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Title: Supporting Clinical leadership through Action: The Nurse Consultant Role

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Summary Box:

What does this paper contribute to the wider global clinical community?

- Organisations should invest in clinical leaders' support to maximise outcomes.
- External facilitation should enable clinical leaders to maximise their achievements in all four dimensions of their role.
- External facilitation and peer support should help clinical leaders recognise the importance of self-leadership and their own potential to influence.

Keywords: Nurse and Therapy Consultants, Action Learning Set, Co-operative Inquiry, Self Leadership, Peer support, Empowerment, Leadership.

The aim is to evaluate the effectiveness of an action learning set (ALS) to enhance clinical leadership and extend their scope and confidence more strategically

Background: As the most senior clinical role in most healthcare systems, the consultant nurse role is a solitary one. They are required to develop personal resilience, commitment and a belief in their ability to lead, with new consultants needing a strong support network to succeed.

Design: Following a two year ALS, four nurse consultants, one therapy consultant, and a university educationalist engaged in a co-operative inquiry approach using four cycles of discussion, reflection, analysis and action over an 18 month period from March 2015 – July 2016, to learn how to change and enhance their working practices. Data were analysed thematically.

Findings: Four themes emerged where the ALS 1) offered structure and support 2) enabled a wider influence 3) empowered them to lead. The co-operative inquiry helped them realise how much they had gained from their collective learning and they felt empowered to lead.

Conclusion: Their motivation to 'make a difference' remains palpable. The outcomes of the co-operative inquiry included an enhanced understanding of the importance of openness and trust and a willingness to share and learn from each other in a respectful and confidential environment with a receptiveness to change. Self leadership has clearly been accepted and embraced and their collaboration has improved communication across the organisation, enhanced their strategic leadership capability and given confidence to disseminate externally.

Relevance to Clinical Practice: The ALS offered structure to support these clinical leaders to keep them focused across the breadth of their role. Additionally, peer review with external facilitation has enabled these clinical leaders to gain a wider influence and empowered them to lead.

INTRODUCTION

Globally, healthcare systems face a myriad of complex challenges, placing clinical leadership firmly in the spotlight. With nurse and therapy consultants occupying the most senior clinical role in the UK healthcare system, the role has been adopted by Australia (Wilkes et al 2015), Hong Kong (Chan et al 2014) and Italy (Portoghese et al 2012), with a range of leadership roles already existing in the USA (Gantz et al 2012). Nevertheless, in spite of its popularity, the role seems to be fraught with ambiguity and lack of clarity. Indeed, such ambiguity has led to workforce problems such as job dissatisfaction, increased intention to leave (Acker 2004) and higher rates of turnover and burnout in both advanced practice roles amongst standard registered nurses (O'Brien-Pallas et al 2010, Spooner-Lane & Patton, 2007). Given the potential isolation of such a senior clinical leader, in order to succeed, those in the role are required to develop personal resilience, commitment and a belief in their individual leadership skills to make a difference to the quality of care. At the express wish of the Director of Nursing (DN), a university educationalist facilitated a two year Action Learning Set (ALS) between four nurse consultants and one therapy consultant. This paper questions the value-added of such an ALS and aims to evaluate its success.

BACKGROUND

The non-medical consultant role was introduced in 1999 with the publication of the strategy documents Making a Difference (Department of Health, 1999) and Meeting the Challenge (DH 2000a). At this time, the government set out its strategic objectives for the contribution of nursing and allied health professions to the health of the population. By retaining nurse and therapy experts in practice, the new role was seen as 'ground-breaking' (McSherry et al

2005). The intention was to strengthen clinical leadership, provide new career opportunities and ultimately enhance patient care by improving the quality of services (Department of Health 1999).

Although well established as a role in the UK, those consultants new in post continue to require support for their leadership, to allow them to flourish. Indeed, Guest et al (2001) recognised in their preliminary evaluation of the role that a key problem for some consultants was a lack of support from their seniors, both financial and emotional, with McSherry et al (2005, p153) advocating a system whereby a 'critical companion' could be identified to share issues and discuss the challenges they face in a non-threatening environment.

The action learning set was introduced, following a serendipitous meeting between an educationalist and the Director of Nursing (DN) in one NHS Foundation Trust in the South of England. Given their recent appointments and lack of established collaboration of the consultants (indeed they hardly knew each other), the DN believed that an ALS would offer them the opportunity to share their vision and learn from each other, particularly across the four dimensions of their role. As a previous consultant nurse herself, the DN recognised the value of an ALS to extend their scope of practice across all four role dimensions of clinical practice, education, research and leadership. With educationalist acting as external facilitator, the set included three nurse consultants new into post and two more experienced consultants to share the strategic and operational issues facing them in practice such as people and systems management and empower them as clinical leaders to create their own solutions.

What is Action learning?

> "*Action learning is a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done. Through action learning individuals learn with and from each other by working on real problems and reflecting on their own experiences. The process helps us to take an active stance towards life and helps to overcome a tendency to think, feel and be passive towards the pressures of life".* (McGill and Beatty 2001, p11).

Most effectively, an Action Learning Set (ALS) is based on the idea that people learn best when working on real-time problems in their own work situation (Raelin 1997), is best undertaken in small groups and in an environment of mutually agreed confidentiality and respect. To enable ground rules and boundaries to be set, often a facilitator is employed for an agreed length of time. Recognising the mutual benefits of such a venture, the ALS was established in October 2013. The group met monthly with the educationalist acting as external facilitator quarterly due to the geographic distance of the University, some 50 miles from the Hospital. Together they decided to map their successes and their challenges against all four dimensions of their role and agreed in advance who would share their own achievements and areas of concern. The ALS meetings were held in an area of the hospital away from clinical practice and were not recorded, offering an unthreatening environment for all. The aim of this paper is to present the findings from the four cycles of reflection and action of a co-operative inquiry to evaluate the ALS.

DESIGN AND METHODS

Co-operative inquiry

Co-operative inquiry, identified by Heron & Reason (2001) is a way of researching *with* rather than *on* people, of working with those who have similar interests and who wish to collectively understand their world and create new ways of exploring it. Following a 2 year ALS, with the educationalist acting as external facilitator, it seemed appropriate to evaluate the ALS, with the external facilitator joining with the consultants as co-researcher and co-participant to progress the relationship we had established and identify what had been achieved. As we progressed in our reflections and actions as part of the co-operative inquiry, this approach helped us learn how to change and how to enhance our collective working practices. With all active participants fully involved as co-researchers in all research decisions a number of meetings were set up quarterly, following the previous pattern used for the ALS to engage in four cycles of discussion, reflection, analysis and action.

This study follows what Heron (1996) refers to as a process of partial co-operative inquiry where the initiating researcher (university educationalist), not a member of the NHS Trust, educates the five consultants to become full researchers and continues to engage in research reflection with the group as peers, but is only partially involved in the action phases. Nevertheless, the group believed that the principles of co-operative inquiry were used. Additionally, the consultants wished to include their line manager, the DN who has fully supported the ALS to seek confirmation of their impact on the wider organisation. Originally, we sought to engage collectively as a group with the DN but it became increasingly difficult to find time when all consultants, the educator and the DN could be together. Exceptionally, and with the agreement of the consultants, the educator engaged in a one-off telephone interview with the DN to present her view of the organisation's perspective of their progress. Whilst we recognised as a group that this might be misconstrued as disempowering the consultants by potentially misrepresenting them, the educator agreed to share the details from the interview with the consultants and engage in further discussion if they felt it appropriate to do so. The evaluation process was planned to last for 12 months, commencing March 2015 and completed in July 2016.

In terms of process and with a focus on evaluating the ALS as a means to enhance their strategic leadership, we engaged in four cycles of discussion, reflection, analysis and action (see Table 1). Meetings took place quarterly and continued for just over one hour. Areas for discussion were generally agreed in principle by email prior to each meeting but the focused discussions were unstructured. Overall, discussions centred around their progress against the four dimensions of their role. Given the investment by the Director of Nursing (DN) to support the ALS financially, she took a keen interest in the group's development and joined the group at the beginning of all ALS meetings to offer any necessary resources. The consultants were keen to have her contribute to the co-operative inquiry towards its completion.

During the co-operative inquiry, all focused discussions were digitally recorded, transcribed and reviewed independently before each meeting. Given our busy schedules, the main challenge was to commit to seeing the co-operative inquiry through to its natural conclusion. In spite of the openness and unanticipated lines of enquiry, each participant experienced the group as a place of safety and respect, having agreed the ground rules at the outset. In spite of her ongoing support, the DN was unable to meet with the group to share her observations

of their progress towards the completion of the co-operative inquiry, and a telephone interview was organised between the DN and the educationalist to satisfy the consultants' curiosity as to the organisation's perspective on the value of the ALS. Using thematic analysis, our reflective journeys explored and clarified our shared understandings of the data. From the process of condensing the data and sorting into clusters, themes and trends (Miles and Hubermann 1994), the main themes emerged. Each data set was analysed separately and agreed among the team before being amalgamated with the analysis of the individual interview with the DN. Heron and Reason (2001, p184) refer to the need for 'critical subjectivity' when analysing the data. They suggest that whilst we can distort how we see ourselves in terms of our interpretations of what we say and do, we can also learn to look at ourselves critically particularly alongside others who are all doing the same. So, in our search for some level of 'objectivity' (Heron & Reason, 2001, p184) in our reflections, we can build and develop our 'personal, living knowledge'. To attempt to achieve this, Heron & Reason (2001) developed a number of inquiry skills and validity procedures (being present and open; bracketing and reframing; radical practice and congruence; non-attachment and meta-intentionality and emotional competence) to help improve the quality of our knowing.

Ethics:

The study was approved by the University Ethics panel. Consultants and the DN were furnished with a participant information sheet prior to engaging in the study and they signed a consent form to participate.

FINDINGS:

The findings from the co-operative inquiry evaluating the action learning set illuminated three main themes that the ALS:

1. Offered structure and support to keep focused,
2. Enabled a wider influence
3. Empowered them to succeed

As their reflections prompted them to think about and move them to action, the initial themes developed and moved on over time with the inquiry, and other themes emerged as they looked more widely at their role both within their organisation and then regionally and nationally. The DN offered confirmation from the organisation's perspective.

1. The ALS offers structure and support to keep focused.

A number of categories emerged from this overarching theme which provided a richness of detail around how the ALS supported them in their own development and gave them confidence in their role. All of the consultants experienced significant challenges in the operational aspects of their role and the findings illustrated just how much of a support they felt from the collaborative group. They also acknowledged how the external facilitator helped formalise their reflections into specific outcomes and kept them focused. Generally, the consultants appreciated the investment by their organisation to permit them time out of their working day to reflect on what they were trying to achieve:

"Yea, um I think collectively we have a greater influence on the organisation and have a bigger voice, and can support each other far more than we were previously in our isolated roles, but it is the structure of the action learning set plus the intermittent facilitation that's made the difference rather than just a meeting once a month. That's my opinion" Denise1 p20

Through the ALS and working as peers, they developed a group identity and a confidence in their leadership. They realised that they were dealing with similar issues and through the support of the group they became confident in teasing out different approaches to address them.

"[I] evolved to become a nurse consultant, I had no peer group at all ..and .. actually there are other nurse consultant therapists within the organisations,.. but I didn't feel I sat within that group… So formally bringing it [ALS] together, so yes I do have a peer group, I do have a group that understands the role". Jenny1p2.

They designed a table of objectives that they set themselves in each of the four dimensions of their role and this was colour coded for priority and assisted in exploring the breadth of their role and helped keep them on track. Two of the consultants previously held different positions in the organisation so required to change direction and realign themselves and found the ALS helped support them:

"there was an expectation that I would cover the shop floor…but everyone still saw me in my old role .. I was really struggling with that…so giving myself permission to do certain aspects of the role and develop in certain ways, I wouldn't have done that without the group" Jenny1 p2

Even the DN recognised their success and the change in them 3 years into the ALS and acknowledged their need to learn how to influence:

"I have seen them all develop more confidence, whereas I think before we started the Action Learning Set they didn't really have a group identity, they didn't meet together, they didn't probably see how they were dealing with the same issues and really as a leadership group they have a greater identity … it is how do you learn to influence and get things done in a way that is more effective, so yeh ..very very positive". DN p1

In spite of their experience, which for some was over 12 years in the role, there remained times when they felt insecure and welcomed the support of the ALS. One particularly wrestled with management issues and benefitted from the ALS:

"it's just given me the stage to be able to sit and kind of explain or go through my frustrations or my challenges ..and actually having some support from my colleagues here about how to manage that from their experience". Robyn p6

Finally, recognition that the ALS gave them the confidence to believe in themselves and set particular targets confirmed their commitment to support and be supported:

"*and I think the action learning sets for me, the main difference is that everybody has got a chance to say and acknowledge what their strengths are, particular issues and there's a much more of an informal base on outcome measures, and I think the group are very good at supporting each other with those"* Connie p1.

2. The ALS enables them to have a wider influence

Early on in the co-operative inquiry, the consultants recognised that prior to the ALS, their main focus for the role was on their clinical expertise and in service development. During the course of the ALS, they had begun to look wider and engage in the other dimensions of

their role. Some were already comfortable with their education role and all began to value the scholarship dimension. Throughout the ALS, we collectively presented our work at international conferences, collaborated in writing a book chapter on the challenges of implementing evidence based practice, and were now collaborating on this paper. During the first discussion of the inquiry, one consultant stated:

"I would have never come across the opportunity [to publish] before this group…you know, again that's been a huge benefit to me…" Jenny1 p17

By the second discussion of the inquiry, external partnerships were being set up across the region before working nationally. And, by the fourth discussion in the inquiry, there was an obvious change in activity, with research projects being initiated, publications planned and joint working in pairs within the ALS:

"*Um, so I've got 3 projects…to university around modelling… and* [submitted an article for publication]: *"Yes I'm just waiting to hear back whether it's been accepted*" Jenny4 p2

One of the most remarkable changes that we witnessed by the fourth discussion in the inquiry, was the moment of discovery of the link between scholarship and clinical practice: "*it's not until you've…given yourself permission that it's ok to spend a couple of hours in your office you know putting something together for an article or discussing some sort of research um but when you actually think about that, it really does have an impact on the clinical part of your role" Jenny4 p1 .*

At the outset of the ALS, for those new into post, they wrestled with the true autonomy of the role, taking time out to engage externally, particularly extending their sphere of influence. Gaining permission was a feature throughout the co-operative inquiry, identifying the need to make their decisions and avoid feeling subservient to the hierarchy within the organisation. By the end of the co-operative inquiry, the DN recognised just how the ALS had supported them to take charge of themselves:

"Whereas they are a group who would seek permission and certainly, I don't think they did recognise that how going and seeing other sites and networking… whereas I think they saw this as a 'nice to do', rather than an essential…[now] they are just letting me know, and that is good. That is what I want." DN p1

Finally, the DN acknowledged that her wider executive team were very supportive of the strategic leadership of the consultants within their organisation. She confirmed that the Chief Executive (CEO), Medical Director and Associate Directors of Nursing all valued their leadership and when a new service was being set up it was the CEO who suggested a nurse consultant be employed to take the lead:

"He [CEO]…talks about the NC all the time and he has a high expectation of what they deliver." DN p8/9

In summary, there was a real richness of data in this theme illustrating the impact that the ALS has had on widening their horizons. The temptation to maintain the status quo in fire-fighting the operational aspects of the role was attractive, especially for novice consultants as they came to terms with their role. Yet the ALS triggered an awakening among them to think more widely about the four dimensions of their role; to reach out to the rest of the

organisation, to the region and nationally. Importantly they saw the need to safeguard their role for the organisation rather than see the role for their personal career progression.

3. The ALS Empowers to lead

Having undertaken the role of nurse consultant herself, the DN visualised its potential. She believed that an expert clinician engaging strategically in the four dimensions of the role should be a peer to work alongside medical colleagues as experts in the field. However, she was keen to encourage them to realise their individual potential, be free from the constraints of previous roles and continue to question the status quo:

"So, yes, it is sort of letting them create their own leadership roles and actually working alongside each other and all we have done is point them at the outside world and say.. go on then .. go out there and come back and tell us what you think they need." DN p6

Yet, the DN was adamant that the way to support them was to push them to find their own solutions rather than simply identifying the problem. She was presented very recently with a nurse consultant frustrated with a lack of space in her department:

"she's been coming to me with " 'someone' has to sort this"… and I'm going… "so who's that then?" … 'I don't know, but it just has to be sorted'... and I'm saying 'I absolutely get that, so how do we find you that space?' ..DN p4

There was clearly a recognition by the DN of the considerable challenges facing the team and how much they had moved forward over the duration of the ALS to realise their maturity and ownership of the problems and seeking solutions:

"I am probably sounding critical …because actually, all of them are really very very good at what they do….. I think they are really light years ahead of what they would have been if they had never done the action learning set and so now I guess we are really raising the bar all of the time" DN p4

Indeed one of the consultants acknowledged the attraction of working operationally yet by the end of the inquiry, she confirmed her resolve to retain her strategic leadership towards achieving the vision:

"the reality is if you don't take that step back, lead it, look at ..the future of what you need and build the team then you just you never grow, so you just get consumed" Vicky 4, p6

Developing their confidence to assert themselves interprofessionally was attributed to the ALS:

"I mean to challenge medical colleagues is tough isn't it, and gaining confidence from being in this group has certainly helped me when you are having those sort of challenges and …it's me accepting myself internally, like you said it's that internal struggle" Jenny1 p10.

Finally, the DN was not optimistic about the future of the role. She recognised their need to develop the future workforce, be the strategic leaders in developing services, continually seeking to enhance the vision by engaging with Trust Boards and establishing themselves alongside medical consultants as the strategic clinical leaders of the organisation. She acknowledged the need for them to work together both internally and external to the

organisation to establish their voice and learn to articulate the need for change to really make a difference. Whilst the organisation remained committed to the role, the DN stated:

"I worry in the long term about the future of these roles. I don't see in the national leadership that they are being talked about at all. And, I have a fear, if I am honest that they will dwindle. I don't think they will be abolished as such but I think we'll see the numbers year on year nationally dwindle.. our national leadership is ceasing to promote this as a good career move and I think that is being massively short sighted" DN, p9.

DISCUSSION

Structure and support:

The professional isolation of consultants and indeed of any autonomous, strategic leader is well recognised. As pioneers in their roles, both McSherry et al (2005 p160) and Young et al (2010) acknowledge the value of ALS as a structure to support consultants in the complexity of their roles and help them to distinguish between the practical aspects and the strategic leadership functions of the role. Regardless of the length of experience, importantly these consultants found invaluable support in the ALS, shared learning and encouragement to recognise that they are not alone in the challenges that they face. Indeed, McGill and Beaty (2013, p12) acknowledge the collegiality of an ALS. McGill & Beaty also confirm the value of shared reflection and the importance of ALS in learning as a collaborative and social process (P159), creating learning that is common to all. Throughout the four co-operative inquiry group meetings, the value of the external facilitator in the ALS was recognised. This is supported by Young et al (2010, p107) who acknowledge the virtues of a skilled facilitator to maintain the focus, allow for shared 'air time' and prevent "circular conversations, moaning and off-loading with no outcome". Setting ground rules, action planning, reflection and facilitating an open and honest environment where sharing is voluntary was formalised through the external facilitator. Additionally, the consultants welcomed the organisation's investment of time and their generosity of an environment free from interruptions to support their learning. Focused on learning from real-time experiences, the consultants recognised the ALS as tool to support them "face conflicts, dilemmas and difficult choices on a regular basis" (Pedlar 2005, p127).

Consultants in this study recognised the need for a peer group and group identity and the stress that this caused without one. The need for support in the role is captured in many of the papers evaluating the role of nurse and therapy consultants (Guest et al 2001, 2004, Hayes & Harrison 2004, Woodward et al 2005). Indeed McSherry et al (2007) identify the need for support at three levels of individual, organisational and national and the ALS provided the structure for all three. It is not surprising that nurses and therapists who have reached this level of strategic leadership in a role which is complex, challenging and autonomous require some degree of support. However, at the outset, each of the consultants in this study were responsible for setting up and developing their own role. As lone workers, McSherry et al (2007) recognise that, by retaining their isolation, they are likely to interpret the role based on their own experience, the demands of the service and vision of the organisation. Therefore by creating the structure of their objectives within the ALS, they had the opportunity to share their common goals and realise a vision for the organisation. Margerison (2005, p173) referred to Revans in his early realisation that "the real laboratory for improving management practice and personal development was in the fire of the

workplace". Posing key questions about real-time work and finding and implementing solutions was, he suggested 'the road to real learning'.

Wider Influence

Until engagement in the ALS the consultants had not had the opportunity to formally consider the wider dimensions of their role. As McSherry et al (p5) recognised, the role of nurse and therapy consultant was introduced as part of the NHS modernisation agenda, not as a substitute for junior doctors but as senior autonomous practitioners at the highest level of career development able to challenge existing practice and embrace new ways of working. Their role embraced four key attributes of expert clinical practice, leadership, education and research (McSherry et al p5). However, consultants in this study admitted that their leadership and expert clinical role seemed to dominate their operational working practices. Creating a structure for their reflections and focusing on a different aspect of their role each meeting allowed them to give attention to the wider range of activities that their role demanded.

The benefits of collaboration in an ALS are thoroughly documented (McGill & Beaty, p159, Young et al 2010), suggesting that learning together is greater than the sum of the learning gained individually. From a global perspective, Lamont et al (2014) confirm that collaboration is a professional expectation (American Nurses Association 2015, Canadian Nurses Association 2008, UK Nursing and Midwifery Council 2015, International Council of Nurses 2012) and a concept that all nurses should expect to embrace but especially those at strategic leadership level. Recognising the challenges of publishing and research that the consultants in this study experienced, Stevenson et al (2011) reinforce this as the most difficult dimension to enact. Although one of the consultants had completed her doctorate, the others had all completed some or all of a masters programme. Indeed, the educational expectations of the role dominated the third discussion of the inquiry recognising that the UK Department of Health (2010) fell short of mandating full masters achievement for advanced practice nurses. The consultants all recognised the challenges of undertaking part time study on top of full time employment, along with family responsibilities and emphatically supported Currie (2007) in her assertions that mandating doctoral level achievement for consultants would lead to recruitment and retention problems. Even with masters level achievement, as the present consultants acknowledge, there are difficulties integrating research into practice and supervising and undertaking research (Currie 2007). Nevertheless, it was a revelation for one of the consultants who recognised the impact of research on her clinical practice. Gaining confidence to write abstracts for conferences, peer reviewed papers and book chapters were skills that the less experienced were beginning to embrace.

Finally, the consultants recognised the influence they were having on the wider organisation and particularly with the directorate and this was validated by the DN. Moving from a 'permission seeking' environment to one of independence was recognised by the senior leaders of the organisation. In spite of some ambiguity in the emerging role of consultant, successful collaboration, as McCaffrey et al (2012) notes, requires respect for the diversity of roles, accepting of differences and a determination to resolve any competing interests. Additionally all parties need to recognise a shared vision and demonstrate their collective willingness to work towards the common goal.

Empowerment to lead

Leadership has been a major political aim in the UK health service since before the commencement of the government's programme of radical reform (Jarman 2007, Department of Health 2000b). Now over 16 years since the introduction of the consultant nurse and therapy role, and in spite of a plethora of studies, there seems little robust evidence of the impact of the role (Kennedy et al 2012). Nevertheless, Kennedy et al (2012) in their systematic review suggest they have had a largely positive influence on both patient and professional outcomes. For the new consultants in this study supported by the ALS, the DN validates their success in the organisation and the organisation's commitment to the role. Indeed, the *professional will* that each of these consultants has demonstrated, has illustrated their deep sense of purpose to achieve the common organisational goal. Pedlar (2005) acknowledges the importance of purpose in action learning. He recognises it can help to support members to create their internal moral and practical compass to steer them through to success. He suggests that it is purpose that motivates and energises individuals and creates a determination to act and empowerment to achieve. By meeting regularly and being highly motivated to support and be supported, they empowered each other to believe in themselves and their success.

There seems no doubt that the consultants in this study aspired to lead and although it has been a process of development and support, of looking beyond their immediate sphere of influence, the ALS has helped them on their journey. Whilst there are many theories of leadership (Jarman 2007), Marriner-Tomey (2004) acknowledges the place of power, defined as "the capacity to influence others" as being inherent in all leadership roles (Hughes et al 1999). No matter the theory that is espoused, accepting of 'self' as leader is, according to Brown & Holroyd (2013) key to achieving success. Believing in 'self' in the concept of self-leadership is about working from the 'inside out' and about thinking and therefore behaving differently. Given the constant change expectation within the health service, those who are able to lead the services through the ambiguity, complexity and the pace of change will recognise the importance of self-leadership and, as Brown & Holroyd (2013) confirm, it is something everyone is capable of. They recognise the value of self leadership in the development of effective and resilient leaders and role models who create a culture of openness and questioning. All consultants in this study acknowledged the empowerment they gained from the ALS in asserting their leadership by resisting the pressure to be 'consumed' by the operational aspects of practice and look to the future to 'grow'. It is evident that the belief of the DN, supported by the senior management team recognised their value and took steps to reinforce strategies to empower.

Given that the role of consultant nurse and therapist has grown globally (eg Chan et al 2014, Wilkes et al 2015), and the evidence of serious deficiencies in clinical leadership (eg Francis 2010, 2013), it is surprising to hear of the potential decline of the most strategic clinical leader in the health services within the western world. It is true that figures reported from England suggest a decline in numbers over the past three years, from n=777 to n=722 (7% reduction) (HSCIC 2016). However, Gerrish and Lathlean (2015) have provided the framework for evaluation. Research now needs to demonstrate their actual impact and promote their importance to the global leadership of health.

CONCLUSION

Following three years of ALS and one year evaluation, this co-operative inquiry encouraged all team members (five consultants and one University educationalist) to share individual and collective gains. The richness of the data arising from four cycles of reflection, analysis and action belied what could be captured within the limitations of this paper. In spite of a reluctance on the part of the educationalist to seek confirmation from the DN, outside of the collaboration, the analysis confirmed the wider organisation's commitment to the role and investment in its support. From a serendipitous meeting with the DN 3 years previously, we had no realisation of its potential nor of its outstanding success and the benefits to all members of the team and to the NHS Trust. We have witnessed considerable change in the group as a whole, realised the importance of structure in the ALS, the value of a peer group particularly to articulate the organisational vision and to embrace the wider dimensions of the role. Self leadership has clearly been accepted and enacted and, given the declining numbers nationally, we remain committed to continue our dissemination of our success and to promote the use of ALS in a variety of role analysis situations.

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References:

Acker, G.M. (2004) The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community Mental Health Journal* 40(1), 65-74.

American Nurses Association (2015) Code of ethics for nurses. Available at: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/default.aspx accessed on 27.7.16

Baldwin, R., Duffield, C.M., Fry, M., Roche, M., Stasa, H. & Solman, A. (2013) The role and functions of Clinical Nurse Consultants, an Australian advanced practice role: A descriptive exploratory cohort study. *International Journal of Nursing Studies*, 50, 326-334.

Brown, K. & Holroyd, J. (2013) Chapter 11: Self-Leadership – a new focus. In: *Leadership and management Development for Social Work and Social Care.* Fern Barrow: Bournemouth University

Canadian Nurses Association (2008) Code of Ethics for registered nurses. Available at https://www.cna-aiic.ca/~/media/cna/files/en/codeofethics.pdf accessed on 27.7.16

Chan, D.S.K.,, Lee, D.T.F., Chair S.Y., Fung S.Y.K., Chan E.L.S. and Chan C.W.H. (2014) A qualitative study on the roles and responsibilities of nurse consultants in Hong Kong. *International Journal of Nursing Practice*, 20: 475-481.

Coady, E. (2003) Role models. *Nursing Management* 10, 18-21.

Currie, J. (2007) Keeping experience at the bedside; the emergency consultant nurse role. *British Journal of Nursing* (Defense Nurse Focus) 16, 18-21.

Department of Health (2010) *Advanced Level Nursing: a position statement*. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215935/dh_121738.pdf Accessed on 29.7.16.

Department of Health (2000a) *Meeting the Challenge*. The Stationery Office, London.

Department of Health (2000b) The NHS Plan: A Plan for Investment, a plan for reform. The Stationery Office, London. Available from: http://1nj5ms2lli5hdggbe3mm7ms5.wpengine.netdna-cdn.com/files/2010/03/pnsuk1.pdf accessed on 27.7.16.

Department of Health (1999) *Making a Difference. Strengthening the Nursing, Midwifery ad Health Visitor contribution to health and healthcare*. The Stationery Office, London.

Gantz, N.R., Sherman, R., Jasper, M., Choo, C.G., Herrin-Grittifh, D. and Harris, K. (2012) Global nurse leader perspectives on health systems and workforce challenges. *Journal of Nursing Management,* 20: 433-443.

Gerrish, K. and Lathlean, J. (2015) (Eds) (7th edition) The Research Process in Nursing. Wiley-Blackwell, Chichester, UK.

Greber, C., Ziviani, J. & Rodger, S. (2007) The Four Quadrat Model of Facilitated Learning: A clinically based action research project. *Australian Occupational Therapy Journal* 54, 149–152

Guest, D., Redfern, S., Wilson-Barnett, J., Dew, P., Peccei, R., Rosenthal, P., et al (2006) *An evaluation of the impact of the nurse, midwife and health visitor consultants*. Kings College, London

Guest, D., Redfern, S., Wilson-Barnett, J., Dew, P., Peccei, R., Rosenthal, P., et al (2001) A *Preliminary evaluation of the Establishment of the nurse, midwife and health visitor consultants*. Kings College, London

Hayes, J. & Harrison, A. (2004) Consultant nurses in mental health: a discussion of the historical and policy context of the role. *Journal of Psychiatric and Mental Health Nursing* 11, 185-188.

Heron, J. (1996) *Co-operative Inquiry: Research into the Human Condition*. Sage Publications Ltd, California.

Heron, J. & Reason, P. (2001) The Practice of Co-operative Inquiry: Research 'with' rather than 'on' People. Chapter 16 in: Reason, P. & Bradbury, H. (editors) *Handbook of Action Research: Participative Inquiry & Practice.* Sage Publications Ltd, London.

Health and Social Care Information Centre (2016) *NHS Workforce Statistics*, January. Provisional statistics published April 27, 2016. Available from: http://www.hscic.gov.uk/catalogue/PUB20465 Accessed on 28.7.16

Hughes, R. Ginnett, R. & Curphy, G. (1999) *Leadership: Enhancing the lessons of experience.* McGraw Hill, Columbus, OH.

Internataional Council of Nurses (2012) The ICN code of ethics for nurses. Available at: http://www.icn.ch/images/stories/documents/about/icncode_english.pdf Accessed on 27.7.16

Jarman, H. (2007) Consultant nurses as clinical leaders. *Nursing Management*, 14(3), 22-26

Kennedy, F., McDonnell, A., Gerrish, K., Howarth, A., Pollard, C. & Redman, J. (2011) Evaluation of the impact of nurse consultant roles in the United Kingdom: a mixed method systematic literature review. *Journal of Advanced Nursing*, 68(4), 721-742.

Lamont, S., Brunero, S., Lyons, S., Foster, K. & Perry, L. (2014) Collaboration amongst clinical nursing leadership teams: a mixed-methods sequential explanatory study. *Journal of Nursing Management,* 23, 1126-1136.

Margerison, C. (2005) Work-based action learning and applied organization science: a process for management research and organization development. *Action Learning: Research and Practice,* 2(2), 171-186.

Marriner-Tomey, A. (2004) *Guide to Nursing Management and Leadership*. (7th Edition), Mosby, St Louis, MO.

McCaffrey, R., Hayes, R.M., Cassell, A., Miller-Reyes, S., Donaldson, A. & Ferrell, C. (2012) The effect of an educational programme on attitudes of nurses and medical residents towards the benefits of positive communication and collaboration. *Journal of Advanced Nursing* 68 (2), 293-301.

McGill, I. and Beaty, L. (2001) (2nd edition) Action Learning: A Guide for Professional, Management and Educational Development. Kogan Page Ltd, London.

McSherry, R., Mudd, D. & Campbell, S. (2007) Evaluating the perceived role of the nurse consultant through the lived experience of healthcare professionals. *Journal of Clinical Nursing* 16, 2066-2080.

McSherry, R., Murray, M. and Johnson, S. (2005) The context of the modernisation agenda. Chapter 1 in McSherry, R. & Johnson, S. (editors) Demystifying the Nurse/Therapist Consultant: A Foundation Text. Nelson Thornes, Cheltenham.

McSherry, R., Francis, W., Campbell, J., Renshaw, T. and Murray, M. (2005) Supporting the Nurse/Therapist Consultant, Chapter 8 in McSherry, R. & Johnson, S. (editors) Demystifying the Nurse/Therapist Consultant: A Foundation Text. Nelson Thornes, Cheltenham.

Miers, M., Coles, J., Girot, E., Wilkinson, G. (2003) Empowering learners: an exploration of mediating learning for care workers. *Learning in Health and Social Care*, 4(4), 180 – 191.

Miles, M. B. & Huberman, A. M. (1994) *Qualitative data analysis* (2nd edn) (Thousand Oaks, CA, (Sage Publications).
Pedlar, M. (2005) (editorial) A general theory of human action. *Action Learning: Research and Practice*, 2(2), 127-132.

O'Brien-Pallas, L., Murphy, G.T., Shamian,J., Li, X., Hayes, L.J. (2010) Impact and determinants of nurse turnover: a pan-Canadian study. *Journal of Nursing Management* 18(8), 1073-1086.

Portoghee, I., Galletta, M., Battistelli, A., Saiani, L., Penna, M.P. and Allegrini, E. (2012) Change-related expectations and commitment to change of nurses: the role of leadership and communication. *Journal of Nursing Management*, 20: 582-591.

Raelin, J. (1997) Individual and situational precursors of successful action learning. *Journal of Management Education,* 21(3), 368-394.

Revans, R. (1997) The enterprise as a learning system. In *Action Learning in Practice*, 3rd edition (Pedlar, M.editor), pp 41-47, Gower Aldershot.

Spooner-Lane, R. & Patton, W. (2007) Determinants of burnout among public hospital nurses. *Australian Journal of Advanced Nursing* 25 (1), 8-16.

Stevenson, K., Ryan, S. & Masterson, A. (2011) Nurse and allied health professional consultants: perceptions and experiences of the role. *Journal of Clinical Nursing*, 20, 537-544.

United Kingdom Nursing and Midwifery Council (2015) The Code: Professional Standards of Behaviour for Nurses and Midwives. Available from https://www.nmc.org.uk/standards/code/ Accessed 27.7.16

Wilkes, L., Luck, L. and O'Baugh, J. (2015) The role of a clinical nurse consultant in an Australian Health District: a quantitative survey. *BMC Nursing*, 14:25, DOI 10.1186/s12912-015-0075-9.

Woodward, V.A., Webb, C. & Prowse, M. (2005) Nurse consultants: their characteristics and achievements. *Journal of Clinical Nursing*, 14, 845-854.

Woodward, V.A., Webb, C. & Prowse, M. (2006) Nurse consultants: organizational influences on role achievement. *Journal of Clinical Nursing*, 15, 272-280.

Young, S., Nixon, E., Hinge, D., McFadyen, J., Wright, V., Lambert, P., Pilkington, C. and Newsome, C. (2010) Action Learning: a tool for the development of strategic skills for Nurse Consultants? *Journal of Nursing Management*, 18, 105-110.

Table 1: Process and timescale of co-operative inquiry

February 2015	1. Discussion: Key areas evaluating the process of the ALS for discussion were identified through email
March 2015:	Nature of co-operative inquiry presented, ground rules set and key areas for discussion agreed. Reflection: First audiotaped discussion
May-June 2015	Analysis: Transcription, independent analysis, individual reflection and exploration of relevant literature
June 2015:	Action:
	2. Meeting to share analyses and action of key themes and Discussion of further issues identify further areas for discussion. Reflection: Second cycle of audiotaped discussion
September 2015	Analysis: Transcription independent analyses
October 2015	Action: Meeting to share analyses and action of key themes and findings.
	3. Discussion of further issues: Identify further areas for discussion in the next cycle.
January 2016:	Reflection: Third audiotaped discussion (audiotape aborted after 12 mins of recording due to technical failure).
February 2016;	Analysis: Transcription independent analyses.
March 2016	Group agreed to a final discussion in three months time to discuss action.
May 2016	Action: Meeting to share analyses and action of key themes and findings.
	4. Discussion of further issues: Identify further areas for discussion in the next cycle.
July 2016	Reflection: Fourth cycle of audiotaped discussion
	Agreement to involve DN. Commitment to continue the ALS for a further 6 months
July 2016	Individual telephone interview with DN.
October 2016	Sharing of analyses and findings and action. Ongoing collaboration through writing papers and practice development