you undertook to meet the needs identified in the Development Needs Tool*
2) *State if the activities were funded, or not*
3) *Specify content, duration and location of activity*

| **1) List activity identified** | **2) Was this activity funded?** *Yes/ No* | **3) Briefly specify content, duration and location of activity** | **4) Did the activity meet your needs?** *Yes/ No* |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |

***4.16 If an activity or activities did not meet your needs please indicate why not***

______________________________________________________________________________

_____________________________________________________________________



## SECTION FIVE: Mentor and mentorship patterns

**5.1 Please insert name and contact details of your mentor**[4]

Name of Mentor ________________________

Workplace address ________________________

Telephone ________________________

Email ________________________

**5.2 Prior to starting the SPDP: can you *briefly* outline your perception of the role of the mentor in the box below?**

5.2 Were you given advice on choosing a mentor?
*(please tick)*

Yes ☐ No ☐ Don't know ☐

5.3 Briefly why did you choose this particular individual to be your mentor on the SPDP?

**5.4 During the course of the SPDP I met with my mentor**
*(please tick as appropriate)*

a) Never ☐ d) 3-5 times ☐

b) Once ☐ e) 6 or more times ☐

c) Twice ☐ f) other ☐
(please specify) ________________________

[4] Mentor's contact details are required for follow up. Your comments will not be discussed with them.

***5.5 Please tick the option that most accurately describes the format of your session(swith your mentor. The mentor session(s) were generally:***

a) structured, focussing on DNAT, activities and related areas ☐

b) fairly structured, with some focus on DNAT, activities and related areas ☐

c) fairly unstructured, with some focus on DNAT, activities and related areas ☐

c) unstructured, no particular focus on DNAT, activities and related areas ☐

e) I never met with my mentor ☐

**5.6 On average, approximately how long did your mentor session(s) last?**
(please tick)

30 minutes ☐

60 minutes ☐

1 hour 30 minutes ☐

More than 1 hour 30 minutes ☐

**5.7 My expectations of mentorship were matched by my experience**
(please tick as appropriate)

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**5.8 I found the mentorship aspect of the SPDP**
*(please complete by ticking the relevant box)*
very useful ☐ useful ☐ undecided ☐ not useful ☐ not at all useful ☐

**5.9 Please provide additional comment on your perceptions and experience on the SPDP that may assist future programmes?**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
_____________________________________________________________________

**SECTION SIX: Details of role**

**6.1 What was your before job title/ role before and after undertaking the SPDP?**

*(please complete the table below)*

| | Job title[5] | Role and grade |
|---|---|---|
| a) Pre SPDP | | |
| b) Post SPDP | | |

**6.2 If you changed your job title/role during or following completion of the SPDP, in your opinion, was that as a consequence of the SPDP?**
(please tick)

yes, totally ☐ yes, to an extent☐ undecided ☐ not really ☐ not at all ☐

*Please read the statements below and tick the responses that most closely match your opinion*

**6.3 Completing the SPDP enabled me to gain the competencies for a consultant NMAHP role**

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**6.4 Completing the SPDP increased my chances of gaining a consultant post**

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**6.5 Completing the SPDP enabled me to decide that I do not wish to become a consultant**

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**6.6 Overall I found the SPDP to be a worthwhile development experience regardless of future consultant role opportunities**

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

**6.7 What do you consider to be the main *strengths* of the Succession Planning Development Pathway including the DNAT and planned activities?**

**6.8 What do you consider to be the main *limitations* of the Succession Planning Development Pathway?**

[5] Details will be coded to protect anonymity

**Please feel free to elaborate further on your answers and provide additional comments you think may be useful.**

| Question number if appropriate | Comment/ elaboration |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Thank you for completing this questionnaire.**

**Please return the completed questionnaire and your signed consent form to M Coulter using the enclosed stamped addressed envelope.**

**Appendix IV**

**SEMI-STRUCTURED INTERVIEW GUIDE Version 1 (07/S1402/95)**

**AREAS OF QUESTION**

- Preamble
- Demographic information
  - Current role
  - Role when on selection panel for SPDP
  - How they were approached/ why they think they were invited
- Selection process (appropriateness, logistics, good, bad)
  - Aim of process
  - Familiarity/ understanding
  - Agreement of criteria beforehand- was this adhered to, agreements/ disagreements in the panel
  - Outcomes and understanding of these. We know x turned down first and second selection rounds
- DNAT and Activities logs
  - Thoughts about the pathway, how effective/ ineffective they think it was ever likely to be.
- Aim and purpose of SPDP, DNAT and Activities logs
  - Types of Activities identified in relation to learning outcomes
- SPDP participant(s) – social network for case study information
  - Knowledge of individual participants
  - Understanding of consultant role, examples in organisation
- Mentorship arrangements
  - Involvement with advising on mentor selection
  - Role of mentor
- Recruitment pool enhancement (e.g. achievement of aim)
- Other

**Appendix V: Case Study Data**

There were four aspects to the case study:

1 – provide 2 week diary to participant to complete prior to visit
2 – interview with participant and one other
3 – observation sessions (over 2 days to include 1 meeting, one clinical session plus one)
4 – documentary analysis of 'evidence' – what has participant produced?
5 – telephone follow-up

1 - Participant to complete 1- 2 week diary – preceding interview/visit
Review prior to visit

2. Undertake one interview with participant
Undertake one other interview or field note with one other
(e.g. peer, other discipline, ?who do they work closest with)

3. Observation schedule:
Observation sites: (aim for 2 days per case study)
Attend minimum of 1 meeting – preferably interdisciplinary
Attend one clinical session
Attend one other: teaching, informal discussions with other staff

4. Documentary analysis:
Request relevant documents participant has been involved in last 2 years
(e.g. since before start of SPDP) – in order to review level of working:
e.g. involvement in policies, publications (journal articles, reports), minutes,

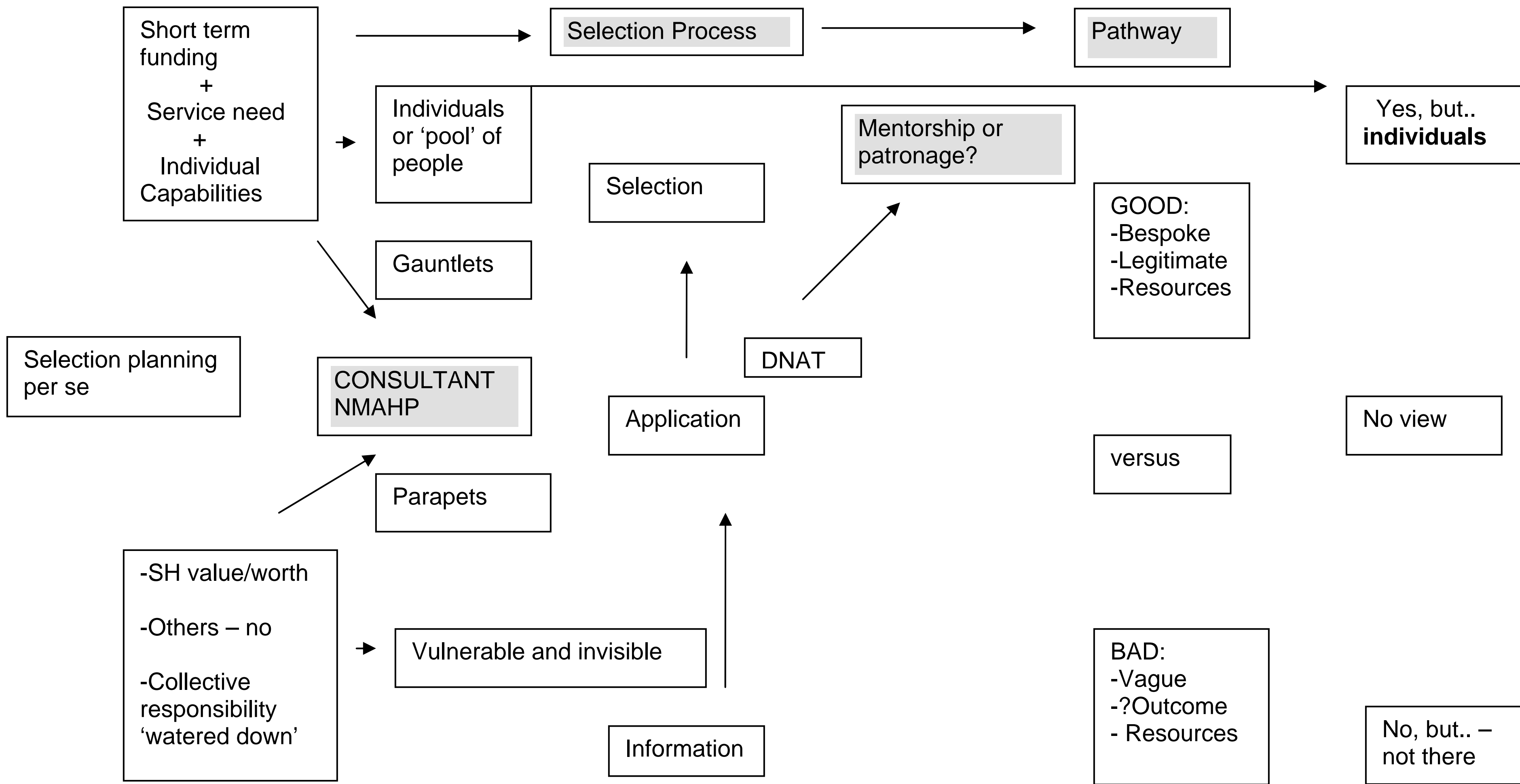
5 – Telephone follow-up
Telephone follow-up to clarify any of above against domains

**Appendix VI: The case studies**

| | **Case study 1** | **Case study 2** | **Case study 3** |
|---|---|---|---|
| **Areas identified by DNAT** | Research Audit Leadership/strategic | Research/Audit Strategic | Research/Audit Strategic |
| **Perception of DNAT** | Valued | Valued, awareness raising of all domains – but confusing | Valued |
| **Funded DNAT Activities** | Initially identified Research but changed to Leadership course | Clinically relevant course – not research | Funded research being undertaken |
| **Highest Academic Qualification** | Degree | Degree | Degree |
| **Number of Domains Case currently active in** | 1 or 2 of 5 | 3 or 4 of 5 | 4 of 5 |
| **Mentorship** | Positive | Positive | Very Positive – more than one mentor |

**PATRONAGE, VULNERABILITY AND VISIBILITY: AN EVER-DECREASING POOL OF INDIVIDUALS**

*CONTEXT* *CONDITIONS, PROCESSES* *OUTCOMES*



**Appendix VIII**

**The aims and objectives of the evaluation and the final report**

Aims

Q - To identify the extent to which the succession planning development pathway for consultant nurses, midwives and allied health professions has contributed to an increase in numbers to the recruitment pool for these senior posts across NHS Scotland

*A – The pathway has minimally contributed to an increase in numbers to the recruitment pool for these posts.*

Q - To ascertain the usefulness of the process (particularly the Development Needs Analysis Tool as a mechanism to identify personal strengths and areas of potential development);

*A – The DNAT was valued by the participants as a means of reflection and ipsative assessment. However, the DNAT needs to ensure that learning outcomes are addressed in all domains and with the expert support of appropriate mentors for the relevant domains.*

Q - To identify the potential of transferability of this model to other staff groups.

*A – The DNAT and mentorship aspect of the pathway are transferable. However, there is insufficient evidence to support the pathway as being transferable. Any future initiatives such as this should be linked to other relevant partners (e.g. HEIs), fully funded, sustainable, with explicit outcomes, expert support, conjoined with a vision for the role. It is the view of the research team that there are other more appropriate models available e.g. fellowship/internships.*

Objectives

The objectives of the project were:

Q - To analyse and review the selection process of how potential participants to the pathway were selected – both by NHS Board employers and the NES Selection Panel

*A – There are improvements that can be made to this process as outlined. Specifically, it would be useful to 'open-up' any future initiatives to non-NHS staff in order to widen the recruitment pool in the first instance.*

Q -To examine the range of activities undertaken by participants in order to ascertain if these activities met the identified needs

*A – A range of activities were undertaken by the participants. These activities did not necessarily meet the identified needs particularly in the domain of audit and research – see case studies specifically.*

Q -To gather information from participants, sponsors and strategic mentors with regard to :

patterns of mentorship

appropriateness of mentorship arrangements
usefulness of mentorship arrangements in helping to meet identified needs
usefulness of coaching / work shadowing / other support and development mechanisms
level of sponsor support
identification of other elements which would have helped in meeting identified needs

*A – The above are outlined in detail in the report.*

Q - To ascertain the level of impact the pathway has had on changing / influencing career development practices across NHS Scotland

*A – This is difficult to ascertain. However, the majority of the cohort has changed job/title since the pathway although only two have acquired consultant NMAHP positions. One of the case studies notably elected not to pursue a consultant position but is now in an executive level position.*

Q - To examine the extent to which the pathway has increased confidence levels and developed the skills profile in those considering applying for a Consultant post

*A- This is difficult to ascertain with any conviction due to the absence of baseline markers. However, the case studies and the questionnaires suggest that there has been an aggregate increase in confidence among the cohort. Moreover, stakeholders reported an increase in confidence among mentees. Self-efficacy markers would however, have proved more useful indicators.*

Q - To examine the extent to which the pathway had increased the confidence, skills and effectiveness of those who already hold Consultant posts

*A – as above.*

**Appendix IX: statistical data**

| Comparison of different levels of domains of current practice | Confident (%) | Some Development required (%) | Needs to be developed (%) |
|---|---|---|---|
| Leadership and consultation skills vs Expert practice | 63.3 vs 82.2 (p=0.012) | 34.2 vs 15.6 (p<0.001) | 2.2 vs 2.5 (p=0.826) |
| Leadership and consultation skills vs Patient/Staff Education | 63.3 vs 58.6 (p=0.535) | 34.2 vs 38.1 (p=0.596) | 2.2 vs 3.3 (p=0.704) |
| Leadership and consultation skills vs Practice/Service Development | 63.3 vs 66.7 (p=0.689) | 34.2 vs 32.9 (p=0.862) | 2.2 vs 0.5 (p=0.116) |
| Leadership and consultation skills vs Audit and Research | 63.3 vs 52.0 (p=0.274) | 34.2 vs 42.0 (p<0.001) | 2.2 vs 6.0 (p=0.472) |
| Expert practice vs Patient/Staff Education | 82.2 vs 58.6 (p<0.001) | 15.6 vs 38.1 (p<0.001) | 2.5 vs 3.3 (p=0.258) |
| Expert practice vs Practice/Service Development | 82.2 vs 66.7 (p=0.035) | 15.6 vs 32.9 (p=0.014) | 2.5 vs 0.5 (p<0.001) |
| Expert practice vs Audit and Research | 82.2 vs 52.0 (p=0.002) | 15.6 vs 42.0 (p<0.001) | 2.5 vs 6.0 (p=0.407) |
| Patient/Staff Education vs Practice/Service Development | 58.6 vs 66.7 (p=0.280) | 38.1 vs 32.9 (p=0.478) | 3.3 vs 0.5 (p=0.258) |
| Patient/Staff Education vs Audit and Research | 58.6 vs 52.0 (p=0.490) | 38.1 vs 42.0 (p=0.562) | 3.3 vs 6.0 (p=0.555) |
| Practice/Service Development vs Audit and Research | 66.7 vs 52.0 (p=0.156) | 32.9 vs 42.0 (p=0.237) | 0.5 vs 6.0 (p=0.197) |

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