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REVIEW ARTICLE

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Impact of clinical leadership in advanced practice roles on outcomes in health care: A scoping review

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Abstract

Aim: To undertake a scoping review of the literature exploring the impact of clinical leadership in advanced practice roles in relation to patient, staff and organisational outcomes.

Background: An increasing number of publications as well as job specifications have identified clinical leadership as a cornerstone of advanced practice roles. However, it is unclear whether embedding clinical leadership in such roles has led to improvements in patient, staff or organisational outcomes. Therefore, identifying the extent to which clinical leadership in advanced practice roles relates to patient, staff and organisational outcomes is needed.

Method: A scoping review examining the relationship between clinical leadership in advanced practice roles and health care outcomes. Searching in SCOPUS, PubMed, Psychinfo and CINAHL Plus and Web of Science identified 765 potential articles. Independent selection, data extraction tabulation of findings and analysis were completed.

Results: Seven studies were identified that met the inclusion criteria. Only studies reporting on nurses in advanced practice roles were included; no studies were identified that reported on the advanced practice roles of allied health professionals. The results indicate that there is no objective evidence of the impact of advanced practitioners' clinical leadership on patient, staff or organisational outcomes.

Conclusion: There is a paucity of objective evidence to identify the extent to which clinical leadership is enacted in advanced practice roles. The review indicates a need for closer alignment of AP clinical leadership policy aspirations and formal operational leadership opportunities for APs.

Implications for Nursing Management: Nurse managers have a key role in supporting and equipping APs with leadership competencies and opportunities to enable both capability and capacity building of such roles. Nurse managers should involve APs in health care leadership at an organisational level to maximize their contribution to health, quality practice environments and health care reform. Additionally, a distinct involvement in staff development, change, operational strategic decisions and policy development should be part of the AP role, which is facilitated by management.

1 | INTRODUCTION

The impact of clinical leadership on health care outcomes has gained increasing interest in health systems worldwide (Mianda & Voce, 2018), not least in the area of advanced practice (Lamb et al., 2018). In nursing and in other health professions, advanced practitioners (APs) are increasingly identified as clinical leaders who have progressed into areas of higher level practice improving care quality and outcomes (Evans et al., 2020; Leggat et al., 2015; Milner & Snaith, 2017; Thompson et al., 2019). While there is an established association between leadership traits of managers and a range of patient, staff and organisational outcomes within health services in general (Cummings et al., 2018; West et al., 2015), demonstrating the impact of clinical leadership on outcomes remains challenging. Examples of objective patient-related outcomes associated with leadership are measures such as 30-day mortality, patient safety, hospital-acquired injuries, patient satisfaction, physical restraint use and pain management (Sfantou et al., 2017). It has been identified that there is a relationship between leadership and staff-related outcomes such as job satisfaction, organisational commitment and increased retention and between leadership and organisation-related outcomes such as organisational commitment, incidence of complaints, organisational readiness and performance measurement (Sfantou et al., 2017). However, there is a need to evaluate the extent to which this evidence is specific to the expression of clinical leadership by APs.

Clinical leadership contribution to the provision of safe and efficient care has been highlighted in governmental reports (Francis, 2013; Keogh, 2013; Kirkup, 2015) and in the academic literature (Jonas et al., 2011; Mianda & Voce, 2018). While there is consensus as to the importance of clinical leadership, there is less agreement on a clear definition of the concept. Nevertheless, common characteristics identified include the following: clinical embeddedness, expertise, visibility within care environments, role modelling, facilitation of care, working within and across professional boundaries and a concern with improving care quality (Elliott et al., 2013; Giles et al., 2018; Santiano et al., 2009; Walsh et al., 2015). In a report evaluating AP roles within nursing, the SCAPE report (NCNM, 2010) suggested a number of activities that give expression to clinical leadership (Table 1). A widely cited definition is that of Jonas et al. (2011:1) who define clinical leadership as:

> The concept of clinical healthcare staff undertaking the roles of leadership: setting, inspiring and promoting values and vision, and using their clinical experience and skills to ensure the needs of the patient are the central focus to the organisation's aims and delivery.

The need to foster clinical leadership development has been embedded into health policy in a number of jurisdictions including the United Kingdom (National Health Service, 2019), the Republic of Ireland (Fealy et al., 2015) and Australia (Pizzirani et al., 2019) where the need for training and development in clinical leadership for the health workforce has been emphasized to produce effective improvements in care quality and outcomes. Clinical leadership has also been promoted as a keystone component of advanced practice roles in health care, where it has been identified as a significant enabler of the role (Walsh et al., 2015); however, it remains unclear how clinical leadership is specifically measured in advanced practice roles.

TABLE 1 Activities which give expression to clinical leadership

Active membership of the multidisciplinary team
Active membership of committees with responsibility for policy, practice and guideline development
Initiating and improving patient/client care through service development
Influencing clinical practice through formal and informal education, mentoring and coaching the multidisciplinary team
Influencing clinical practice through positive role modelling of autonomous clinical decision-making and ongoing professional development for the multidisciplinary team.

Therefore, the authors conducted a scoping review to develop an understanding of the impact of clinical leadership in practice, as such reviews are exploratory and systematically sift through available literature on a particular subject (Anderson et al., 2008). This review will synthesize the available evidence on how clinical leadership is enacted by APs in relation to patient, staff and organisational outcomes.

2 | AIM

The aim of this scoping review was to examine the literature exploring the enactment of clinical leadership in advanced practice roles in relation to patient, staff and organisational outcomes. Enactment of clinical leadership in AP practice was defined as those activities which give expression to clinical leadership (Table 1) reported in the SCAPE report (NCNM, 2010).

3 | METHODS

To prevent redundancy and duplication of effort, a protocol search was performed using two registers of systematic reviews: the international prospective register of systematic reviews (PROSPERO) and the *Cochrane Database of Systematic Reviews* (CDSR). No reviews matched 'clinical leadership' in title or abstract. The guidelines from Arksey and O'Malley, (2005) for conducting scoping reviews were used. The search strategy for this literature review was guided by the protocol outlined by Aromataris and Riitano (2014), which provides stepwise guidance on developing a search strategy.

3.1 | Eligibility criteria

Inclusion criteria were as follows: primary studies; conducted in any of the 36 OECD member countries listed as of August 2019 (https://www.oecd.org/about/members-and-partners/); published between 2009 and 2019; and reporting on outcomes from clinical leadership among health care professionals working in advanced clinical practice roles. Only the 36 OECD countries were included as eligible study settings as clinical leadership development is not well established in lower income countries (Mianda & Voce, 2018). The date range was guided by the emergence of values based leadership styles such as clinical leadership in the literature, which has occurred over the past decade in response to moral and ethical deficiencies in organisational leadership (Copeland, 2014). Excluded were studies published in a language other than English, as well as editorials, notes, letters, unpublished theses, discussion papers, reviews and single case reports.

3.2 | Databases

The following databases were searched: SCOPUS, PubMed, Psychinfo and Cinahl plus (via EBSCO Databases) and Web of Science. A search strategy was developed which combined key terms using a series of free text terms and MeSH terms for Advanced Practice AND clinical leadership. Boolean operators and appropriate 'wild cards' were used to account for plurals, and variations in databases and spelling. The PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation guided the review (Appendix S1—PRISMA-ScR Checklist).

3.3 | Review process and extraction

An initial identification and screening of titles and abstracts was independently performed by two authors (MD and VMC) against predefined inclusion and exclusion criteria. These two authors subsequently reviewed the full texts against the same criteria. Conflicts between reviewers were resolved by consensus and the input of the third author (JD). No assessment of study quality as part of the review process was included consistent with the guidance from Peters et al., (2015). Data synthesis was undertaken in three stages: (a) evidence extraction and mapping, (b) identification of evidence gaps and (c) a narrative synthesis of selected research areas. A single author (MD) extracted and mapped the data from included studies according to a specifically designed data extraction table (Table 2—Data Extraction), while a second author (VMC) checked the extracted data. Double extraction is generally not required in scoping reviews (Powell et al., 2019).

The data extracted included: author, year, country, data collection methods, study population and relevance to the aim. Additionally, data were extracted on the following factors: study design, geographic region and setting. The identified papers were explored using tabulation of findings and narrative synthesis to identify the key concepts (Table 2—Data Extraction). The narrative descriptive synthesis was conducted for primary qualitative, quantitative and mixed-methods studies meeting the inclusion criteria.

4 | RESULTS

4.1 | Description of studies

A total of 765 articles were retrieved and initially screened, with an additional six articles retrieved from hand searching. After removing duplicates and studies judged to be non-relevant, 57 papers were identified for full-text review and seven met the review eligibility criteria. The primary reason articles were excluded was that they did not address the review question (Figure 1 PRISMA 2009 Flow Diagram for APs clinical leadership scoping review). The reviewed studies were conducted in three countries: Ireland (citations), Australia (citations) and Belgium (citation) (Table 3). No studies from the remaining 33 OECD countries were found in the defined time frame.

Included studies were conducted in both acute and community settings (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013; Giles et al., 2018) or involved both university and non-university hospitals (Van Hecke et al., 2019). Most studies were either qualitative (Coyne et al., 2016; Elliott et al., 2013; Santiano et al., 2009; Walsh et al., 2015) and/or of mixed-methods design (Begley et al., 2013; Giles et al., 2018) with one using a quantitative approach (Van Hecke et al., 2019). Studies' sample sizes ranged from two (Santiano et al., 2009) to 151 (Coyne et al., 2016).

4.2 | Advanced practitioners

Despite all advanced health care practitioners (nurses and allied health professions) being included in the search criteria, only studies involving the clinical leadership role of nurses working in advanced practice roles were identified. The majority of the studies sampled a range of other health professionals in addition to APs in identifying the clinical leadership role of APs (Begley et al., 2013; Coyne et al., 2016; Walsh et al., 2015). Several studies aimed to investigate and understand the various roles and clinical services provided by APs (Begley et al., 2013; Coyne et al., 2016; Giles et al., 2018; Santiano et al., 2009), with other studies specifically aiming to identify (Elliott et al., 2013), investigate (Van Hecke et al., 2019) and provide understanding (Giles et al., 2018) of the leadership capabilities of such roles.

It was evident from the included studies that a range of titles were used to describe nurses working in advanced practice roles. Clinical nurse consultant was the title used in Australian studies (Giles et al., 2018; Santiano et al., 2009; Walsh et al., 2015), while in the Belgian study the title advanced practice nurse was preferred (Van Hecke et al., 2019). Among papers published from the SCAPE

TABLE 2 Data extraction table APs clinical leadership scoping review

Author, year & Country of study	Research question or study aim	Research design	Data collection including research instruments	Study population	How Clinical Leadership was expressed	Comments
Begley et al. (2013) Ireland	'To compare the roles, responsibilities, and perceived outcomes of Clinical Nurse Specialists, Clinical Midwife Specialists, and Advanced Nurse Practitioners in Ireland' (pg 1,324)	Mixed-method case study	Non-participant observation (92 hr) of 23 Clinical Specialists and Advanced Practitioners, documentary evidence (audit, diaries, work programmes), interviews, questionnaire (developed for this study)	*N* = 21 clinicians *N* = 13 Directors of Nursing or Midwifery *N* = 154 service users Acute and Community	*Staff*: Acted as a resource within the MDT (Qual) *Organisation*: sat on committees, participant in policy development and took part in service planning (Qual)	
Coyne et al. (2016) Ireland	'1. To explore the provision of care received in sites with CS and AP and without from the perspective of service users, clinicians and decision-makers. 2. To explore clinicians' perceptions of care given to service users in sites with and without accredited clinical specialist and advanced practitioner postholders'. (pg 3)	Multiple case study	Interviews	*N* = 23 Directors of Nursing and Midwifery *N* = 41 health care professionals *N* = 41 service users/ family members/carers *N* = 23 Postholders (CNS/ANP) *N* = 23 Non = postholders (nurses, midwives or doctors) Acute, community and residential sites	*Patient*: Facilitates access to services *Staff*: Mentors and acts as a resource to other staff. Works across boundaries with MDT *Organisation*: Involvement in policy and guideline development. Provide leadership in clinical practice. Perceived to reduce readmission rates. Documentary evidence of a reduction in waiting times in ED and colposcopy	Participants promoted interprofessional team working and smoothed transition of patients/clients through the health care system
Elliott et al. (2013) Ireland	'To report a case study that identifies how leadership is enacted by advanced practitioners in nursing and midwifery and differentiates between clinical and professional leadership in advanced practice' (pg. 1,039)	Multiple case study methodology	Non-participant observation, interviews, and the collection of on-site written records	23 CS/APs across 28 health service provider sites	*Patient:* Introduces and develops patient/ client care services *Staff*: Mentors and educates the MDT ANPs guides and co-ordinates The MDT, Acts as a positive role model for autonomous clinical decision-making and ongoing professional development *Organisational*: initiates practice change, takes responsibility for policy and guideline development and implementation, involved in service planning, Changes clinical practice through formal education of MDT	Seven key activities that indicated clinical leadership were identified

(Continues)

TABLE 2 (Continued)

Author, year & Country of study	Research question or study aim	Research design	Data collection including research instruments	Study population	How Clinical Leadership was expressed	Comments
Giles et al. (2018) Australia	'To provide understanding of the nature of CL in the nurse consultant role by describing how it is enacted by NCs, how key stakeholders perceive its impact within the role and what elements influence NCs effectiveness as clinical leaders'. (pg. 1983)	Qualitative findings from a larger sequential mixed-method study	Sequential mixed-method design. Used online survey, online discussion forum and stakeholder focus groups	2 nurse consultants ($n = 26$), managers (n–20), other stakeholders ($n = 16$) Acute, primary and community care settings	*Patient*: Care coordination *Staff*: Act as a resource. CNCs are the 'go to person' *Organisational*: Trans-boundary working. Enhance service quality, act as change agents	As clinical leaders, nurse consultants were found to facilitate care, work across boundaries, provide education, mentor colleagues, coordinate care and change practice
Santiano et al. (2009) Australia	'To explore how CNCs who provide hospital wide support after hours (AHCSs) construct their role'. (pg. 87)	Ethnographic study	Videoing of CNC work and Semi-structured interviews	Two clinical nurse consultant providing after hours clinical support	Patient: moderates the influence of the social determinants of health on patients and populations Staff: promote MDT clinical partnerships Organisation: Influences health care policy and practice	Found that CNC acted as clinical leaders by influencing and progressing clinical care, policy and collaboration through all levels of the health service
Van Hecke et al. (2019) Belgium	'To explore the practice profile and competencies of advanced practice nurses (APNs) and midwives (AMPs), and factors associated with task non-execution' (pg. 1,261)	Quantitative cross-sectional study	Questionnaire	63 questionnaires met the data analysis criteria All APN and AMPs working in a region of Belgium were sampled	*Patient* Initiate, implement and evaluate QI initiatives *Staff* Mentor students. Translate theory into clinical practice *Organisation* Guideline and care protocol development Policy development. Involved in change management and innovation	
Walsh et al. (2015) Australia	'The aim of this research project was to investigate the role of the Clinical nurse consultant (CNC) from the multiple perspectives of CNCs and other stakeholders who work with CNC' (pg. 172)	Inductive, participatory, and qualitatively descriptive	Cooperative research, situational analysis, one-to-one interviews, focus groups, reflective techniques	103 stakeholders Describes the CNCs as being from one clinical stream in a local health district	*Patient*: Stakeholders opined that specialist knowledge allowed CNC to advocate for patients thereby improving outcomes *Staff*: CNCs mentor and educate staff *Organisation*: CNC viewed as spinners, interweaving services and connecting parts of care and care delivery	Found that clinical leadership was core to the CNC role. Manifested as CNCs' way of working with health professionals, managing professional agency, and weaving a dance between providing support and enabling others

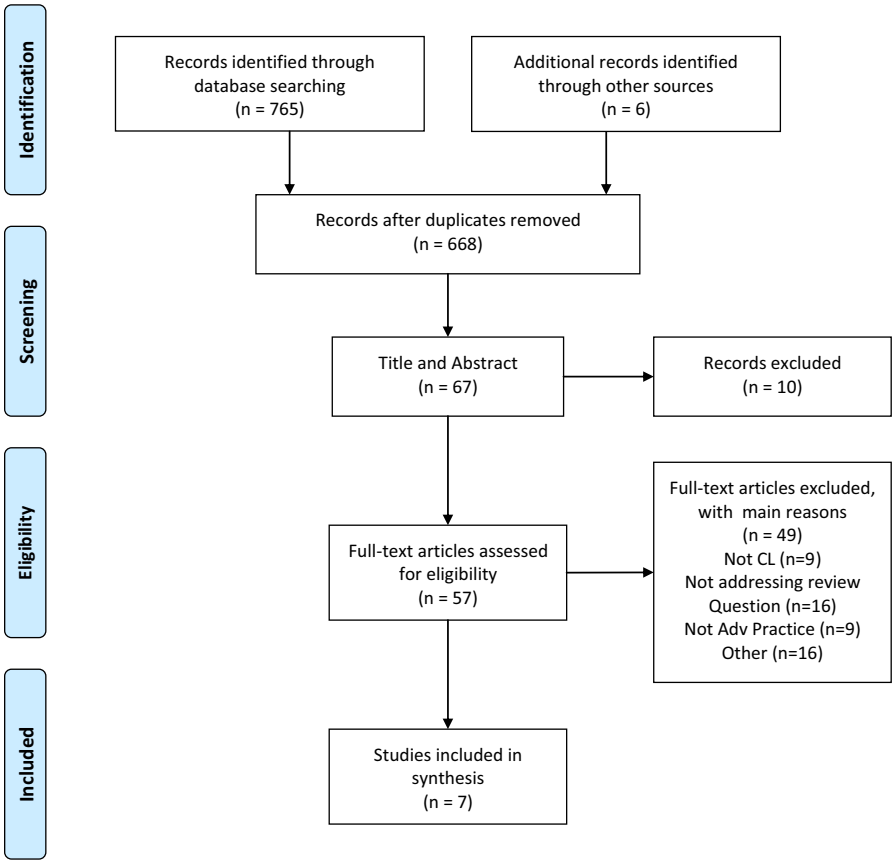

FIGURE 1 PRISMA 2009 flow diagram for APs clinical leadership scoping review. Adapted from Moher et al. (2009)

report in Ireland, the titles clinical nurse specialist, clinical midwife specialist and advanced nurse practitioner were used (Begley et al., 2013; Elliott et al., 2013). It has been acknowledged that the confusion created by such variation in titles and lack of role clarity has exacerbated the difficulty in measuring the impact of clinical leadership and its contribution to patient, staff and organisational outcomes (Giles et al., 2018).

4.3 | Measurement of clinical leadership

Two studies used quantitative instruments as part of their research measuring role integration, the potential impact of the AP role in health services and selected outcomes. As part of Begley et al. (2013) study, a questionnaire was used to measure service users' experiences of various aspects of their care. Van Hecke et al. (2019) explored clinical/professional leadership as one aspect of a wider suite of advanced practitioner tasks and competencies. However, none of the instruments in the papers reviewed solely measured clinical leadership from the perspective of the APs or other key stakeholders.

A number of studies (both qualitative and quantitative) reported on the opinions and/or perceptions of research participants (these included APs and other health care professionals) (Giles et al., 2018; Van Hecke et al., 2019; Walsh et al., 2015), rather than measuring the impact of clinical leadership on outcomes. Two studies reviewed highlighted the importance of clinical leadership to advanced practice roles and the positive influence of clinical leadership on patient, staff and organisational outcomes (Giles et al., 2018; Walsh et al., 2015). However, despite studies highlighting clinical leadership as a central tenet of the role, no objective evidence was presented to identify the extent to which this occurred in practice (Begley et al., 2013; Elliott et al., 2013; Santiano et al., 2009) with it being suggested that a lag in service and organisational responsiveness inhibited APs' ability to enact their clinical leadership role (Giles et al., 2018).

4.4 | Patient-related outcomes

A number of studies highlighted that APs improved outcomes for patients by collaborating with and co-ordinating the multidisciplinary team and facilitating continuity of care (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013; Higgins et al., 2014; Santiano et al., 2009; Walsh et al., 2015). Some studies showed evidence that APs' clinical leadership role improved access to care for patients, patient satisfaction and waiting times, and developed services in response to patient need (Coyne et al., 2016; Elliott et al., 2013; Walsh et al., 2015) with stakeholders reporting that APs' clinical leadership resulted in quality clinical care (Giles et al., 2018). It was also found that APs in their clinical leadership role influenced clinical practice, but this was primarily by mentoring and educating other colleagues rather than exerting a direct impact on patient outcomes. Both Begley et al. (2013) and Santiano et al. (2009) found that APs contributed to optimized patient outcomes by establishing, educating,

TABLE 3 Characteristics of selected studies included in the Scoping Review

Category	Details	Total
Design of studies	Qualitative (Coyne et al., 2016; Elliott et al., 2013; Santiano et al., 2009; Walsh et al., 2015)	4
	Quantitative (Van Hecke et al., 2019)	1
	Mixed Methods (Begley et al., 2013; Giles et al., 2018)	2
Geographic Location OCED	Australia (Giles et al., 2018; Santiano et al., 2009; Walsh et al., 2015)	3
	Ireland (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013)	3
	Belgium (Van Hecke et al., 2019)	1
Settings	Acute & Community (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013; Giles et al., 2018)	4
	Acute Only (Santiano et al., 2009; Walsh et al., 2015)	2
	University *and non-university hospitals* (Van Hecke et al., 2019)	1
Study Participants	Multiple stakeholders (excluding Service Users) (Elliott et al., 2013; Giles et al., 2018; Walsh et al., 2015)	3
	Multiple stakeholders (including Service Users) (Begley et al., 2013; Coyne et al., 2016)	2
	Advanced Practitioners Only (Santiano et al., 2009; Van Hecke et al., 2019)	2
Nomenclature Used	Clinical specialist/advanced practitioners (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013)	3
	Nurse Consultants (Giles et al., 2018)	1
	Clinical Nurse Consultants (Santiano et al., 2009; Walsh et al., 2015)	2
	Advanced practice nurses and midwives (Van Hecke et al., 2019)	1

mentoring and leading in effective relationships within the interdisciplinary team.

4.5 | Staff-related outcomes

A number of studies highlighted that APs as clinical leaders acted as a resource for staff providing clinical expertise offering education, mentoring and coaching within interdisciplinary teams (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013; Giles et al., 2018; Van Hecke et al., 2019; Walsh et al., 2015). This included APs acting as a mentor for disciplines outside of their own professional group (Begley et al., 2013; Elliott et al., 2013; Giles et al., 2018; Higgins et al., 2014; Santiano et al., 2009). In addition, Giles et al. (2018) highlighted that APs enacted clinical leadership through their role as a collaborator across professional boundaries (clinicians, managers and senior medical colleagues) through the coordination and management of complex patient cases.

Despite this, none of the studies established a relationship between AP clinical leadership enactment and commonly measured staff outcomes such as job satisfaction, organisational commitment or increased retention. Moreover, the studies reviewed reported outcomes for members of the interdisciplinary team who were within the APs' sphere of influence rather than outcomes for the AP themselves.

4.6 | Organisational-related outcomes

Contributing to organisational outcomes through service planning as well as updating organisational guidelines and protocols by APs were reported by Elliott et al. (2013). Giles et al. (2018) also found that the APs provided a link between managerial decision-making and the clinical-level enactment of strategic initiatives. Furthermore, the positioning of APs providing clinical leadership to influence organisational outcomes was highlighted in a number of studies (Elliott et al., 2013; Giles et al., 2018; Walsh et al., 2015). Nevertheless, it was identified that APs required role flexibility to respond and optimize their clinical leadership capacity to influence strategic organisational goals (Giles et al., 2018; Santiano et al., 2009).

5 | DISCUSSION

As far as the authors are aware, this is the first scoping review conducted on outcomes associated with clinical leadership in advanced practice roles. Literature was identified that focused on clinical leadership in AP roles; however, no objective evidence of the impact of this aspect of APs' role on patient, staff or organisational outcomes was identified.

A number of studies highlighted that clinical leadership was important to a range of outcomes, in particular in achieving optimal health outcomes for patients. A number of studies reviewed reported that the clinical leadership role of APs positively impacted on patient, staff and organisational outcomes by reducing care fragmentation and spanning professional boundaries to achieve increased integration of care (Coyne et al., 2016; Elliott et al., 2013; Giles et al., 2018; Santiano et al., 2009; Walsh et al., 2015). Elsewhere, participants in Hecke et al. (2019) expressed clinical leadership predominantly through care guideline and policy development as well as networking with other APs. However, the evidence presented relating to an association between these activities and outcomes was weak. The majority of studies had relatively small sample sizes and based this conclusion primarily on data, which was not amenable to measurement. For example, both Coyne et al. (2016) and Santiano et al. (2009) used a structured observation schedule to determine outcomes, which may raise questions regarding the validly of findings especially when participants know that they are being observed (Hackshaw, 2015). Elsewhere the perspectives of key stakeholders in addition to APs (Elliott et al., 2013; Giles et al., 2018; Walsh et al., 2015) or APs alone (Van Hecke et al., 2019) were used to establish a relationship between AP clinical leadership activities and outcomes. The perspectives of stakeholders may be problematic as research has found that stakeholders, such as those sampled in the reviewed papers, often lack understanding regarding advanced practice roles (Giles et al., 2018; Steinke et al., 2018). Moreover, while the perspectives of stakeholders and APs contribute to an understanding of the leadership role of APs, they lack tangibility and are not amenable to measurement. With respect to staff outcomes, a prominent finding from this review is that the majority of studies reviewed reported on the impact of APs' clinical leadership with respect to their clinical colleagues who benefited from mentoring and education by the APs. This contribution to the learning and development of the MDT often occurred on an informal basis (Begley et al., 2013; Elliott et al., 2013) adding to the challenge of establishing a link between this clinical leadership activity and staff outcomes. Staff outcomes for APs were not addressed so it is unknown if there is an association between clinical leadership and APs' job satisfaction, organisational commitment or intention to leave for example.

Clinical leadership has been identified as a key element in the role of APs; however, the extent to which this is operationalized is debateable (Lamb et al., 2018). Moreover, the informal nature of this leadership role may be contributing to a situation where APs are absent from involvement in health policymaking (Denker et al., 2015) and where there is an absence of interventions to sustain leadership among APs (Bressan et al., 2016). The absence of enabling structures and processes which prioritize clinical care delivery over other AP subroles (Higgins et al., 2014; Walsh et al., 2015) decreases the visibility of AP led care and leads to challenges in measuring their unique contribution.

In this review, six of the seven studies originated from Ireland or Australia where there are consistencies in the advanced practice models insofar as APs in both jurisdictions practice autonomously, are educated to master's level and have highly developed knowledge, attitudes and advanced skills which they apply in a specific area of practice (Begley et al., 2013; Lowe et al., 2013). The lack of consensus of titles related to the role may confuse and undermine confidence in advanced practice roles, act as an obstacle to role progression and may undermine an attempt to measure the impact of clinical leadership among APs (Thompson & Astin, 2019). The variety of titles used thus complicates the interpretation and synthesis of the study findings.

Many studies in this review reported different conceptualizations of clinical leadership. The studies which conceptualized clinical leadership as occurring at the clinical interface (Begley et al., 2013; Coyne et al., 2016; Elliott et al., 2013) may reasonably be expected to find different outcomes to clinical leadership enactment by APs functioning at a more strategic level where their role involves critical appraisal of service delivery, informing policy and education (Giles et al., 2018; Santiano et al., 2009).

Despite all advanced health care practitioners being included in the search criteria, only studies involving nurses working in advanced practice roles were identified. This may be reflective of the nursing focus on advanced practice (Thoun, 2011) but may also reflect a difficulty in broadening the scope of practice of other health care roles to advanced practice level (Snaith et al., 2019), which has resulted in a lack of clinical leadership research among non-nursing disciplines.

6 | STRENGTHS AND METHODOLOGICAL LIMITATIONS

Among the main strengths of this review were the systematic approach and the adoption of a reproducible method. Unambiguous search terms were used and were adapted to meet the specific requirements of the five databases searched.

Only studies published in the English language from the 36 OECD member countries were included. This risked excluding studies from middle and low income countries. The geographical concentration of studies may limit the transferability of study findings to other health care systems as leadership tends to be context specific.

To minimize the possibility of selection bias, the procedures for selecting studies detailed in the methods were rigorously adhered to. Limiting the review to papers published in the English language may have caused an incomplete overview of the relevant studies.

7 | CONCLUSION

The association between clinical leadership in advanced practice and patient, staff or organisational outcomes has not, to date, been

substantiated with robust evidence. This review illustrated that APs are valued in the clinical environment as a source of expertise and as clinicians concerned with improving care quality. However, leadership at the clinical interface is insufficient in facilitating APs to practice to capability. Efforts to encourage APs to be more closely involved in health care leadership at an organisational level should be encouraged. The benefits of this involvement should be clearly presented in an objective manner allowing clear demonstration of APs conducting clinical leadership activities for the enhancement of patient, staff and organisational outcomes.

8 | IMPLICATIONS FOR NURSING MANAGEMENT

Arising from this review, nurse managers need to maximize the leadership contribution of APs by involving them in strategic leadership teams to ensure that their expertise effectively impacts on longer-term patterns of service delivery and ultimately on patient, staff and organisational outcomes. The importance of clinical leadership in health care has been well described, and a positive association between effective clinical leadership and improved care has been identified (Giles et al., 2018; Swanwick & McKimm, 2012). While advocated at a policy level, clinical leadership may not be positioned as an important part of the role at an operational level, and consequently, an important finding from this review is that APs require support from nurse managers to formalize involvement in activities that give expression to clinical leadership.

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CONFLICT OF INTEREST

The authors have no affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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