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Developing Nursing Leadership in Europe -

A Study of Nursing Leaderships Needs

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HOHATd (Mal)

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Contents

Summary

1. Introduction

1.1 This study involved a literature review and workshops for health care leaders from fifteen countries in Europe (to varying degrees). The most represented were Poland, Hungary, Czech Republic, Netherlands, and the UK. The majority of the participants in the workshops had a background in nursing, but there were some doctors and managers. The workshop drew academics, practitioners, policy makers, strategists and managers.

2. Needs for Development - similarities and differences

2.1 The study has revealed the need for nursing leadership development and that this should be part of a wider approach to leadership development for the clinical professionals[1]. Leadership development across Europe is needed because of the similar health agenda's within countries:

- The shift across Europe to providing care in community settings (primary / home care) rather than hospitals
- The cross Europe drive to decentralisation (particularly in west, north and south Europe)
- The similar health reform agenda's of mixed economy of health care.
- The need to develop new ways of leading complex services
- The need for new partnerships between professionals and across the system within countries and across countries
- The desire to develop better collaboration between users and professionals in health service delivery and design

And also because of the opportunities offered by learning together across countries.

2.2 The workshops confirmed a desire for leadership development across Europe to develop leaders who can operate within a European and Global context; to enable lessons to be learnt across Europe; to build on each others experiences; to learn together where there are common agendas / issues.

2.3 Whilst the initial focus for development was nursing, the workshops in particular highlighted the need for multidisciplinary development as well (not instead of) uni-disciplinary development. In all the countries involved, there were less leadership development opportunities specifically for nurses than there were for doctors of managers[2]. There is a need for nursing development particularly to enable nurses to work in partnership with other disciplines who have had the opportunity for more development. However the major issues facing nurse leaders also face the other clinical professions (particularly health reform, working in teams, issues of health gain, working in a politically

[1] By clinical professionals we mean nurses, doctors, therapists (professions allied to medicine).
[2] There were more opportunities for nurses in the UK, Nordic countries, Netherlands and Denmark than in other countries.

dominated system). There are also particular nursing development needs in relation to influencing the broader European agendas.

2.4 As a result of the study we now believe that there are common needs across countries in Europe in terms of content and process, but these needs are on different levels. All countries involved in the study identified the need for development for leaders from clinical backgrounds (particularly nurses) in the following areas:

- **Health Reform** - with all the countries moving towards a mixed economy of health care, utilising to various degrees both public and private sector funding and provision. The increase in specialisation in acute care, and the increase in generalisation in continuing / primary / non-acute care, the move towards primary health care provision; influencing and shaping health services within a political environment; recognising the political systems in which health care is designed and delivered; working with politicians; influencing health policy; finding a voice. Health Gain - looking at population needs for health care, public health issues, ways of improving clinical effectiveness; and recognising the impact of collaboration between disciplines in improving patient outcomes.

- **Involvement of users** - consumerism; finding ways of involving the user positively and actively in service design and delivery, not passively as a commentator on their own personal experiences.

- **Partnership Working** - with other agencies in the system; with other health care providers within the system; with industry; cross boundaries between professionals; within teams, across hierarchies. A range level of need was identified, from strategic level in order to maximise the potential and possibilities within the system, to clinical teams wanting to improve their impact as a team with patients and within the wider system.

- **Being European** - what does it mean to be European? Sharing and exploring similarities and differences; working through the potential of Europe; developing new possibilities between countries; developing insights into your own country and health service.

and specific to nurses:

- The need to develop nurses understanding of the value they add to organisations and their confidence in working on corporate issues.

2.5 Underpinning these threads was a cross Europe interest in:

- **Change** - how to improve change management; how to use change as a continuous process; how to influence change process'; how to develop long standing approaches to change rather than short term 'fixes'.
- **Power** - how to influence and shape policy and service delivery; issues of gender, race; the imbalance between the clinical professionals; different approaches to diversity and power in countries.

2.5 The main difference in terms of development needs is the current style of leadership within countries - some dependent on a very autocratic style of management and leadership, other looking at developing leaders across the system. Designing a leadership programme which address' this diversity across Europe is key.

2.6 Other issues of difference are more related to context, and we believe that exploring these differences will be a critical part to learning within any programme. Differences include:

- economic status
- source of funding for health care
- population profiles
- approach to ethical issues
- service profiles
- user power varies
- health reforms at different stages
- use of technology
- current investment in leadership development
- relationships between the clinical professions vary

3. The Profile of the Strategic Level Leader in Europe

The profile of the strategic leader in Europe which emerged from the study is:

- **Strategist** - Sees possibilities, has clear ideas, creative, works within the 'big' picture, shapes and influences, opportunistic, able to develop and implement strategy to achieve health gain. Understands the use of power and politics, able to work with national and local priorities, politically aware

- **Systems Leader** - Develops generative relationships, works where there is energy in the system, sees connections and networks, works across boundaries, develops groups, creates meaning and identity, understands knock on effects of short term decisions, widely networked, develops information process'. Works with users, sensitive to local community needs.

- **Courageous** - Develops choices, takes risks, entrepreneurial but with feet on the ground, committed, positive, ethical.

- **Confident and credible** - Achiever, works hard and uses time well, knows the business, can work with the media, clear presenter of ideas, and able to manage the business. Able to lead beyond hierarchy in complex organisations.

- **Learner and developer** - Reflective, learns from work and personal situations as well as from reading and formal learning experiences (programmes), seeks supervision. Develops others, coaches, mentors others, recognises own role as a role model, sees potential in others. Able to act as process consultant. Self aware and able to recognise and maximise personal impact, comfortable with self and able to express themselves through their work

4. Leadership Development

3.1 As a result of these initial ideas the workshops lead to three main ideas for leadership development across Europe. These ideas were refined and tested at the second workshop and endorsed by the participants, with a number of outstanding questions about the detail of delivery, and the nature of the partnerships and commitment within countries.

3.2 The purpose of leadership development across Europe would be to bring depth to countries strategic leaders perspective and strategic approach; to develop leadership across Europe; to forge new relationships between the clinical professionals in Europe in order to maximise the potential of the clinical voice; to develop capacity to work across boundaries.

3.3 In terms of process' of leadership development participants personally valued the following:

(a) Formal Programmes
(b) Self development - including reading, research, self reflection, modeling others, trial and error, pre-meeting briefing and debriefing
(c) Supervision
(d) Confidence in being able to do your own job - including using information well, being able to contribute to the social side of work,
(e) Some skills development - presentation, media
(f) Networking - formally and informally
(g) Mentorship
(h) Shadowing - for example to develop political skills
(I) Internet

3.2 The initial ideas[3], which, if of interest to the Philanthropy committee, need further development into full proposals are:

1. **European Summer School for Strategic Leaders with Clinical Backgrounds.**
2. **Learning Network for current strategic level nurse leaders who have been involved in the needs assessment study**
3. **Internet Web Site and Distance Learning**

[3] For more details see the proposal paper

3.3 These ideas together form an initial contained set of process' for making a wide impact across Europe. We expect that together they will enhance in-country development of leadership as well as maximising the potential for cross country learning and development.

Introduction

1. Issues Arising from our UK Needs Assessment

1.1 During the needs assessment study for the UK programme[4] we were asked to include a European component to the UK programme, and to consider developing a European programme. We begun with informal discussions with Mrs Moores the Chief Nurse at the Department of Health, the current and previous nurse leaders at WHO Europe (Ainnia Fawcett-Hennessy and Jane Salvage), and the Royal College of Nursing International Adviser (Sheila Murphy). All of these described the real need for a Europe wide programme for nurse leaders, and talked about the frequency with which issues of leadership are raised in European and International meetings.

1.2 At present there is no-one providing a leadership programme for nurses across Europe, and there is very little happening within countries to specifically develop nurses leadership skills at strategic level.

1.3 At a recent meeting of programme directors who are members of EHMA[5] the following themes for development within countries in Europe were identified:

- Managing uncertainty, understanding and thriving in complex organisations.
- Managing professionals.
- How to move from concept to strategy implementation.
- Policy is driving management activity.
- Health care management ethics.
- Working in mixed teams across boundaries.
- Need for longer term view of health gain.
- The general trend towards personal development and theories of cognitive learning and reflection in action.

This mirrors many of this study's findings.

2. The European Workshop

2.1 In order to further gauge the need for such a programme, and to explore how we should assess that need, and to begin to develop ownership across countries for this initiative, we held a 24 hour workshop in Prague in July 1996. We invited named individuals considered to be influencers within their country, some of whom also have a Europe wide perspective (from working with the chief nurses through WHO, or from working within the International Council of Nurses).

2.2 Individuals were invited on the understanding that there was no commitment as yet from Johnson & Johnson to a European programme, and that their contribution was both personal and confidential. The workshop was undertaken

[4] For more details about this study please see UK Needs Assessment Study, available from the King's Fund.

[5] EHMA - European Health Management Association

in the spirit of collaboration and mutual learning. We had participants from seven countries. A summary of the workshop follows in the next chapter. The workshop confirmed the view that there is the need for a European Nursing Leadership programme, particularly because of:

- the transition in nursing leadership at this time;
- the need for new approaches to health service leadership to take a customer and community focused approach to service development and delivery;
- the drive towards to Primary Care across Europe and its impact on nursing;
- the patchy development of nursing leadership within countries;
- the need to work across the traditional professional and service boundaries in health and social services.

3. Undertaking a Needs Assessment

3.1 In essence this workshop and our discussions give us grounds undertake a more comprehensive Needs Assessment study within countries and across countries in Europe to:

- determine more exactly the need for a European nursing leadership programme;
- develop local country ownership and commitment to a programme;
- determine the design and mode of delivery of a programme.

3.2 *Determining the Need, Developing Ownership, Initial Design*

3.2.1 The purpose of this Needs Assessment study was to determine the need within separate countries and across countries looking for differences and similarities. In order to generate the necessary relationships to ensure delivery of a high quality programme the study also set out to develop local commitment to the programme at the highest level within each country, amongst the countries locally respected current leaders. The programme (if a need is identified) is more likely to be successful if these 'stakeholders' are involved in determining the features and shape of any programme. This is backed up by experience in the UK with the Johnson & Johnson / King's Fund UK Nursing Leadership Programme.

3.2.2 The approach taken included:

- a literature review of nursing leadership development within countries;
- two workshops for leaders from each country in Europe over 24 hours, mirroring some of the initial workshop.

These are to be followed by a top level stakeholder 2 day Leadership Seminar where we offer seminars on leadership in Europe, as well as elicit countries views about leadership development within nursing and other professions. The emphasis would be on getting their support as well as offering opportunities for sharing and networking across countries.

3.2.3 We looked for cross discipline contributions to the workshops, and found our leaders through networks including the Departments of Health in countries, the National Nurses Associations, the European Nurse Directors Association, the European Health Managers Association, European Nurse Journal, WHO Europe. We asked for nurses (practitioners, educators, academics, strategists, policy makers), doctors, health managers, civil servants. ***In total over 50 leaders from across Europe have been involved.***

Initial Workshop - European Nursing Leadership, 10th & 11th July 1996

Summary of Proceedings

1. Introduction

1.1 This workshop was held in Prague and was aimed at a few enthusiastic 'influencers' from countries in Europe. They were invited in a personal capacity, not as representatives from their countries.

1.2

> *The purpose of this workshop was to*:
> - determine this group's perceptions of the need for nursing leadership development within countries and across Europe;
> - explore and share initiatives in nursing leadership development in countries;
> - discuss a framework for undertaking a study to fully assess need;
> - discuss potential design and delivery partners within countries.

1.3 For the workshop programme please see Appendix 1. For a list of attendees please see Appendix 2.

2. Leadership in Countries

2.1 This exercise explored where leadership is coming from within countries and why that situation exists.
Themes that emerged:

- Fragementation - leading to new opportunities for nursing; there is no one system organiser any more.
- Traditional Models of professional leadership are weak (these are often demonstrated in our nursing associations)
- Leadership in the system is effective where it gives meaning to change
- There are opportunities for nursing around the Primary Care policy agenda
- Leaders who can work with consumers will become more influential
- There is an ambivalence about the consumer role
- The politics in the system which tend to be risk adverse are a barrier to change and to leadership
- What is the way forward for nursing roles? There needs to be more flexibility and leadership that can embrace that flexibility.
- Power lies in the hands of those that lead the health gain / outcomes agenda. This tends to discriminate against nursing.
- Those who understand and know how to influence the whole system can lead effectively
- Legislation can influence e.g. the impact of deregulation

- The 'More Skills & Knowledge' approach to improving leadership hasn't worked.

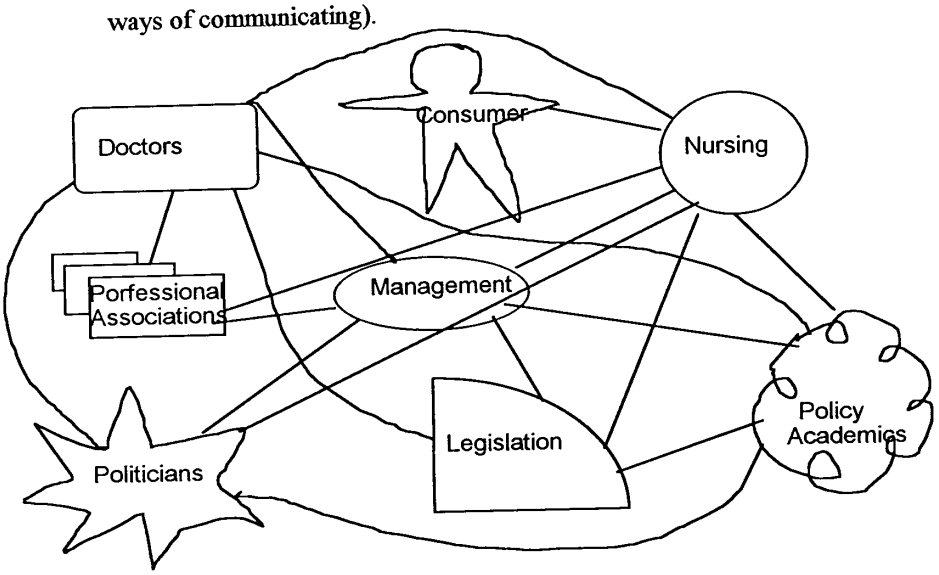
3. What do we think should be different?

1. What one change would you like to see in nursing leadership in your country?

2. What one change would you like to see in the health service in your country?

3.1 The theme that came out of our discussions were:

- The need to develop relationships between all parts of the system (including ways of communicating).



- The tensions between different models of leadership development within countries
- The absence of strategy
- The need to work with stakeholders when working on change.
- The need to develop nurses understanding of the value they add to organisations and their confidence in working on corporate issues.
- Better ways of working across the primary / secondary care boundary.
- Decentralisation will mean that we need to develop different approaches to leadership at a more local level.

4. What conditions are necessary for that to happen?

4.1 The group came up with the following conditions that are necessary across all these changes.

- Esteem / confidence in nursing
- Relationships across professional boundaries
- Systems perspective
- Connectedness with others pushing the nursing agenda (coming out of the organisation that you work in to look for wider support).
- Model of strategy

5. Conclusions from the workshop

5.1 This workshop identified a number of issues that we should consider in relation to a further study and design of a programme. Firstly, this groups believed that there is a need for nursing leadership development, but were unsure about how uni-disciplinary a programme should be. This should be a major focus for the needs assessment study, alongside views within countries about future health trends and requirements for nursing leaders.

5.2 There does appear to be a transition going on in nursing leadership across countries. Traditional, centralised forms of leadership, where leadership comes from nursing associations, government and policy institutions, are weakening. New models for leadership have not yet emerged across Europe. In addition there is fragmentation within the system and no one natural organiser of the system is emerging.

5.3 The customer is still a weak partner in health, and new forms of leadership must address the central role of customers.

5.4 The health gain agenda is dominating service delivery, and power is invested in those that lead this agenda.

5.5 Better relationships between all the people in the system is essential.

5.6 There are opportunities for new approaches to leadership coming out of the drive towards primary care.

5.7 Nurses need to develop political awareness and ability to influence as politics, policy and legislation are still powerful drivers in the system.

5.8 In all countries leadership development is patchy, with no overall strategic approach to developing the future nurse leaders.

5.9 There is a need for new partnerships between organisations and professionals, and for new networks to transcend organisational and country boundaries.

A Review of the Nursing Leadership Literature in Europe

Keith Hurst, Senior Lecturer, Nuffield Institute, University of Leeds

Main Summary[6]

1. The Process

1.1 Periodical, deep and broad reviews of the literature on nursing leadership are important for stocktaking and generating new insights.

1.2. Although not exhaustive, around 170 books and articles on leadership were reviewed. Seven hundred leadership issues were extracted and placed into 15 themes. Disappointingly, only a small minority of publications were empirically based. Nevertheless, the 15 themes form an excellent framework for the literature review, and their subthemes include a rich database of information.

2. Themes from the Review : Nurse leaders and nursing leadership

2.1 *The Nature and Purpose of Nursing Leadership*

2.1.1 Writers spent time and effort distinguishing nursing managers from nursing leaders. Managerial skills were reported more negatively than leadership skills. Second, writers categorise leaders' attributes as (a) intellectual (such as ingenuity); (b) affective (such as empathy); and (c) psychomotor (such as clinical skills). Leaders are able to select one or more of their cognitive, affective, and psychomotor abilities according to the situation in which they find themselves, and to use them effectively. Third, although nurse leaders are loyal to their organisations, their main aim is to maintain and improve patient care via a cohesive workforce. Fourth, leaders occasionally take risks, but remain accountable for their actions. Fifth, the more cynical writers point out in their definitions the problems and pitfalls faced by nurse leaders and nursing leadership.

2.2.2 Writers are fearful that the effect of healthcare changes in the last decade, such as the introduction of general management, may have done nursing irreversible harm. There is hope however, that after a period of neglect, local, national and international awareness of nursing leadership's perilous state has never been stronger; the so-called nursing leadership barometer. Owing to developments in treatment and care, the need for nurse leaders has never been greater.

2.2.3 The debate about nursing leadership in the literature is wide rangeing, including in it nursing's leadership crisis; and a rising awareness of nursing leadership's unsatisfactory state.

[6] For the full review please see Appendix Three

2.3 *Change and Change Management*

2.3.1 This themeexplores: (a) healthcare change; and (b) nursing leaders as change agents. More attention is paid to healthcare changes since the 1980s and especially their effects upon nursing leadership. One certain outcome of healthcare change however was that nurses would get accustomed to a culture of change and to shifting boundaries.

2.3.2 Writers believed that one role of nursing leaders was to implement change, especially to improve nursing's effectiveness The part nurse leaders play as change agents, and how their roles can be enhanced are well argued in the literature.

2.4 *Nursing Leadership and Organisations*

2.4.1 The shift from traditional, hierarchical organisations to flatter, leaner healthcare organisations, and especially the shift's effect upon nurse leaders occupies many writers. Nurse leaders it seems have a difficult task. Not only are they expected to contribute to and support their employing organisations, but also create an atmosphere that promotes job satisfaction, thereby enhancing performance. Moreover, if leadership does not evolve with the organisation then both the leader and led are at risk. Developments that were classed as evolving were: (a) clinical specialist nurses; (b) multidisciplinary teams; (d) nursing development units; (e) primary care led health services; and (f) shared governance.

2.5 *Nursing Leadership and Conflict*

2.5.1 Writers pointed out that an important nursing leadership function was to handle intrinsic and extrinsic conflict. These conflicts consume much energy and demand great skill to resolve them.

2.6 *Leadership Styles*

2.6.1 This was the most discussed theme. More than 40 styles are listed; their overlaps, strengths and weaknesses pointed out. No leadership style was judged universally suitable for nursing. Transformational leadership, as a nursing front runner, is explained.

2.7 *Characteristics of Nursing Leaders*

2.7.1 This theme logically extracts 86 desirable and 12 undesirable nursing leadership characteristics. How these characteristics might be used for selecting and developing nursing leaders is well explained in the literature.

2.8 *Functions of Nursing Leaders*

2.8.1 This theme synthesises some the 86 desirable characteristics into nursing leadership functions. These five subthemes combine to explain three main

leadership functions: (a) achieve tasks; (b) build and maintain teams; and (c) develop individuals.This section draws heavily on the persuasion and influence literature.

2.9 *Leaders, Followers and Groups*

2.9.1 This theme turns to followers, how they operate individually and in groups, and how followers might be influenced by nursing leaders. The importance of leaders' understanding of group processes is emphasised.

2.10 *Communication*

2.10.1 This theme concentrates on two important leadership skills - talking and listening.

3. Themes from the Review : Nurse leader selection, their education, and how leaders can survive

3.1 *Surviving as a Nurse Leaders*

3.1.1 This section, although small, was empirically strong. Reported data indicated the high turnover of senior nurses. Other sections explored the dangers and barriers for nurse leaders and what must be done to overcome problems and pitfalls. Discussions about survival in the literature, while depressing for nurses, were sobering.

3.2 *Succession Planning*

3.2 Actions that can be taken within the profession and actions that are happening outside and sometimes beyond nursing control are discussed in a succession planning context. One emerging, important argument, that is likely to gain momentum, is the shift from developing nurse leaders from management ranks to selecting and developing leaders from clinicians.

3.3 *Appraising Nursing Leaders*

3.3.1 The nature, purpose and problems of nursing leader appraisal are explained. Views about the nature and value of appraisal in a leadership context were mixed.

3.4 *Developing Nurse Leaders.*

3.4.1 This, the second largest discussion topic in the literature, lists many of the existing and planned nursing leadership development programmes. Writers spend considerable effort, including robust empirical work, explaining the leadership curriculum. There was a hint in the literature that multidisciplinary education may improve nursing leadership.

3.5 ***Challenges Facing Nurse Leaders***

3.5.1 Clearly, the literature review shows that much has been achieved in the realm of nursing leadership theory and practice. No writer however was complacent about nursing leadership. This theme summarises the internal and external challenges facing nurse leaders.

3.6 ***Recommendations for Nurse Leaders and Nursing Leadership***

3.6.1 The final theme, combines the recommendations made by writers with those falling out of the present literature review. Recommendations are subthemed into: (a) research; (b) education; (c) practice; (d) management; (e) political; and (f) media.

3.6.2 Examples of recommendations from the six subthemes above include:

- Preparing nurses for jobs in which they can shine as leaders such as commissioning healthcare, and settings that emphasise care rather than diagnosis and treatment.
- Selecting nurse leaders of the future using empirically derived assessment and evaluation criteria.
- Reinforcing existing or developing new basic and postbasic leadership education programmes with curricular issues derived from empirical studies.
- Educating nurses to communicate effectively through the media.
- Educating nurses about healthcare political issues; campaigning and lobbying; setting up coalitions with other professional groups; and raising the profile of government nurses.
- Organising regular seminars and workshops on nursing leadership.
- Commissioning research and development.
- Creating a nurses' think-tank.
- Boosting empirically-based publications by nurses on leadership issues.

Workshop One - European Nursing Leadership, 3rd & 4th February 1997

Summary of Proceedings

1. Introduction

1.1 This workshop was held at The European Surgical Institute, Hamburg, Germany. The workshop used participants personal experiences and opinions. The group were invited in a personal capacity, not as representatives of their country.

1.2 The purpose of the workshop was to:

- determine this group's perception of health care leadership within countries across Europe;
- determine the particular needs for nursing leadership if appropriate;
- explore and share leadership development opportunities within countries across Europe.

2. Workshop Findings

2.1 Each participant was asked to explore their own countries leadership across the whole system (institutions, primary care, professions, education, professional associations, ministries). They were asked the following questions about their country within groups:

(a) Explore your own countries current leadership of health care across the whole system. Describe leadership as it currently exists within your own country.

(b) Go on to explore the possibilities and potential for leadership within your own country. How should it be different?

(c) Do you have views about leadership development across Europe?

2.2

Country	Describe leadership as it currently exists within your own country.
Poland	• Great challenges • Unstable and risky • Hard life but with career opportunities
Estonia	• Old paradigm about leadership .... hierarchical, management etc. • Very professional and medical driven leadership • No clear roles (rights and responsibilities) in the health care organisation
Netherlands	• National Centre for nursing and caring enhancing the position of nursing by bringing groups together, 'Spider in the Web', theory - practice transfer
Slovenia	• No team leadership and therefore no good synchrionised team work

	• Leaders do not know enough health economics • Missing links between the primary and secondary health care services
England	• Health care reforms "fragmented" the voice of leadership. • Professional leadership under attack from mangerialism • Media driven leadership - leaders are reactive to issues rather than leading proactively
Denmark	• Health care leadership in the centre of the political arena. Severe consequences are: - changes of professional priorities - lack of resources - questionable ethical standards - traditional thinking as barriers for modernisation of the health care system
Hungary	• Somewhat contra selected but generally: 1. confused 2. uncertain 3. uncommitted
Germany	Split system. • At political level - federal / state / provincial : different inventions (nursing associations weal, politicians have voice, consumer voice weak) • Insurance system - finance, economist most powerful, nurses no influence at all • Professional level - Doctors are on top, difficult for nurses to be involved - Medicine has the leadership of nurses
Sweden	• County Council - politicians, administrators (hard to reach), advisers
Czech Republic	• High centralisation of institution • Low percentage of nurses members of nursing association • Positions of leaders not very clear
Spain	• We have leaders in the whole system, but they are very far from the reality of most nurses • There are contradictions between the ideas of the University and the reality of health care system • The problems of the nurses are not shared by the leaders • 25% of the nurses have left the profession
Belgium	• No clear cut professional leadership - professional are not leaders; within professional groups there are no leaders • Budget departments of ministries • Hospital centres
Ireland	• 6 health boards (beurocracy • Strong influence of the religious orders • Strong medical model • Matrons

2.3

Country	Go on to explore the possibilities and potential for leadership within your country. How should it be different?.
Poland	• Better financial conditions • Higher social status and better clear legal status • Higher criteria for managerial posts
Estonia	• New leaders with appropriate knowledge and skills • Multi - professional groups • Less hierarchy and more integration in the organisation
Netherlands	• "Nursery" assessing potential • Proactivity
Slovenia	• Collaboration of all health professionals in leadership • Elimination of hierarchical pyramids • Development of a good health information system
England	• Leaders need to develop vision, have courage - be allowed to lead • Primary health care reforms will open up possibilities • Need Multi-professional / agency preparation for leadership
Denmark	• More possibilities for networking and multi-professional training at higher levels for Drs, nurses, and administrators both at community and hospital levels • Better knowledge of and tool for communication with consumers / citizens
Hungary	• Solving moral crisis - corruption, lies, deception • Communication, inform, network, new approaches • More technology (including telephones)
Germany	• New faculties and universities - can develop concepts of leadership and higher academic qualifications • Clarity re professional boundaries / expertise and what nursing expertise is • Having integrated nursing across hospital and not splitting into specialties • Show the effectiveness of nursing outcome - multi - professional quality circles
Sweden	• Hospital Boards - sometimes politicians or physicians, seldom nurses. • DRG too narrow a definition of health need
Czech Republic	• Encourage nurses for leadership and more responsibility • New educational programmes (approximate to EU)
Spain	• The potential for leadership must look at the young and place attention on the problems of low salary, working conditions, and the possibility of development, with a clear strategy to support the new leaders
Belgium	• Selection, training, and promotions of talented professionals that continue as role models for nurses • Promote credibility of clinical leaders "merchandise" • Improve the evidence base science
Ireland	• Increase the status of nursing • Research and development • 3rd level diploma • Trade Unions

2.4

Country	Do you have a view about leadership across Europe?
Poland	• Quite a lot of similarities • Differences in economic status • Different cultural backgrounds
Estonia	• Certain organisations have leaders • We need leadership in managing health
Netherlands	• That's why we are here!
Slovenia	• Yes - many countries have leaders who have only short term goals, because their health services are treated by politicians as consumers and not as producers of the health - their policies are dictated by financial and not by professional authorities
England	• A lot of common issues
Denmark	• Big value in networking across Europe
Hungary	• Professional competence • Commitment (higher in western Europe) • Respect of human rights
Germany	• Examples of integrated care e.g. Elderly care in Holland, good practice and outcomes • Sharing positive successes and innovation
Sweden	• Clinical or divisional level - leadership only one profession represented
Czech Republic	• Older nurses • Lack of license and registration • Better social position
Spain	• The potential leadership must have a European identity and not be limited to their own country
Belgium	• No comment made
Ireland	• No comment made • Matrons

2.5 ***Mapping Leadership Across Europe***

2.5.1 Groups explored their common ground and their differences, listing the most important

2.5.2

Sweden / Germany

Common	Different
• Politicians have a lot of power, significant diversity at local levels • Users have very little influence • Hospital level, doctors and their acute technocratic models dominate • Physicians dominate all professional issue and define the nursing boundaries	• Germany : Competitive insurance companies. Separation of health and social care • Sweden : nurses have senior management positions

Poland / Spain / England / Ireland

Common	Different
• The gap between policy makers and the clinical staff • Much is happening, particularly with tradition but what is there to replace it? • The power balance / struggle between the nurses, doctors and managers	• The centralisation and decentralisation of leadership • Each country has taken a different journey to come to the same place • The markets differ, different population and service profiles

Belgium/Czech Republic / International Groups

Common	Different
• No clear cut professional leadership • Hospital dominated • Beurocratic • Financially driven • Need for new models that are evidence based	• Starting points ....education and research • Pie in the Sky (e.g. HFA 2000) versus pragmatic real world leadership

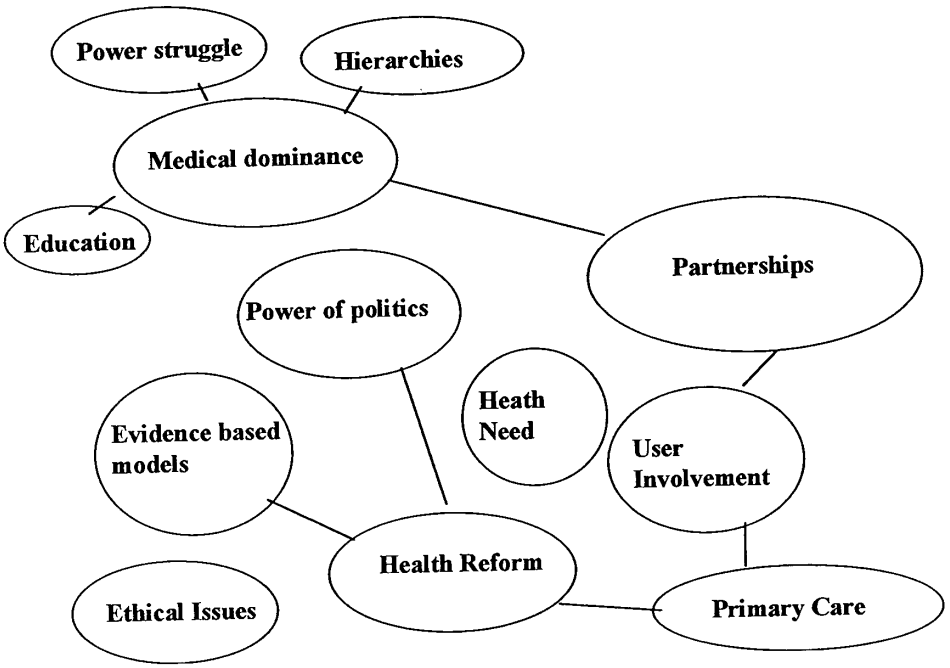
Estonia / Slovenia / Holland

Common	Different
• **Current leadership** - Hierarchies - Leadership happening outside nursing - Changing emphasis on nursing - Not team based • **Possibilities** - Getting away from hierarchy - Movement to community based services - Multi-disciplinary working • **Europe** - Focus back on health - Influencing the politicians - Building on current leadership work	• Different countries at different stages of transition • Current investment in nursing leadership

Hungary / Denmark

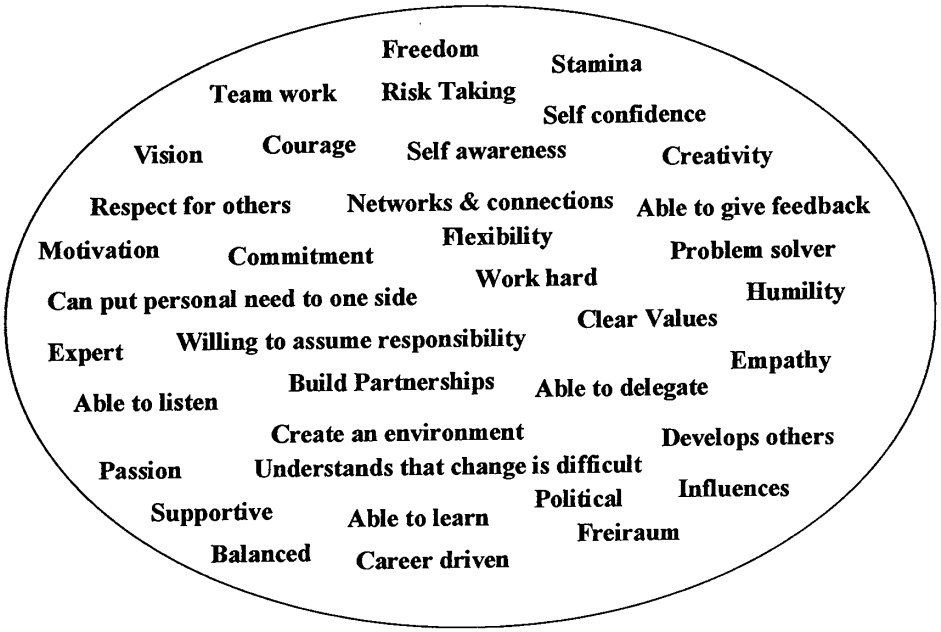
Common	Different
• The connection between politics and health care • Doctors and nurses roles - how much autonomy should nurses have? • A moral and ethical crisis • Communication and networking • Needs for multi-professional training	• Hungary (New Act) Doctors need to order nurses - not true in Denmark • Moral crisis common but more extreme in Hungary (i.e. lies and deception from old regime) • In Hungary patients tip the doctors (secretly). The doctors say it keeps the system going but the team does not believe this • No nurses in the ethics committees in Hungary • Denmark, the leadership selection is based on training and experience, whereas in Hungary it is based on politics

2.5.3 Common themes of areas requiring cross Europe development emerging in the discussion appeared to be:



2.6 *The Essence of Leadership*

2.6.1 Each participant was asked to share their personal experiences of leadership, and feedback using key words to capture the essence of their leadership.



2.6.2 Participants were asked to draw their view of leadership now, and how they would like it to be. The drawings are at Appendix Four.

2.7 *Process' and Conditions for Change*

2.7.1 Participants were asked to look at what would stimulate change within their countries and across Europe, in terms of priorities for future leaders, activities that would support these priorities, qualities required of the leader, support needed by the leader.

2.7.2

PRIORITIES
• Re focus on health and health needs
• Care seen as equal to cure
• Become more patient centred
• Partnerships & Collaboration with others
• Change some existing regulation
• Nursing to become more political

ACTIVITIES
• Move from service need to population need • Reduce hierarchies • Get rid of ineffective rituals • Define the meaning of care • Research into the nature and effect of therapeutic interventions • See the systems deficits, and get other perspectives • Open up access to knowledge and information • Get the patients voice heard • Increase user expectations • Improve partnerships between professionals • Start before you have the answer • We need a nursing perspective on top level strategic decisions • Marketing

QUALITIES
• Holistic • Recognise all players have a legitimate perspective • Be able to argue and not be Political whilst keeping a nursing perspective • Have the understanding and ability to communicate with politicians • Able to influence other professions and the public • Not to se power and politics as dirty • Pride in and understanding of the care role • Need more talent • Have social values • Open outlook • How to communicate • Work out what the message is • Be realistic

SUPPORT
• Support high flyers • For gender issues • to change professional education - multi-professional education • Help with all aspects of leadership development • More sponsors and industrial partnerships • Strengthen trade unions • Research programmes • To develop ability to put ideas across to the public and too find more ways of working with the public • Media training • Networks • Financial support • More role models

2.8 *Current Leadership Development*

2.8.1 Each country was asked to describe current leadership development opportunities in each country, and what they would like to see in their own country and across Europe.

Country	What we have now	What we would like
Hungary	• Management, but expensive • Chaos (theory) • Jungle • Capitalism	• Cheaper management • Teach the teachers • Good curriculum • Clear standards (professional, legal, moral) • Ombudsman • Incentives • Mentoring • Projects
Czech Republic	• Postgraduate management in health care system including leadership • Pre and post graduate education about leadership, including the psychology • We import the King's Fund Clinical Exchange Programme, as well as other programmes and individuals from Holland, USA, France	• Increased basic training in leadership • Improve the socio- economic conditions for nurses • Improve communications • Enhance the quality of the nursing association IMPORT • Continuity with exchange programmes • Continuity with leadership programmes • Contact with ICN & WHO • Programmes for all levels of nurses and doctors • Literature and audiovisual programmes
England	• Plenty! • Johnson & Johnson / King's Fund National programme for nurses • King's Fund national and regional programmes • Universities - Durham MBA, Nuffield, Keele, Birmingham.... • Associations - IHSM, RCN • Programmes - MESOL, NHSTD • Organisations - Each trust has its development programmes • Independent sector • Individuals - mentors, networks, career advice, secondments • International study tours • Fellowships	• Coordination of programmes • Wider global ad European perspectives • Sabbaticals • Funding • Evaluation / Impact / Quality issues • Accreditation of development • Development posts • Succession planning • Secondments • The need for leadership to be made explicit • Two level of development : New Generation / Rehabilitation programme to support current generation
Spain		• We need an idea to act as a catalyst for the nurse leaders to focus on • Training in political skills • Training in management • Training in administration • To identify at all levels - the young nurse; registered nurse; administrator, teacher.

Ireland	• Development programmes for senior nurses • Leadership development sets • Institute of Public Administration, general management in health care initiative • CRED (strategy for nursing development)	• Accelerated development programmes • Women in health care development • Experiential processes • Increased networking • Shadowing and mentorship • increase the possibilities for innovation for clinical leadership
Germany	• A base through law • Nursing studies at universities, through research, polytechniques, teaching • Training, post graduate • Quality circles - specialty for nursing, multi-professional, linking sectors.	• More goal orientated working • The development of higher education Reflection and coaching • Finance for further developments • An evaluation of new developments • Multi-dimensional and multi-professional • A European law • Action learning • Support by other professionals
Sweden	• Career ladder • Diverse academic courses in leadership in health care • Networks of research and development groups • PhD groups	• Power to develop the profession in practice • Positions for PhD nurses • Bridges between the theory and clinical teaching • Documented rules for nurse leadership development by nurses and the needed qualifications for leadership
Belgium	• Well developed structures of health care and education • Accessible quality health care for every citizen • Still plenty of financial resources • Educational programmes • Large data sets	• Poor acceptance of leadership due to high degree of individualism • Poor assertiveness and poor merchandise of existing competence and performance • Lack of incentives for executive leadership • Lack of systematic multi-disciplinary approach to higher management and policy level • Paucity of health service outcomes, and epistemological research • Poor accessibility linkage and use of existing data sets
Poland & Estonia	• Young active generation of nurses • New extended training programmes • Conservative nursing organisations	• To promote the status of nursing leadership • To develop leadership programmes for nurses • To change the role and functions of nursing organisations to become more

		pro-active and progressive
Slovenia	• Management courses - pre & post graduate • Management courses for doctors and nursing director of hospitals • The WHO Collaborating centre • The WHO centre to organise projects for young nurse leaders • We have translated the ICN manual in nursing management's	• Broader leadership knowledge • Possibilities for the young nurse leaders to become aquainted with the situation in other European countries • We need a workshop on the necessary qualities of a nurse leader with an international perspective • We would like to translate a good book on communication skills
Netherlands	• Breeding Pond (Nursery) for Nursing at National Level • Formal organisations • Chairs for nursing professionals • Network database • TREEK group • Congress • A new leadership programme at the National Centre in partnerships with Utrecht	• Module leadership education • Supporting facilities of local leaders • Means to extend the idea - Structure, the breeding pond, and networks • Nurse scientists are too strongly focused on science they should also be partners in leadership discussions • First step the development of nurse leaders • The next step the development of multi-professional leaders
Denmark	• Several training institutions • Nordic school of public health • Principally access to all Nordic training institutions • Collaboration with other Nordic countries Northern Nurses Federation • EEC, Permanent Committee of Nurses • ICN • WHO	• Need for more possibilities for nurses at high level for professional leadership training • Expand on collaboration in International networks for inspiration, exchange of experience and support for nurse leaders • A European educational centre for health, professionals in general • Doctors, chief executives with chief nurses to form the highest level of leadership in the hospital system • Interdisciplinary teams in the home care / community system

International	• ICN Leadership Programme - modular • WHO (Europe) - acting regional adviser, LEMON project, Networking at government / Chief nurses level, European Forum, Newsletter, Meetings, Databases • WHO (International) - Global Advisory Group, Chief Scientist for Nursing. • European Union - nothing • Council of Europe - nothing • European Health Care Management Association - Input to Annual Conference form the RCN	• ICN 1. To expand existing programmes to other geographical areas 2. More focused networking processes 3. Continue to sell the importance of nursing • WHO (Europe) 4. Establish permanent staff 5. Expand the LEMON project ton include leadership module 6. Identify more specifically the role of the nurse in Health For All • WHO (international) To fulfill and implement WHA resolution • Europe (EU & CofE) 1. Leadership programmes to be initiated 2. Information on what EU / CofE is and how nurses fit in 3. Involve existing established bodies • Databases • Literature • Hope programme • For people who can influence or for the high flyers within a European Leadership Module

2.8.2 Finally participants were asked to describe their wish list as a result of the workshop and this is what they came up with:

- A Think Tank - health care and nursing, across Europe, twice a year
- European Leadership Curriculum
- Learn from one another - strengths and weakness of our respective systems
- General model for leadership respecting cultural differences
- European centre with secondment across countries
- That UK nurses look to network in Europe not just the USA
- Inclusive strategy
- Translation of any leadership work into national languages
- Develop the LEMON project to include a leadership module
- Database of leaders and their experiences
- In 5 years nurses will be real partners in health care leadership
- Users decide what they want
- Web site - Internet discussion group.

3. Conclusion

3.1 This workshop confirmed a desire for leadership development across Europe to:

- develop leaders who can operate within a European and Global context;
- enable lessons to be learnt across Europe;
- build on each other's experiences;
- earn together where there are common agendas / issue for instance the move towards primary care based services and the need for partnership working.

3.2 Leadership development within countries is patchy, but there is a growing interest within all countries to develop their future leaders. A wide range of approaches to development were explored, with a strong interest in uni-disciplinary development alongside and as part of multi-disciplinary development. In addition there was interest in supporting current leaders through Internet and distance learning, as well as through Think Tank approaches.

Workshop Two - European Nursing Leadership, 20th & 21st February 1997

Summary of Proceedings

1. Introduction

1.1 This workshop was held at EADA, Barcelona, Spain. Whilst some elements of the previous workshop were repeated, we spent more time here exploring more focused ideas about future options.

1.2 The purpose of the workshop was to:

- determine this group's perception of health care leadership within countries across Europe;
- determine the particular needs for nursing leadership if appropriate;
- explore and share leadership development opportunities within countries across Europe.

2. Workshop Findings

2.1 Each participant was asked to explore the following questions about their country within groups

(a) Explore your perceptions about future trends for health care development in your country. How do you think health care in your country will develop over the next decade?

(b) Explore your own countries current leadership of health care across the whole system. Describe leadership as it currently exists within your own country.

(c) Go on to explore the possibilities and potential for leadership within your own country. How should it be different?

(d) Do you have views about leadership development across Europe?

2.2

Country	**How do you think health care in your country will develop over the next decade?**
Poland	• Following UK model - Health reform law 1999 • Purchaser provider split • Market forces • Increased communication • Strong political influence • Improved quality • Employees want more money • Patient centred care
Finland	• Percentage of Elderly people increasing • Money from primary health care to the elderly • Focus: More on curing than on preventing - chaos?

Netherlands	• Specialisation in cure • More attention for care (chronically ill, mentally handicapped, chronic psychiatric patients) • More transmural programmes • More continuity of care
UK	• Consolidation of reforms currently in place • Primary care led NHS • Reducing professional boundaries • Evidence based health care • Health technology assessment • Outcome rather than input focus • More involvement of the public in resource allocation • Slow expansion in private care • Attempts to reduce lifestyle risk factors
Norway	• Health problems due to the ageing population • More chronic illness • Advances in IT • Hospital functions will change - increased IT and the downsize of hospital beds • Increase in nursing homes • Telemedicine
Slovenia	• Public / Private mix • Nurses not a strong group • Medical domination
Spain	• More integrated move to a national system • Increased national audit • 1986 new health law - Health reforms • Moving towards single management units

2.3

Country	**Describe leadership as it currently exists within your own country.**
Poland	• Historically doctors in many of the leadership roles • Nurses have the right attitude to change
Finland	• Is there any leadership in Finland? • The person is missing as a whole • Traditions! • Status! • There should exist some skills as well!
Netherlands	• Medical / treatment • Inspiring : minority • Not enough attention for nursing • "Money makes the world go round" Too much attention to the economic issues.

UK	• Demarcation by professional groups, limited cooperation, tribalism
Norway	• Sparse population • Changes in progress due to new health minister • Patient centred care • Three levels of government pay for healthcare : 1. State 2. Municipalities 3. Community
Slovenia	• Directors of health care always doctors • Teamwork not practiced • Doctors all have different levels of education
Spain	• A lot of change • Clinical staff are given management training to run units • Need more role models • Doctors taking more power.

2.4

Country	**Go on to explore the possibilities and potential for leadership within your own country. How should it be different?**
Poland	• Aim to get team leaders through each layer of the organisation • Leadership training and management for each layer - presently concentrating on all the ward managers • Nurses moving towards department management
Finland	• Analysis - what is the need? • From organs to person - a holistic view • The leader also a clinical expert
Netherlands	• More nursing leaders • More co-operation of other disciplines
UK	• More inter-disciplinary cooperation • Early recognition of leadership potential • Devolution of responsibility an autonomy
Norway	• Leaders of nurses, doctors and managers should have the same education • Should have the same pay - resources • Nurses need more political knowledge
Slovenia	• The development of team leadership
Spain	• Need to have managers as leaders • Need to know how to conduct

2.5

Country	Do you have views about leadership development across Europe?
Poland	• Similar problems
Finland	• More or less the same • The role of politicians may vary
Netherlands	• Many differences / much similarity
UK	• Learning from each others good practice • Potential for influence
Norway	• Many of the same problems • Need minimum health data set • Need better knowledge on heath outcomes and treatment
Slovenia	• Use of European leadership • Inter country workshops • Creates support for less strong countries
Spain	• More sharing

2.6 ***Mapping Leadership Across Europe***

2.6.1 Groups explored their common ground and their differences, listing the most important

2.6.2

Finland / Holland / Poland

Common	Different
• Trends - increasing specialisation in acute services, danger of fragmentation and lack of holism • Dominance of the medical model in managers (many of them are doctors) • Over emphasis on finance not care • Need more networking • Need to be better at inter-disciplinary working - separate development programmes increase the tribalism • Although structures, politics etc are different, power struggles between doctors and nurses are the same	• Focus is on user power in Finland and Holland, but not Poland • Tension between doctors and mangers in Poland - there managers are all doctors.

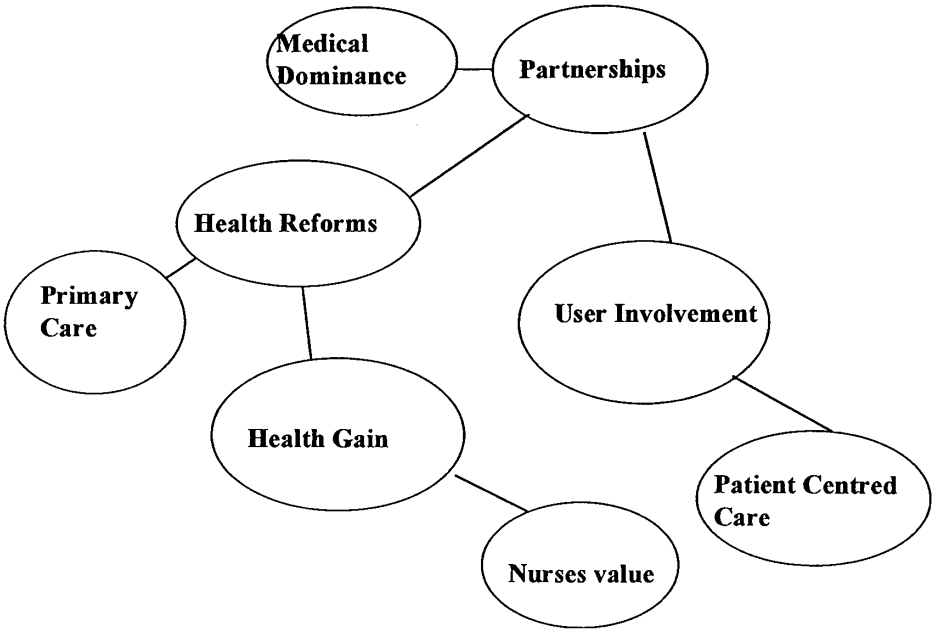
Poland / Spain

Common	Different
• A lot of change • Decentralisation • Health reforms • Patient centred care • Strong political influences • Increased market forces and competition	• History different • Cultures different • Spain ahead with health reforms 1989, whereas Poland to be introduced by 1999.

UK / Slovenia / Norway

Common	Different
• Health gain • Health reforms - mixed economy • Increased specialisation • Increased teamwork - Norway and UK rapidly breaking down barriers • Issues of clinical focus on reductionism and managerial trend towards systems thinking • Medical domination - gender issues • Nurses on the rise in UK and Norway • Primary care in all systems • Race issues • Team Leadership • Preparation for leadership essential • Learning from each other • Supporting colleagues in less developed countries • Critical mass for change	• Use of technology less advanced in Slovenia • Nurses less well developed, and less powerful in Slovenia.

2.6.3 Common themes emerging in the discussion appeared to be:



2.7 *The Essence of Leadership*

2.7.1 Each participant was asked to share their personal experiences of leadership, and feedback using key words to capture the essence of their leadership.

2.7.2 Participants were asked to draw their view of leadership now, and how they would like it to be. The drawings are at Appendix Four.

2.8 *Current Leadership Development*

2.8.1 Firstly participants explored their own understanding about process of leadership development. They personally valued the following:

(a) Formal Programmes
(b) Self development - including reading, research, self reflection, modeling others, trial and error, pre-meeting briefing and debriefing
(c) Supervision
(d) Confidence in being able to do your own job - including using information well, being able to contribute to the social side of work,
(e) Some skills development - presentation, media
(f) Networking - formally and informally
(g) Mentorship
(h) Shadowing - for example to develop political skills
(I) Internet

2.8.2 All of these were considered useful by the group for any programme we might design. They also considered approaches that could be useful across Europe including training the trainers; some programmes for experienced staff, and some for bright young innovators. Mentoring to support translation of any programme into practice was seen as key.

2.8.3 Each country was asked to describe current leadership development opportunities in each country.

Country	Current Opportunities
Netherlands	• High qualified management orientated courses at Universities • Lots of leadership programmes for women and ethnic minorities • For nurses a leadership programme is starting in March for 15 people • A course for one year is organised by the national centre for nursing and in cooperation with the management school of industry and business
Finland	• Universities open to different disciplines • Courses are more focused on limited areas of leadership, or they have a theme • Courses are included in the post graduate of nursing science • Private enterprises - but this is not high quality - the best experts work in the Universities • More of less courses on management
UK	• Doctors - Royal Colleges, practical training, short courses, management training, specialist association meetings

	• NHS Management - Formal academic courses, short courses, distance learning, individual courses, leadership courses in Universities • Nurses - Post graduate, RCN Leadership courses, King's Fund Leadership course
Spain	• Numerous management courses • There are few programmes that are dedicated • The council of nurses • The nursing associations are very keen to develop leadership but the problem is that everything falls to 3 people who are very busy. • Some professional associations
Poland	• The development of education programmes • Creation of associations • Publications / educational material • New legislation for the profession and education • New rules for choosing leaders, no longer political - It is open to competition • Strong government bodies (Chamber of Nurses) • Trends to support leader - position
Slovenia	• Programmes for Directors of Institutions Organised by MOH and Medical faculty • No special leadership programme for nurses, but introduction to organisational management during initial nurse preparation • General faculty undertaking leadership training to which any profession can apply (nurses go to this not for leadership, but it is one of the few that nurses can access).

2.9 ***Future Developments***

2.9.1 The initial ideas coming out of the first two were refined and tested at the second workshop and endorsed by the participants, with a number of outstanding questions about the detail of delivery, and the nature of the partnerships and commitment within countries.

2.9.2 Here we provide those initial ideas.

1. **European Summer School for Leaders with Clinical Backgrounds.**
2. **Think Tank - Learning Network for current strategic level nurse leaders**
3. **Internet Web Site and Distance Learning**

These ideas together form an initial contained set of process for making a wide impact across Europe. We expect that together they will enhance in country development of leadership as well as maximising the potential for cross country learning and development.

3. Conclusions

3.1 This workshop endorsed the need for cross discipline leadership development recognising that we need to include uni-disciplinary process alongside collaborative process. In particular this workshop worked on the three ideas identified above and came up with the following outline.

3.2 ***European Summer School***
(see diagram 1)

3.2.1 Programme
The summer school will last for up to two months over the summer, and will comprise of a range of elements and modules:

- There will be uni-disciplinary elements to the programme where we work with clinical professionals within their own discipline.
- There will be team elements where doctors, nurses and therapists who work in a team in their own country learn together, both about content and about how to develop themselves as a team.
- There will be multi disciplinary elements where disciplines work together across countries.

These elements will be built into each of the modules.

The summer school will combine the following learning approaches:

- Theory - about the themes identified, as well as leadership, change and power. This will include pre-reading; lectures, and reflective exercises
- Action reflection - in unidisciplinary, team and multidiscplinary groups
- Workshops - experiential based
- Skills training
- Mentor / coaching relationships
- Development of process facilitation skills in all participants to enable them to facilitate change process in their own country
- Personal development - including awareness of personal impact, developing personal insights.
- Projects - each team will have to undertake a project that will be supported during the following year by their sponsor and the programme in which they are participating in their own country.
- Return and Follow up - Summer school participants will return to the summer school for a week the following year to share their learning and to develop their network
- Network

Different Modules will take place in different countries (probably 2 or 3). For instance a module that predominately develops skills, and which we think would for instance be of most benefit to eastern and southern Europe would take place in one of these.

3.2.2 Target Groups

The summer school will be open to applicants who are:

(a) Connected to a leadership or management development program in their own country (e.g. the nursing leadership programme in the UK and the one run by the National Centre for Nursing and Utrecht University in the Netherlands) and who are aiming to be strategic level leaders. This connection is needed to provide support to project work within the applicants own country.

(b) Teaching / providing development programme in their own country as for instance in Poland where there are trainers developing ward sisters.

3.2.3 Selection

Applicants will go through a self - assessment exercise in partnership with their sponsor in their own country. This exercise will help the applicants identify which parts of the summer school they need to attend, and if the summer school is appropriate for their own development. We need to match the programme and the participants. The assessment exercise will be made available to the programme designers to enable them to shape the program for that year's intake. We expect applications to be a partnership between the individual, their employing organisation and the director of the programme in which they are participating in their own country (where appropriate)

It may be that different countries and certainly different individuals) join the summer school at different times depending on the level of development offered in their own countries.

3.2.4 Context

There are two major issues for us to consider in designing the summer school. The first is the differences in leadership style and process in different countries. We need to work with the diversity between countries and use this in the programme itself and model it ins the way we work with partners across countries. We are not going to set up a western model of leadership for all countries to engage in.

Secondly the programme needs to model effective and productive partnerships, both in its funding and in its delivery and design.

3.2.5 Language

There is an issue of language. It is obviously cheaper to undertake the school in English. One way round this may be to run pre-school language development. Another might be to identify the best language for parts of the summer school depending on country uptake.

3.2.6 Access Workshops

There are other issues for those countries without leadership development of any kind (some of the Eastern European countries) where we might need to provide access workshops.

3.3 *Think Tank*

3.3.1 Specific to nursing was a need to be influencing European Policy, and finding ways of working together at strategic level outside the 'normal' meetings associated with ICN / ENDA (both associated with nursing associations) or WHO. An independent group committed to learning together, working across hierarchies, working outside the 'formal' bodies, but coming from the strength of their current positions within countries, and with the freedom to think and act independently, could provide a policy think thank that could influence and shape the European policy, bringing together people from across the system (universities, providers, purchasers, policy makers).

3.3.2 We propose that we establish a cross Europe think tank, which pulls together strategic level nurse leaders to :

- learn from each other about their own leadership
- to undertake joint cross country projects
- to find common ground from which to develop ideas for nursing across Europe
- to influence European Policy and Legislation

3.3.3 This group would be self selecting and would meet every 6 months over two to three days to develop its thinking and position. The groups will commit to both developing joint projects and to finding ways to influence European policy and legislation between meetings.

3.4 *Internet*

3.4.1 The last thread from the workshops is to develop a web site for discussion and sharing, and through which we could offer development material for anyone interested in developing their leadership in Europe. The site would include distance learning materials; the summer school self assessment; updated information about European policy as it affects the clinical professions; pointers to other web sites; opportunities for sharing information and for networking.

Combined Workshop Issues

1. Introduction

1.1 There are a few issues where combining the workshop findings are helpful, particularly in relation to the current context for leadership and the profile of the leader for the future.

2. The Context for Leadership

2.1 *The state of the system*

- Increased pace of change
- The introduction of health reforms
- Lack of resources for health
- Politicians have a lot of power
- Finance driven not health need driven
- A moral and ethical crisis in Eastern Europe
- Increased market forces
- A drive towards patient centred care
- A desire for partnerships, collaboration, teamwork
- The shift into primary care
- Move to more chronic illness and need for more care
- Attention on boundary issues

2.2 ***Structural Issues***

- Increased decentralisation
- Purchaser provider split
- The continuing development of technology
- Professional boundaries, although a move towards team working
- Hierarchies
- Increased communication and networking
- Increased specialisation in acute hospitals
- Increased generalisation in primary care
- Services more outcome focused

2.3 ***Policy Issues***

- Mixed economies (including social care)
- Increasing evidence base
- increased research and development
- Gap between policy makers and clinical staff

2.4 *Workforce Issues*

- Changing professional roles - a fuzzing of the edges
- Strong medical model remains
- A willingness to change amongst some nurses
- Increased level of education
- Nurses on the ascendancy
- Recognition that preparation for leadership is essential
- Retraining and cross training needs

3. Common Ground

3.1 As a result of the study we now believe that there are common needs across countries in Europe in terms of content and process, but these needs are on different levels. All countries involved in the study identified the need for development for leaders from clinical backgrounds (particularly nurses) in the following areas:

- **Partnership Working** - with other agencies in the system; with other health care providers within the system; with industry; cross boundaries between professionals; within teams, across hierarchies. A range of needs was identified, from strategic level in order to maximise the potential and possibilities within the system, to clinical teams wanting to improve their impact as a team with patients and within the wider system.
- **Health Reform** - with all the countries moving towards a mixed economy of health care, utilising to various degrees both public and private sector funding and provision. The increase in specialisation in acute care, and the increase in generalisation in continuing / primary / non-acute care, the move towards primary health care provision.
- **Health Gain** - looking at population needs for health care; public health issues; ways of improving clinical effectiveness; and recognising the impact of collaboration between disciplines in improving patient outcomes.
- **Involvement of users** - consumerism, finding ways of involving the user positively and actively in service design and delivery, not passively as a commentator on their personal experiences.
- **Health Policy and Politics** - influencing and shaping health services within a political environment; recognising the political systems in which health care is designed and delivered; working with politicians; influencing health policy; finding a voice.

and specific to nurses:

- The need to develop nurses understanding and ability to market the value they add to organisations and their confidence in working on corporate issues.

3.2 Underpinning these threads was a cross Europe interest in:

- **Change** - how to improve change management; how to use change as a continuous process; how to influence change process'; how to develop long standing approaches to change rather than short term 'fixes'.

- **Power** - how to influence and shape policy and service delivery; issues of gender, race; the imbalance between the clinical professionals; different approaches to diversity and power in countries.

4. Current Differences Between Countries

4.1 The workshops attempted to explore differences as well as common issues. The main difference in terms of development needs is the current style of leadership within countries - some dependent on a very autocratic style of management and leadership, other looking at developing leaders across the system. Designing a leadership programme which address' this diversity across Europe is key.

4.2 Other issues of difference are more related to context, and we believe that exploring these differences will be a critical part to learning within any programme. Differences include:

- economic status
- source of funding for health care
- population profiles
- approach to ethical issues
- service profiles
- user power varies
- health reforms at different stages
- use of technology
- current investment in leadership development
- relationships between the clinical professions vary

5. The Profile of the Health Care Leader in Europe

5.1 The workshop results combined with the literature review lead us to the following profile of the health care leader who has a clinical background. We recognise that this is probably applicable to all health care professionals, but that was not the focus of this study.

5.2

- **Strategist** - sees possibilities, has clear ideas, creative, works within the 'big' picture, shapes and influences, opportunistic, able to develop and implement strategy to achieve health gain. Understands the use of power and politics, able to work with national and local priorities, politically aware

- **Systems Leader** - develops generative relationships, works where there is energy in the system, sees connections and networks, works across boundaries, develops groups, understands knock on effects of short term decisions, widely networked, develops information process'. Works with users, sensitive to local community needs.

- **Courageous** - develops choices, takes risks, entrepreneurial but with feet on the ground, committed, positive, ethical.

- **Confident and credible** - Achiever, works hard and uses time well, knows the business, can work with the media, clear presenter of ideas, and able to manage the business. Able to lead beyond hierarchy in complex organisations

- **Learner and developer** - Reflective, learns from work and personal situations as well as from reading and formal learning experiences (programmes), seeks supervision. Develops others, coaches, mentors others, recognises own role as a role model, sees potential in others. Able to act as process consultant. Self aware and able to recognise and maximise personal impact, comfortable with self and able to express themselves through their work

6. Priorities for Leaders

6.1 Participants on the workshops shared their priorities for change in their countries. Common ground across countries included:

- Partnership between countries
- Care to become an equal priority to treatment
- Re-focusing on health, not health services; concentration on population needs not health service needs
- Develop a systems approach to the organisation of health care services including reducing hierarchies
- Challenge rituals, develop a user focus
- Improve availability of information
- Change some existing regulations
- Develop nurses political awareness

7. Conclusions

7.1 The workshops clearly demonstrated the need for a European leadership programme for nurses and other clinical professionals, to improve both personal and organisational effectiveness, and to enhance change management capability across Europe. The main gap identified is for those who aim to work at strategic level, and have the potential to be strategic leaders within a European context in the immediate future. The groups also recognised the need for development in the short / medium term for those who are already in strategic roles.

7.2 All the countries involved are moving towards better collaboration between professionals and with users, developing more patient centred services, and team based service delivery. This could be supported by a programme that brings teams of clinical professionals together for learning and development.

7.3 Finally, all participants contributed enthusiastically to the discussions, and there was a great deal of excitment and interst in a cross Europe programme.

European Nursing Leadership Seminar at Leeds Castle, 3rd & 4th April 1997

Summary of Proceedings

1. Introduction

1.1 A group of European Health Leaders (Appendix 2) were invited to attend a leadership seminar held at Leeds Castle, Kent. Participants were issued with a draft of this study report before the seminar. The focus of the seminar was:

- To work with country level leaders to share the findings of the study.
- To explore our ideas about potential leadership development opportunities.
- To demonstrate our approaches to leadership development.
- To provide opportunity for cross country networking and privacy for exploring some of the main challenges to health care development within countries and across countries.
- To gain country support and commitment for leadership development.
- To develop new partnerships

2. The Need for Nursing and Health Care Leadership in Europe.

2.1 Questions which were to be addressed during the seminar to further shape the proposal were identified.

- What are your reactions to the draft ideas?
- Are you satisfied with use of the profile and themes as a vehicle for leadership development?
- What are the pro's and con's of a nursing programme?
- How can a European initiative be integrated to your own countries initiatives?
- How can we sustain / transfer learning from the European programme?
- How does all this fit into your own experience?
- What are the wider reactions in your country to these ideas?

3. Overall First Impressions

3.1 "This work itself has been a real contribution to the integration of Europe" (referring to the workshops over the past few months as part of the study). The oparticipants commented on thier first impressions of the study and proposal, exporessing excitment, opportunity, a sense of possibility, feeling posytive that theuy had been included from the stsrt, and that the study report accurately reflected thier views. In addition there was suport for the summer school "*Summer School is a very positive priority*" with some concerns *that "We must consider language, written language and translation problems"*

4. Development Needs

4.1 The group discused the themes of:

- Partnerhsip Working
- Helth reform
- Health Gain
- involvement of Users
- Helath Policy and Politics

4.2 One additional theme was identified:

Being European
Analysis of the common and different factors, European regulation. European reforms. The potentials in being European. How can we become more European?

4.3 There was also a suggestion that there should be more emphaiss on the User Involvmetn theme which was considered a major vehicle for change. It was also seen as the underpinning for health systems, reform, policy development and politics.

4.4 Another 'gap' identified was the place of health technology, and that health gain should also include soical care

5. The Profile

5.1 The profilel should reflect that leaders giving meaning, need authenticity, and are knowledge brokers.

6. The Proposal

6.1 Internet

6.1.1 The proposal was to develop a web site with discussion pages as well as to develop distance learning material for wide access.

6.1.2 The ideas of distance learning material was particularly interesting to eastern Europe. In reality, if this is to advance ideas developed within the summer school, then it is going to be developed in 1999. There may be opportunities for European funding for this type of development. Developing web site access is more straightforward.

6.2 Think Tank

6.2.1 The proposal here was to develop a nursing policy think thank that could influence and shape the European policy, and act as a learning network.

6.2.2 It became evident at the semianr that this is a bit of a political hot potato. We discussed how people wanting to engage inn this activity could do so with funding from within their own countries. However, there was a lot of support for continuing to learn across the network already established as part of this study. The group who have been involved here and at previous workshops have already learnt from each other, and are interested in providing support to the development of the summer school. **They suggested a 2 day workshops for all who have been involved, to take place next spring. The purpose would be to explore developments in their own countries; to develop some joint project work across countries; and to continue to explore the concept of being European.**

6.3 Summer School

6.3.1 The idea of a summer school was endorsed. First impressions were of excitement, opportunity, possibility.The majority of the debate was about whether the school should be to develop nurse leaders or to develop leaders of health systems; whether it should be interdisciplinary or uni-disciplinary. It was agreed that the need is for **an interdisciplinary school for strategic level leaders from clinical backgrounds**, and that these should come as 'partners' to the school. There should be opportunities within the school for uni-discplinary learning if needed, but that this would emerge during the school.

6.3.2 The interdisciplinary team should include doctors, nurses and profession allied to medicine (e.g. physiotherapists, speech therapists), groups coming from a country, with the explicit intention of undertaking a piece of work together in their own country, and learning together after the summer school. We discussed countries 'pairing' for additional work / network learning after the school.

6.3.3 There was an isue about th length of the School. The pros and cons for the Summer School being a minimum of 4-8 weeks were discussed:

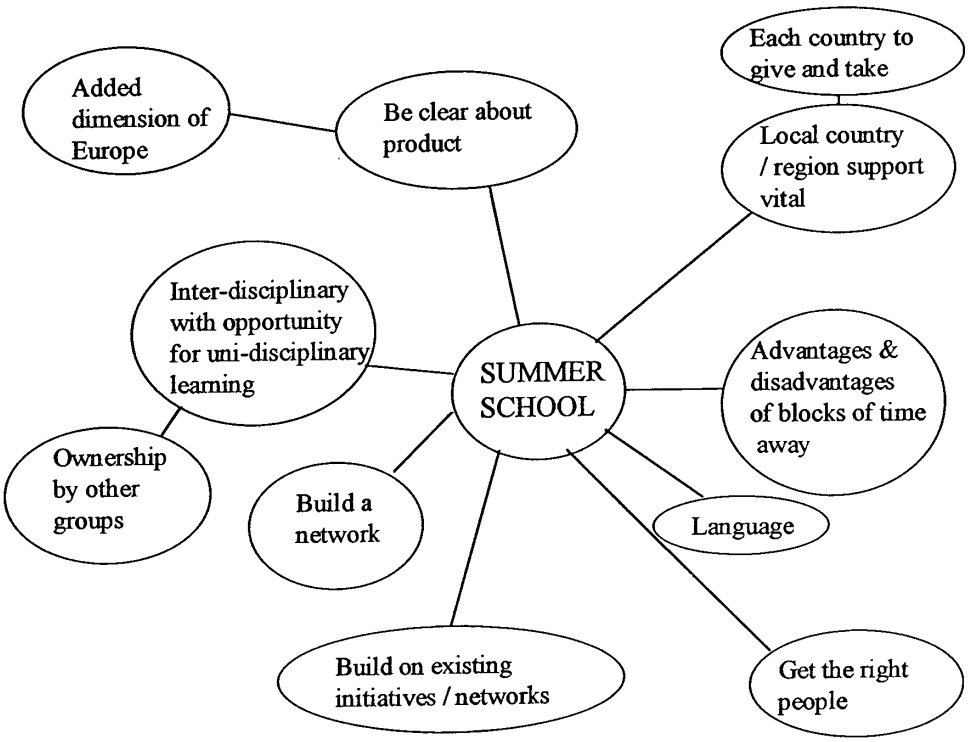
PRO'S	CON'S
• It will show commitment from each delegate and thier organisation • It allows for continuity, and working in depth on issues • You do not loose time by having to do an update / learn to work toghether again, from the last time the group were toghether • It allows for greater personal development	• The inability to get away for 4 weeks • The problem of re-entry back into your organisation • Family commitments

Overall the seminar thorugh that the balance was in favour of a block of time dedicated to learning rather than modular programmes for this type of learning.

6.3.4 One of the main messages was about the need for clarity of the 'product'. What will those attending get out of the process? What is the added value of a European programme? At the end o the seminar, most agreed that they could see the benefit, but found some difficulty in articulating it. A stronger focus on the product will also help identify how we measure success, particularly within cultural differences. Ideas expressed at the seminar were:

- To help country leaders become european leaders.
- To develop breadth in strategi leaders.
- To develop the added dimansion of Europe to country working.
- To enable strategic leaders to transend barriers.
- To develon the clinical voice at strategic level.
- To be able to challenge mind sets, expand thinking, broaden the focus, look into a different mirror.

6.3.5 Language could be a barrier. Comments made emphasised that the programme should not be UK dominated and being multi-national was key to its success. However, it was recognised that the programme initially should be run in English and that future considerations should be made to overcome the language barriers.



7. Country Support

7.1 We also spent time exploring what countries could offer in terms of support. The main ideas were:

- time off work to attend the school;
- mentors;
- support networks;
- help with recruitment to the school;
- high profile support for local seminars;
- opportunities for real time work across countries;
- possibly teaching on the programme;
- linking the school into thier own countries leadership strategy;
- networking with other leadership programmes in Europe;
- share the results of this study;
- contact Johnson & Johnson locally

8. Conclusions from the Seminar - refining the ideas

8.1 At the end of the seminar, participants commented on how much they had learnt, and their commitment to continue to support this development. The

overwheoming support was for the Summer School idea, with a longer term committment to developing distance learning materials. The group would also like to continue learning as a netowork, with the opportuniity to get together again next year.

8.2 In order to ensure that these ideas are relevant to doctors and professions allied to mendiicne we need to check out the study findings with these profesional groups, and the put toghether a porposal to suport these ideas.

Conclusions

1. Needs for Development

1.1 The study (literature review and workshops) has revealed the need for nursing leadership development alongside and that this should be part of a wider approach to leadership development for the clinical professionals. Whilst the initial focus for development was nursing, the workshops in particular highlighted the need for multidisciplinary development as well (not instead of). There is a need for nursing development particularly to enable nurses to work in partnership with other disciplines, but the major issues facing nurse leaders also face the other clinical professions (particularly working in teams, issues of health gain). There are also particular nursing development needs in relation to influencing the broader European agendas.

1.2 As a result of the study we now believe that there are common needs across countries in Europe in terms of content and process, but these needs are on different levels. All countries involved in the study identified the need for development for leaders from clinical backgrounds (particularly nurses) in developing partnerships, health reforms, health , involvement of users, health policy and politics.

1.3 The study lead to the devlopment of the profile of the strategic leader in Europe, which was a Strategist, Systems Leader, Courageous, Confident and Credible, Learner and Developer.

2. Leadership Development

2.1 As a result of these initial ideas the workshops and seminar lead to three main ideas for leadership development across Europe.

1. **European Summer School for Strategic Leaders with Clinical Backgrounds.**
2. **Learning Network for current strategic level nurse leaders who have been involved in the needs assessment study**
3. **Internet Web Site and Distance Learning**

2.2 These ideas together form an initial contained set of process for making a wide impact across Europe. We expect that together they will enhance in country development of leadership as well as maximising the potential for cross country learning and development.

Appendix One

Workshop Programmes

Initial Workshop - European Nursing Leadership, 10th & 11th July 1996
Ambassador Hotel, Prague

Programme

10th July

4.00pm **Welcome and Introductions**

- Johnson & Johnson's interest in developing nursing - Terry Mullens, Johnson & Johnson
- Introducing Ourselves - King's Fund and then Guests

4.30 pm **Ground Rules for the Workshop** - sharing our expectations of the workshop and each other.

5.00pm **Leadership in Countries**
An exercise to explore where leadership is coming from within countries and why that situation exists.

When this is completed we will review the programme for tomorrow with participants, and change it as necessary.

We expect to finish about 6.30pm

7.00pm **Time for informal gathering before dinner at 7.30pm. We will be joined by Kurt Schleup, Managing Director, Johnson & Johnson based in Prague.**

11th July

Draft - this day may change depending on how far we get on the previous day.

9.00am **Sharing current initiatives (or lack of them) in developing nursing leadership within countries.**

10.00am **What do we think should be different?**
An exercise in groups of three, and then shared by the whole group.

11.00am **What conditions are necessary for that to happen?**
An exercise in groups of three, and then shared by the whole group.

12.00am **What does this mean for a programme to develop nursing leadership?**
Whole group discussion.

12.30 / 1.00pm **Lunch**

1.30 / 2.00pm **Developing a wider study to determine the need for nursing leadership development across countries.**

Exploring ideas for:

- terms of reference for a study to determine need;
- the process / approach to the study;
- partners we would need to undertake the study;
- partners we would need to run a programme;
- who else (stakeholders) should be involved from each country.

4.00pm **Close**

Workshop One : 3rd and 4th February 1997
European Surgical Institute, Hamburg, Germany

Purpose of the Workshop

- **To determine this group's perception of health care leadership within countries and across Europe**
- **To determine the particular needs for nursing leadership**
- **To explore and share leadership development opportunities within countries and across Europe**

Monday 3rd February

16.00 Arrive, coffee and registration

16.15 **Introduction to the workshop and each other**
Johnson & Johnson partnerships and philanthropy
Purpose, shape and outcomes of the workshop
Introductions to each other

16.45 **Leadership Within Countries**
(a) You will be put into groups to explore your own countries current leadership of health care across the whole system (institutions, primary care, professions, education, professional associations, ministries). Describe leadership as it currently exists within your country using pictures and words.

(b) Go on to explore the possibilities and potential for leadership within your country. How should it be different?

(c) Do you have a view about leadership across Europe?

(Tea and coffee will be available during this session)

17.45 **Mapping Leadership in Europe**
Pulling together our individual country pictures to explore common ground across Europe.

18.15 **Briefing for the evening** - telling our stories about our own leadership

18.30 Close - a coach will take us to the hotel

20.15 **Dinner** - hosted by Johnson & Johnson

Tuesday 4th February

9.30 **Review** of our progress yesterday

10.00 **Feedback** from our conversations over dinner.
What seems to work personally for us in our leadership of health services?
Themes from our stories.

10.45 Coffee/Tea

11.00 **Process and Conditions for Change**
You have described current leadership and possible future leadership for your country. You have also described processes that work for you as a leader. What would help and stimulate change within your country and across Europe.

12.00 Lunch

13.00 **Nursing Leadership**
What is special/different about nursing needs for leadership? What do we want from our nurse leaders? Here we will explore how nursing leadership differs from other disciplines, and its particular needs for development.

14.30 Tea/coffee

14.45 **Opportunities for Development**
What leadership development exists to fill the gaps we have identified. What leadership development would we like to see in our own countries and across Europe (focus, shape, target group, duration, style).

15.45 **Summary** of the two days

16.00 Close and tea/coffee

Workshop Two : 20TH AND 21ST FEBRUARY 1997
EADA, BARCELONA

Purpose of the Workshop

- **To determine this group's perception of health care development and leadership within countries and across Europe**
- **To determine the particular needs for nursing leadership**
- **To explore and share leadership development opportunities within countries and across Europe**
- **To develop options for future leadership development across Europe**

Thursday 20th February

14.00 **Arrive, coffee and registration**

14.15 **Introduction to the workshop and each other**
Johnson & Johnson partnerships and philanthropy.
Purpose, shape and outcomes of the workshop.
Introductions to each other.

15.00 **Leadership within countries**

(a) You will be put into groups to explore your perceptions about future trends for health care development in your country. How do you think health care in your country will develop over the next decade?

(b) Go on to explore your own countries current leadership of health care across the whole system (institutions, primary care, professions, education, professional associations, ministries). Describe leadership as it currently exists within your country using pictures and words.

(c) Now go on to explore the possibilities and potential for leadership within your country, how should it be different?

(d) Do you have a view about leadership across Europe?

(Tea and Coffee will be available during this session.)

16.15 **Mapping Leadership in Europe**
Pulling together our individual country pictures to explore common ground across Europe.

17.00 **Briefing for the evening** - telling our stories about our own leadership.

17.30 **Close of Workshop and Opportunity for Individual Interview** (until 19.30).

20.00	**Dinner** - hosted by Johnson & Johnson

Friday 21st February

9.30	**Review of our conversations over dinner** What seems to work personally for us in our leadership of health services? Themes from our stories.
10.15	**Coffee**
10.30	**Nursing Leadership** What is special/different about nursing needs for leadership? What do we want from our nurse leaders? Here we will explore how nursing leadership differs from other disciplines, and its particular needs for development. What is the added value of developing nursing across countries?
11.30	**Opportunities for Development** What do we understand by leadership development? What options are open to us?
12.15	**Lunch**
13.00	**Opportunities for Development** (cont'd) What leadership development exists to fill the gaps we have identified. What leadership development would we like to see in our own countries and across Europe (focus, shape, target group, duration, style).
14.00	**Summary** of the Workshop and close. (Tea and Coffee available)

Appendix Two

Workshop Participants

Initial Workshop 10th and 11th July 1996 - Ambassador Hotel, Prague

List of attendees

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Appendix Three

A Review of the Nursing Leadership Literature

Keith Hurst, Senior Lecturer, Nuffield Institute, University of Leeds

A Review of the Nursing Leadership Literature

Introduction and Background

A review of the literature on nursing leadership is important for several reasons:

- Changing health services can have a remarkable affect upon nursing leadership. Consequently, the literature on nursing leadership reflects wider healthcare changes.
- Like many nursing issues, nursing leadership literature is steadily expanding and benefits from regular stocktaking.
- As the leadership literature develops and grows, meta analyses will not only corroborate existing knowledge but also generate new insights about nursing leadership that can be confirmed later by empirical work.

Consequently, the King's Fund Management College, supported by Johnson and Johnson funding, began a nursing leadership development project in 1996. One component of the Project is the literature review reported here.

Literature Review Method

Briefly, four computerised literature databases:

1. CINAHL.
2. HELMIS.
3. Medline.
4. RCN CD ROM.

were thoroughly searched using the key words listed in Table 1 below.

Table 1. Computer Literature Search Key Words

1. Leadership. 2. Nursing. 3. Management. 4. Authority. 5. Administration. 6. Organisations. 7. Education 8. Europe. 9. Practice. 10. Role. 11. Skill.	12. Supervision. 13. Mentorship. 14. Accountability. 15. Politics. 16. Profession. 17. Women. 18. Feminism. 19. Power. 20. Empowerment. 21. Image. 22. Motivation.

The four computer databases given above were interrogated using the 22 keywords listed in Table 1 individually or in combination. The search located 170 articles and books (see References and Bibliography on p.23).

Articles and books were systematically dissected, and 700 distinct nursing leadership and related issues (from mostly theoretical discussions and some empirical findings) were extracted and organised into a card-index database. Each card in the database carries a distinct nursing leadership issue along with its source. All 700 cards were coded and filed under 15 nursing leadership themes (listed in Table 2 below).

Table 2. Nursing Leadership Themes in the Literature

1. Nature and purpose of nursing leadership.
2. Change and change management.
3. Nursing leadership and organisations.
4. Nursing leadership and conflict.
5. Leadership styles.
6. Characteristics of nursing leaders.
7. The functions of nursing leaders.
8. Leaders, followers and groups.
9. Communication.
10. Surviving as a nurse leaders.
11. Succession planning.
12. Appraising nurse leaders.
13. Developing nurse leaders.
14. Challenges facing nurse leaders.
15. Recommendations for nurse leaders and nursing leadership.

The 15 categories in Table 2 above not only theme the leadership literature but also serve as a useful framework for this literature review.

Theme 1. Nature and Purpose of Nursing Leadership

Discussion in the literature, which introduces readers to nursing leadership, spans eight subthemes listed, along with their sources, in Table 3 below.

Table 3. The Nature and Purpose of Nursing Leadership: Subthemes

Subtheme	Source
1. Definitions of nursing leadership. Difference between management and leadership.	Bowman 1980 p.37; Sullivan 1990 pp.7-9, p.47; MacPherson 1991 p.51; Hunt 1992 p.14; Rafferty 1993 p.1; Benton 1994 p.50; King and Cunningham 1995 p.7; Girvin 1996a p.10. *See also Table 4 below.*
2. Nursing leadership - a crisis	King's Fund 1985 pp.24-35; Marriner- Tomey 1988 p.182;

situation.	Davidson and Cole 1991 pp.22-24; Rafferty 1993 p.1, p.10; Rowden 1995 p.50; Girvin 1996c p.21.
3. The debate about nurse leadership.	Dean 1993 p.33; Bowman and Thompson 1993 p.4; Rafferty 1993 p.3; Wedderburn- Tate 1996, p.8.
4. The need for nurse leaders.	Johnson and McCloskey 1988 p.106 p164; Marriner-Tomey 1988 p.182; DoH 1989 pp27-29; Rafferty 1993 p.1; Salvage 1993 p.99; Deffenbaugh 1994 p.28; Rowden 1995 p.50; Wedderburn-Tate 1996 p.8.
5. Nursing leadership's Strengths, Weaknesses, Opportunities, and Threats.	King's Fund 1985 pp.24-35; Norman 1987 p.52; Marriner-Tomey 1988 p.182; DoH 1989 p.29; Mellish 1989 p.156; davidson and Cole 1991 p.25; DoH 1993 p.13; Rafferty 1993 p.1; Rowden 1995 p.50; King and Cunningham 1995 p.7.
6. The nursing leadership barometer.	Dean 1993 p.33; Rafferty 1993 p.26; Girvin 1996d p.16.
7. Internal and external leadership factors.	Rafferty 1993 pp.1-2.
8. The barriers facing nursing leaders.	Henry et al 1994 pp.153-155; Naish 1995 p.3.

As might be expected, the first and largest subtheme in the introductory sections of the leadership literature were leadership definitions. In view of their important, scene-setting role, the definitions of nurse leaders and nursing leadership are summarised in Table 4 below.

Table 4. Definitions of Nursing Leadership and Leaders

Definition	Source
Leadership isn't management, and management isn't leadership. Leadership is dynamic and interpersonal.	Sullivan 1990 pp.6-7, p.9.
Leadership is the ability to initiate change in an area where practice needs improving.	Woan and Whilby 1996 p.16.
Leadership is about: setting the pace; directing change; facilitating; innovating; updating; and about maintaining standards.	Marriner-Tomey 1988 p.182; DoH 1989 p.27.
Leadership is a quality possessed by anyone who conducts, guides, and directs nursing activity.	Mellish 1989 p.156.
Leadership is the ability to set goals, strategies and inspire teams to reach goals.	Rafferty 1993 p.1.
Leadership is: a constellation of attributes, complex and unpredictable; a process of influencing and managing change depending upon the situation, the task and the group; fixed or movable according to need.	Rafferty 1993 p.3, p.7.
Leadership is both a problem and a solution.	Rafferty 1993 p.6.
Leadership is about: credibility; power; controlling; and accountability.	Hardy and Rafferty 1982 p.1430.
Leadership is about using a special form of power to create and protect the culture in organisations that support and motivate staff.	Girving 1996a p.31.
Leadership isn't a problem it's a crisis.	King's Fund 1985 p.48.
Leadership is probably the most studied yet least understood behaviour.	Norman 1987 p.52. See also Wedderburn-Tate 1996 p.8; King and Cunningham 1995 pp.3-4.

Leadership is a special form of power. It is a collective activity involving the resources and motives of both leader and follower to reach shared goals.	Mackie 1987 p.10.
Leadership can be exercised at any level, but it is usually linked to managerial authority. It is about: speed; commitment, releasing energy; risk taking and making mistakes.	Hunt 1992 pp.13-14.
Leadership is: authority in its widest sense; objective - based on evidence; subjective - based on personal qualities.	Lorentzon 1992 p.525.
Leaders: inspire, act as role models; deliver expert care based on evidence; support the organisation and influence policy; collaborate with other key staff; assume responsibility for decisions; use advocacy to effect change; are cost conscious.	Sullivan 1990 pp.6-7, p.9.
Leaders: plan; organise; direct; coordinate; facilitate; and control.	King's Fund 1985 p.49.
Leaders: guide individuals and groups.	Henry et al 1994 p.153.
Leaders: shape behaviour; mould subordinates; decide goals and objectives; make a group cohesive; are accepted but may be distant from their groups without alienating themselves; are usually close to the action however.	Bowman 1980 p.37.
Leaders apply the right knowledge and skills to a situation.	Broome 1990, p.24.
Leaders: have staff skills; share goals; are proactive; are focused on substance; pay attention to the effects of events on staff; have empathy; attract indifference, love or hate.	King and Cunnigham 1995 p.7.
Leaders make a vital contribution to nursing management, education, research and practice.	DoH 1989 p.29.

There are a number of striking features in the definitions of nursing leadership in Table 4. First, nurses are at pains to distinguish managing from leading by comparing the characteristics of managers and leaders. Interestingly, managerial skills were reported more negatively than leadership skills. Writers admit however that nurses can be managers, leaders or both. Second, writers categorise leaders' attributes as (a) intellectual (such as ingenuity); (b) affective (such as empathy); and (c) psychomotor (such as clinical skills). Leaders are able to select one or more of their cognitive, affective, and psychomotor abilities according to the situation in which they find themselves, and to use them effectively. Third, although nurse leaders are loyal to their organisations, their main aim is to maintain and improve patient care via a cohesive workforce. Fourth, leaders occasionally take risks, but remain accountable for their actions. Fifth, the more cynical writers point out in their definitions the problems and pitfalls faced by nurse leaders and nursing leadership (explored in later themes).

The second main nursing leadership subtheme in Table 3, nursing leadership's crisis, includes issues discussed in some definitions of nursing leadership. Writers are fearful that the effect of healthcare changes in the last decade, such as the introduction of general management, may have done nursing irreversible harm. There is hope however, that after a period of neglect, local, national and international awareness of nursing

leadership's perilous state has never been stronger; the so-called nursing leadership barometer (see item six in Table 3). These views are also linked to item four in Table 3. That is, owing to developments in treatment and care, the need for nurse leaders has never been greater.

The third subtheme in Table 3 is the debate about nursing leaders. The debate in the literature is wide ranging. Some writers blame colleagues in other professionals groups for the lack of nursing leadership. Others blame nurses themselves, or at least nursing's history. For example, some say that nursing attracts professionals who are not natural leaders, or that nursing instils knowledge, attitudes, and skills that suppress potential nurse leaders.

A SWOT analysis of the nursing leadership literature unearths an array of strengths, weaknesses, opportunities and threats. Some writers go on to capitalise nursing's strengths and opportunities, while minimising the profession's weaknesses and threats. Understandably, SWOT elements feature heavily in nursing leadership development programmes (discussed later). Also linked to a SWOT analysis of nursing leadership is Subtheme 8 in Table 3 - the barriers facing nurse leaders.

Perhaps the most disappointing aspects of definitions and related issues in the literature was that few sources were empirically based. Nevertheless, the richness of the books and articles will materialise in the forthcoming Themes' 2 to 15.

Theme 2. Change and Change Management

As shown in Table 3 above, and discussed in the introduction to nursing leadership section, the interplay of change upon nursing leadership features strongly in the literature. Some writers for example blamed nursing leadership's present unsatisfactory state upon healthcare changes over the years. Other subthemes are listed in Table 5 below.

Table 5. Change and Change Management: Subthemes

Subtheme	Source
1. History of nursing and nursing leadership.	Hardy and Rafferty 1982 p.1430; King's Fund 1985 p.22; Hezekiah 1988 p.155; Huston and Marquis 1988 p.39; Savage 1990 p.7; Kay and Dickens 1991 p.18; Davies and Cole 1991 p.22; Hunt 1992 p.14; Rowden 1995 p.50; Girvin 1996a pp.10-11; Starns 1996 p.34.
2. Healthcare changes and nursing leadership.	King's Fund 1985 p.15; Johnson and Mclosky 1988 p.106; Broome 1990 p.22; Kay and Dickens 1991 pp.18-19; Davidson and Cole 1991 p.22; Hunt 1992 p.14; Hempstead 1992 p.37; DoH 1993 p.7,13; King and Cunningham 1995 p.5; Malby 1996 p.148.
3. Demographic issues.	Hutt 1986 p.9; Sullivan 1990 p.82; Rothwell 1991 p.28; Hunt 1992 p.14; Girvin 1996c p.20; Chapman 1996 p.3.
4. The future.	Duffield 1988 p.126; Rafferty 1993 p.6; King and

	Cunningham 1995 p.5.
5. Leaders as change agents.	Broome 1990 p.21; Sullivan 1990 p.42,81; Andrews 1993 p.437; Rafferty 1993 p.4; DoH 1993; DoH 1994 pp.12-18.

The discussion of change in the nursing leadership literature can be divided into two sections: (a) healthcare changes impinging on nursing leadership; and (b) nursing leaders as change agents.

Healthcare changes impinging on nursing leadership

The history of nursing prior to the early 1980's was discussed in three periods: (a) the ascetic period before 1880; (b) the romantic period between 1880 and 1950; and (c) the humanistic period from 1950. Some of the changes experienced by nurses since the 1980's were described as unprecedented upheavals, including: (a) flatter management structures and especially the introduction of general managers; (b) market forces such as the purchaser-provider split; (c) multiskilling the workforce; (d) financial and political issues such as rationing; (e) demographic; (f) consumerism; (g) environmental; (h) technological; and (i) educational. These sometimes negative changes led to disruption and dissonance for nurses, who were likely to react in three ways: (a) adapt to the situation; (b) accept the challenge and compete with their colleagues for resources and promotion; or (c) react negatively by closing their minds. One certain outcome of healthcare change however was that nurses would get accustomed to a culture of change and to shifting boundaries.

Nursing leaders as change agents

Writers believed that one role of nursing leaders was to implement change, especially to improve nursing's effectiveness. Many agreed that some of the healthcare changes described above provided opportunities for nurse leaders to shine. Other writers called for a strengthening of nursing's power and intellectual bases to enhance their change-agent role. Subtheme 2 in Table 5 above included empirical evidence that supported the arguments for developing nursing's infrastructure.

Theme 3. Nursing Leadership and Organisations

Although only a small section in the literature, some powerful arguments were expressed in Theme 3. Subthemes and their sources are listed in Table 6 below.

Table 6. Nursing Leadership and Organisations: Subthemes

Subtheme	Source
1. Health policy.	Bowman 1979 p.xviii; Dean 1996 p.8; Girvin 1996b p.21; Legg 1996 p.10.
2. Leadership in older (hierarchical) healthcare organisations.	Sullivan 1990 p.26,30-31,53,63; Girvin 1996a p.12; King and Cunningham 1996 p.8.
3. Leadership in newer (flatter-leaner)	DoH 1989 p.28; Carlisle 1991 p.26; Davidson and

organisations - opportunities for nurse leaders.	Cole 1991 p.25; Girvin 1996c p.30; Dean 1996 p.8; Chapman 1996 p.4; Cox 1996 pp.6-7; Legg 1996 p.11; Fagin 1996 p.31.

The subthemes in Table 6 cover three issues: (a) the influence of central health policy upon organisations and leadership; (b) leadership in fading (hierarchical) organisations; and (c) leadership in emerging (flatter and leaner) organisations. Clearly, nurse leaders' functions and styles depend upon the type of organisation in which they find themselves. These functions are broadly classified as: (a) task-centred; (b) team-centred; or (c) patient-centred. The advantages and disadvantages of (a), (b) and (c) are well argued in Table 6 Subtheme's 2 and 3.

Nurse leaders it seems have a difficult task. Not only are they expected to contribute to and support their employing organisations, but also create an atmosphere that promotes job satisfaction, thereby enhancing performance. Moreover, if leadership does not evolve with the organisation then both the leader and led are at risk. Developments that were classed as evolving were: (a) clinical specialist nurses; (b) multidisciplinary teams; (d) nursing development units; (e) primary care led health services; and (f) shared governance.

Theme 4. Nursing Leadership and Conflict

Again, while not a big section, some important leadership and conflict issues were raised in the literature. Issues have been sorted into two main subthemes in Table 7 below.

Table 7. Nursing Leadership and Conflict: Subthemes

Subtheme	Source
1. Intrinsic (within the professional) conflict.	King's Fund 1985 p.45; Duffield 1988 p.125; Savage 1990 pp.7-8; Sullivan 1996 p.43;
2. Extrinsic (outside the profession) conflict.	King's Fund 1985 p.45;Duffield 1988 p.125; Sullivan 1996 p.43; Legg 1996 p.10.

Writers pointed out that an important nursing leadership function was to handle conflict. Examples of intrinsic conflict included: (a) changing education; and (b) devaluing caring in favour of resource management. Examples of extrinsic conflict included: (a) adverse economic climates: (b) technology; (c) consumerism; (d) privatisation; and (e) limited resources. These conflicts consume much energy and demand great skill to resolve them.

Theme 5. Leadership Styles

Leadership style is one of the largest sections in the nursing leadership literature. Styles and their sources are listed in Table 8 below.

Table 8. Leadership Styles

Style (alphabetically)	Source
Autocratic (type 1 and type 2).	Mellish 1989 p.158; Marriner-Tomey 1988 p.18; Sullivan 1990 p.8; Vroom and Yetton 1990 p.54; Savage 1990 p.6,8; Benton 1994 p.54.
Behavioural (functional).	Benton 1994 p.54.
Boss-centred.	Marriner-Tomey 1988 p.18.
Bureaucratic.	Sullivan 1990 pp.8-9.
Charismatic.	Marriner-Tomey 1988 p.183; Lorentzon 1992 p.525; Davidhazar 1993 p.675; Rafferty 1993 p.3; Girvin 1996b p.21.
Circumstantial.	Rafferty 1993 p.7.
Consultative.	Vroom and Yetton 1990 p.54.
Connective.	Klackovich and Burns in Girvin 1996b p.21.
Contingency.	Fielder in Sullivan 1990 p.58; King and Cunnigham 1996 p.4.
Constitutional.	Rafferty 1993 p.7.
Constructivist.	Rafferty 1993 p.7.
Democratic.	Mellish 1989 p.157; Sullivan 1990 p.8; Savage 1990 p.6,8.
Driver-type.	Searle in Mellish 1989 p.158.
Employee-oriented.	Blake and Mouton in King and Cunningham 1996 p.4.
Four-type.	Schutz et al 1988 p.77.
Goal oriented.	Benton 1994 p.54.
Great person.	Marriner-Tomey 1988 p.183; Sullivan 1990 p.36.
Highly-visible-Less-visible.	Rafferty 1993 p.3.
Interactional.	Sullivan 1990 p.36; King and Cunningham 1996 p.4.
Integrative.	Marriner-Tomey 1988 p.189.
Laissez-faire.	Sullivan 1990 p.8; Searle in Mellish 1989 p.158.
Life-cycle.	Marriner-Tomey 1988 p.187.
Material type.	Searle in Mellish 1989 p.158.
Medical.	Johnson and McCloskey 1988 p.106.
Motivation.	Benton 1994 p.53.
Multicratic.	Sullivan 1990 pp.8-9; Benton 1994 p.54.
Parental.	Sullivan 1990 pp.8-9.
Path-goal.	Sullivan 1990 p.56.
People centred.	Savage 1990 p.6.
Power based.	Mackie in Girvin 1996b p.20; Girvin 1996b p.20.
Product oriented.	Blake and Mouton in King and Cunningham 1996 p.4.
Relationship.	Davidhazar 1993 p.677.
Situational.	Marriner-Tomey 1988 p.184; Sullivan 1990 p.36; Benton 1994 p.54; King and Cunningham 1995 p.4.
*Stupe*rvisor (yes-man type).	Searle in Mellish 1989 p.158.
Subordinate centred.	Marriner-Tomey 1988 p.18.
Task centred.	Savage 1990 p.6.
Team-building.	Searle in Mellish 1989 p.158.
Trait (inherent or learned).	Marriner-Tomey 1988 p.184; Sullivan 1990 p.36; King and Cunningham 1995 p.4.
Transformational.	Broome 1990 pp.20-21; Davidhazar 1993 p.675,677; Burns in Girvin 1996b p.20; Legg 1996 p.10; King and Cunnigham 1996 p.4.
Transactional.	Broome 1990 pp.20-21; Rafferty 1993 p.7; Girvin 1996b p.20; King and Cunnigham 1996 p.4.

While the list in Table 8 is not exhaustive, almost 40 styles give a representative view of the theories used to explain nursing leadership. Clearly, there is overlap between some of the styles above, probably because some writers used synonyms to describe established leadership theory. For example, the similarities between integrative and multicratic styles in the literature are strong. One caveat is that the styles in Table 8 with more references attached are not an indication of their robustness or their suitability for nursing. The frequent citations, as in autocratic leadership style for example, in some cases were negative.

Several issues emerged in the literature on nursing leadership styles. First, styles seemed to be argued from: (a) professional; (b) empirical; or (c) clinical standpoints. Second, no leadership style was judged universally suitable for nursing. Indeed, several authors pointed out that nurse leaders need to be adaptive and select an appropriate leadership style for the situation in which they find themselves. In short, leadership styles will be influenced by: (a) the leader's personality; (b) followers' behaviours; and (c) the tasks at hand. Third, certain leadership styles proved more popular at certain times, which may reflect contemporary healthcare issues of the time. However, if there is a leadership style that is a front runner today, it is the transformational approach - deemed more appropriate for today's ever-changing healthcare structure and processes.

Theme 6. Characteristics of Nursing Leaders

After describing one or more leadership styles, many writers went on to explain the characteristics of good or poor nursing leaders. These discussions are subthemed in Table 8 below.

Table 8. Characteristics of Nursing Leaders: Subthemes

Subtheme	Source
1. Nurse leader characteristics and qualities.	Hardy and Rafferty 1982 p.1429; King's Fund 1985 p.26; Hutt 1986 p.12; Norman 1987 p.52; Schultz 1988 p.68,76; Broome 1990 p.20; Sullivan 1990; p.89; Rafferty 1991 p.1,3; Rothwell 1991 p.28; Ward and Price 1991 p.41; MacPherson 1991 p.51; Hunt 1992 p.13; Lorentzon 1992 p.525; Davidhazar 1993 p.677; Salvage 1993 p.101; Bowman and Thompson 1994 p.40; Benton 1994 p.54; Henry et al 1994 p.154; Girvin 1996a p.12; Reeder 1996 p.4; Legg 1996 p.10; Malby 1996 p. 149; McGleish 1996 p.14; Woan and Whitby 1996 p.15.
2. Gender issues.	Hutt 1986 p.9,14; Wedderburn-Tate 1996 p.8.
3. Stereotypes and misconceptions.	MacPherson 1991 p.51; Bowman and Thompson 1994 p.40; Booth 1995 p.58; Dean 1996 p.8.
4. Leader's professional background and experience.	Hutt 1986 p.9,12.

Perhaps the easiest way of describing the myriad of desired and unwanted nursing leadership characteristics would be to summarise them in a separate table using Table 8 as a source and guide.

Table 9. Desirable, Undesirable and Misconceived Nurse Leader Characteristics

Desirable	**Desirable Continued**	**Undesirable**
Achiever.	Open-minded.	Arrogant.
Approachable.	Operationally sound.	Bureaucratic.
Articulate.	Organisational aware.	Controller.
Assertive.	Literate.	Embittered.
Astute.	Motivator.	Intellectually lightweight.
Clear thinker.	Numerate.	Old boy's club member.
Coacher.	Persistent.	Lacks vision.
Committed.	Persuasive.	Maintains status quo.
Communicator.	Policy maker/interpreter.	Mutually appreciation society member.
Competent.	Politically aware.	Status conscious.
Compromiser.	Positive.	Stifles innovation.
Collaborator.	Pragmatic.	
Confident.	Progressive.	
Considerate.	Quick thinker and learner.	**Misconceived**
Cost conscious.	Questioner.	Colourful personality.
Courage.	Reflective.	Speeches that make good copy.
Creative.	Resolves conflicts.	Glitzy presenter.
Credible and respected.	Respected.	High profile.
Critical.	Risk taker.	Power dresser.
Decisive.	Runs a tight ship.	Recite platitudes.
Delegates.	Secure.	Gender imbalance.
Developer.	Self respect.	
Discriminator.	Sensitive.	
Drive.	Sense of purpose.	
Dynamic.	Shares goals and values.	
Educated.	Socially assured.	
Empirically oriented.	Sound clinically, managerially, and educationally.	
Enjoys challenges.	Sticks to the agenda.	
Enthusiastic.	Staying power and stamina.	
Expert.	Strong values.	
Feminine, soft skills.	Systematic thinker.	
Fights the corner.	Takes criticism.	
Fits in.	Takes people along.	
Flexible.	Thoughtful.	
Fosters a team spirit.	Tough.	
Gets on well with others.	Tolerant.	
Gives feedback.	Trusted.	
Good listener.	Vision.	
Guides subordinates.		
Has followers.		
Honest.		
Humorous.		
Imaginative.		
Inspirational.		
Integrity.		
Intelligent.		
Initiative.		
IT&M aware.		

Clearly, no leader would possess all the desirable nor indeed the undesirable qualities listed in Table 9 above. Although few items in the list were derived empirically, the items in Table 9: (a) help to create assessment and selection criteria; and (b) create a curriculum for educating nurse leaders.

Theme 7. Functions of Nursing Leaders

Writers also synthesised several functions of nurse leaders from the leadership literature. Leadership functions can be grouped into five subthemes. These five subthemes combine to explain three main leadership functions: (a) achieve tasks; (b) build and maintain teams; and (c) develop individuals.

Table 10. Functions of Nursing Leaders: Subthemes

Subtheme	Source
1. Power: charismatic; coercive; expert; legitimate; position; personal; referent; reward; socialised.	King's Fund 1985 p.12,16; Marriner-Tomey 1988 p.186, Duffield 1988 p.127; 206; Sullivan 1990 p.46; Ward and Price 1991 p.41.
2. Influence: circumvent; create; guide; steer.	Hardy and Raffery 1982 p.1430; Sullivan 1990 p.46,63; Ward and Price 1991 p.41; Kaye and Dickens 1991 p.18; Lorentzon 1992 p.526; Cox 1996 p.6.
3. Persuasion.	Sullivan 1990 p.46; Broome 1990 p.20; Ward and Price 1991 p.41.
4. Motivation: job satisfaction; liberate.	Sullivan 1990 p.46,64; Ward and Price 1991 p.41; Defenbaugh 1994 p.28; Girvin 1996a p.12; Girvin 1996d p.16; Wedderburn-Tate 1996 p.8.
5. Assertiveness: confidence.	King's Fund 1985 p.16; Sullivan 1990 p.46; Lorenzton 1992 p.525.

As well as providing a framework in which to develop and test knowledge about nursing leadership, writers used the five subthemes in Table 10 above, along with examples (sometimes empirically derived), to clarify leadership functions. Aspects of nurses' personal power and influence for example could be used to improve patient care by strengthening multidisciplinary teams. Some writers also used the five subthemes to explain why nursing leadership was diminishing and failing. A lack of assertiveness and confidence in nurse leaders for example, reduced nursing's voice. Finally in this section, some articles suggested nurse leaders' priorities. At the top was

addressing nursing shortages; and the lowest priority (although important) was seeking and forming new coalitions.

Theme 8. Leaders, Followers and Groups

Studying followers and the ways they form groups helps to explain the delegating and facilitating functions of leadership. Four subthemes emerge in Table 11.

Table 11. Leaders, Folowers and Groups: Subthemes

Subtheme	Source
1. Subordinates/Followers.	Mackie 1987 p.10; DoH 1989 p.28; Rafferty 1993 p.4; Davihazar 1993 p.676.
2. Teams/Teamwork.	DoH 1993 p.14; Sullivan 1990 p.69.
3. Meetings.	Sullivan 1990 p.69.
4. Group structures and processes.	Sullivan 1990 p.45; Salvage 1993 pp.99-109.

Writers make three points about leaders, followers and groups. First, leaders should not under estimate the influence followers and groups of followers can have upon work processes and outcomes. Second, leaders should be aware of group processes to make team work efficient and effective. Third, leaders should select an appropriate leadership style for the situation (see also Theme 5).

Theme 9. Communication

Three subthemes emerge in Table 12.

Table 12. Communication: Subthemes

Subtheme	Source
1. Being heard.	Sullivan 1990 p.67.
2. Networking.	Sullivan 1990 p.67.
3. Listening.	Sullivan 1990 p.46.

Articulate leaders, speaking to appropriate audiences, were judged important. Good listening however was judged equally important.

Theme 10. Surviving as a Nurse Leaders

Once writers had explained the nature of leadership and nurse leadership types, many went on to explore how nurse leaders might be selected and developed. The first theme in this batch explores survival issues for nurse leaders.

Table 13. Survival: Subthemes

Subtheme	Source
1. Survival issues.	Sears 1996 p.9; Dean 1996 p.8.
2. Survival actions.	Salvage 1993 p.100; Cox 1996 p.6.

This section, although small, was empirically strong. Reported data indicated the high turnover of senior nurses. Other sections explored the dangers and barriers for nurse leaders and what must be done to overcome problems and pitfalls. Discussions about survival in the literature, while depressing for nurses, were sobering.

Theme 11. Succession Planning

Writers' discussion of survival sometimes naturally flowed into succession planning. Subthemes are listed in Table 14 below.

Table 14. Succession Planning: Subthemes

Subtheme	Source
1. Rationale behind succession planning.	Hardy and Rafferty 1982 p.1430; Carlisle 1991 p.25; Lorentzon 1992 p.525; Hunt 1992 p.15; Muller 1995 p.22; Dean 1996 p.12.
2. Intrinsic and extrinsic pressures.	Dean 1993 p.33; Salvage 1993 p.101; Legg 1996 p.12.
3. Central policy.	DoH 1989 p.34; Savage 1990 p.8; Girvin 1996c p.21.
4. Methods.	Salvage 1989 p.34; Davidson and Cole 1991 p.24; Rothwell 1991 p.28; Carlisle 1991 p.26; Hunt 1992 p.14; Lorentzon 1992 p.525; Auld 1992 p.29; Hempstead 1992 p.38; Bowman and Thompson 1994 p.40; Dean 1996 p.8,12; Zanderbergen 1996; Reeder 1996 p.5.
5. Outcomes.	Carlisle 1991 p.26; Lorentzon 1992 p.526; Chapman 1996 p.3.

Succession planning discussions can neatly be categorised into issues and actions within the nursing profession and issues and actions external to the profession. Intrinsic and extrinsic issues and actions however interplay. For example, one intrinsic issue was the diminished stock of nursing leaders caused by external factors such as: (a) demographic changes and (b) the introduction of general managers that sidelined nurses and nursing or altered nurses' promotion route. One emerging, important argument, that is likely to gain momentum, is the shift from developing nurse leaders

from management ranks to selecting and developing leaders from clinicians. No doubt the growing band of nursing and practice development units have fuelled these arguments.

Government policies were cited more often in the Succession Planning Theme than in any other theme. Policies were praised for their contribution to understanding leadership and related issues, and for sponsoring leadership programmes. Occasionally, writers criticised government policy makers for not distinguishing between management and leadership. It was accepted however that leadership succession planning is not solely the government's responsibility. Academic units, professional organisations and individuals can contribute too.

Theme 12. Appraising Nursing Leaders

Health service staff appraisal is a popular literature topic in its own right. It is not surprising therefore that writers should draw on staff appraisal literature to assess and evaluate nurse leaders. Three subthemes emerge - listed in Table 15 below.

Table 15. Appraisal: Subthemes

Subtheme	Source
1. Assessing leaders.	Rothwell 1991 p.30; Carlisle 1991 p.26; Auld 1992 p.28; Lorentzon 1992 p.525; Rafferty 1993 p.16.
2. Individual performance review.	Hutt 1986 p.15; Sullivan 1990 p.66; Carlisle 1991 p.26.
3. Assessment centres.	Rothwell 1991 p.30; Carlisle 1991 p.26.

Views about the nature and value of appraisal in a leadership context were mixed. Negative views: (a) doubted some of the processes involved, especially the link to financial reward; (b) questioned the cost-effectiveness of appraising; and (c) highlighted some patchy outcomes from evluation research. Positive views, on the other hand, applauded: (a) peer review as a method of appraisal; (b) protagonists' attempts at objectivity; and (c) protagonists' intelligence gathering, notably about refining assessment criteria.

Theme 13. Developing Nurse Leaders

Structures, processes and outcomes of nurse leadership education programmes was the second largest theme in the literature. Six subthemes emerge in Table 16 below.

Table 16. Developing Nurse Leaders	
Subtheme	**Source**
1. Developing nursing leaders.	Davidson and Cole 1991 p.24; Hunt 1992 p.13; Dean 1993 p.33; Rafferty 1993 p.18,24; MacPherson 1992 p.51; Salvage 1993 pp.101-109; Cox 1996 p.7; Legg 1996 p.10; Malby 1996 p.149; Rowden 1995 p.50; Sears 1996 p.9.
2. Basic and post basic education.	Duffield 1988 p.129; DoH 1989 p.29; Chapman 1996 p.5.
3. Curricular issues.	Bowman 1979 p.xx; Hardy and Rafferty 1982 p.1429; Norman 1987 p.52; Rafferty 1993 p.15,24; Henry et al 1994 p.155; Legg 1996 p.10; Reeder 1996 p.5; Woan and Whitby 1996 p.16.
4. Mentoring and supervising.	Hardy 1983 p.3; Malby 1996 p.149.
5. Established educational programmes.	Hempstead 1992 p.39; Lorentzon 1992 p.52; Rafferty 1993 p.13,21,23; Sears 1995 p.14; Chapman 1996 p.3,5; Dean 1996 p.8; Legg 1996 p.11; Malby 1996 p.149; Woan and Whitby 1996 p.15; Zanderbergen 1996(no p.).
6. Evaluating leadership education.	Salvage 1993 p.109; Malby 1996 p.149; Woan and Whitby 1996 p.16.

As discussed in earlier themes, poor basic and postbasic leadership education was one reason for the unsatisfactory state of nursing leadership in the 1990's. Unsurprisingly therefore, many writers: (a) stressed the importance of the curriculum for developing nurse leaders; (b) described established programmes (see Table 17 below); (c) suggested curricular content (see Table 18 below); and (d) described leadership curricular successes and failures. Encouragingly, some of the approaches and curricular items below were empirically derived.

Table 17. Established Nurse Leadership Development Programmes	
Programme/Method (alphabetical)	**Source**
Academy of learning.	Legg 1996 p.11.
Advanced practitioner/Consultant nurse.	Dean 1993 p.33; Rafferty 1993 p.15.
Apprenticeships.	Rafferty 1993 p.15.
Development centres.	Rafferty 1993 p.25.
DoH Rainbow Pack - Information Management.	Hempstead 1992 p.39; Dean 1993 p.33.
Inservice education.	Rafferty 1993 p.24.
Johnson and Johnson.	Rafferty 1993 p.23.
King's Fund College.	Hempstead 1992 p.39; Dean 1993 p.33; Rafferty 1993 p.24.
King's Fund Management College.	Malby 1996 p.149.
King's Healthcare	Sears 1995 p.14.
Matrix learning sets.	Rafferty 1993 p.24.
Mentorships and supervision.	Rafferty 1993 p.15,25.
Mersey Nursing Succession Planning.	Hempstead 1992 p.39.
NHSTD: Managing Health Services; Health Pick-up.	Hempstead 1992 p.39.

Nuffield Institute Management and Leadership.	Nuffield Institute 1995 (no p.)
Nurse Executive Networking.	Rafferty 1993 p.25.
Open University - The Effective Manager.	Hempstead 1992 p.39.
Open University - Planning and Managing Change.	Hempstead 1992 p.39.
Opportunity 2000.	Rafferty 1993 p.13; Dean 1993 p.33; Chapman 1996 p.5.
Preston Hospitals.	Woan and Whitby 1996 p.15.
Robert Wood Foundation.	Rafferty 1993 p.23.
Royal College of Nursing: Nurses in Leadership.	Chapman 1996 p.3; Dean 1996 p.8.
UKCC PREP.	Rafferty 1993 p.15.
Workshops and seminars.	Rafferty 1993 p.25.
Workplace learning.	Chapman 1996 p.5.
York University Leadership Programme.	Fritchie 1996 p.26.

Programmes for male and female leaders, it was suggested, should differ (worker shadowing in Opportunity 2000 for example) for efficiency and effectiveness.

A large area of discussion was the content of the nursing leadership curriculum. In view of their importance, curricular topics are listed below in Table 18.

Table 18. The Leadership Curriculum

Items (alphabetical)	
Advanced technology. Advocacy. Assertiveness. Audit. Career guidance. Change. Clinical broadening. Clinical supervision. Communication. Comparative healthcare. Confidence building. Corporate thinking. Cost-benefit analysis. Creativity. Critical thinking. Decision analysis. Delegating Economics. Ethics. Experiential learning. Finance. Goal setting. Group dynamics. Health need assessment. Health policy. Innovation. Information management and technology. Individual performance review.	Motivation. Marketing. Multi-agency working and multiskilling. Negotiating. Networking. Organisations. Performance evaluation. Personal effectiveness. Personnel. Persuasion. Planning. Policy. Politics. Power broking. Primary led healthcare. Public speaking. Realising potential. Quality assurance. Reflective practice. Report writing. Research and development. Statistics. Strategy. Vibrancy. Women in management. Workforce planning. Workplace learning. Work shadowing.

Management theory.	Work values.

Undergraduate nursing programmes, it was suggested, may include more of the curricular itmes in Table 18 than diploma or certificate programmes; implying that graduate nurses may leave their programmes with more of the leadership knowledge, attititudes and skills in Table 18. There was a hint in the literature that multidisciplinary education may improve nursing leadership. Finally, few writers suggested how nursing leadership programme completers might be examined.

Theme 14. Challenges Facing Nurse Leaders

Clearly, the literature review shows that much has been achieved in the realm of nursing leadership theory and practice. No writer however was complacent about nursing leadership. Many writers reminded readers about the present and future challenges facing nurses. These are grouped into three subthemes in Table 19 below.

Table 19. Nursing Leadership Challenges

Subtheme	Source
1. Challenges intrinsic to nursing.	Hutt 1986 p.14; Hempstead 1992 p.38; MacPherson 1992 p.51; Rafferty 1993 p.18; Henry et al 1994 p.153; Dean 1996 p.13; Malby 1996 p.148; Naish 1995 p.3; Wedderburn-Tate 1996 p.8.
2. Challenges extrinsic to nursing.	Hardy and Rafferty 1982 p.1429; Hutt 1986 p.14; DoH 1993 p.9; Henry et al 1994 p.153; Naish 1995 p.3;Cox 1996 p.8; Dean 1996 p.13; Malby 1996 p.148; Rafferty 1993 p.1; Reeder 1996 p.6; Wedderburn-Tate 1996 p.8.
3. Prejudice and bias.	Hardy and Rafferty 1982 p.1429; Hardy 1983 p.2; Rafferty 1993 p.11,18,26; Henry et al 1994 p.153; Dean 1996 p.13; Girvin 1996a p.11; Girvin 1996c p.21; Girvin 1996d p.16; Wedderburn-Tate 1996 p.8.

In view of their importance, examples of each type of challenge are listed in Table 20 below.

Table 20. Intrinsic, Extrinsic and Bias Challenges

Intrinsic	Extrinsic	Bias
Changing nurse education such as an all graduate profession. Articulating nursing to improve nurses' credibility. Board level nurses questioned. Creating the strategic leader.	Adapting to changing healthcare. Keeping abreast of medical advances. Responding to consumerism. Demographic change and nursing shortages. Ethics. Financial - underfunded nursing.	Racial prejudice. Sexism.

Overcoming nurses' crisis in confidence. Shift from nurse manager to professional advisor. International differences in nurses' standing. Reducing nurses' powerlessness.	Gaining equal footing with doctors. Handling the information overload. Regaining lost ground following the introduction of general management. Multiskilled worker. Political uncertainties. Shift from acute to chronic illness. Surviving in corporate structures.	

As in the case of evidence in other themes, the issues above were largely anecdotal.

Theme 15. Recommendations for Nurse Leaders and Nursing Leadership

The recommendations that naturally fall out of the present literature review are very similar to ones in the literature. Recommendations are grouped into six subthemes in Table 21 below.

Table 21. Recommendations for Nurse Leaders and Nursing Leadership

Subtheme	Source
1. Research.	King's Fund 1985 p.6; Rafferty 1993 p.1,18,25; Henry et al 1994 p.157; WHO in Henry et al 1994 p.157.
2. Education.	King's Fund 1985 p.33; King's Fund College 1993 p.19.
3. Practice.	King's Fund College 1993 p.19; Rafferty 1993 p.18.
4. Management.	Hunt 1986 p.13; King's Fund College 1993 p.19; Malby 1996 p.149.
5. Political.	King's Fund 1985 p.33.
6. Media.	King's Fund 1985 p.33.

Examples of recommendations from the six subthemes above include:

- Preparing nurses for jobs in which they can shine as leaders such as commissioning healthcare, and settings that emphasise care rather than diagnosis and treatment.

- Selecting nurse leaders of the future using empirically derived assessment and evaluation criteria.

- Reinforcing existing or developing new basic and postbasic leadership education programmes with curricular issues derived from empirical studies.

- Educating nurses to communicate effectively through the media.

- Educating nurses about healthcare political issues; campaigning and lobbying; setting up coalitions with other professional groups; and raising the profile of government nurses.

- Organising regular seminars and workshops on nursing leadership.

- Commissioning research and development to explore: (a) nursing leadership roles; (b) the characteristics of good nurse leaders; (c) selection criteria; (d) the number of potential nurse leaders; (e) how to make the right kind of leaders coming forward; (f) what nurses can learn from other organisations and professions; (g) the leadership curriculum; (h) nurses' historical legacy and its effect on the leadership crisis; (i) what lies behind the nursing leadership debate; (j) what general managers think of their nurse leaders; (k) what patients' perceive about nursing leadership; and (l) nursing policy making and implementing.

- Creating a nurses' think-tank.

- Boosting empirically-based publications by nurses on leadership issues.

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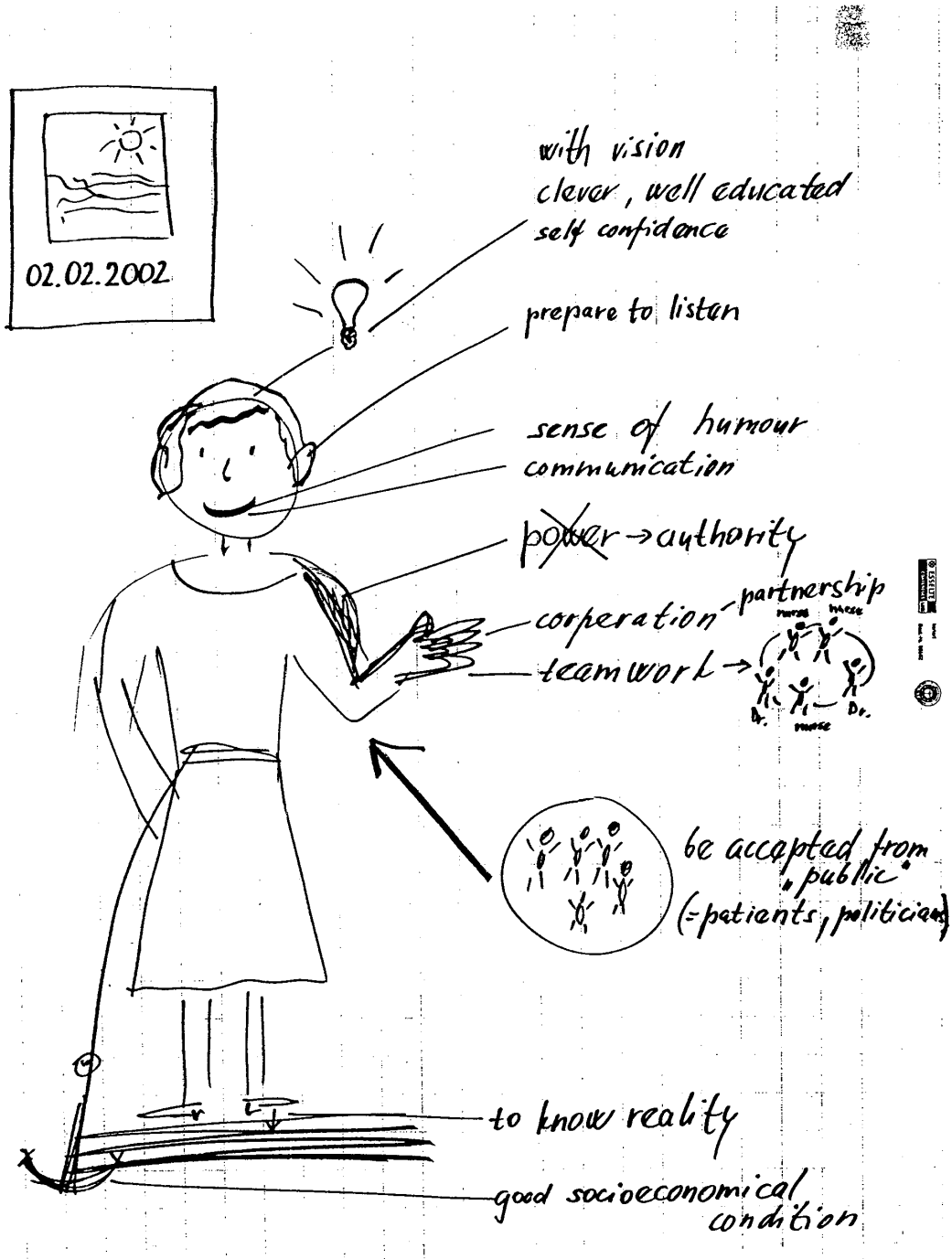
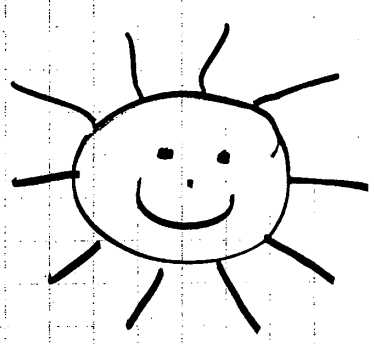
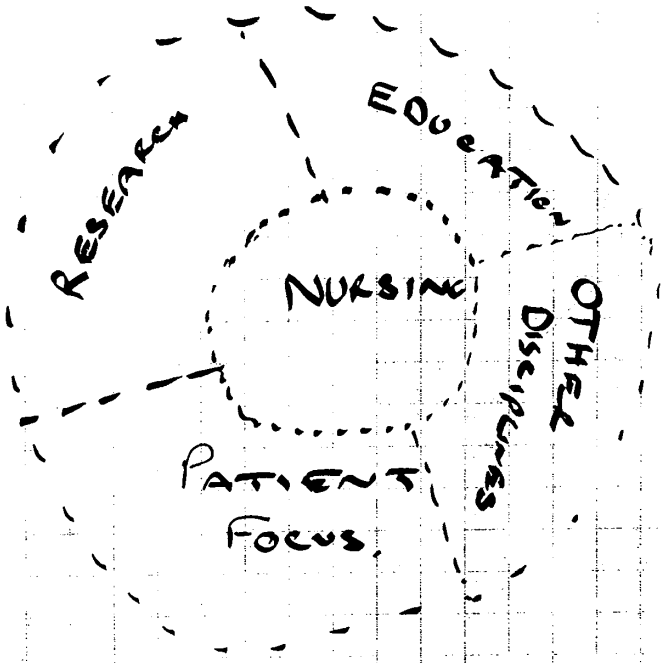
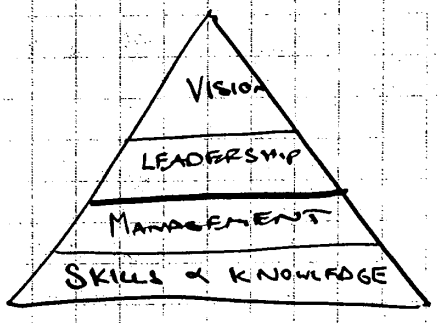
Appendix Four

Leadership pictures


02.02.2002
with vision
clever, well educated
self confidence
prepare to listen
sense of humour
communication
power → authority
corperation
teamwork
partnership
Dr.
nurse
Dr.
nurse
be accepted from public
(= patients, politicians)
to know reality
good socioeconomical condition




RESEARCH
EDUCATION
NURSING
OTHER DISCIPLINES
PATIENT FOCUS


VISION
LEADERSHIP
MANAGEMENT
SKILLS & KNOWLEDGE

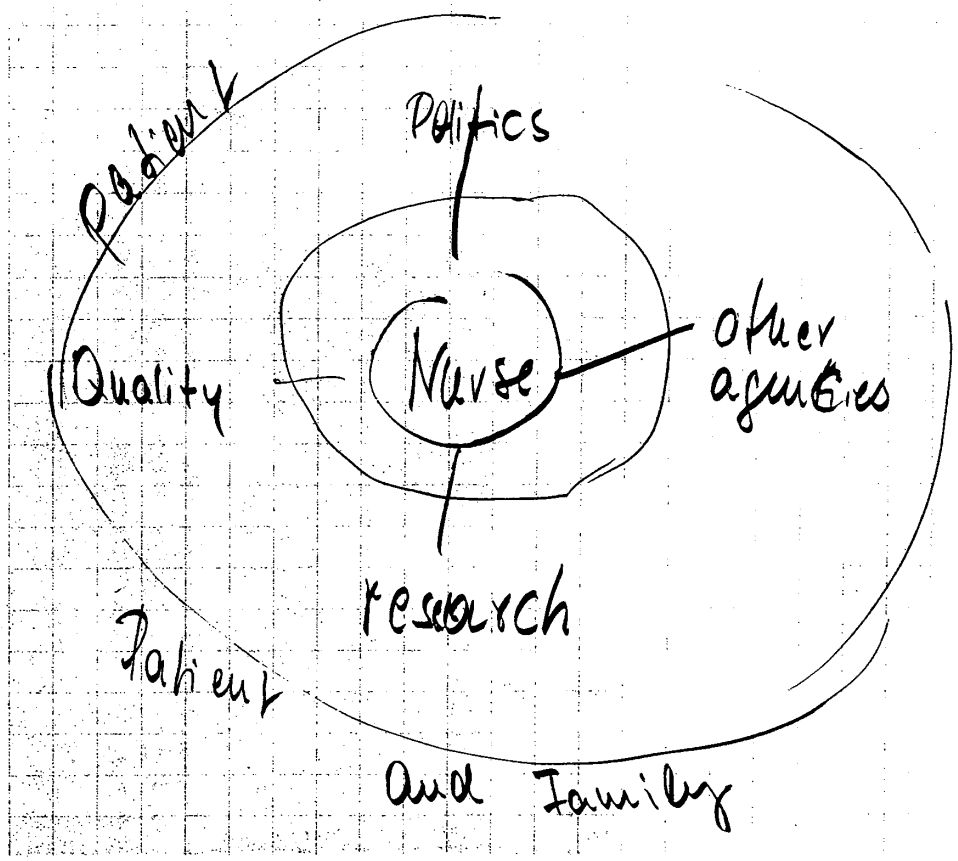
ETC
ETC
HEALTHCARE
NURSING
HEALTHCARE
FLEXIBLE
RESPONSIVE
"ORGANISATION"
LEADERSHIP
KNOWING
NO BOUNDARIES
OTHER MINISTRY eg TRANSPORT
"UNCHARTED SEA"
Is this a route of info or control/command?
OTHER DEPT.
OTHER DEPT.
INDIVIDUAL PROVIDER ORGANISATIONS or PROF. ORGS.
LEADER ON THE BOARD
CLINICAL LEADERS
"THE PUBLIC"
"free flowing as change is so rapid

Planning with Specialists and other agencies and with the PATIENT

Role of leader for Nurses is to support and enable nurses

Directs multidisciplinary team for Quality Assurance

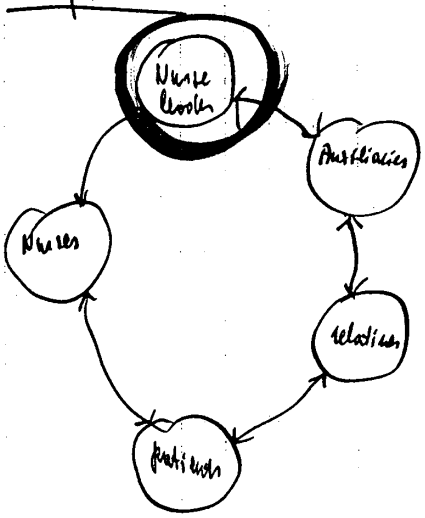
Advises key stakeholders (politics insurance companies, industries



in 5 years

I.

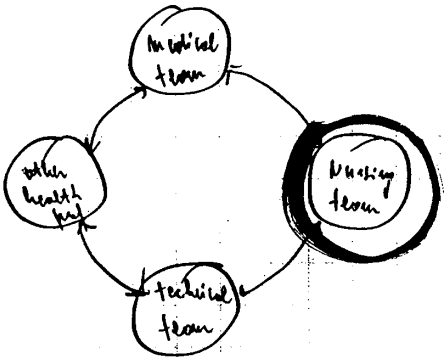
Nursing team



II.

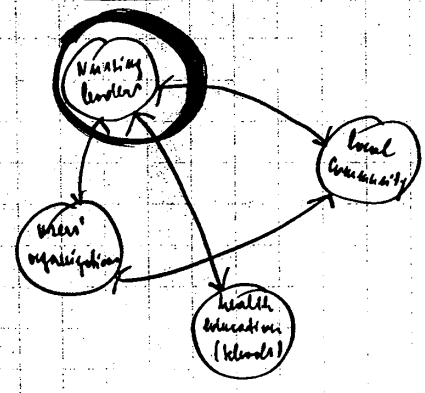
Health team e.g.

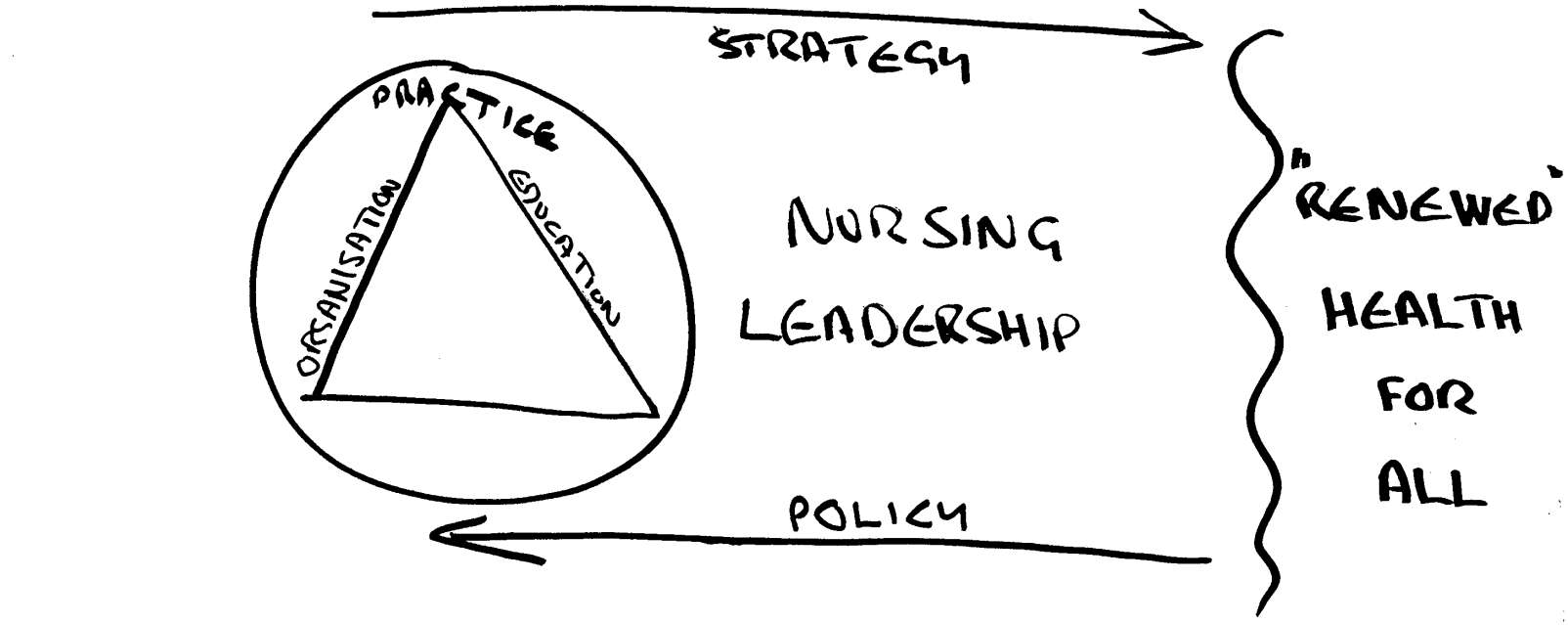
(all levels)



III.

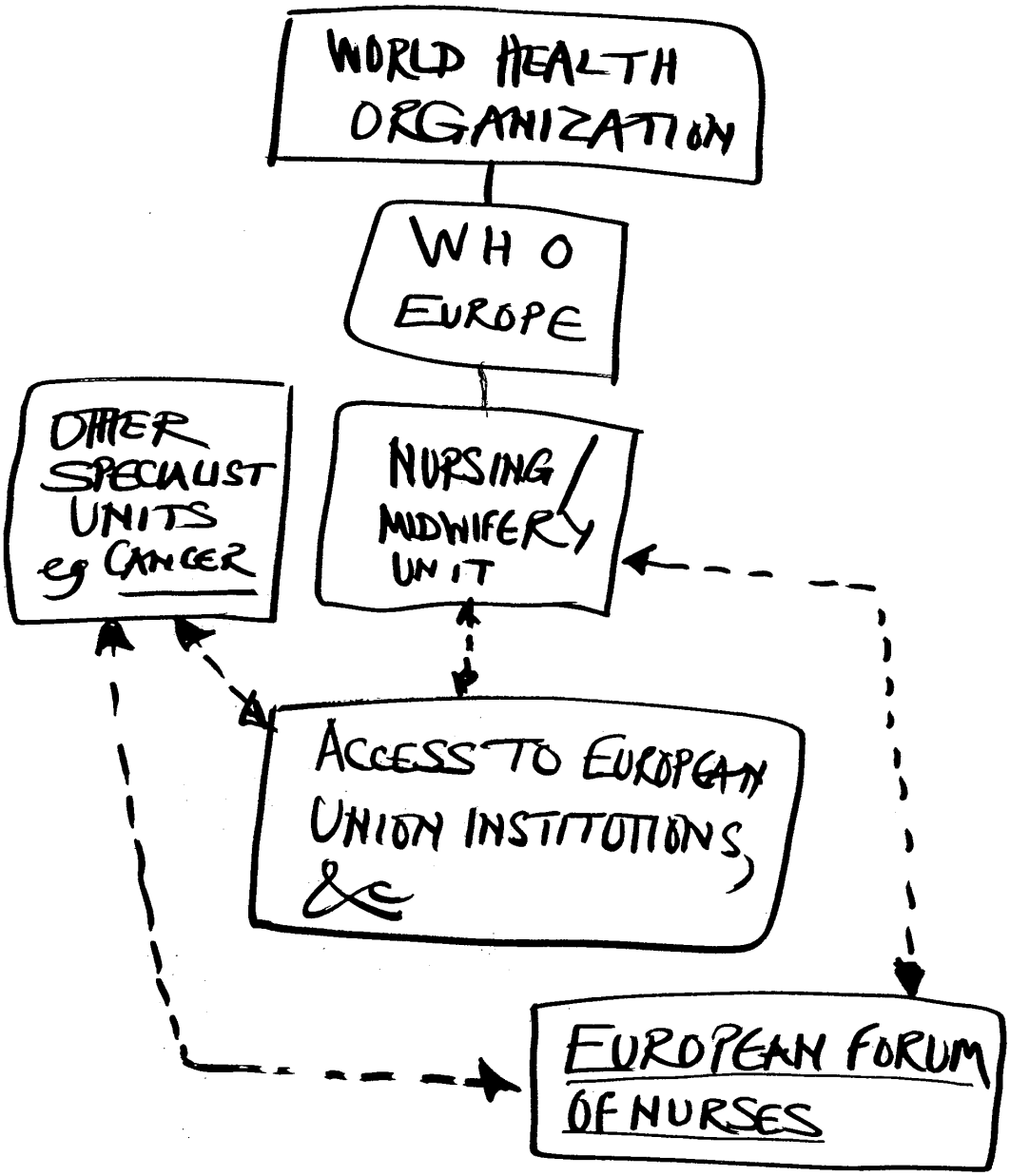
in public function



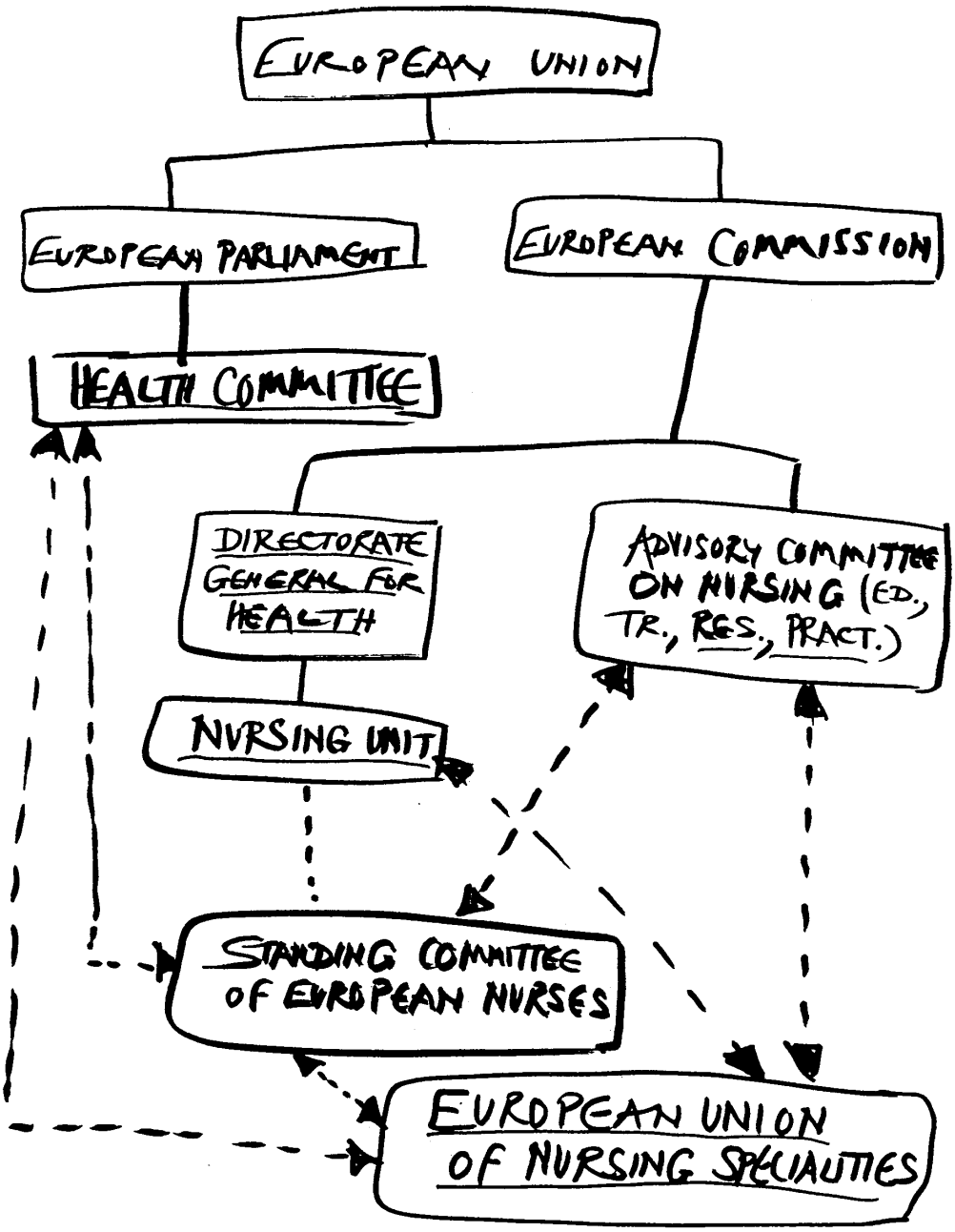

STRATEGY
PRACTICE
ORGANISATION
EDUCATION
NURSING
LEADERSHIP
POLICY
"RENEWED"
HEALTH
FOR
ALL

© T.J. RYDE

KEY: NEW UNITS, COMMITTEES, &c IN GREEN



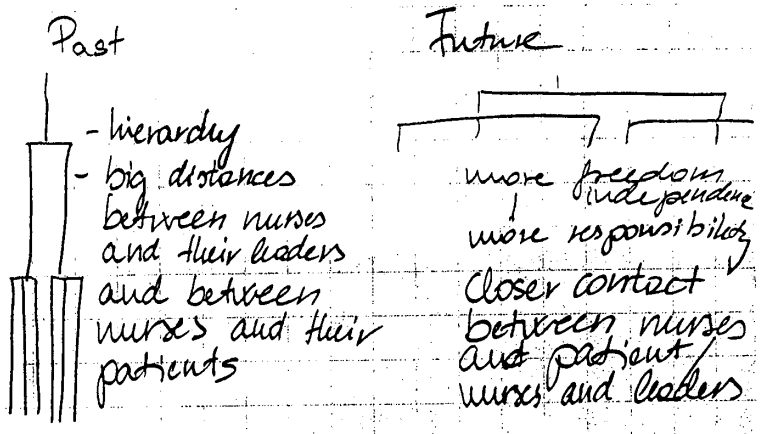
? MONITOR DEVELOPMENTS WITHIN THE COUNCIL OF EUROPE

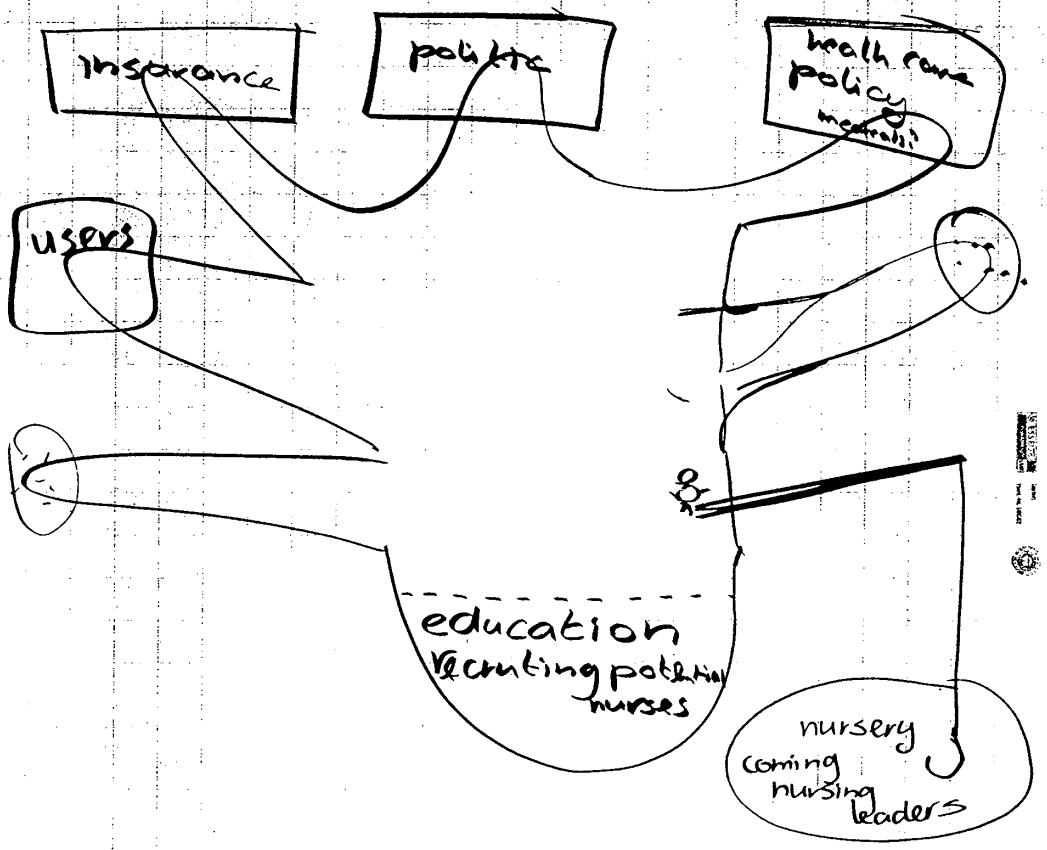


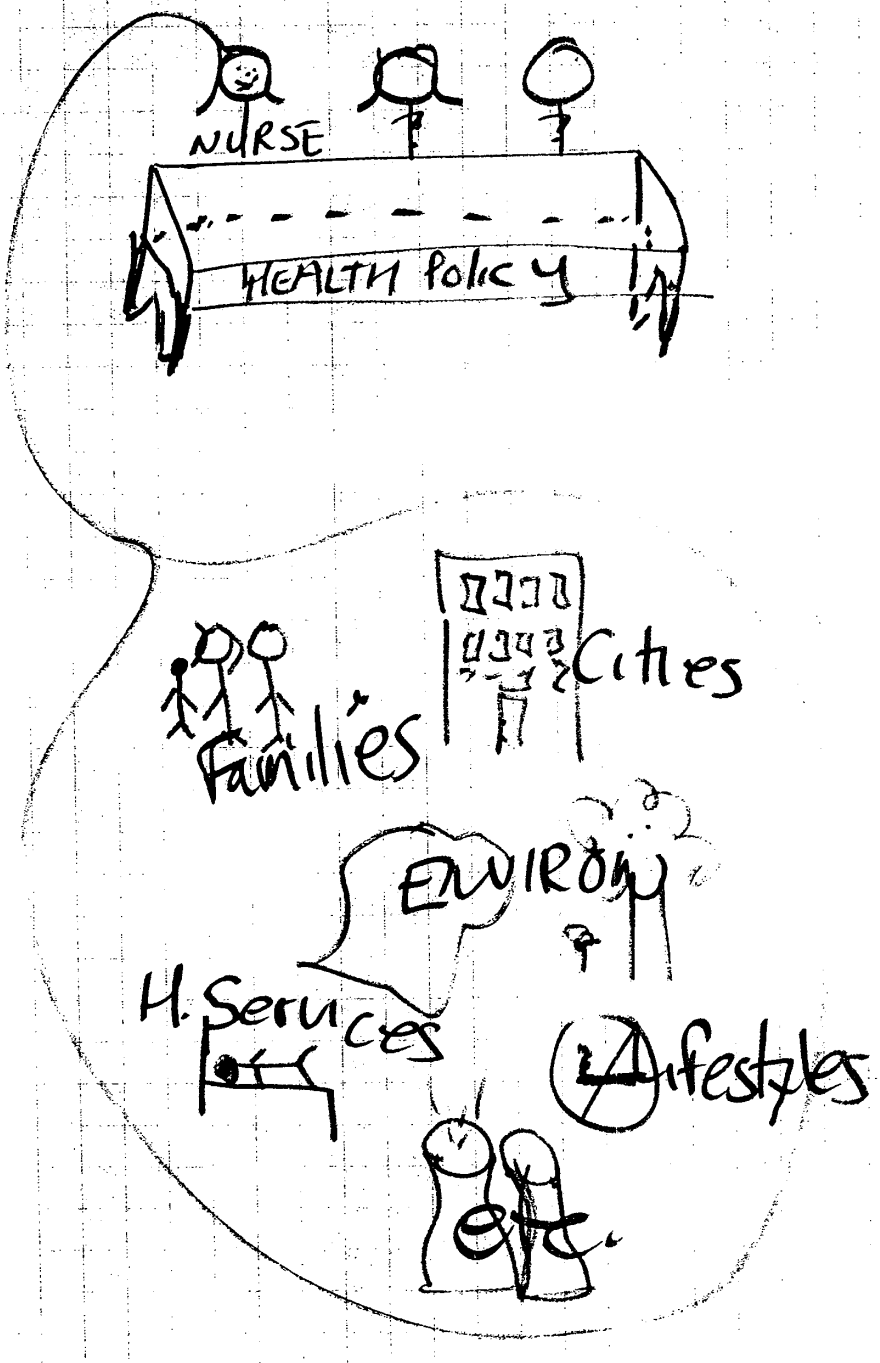
KEY: NEW UNITS, COMMITTEES, &c IN GREEN

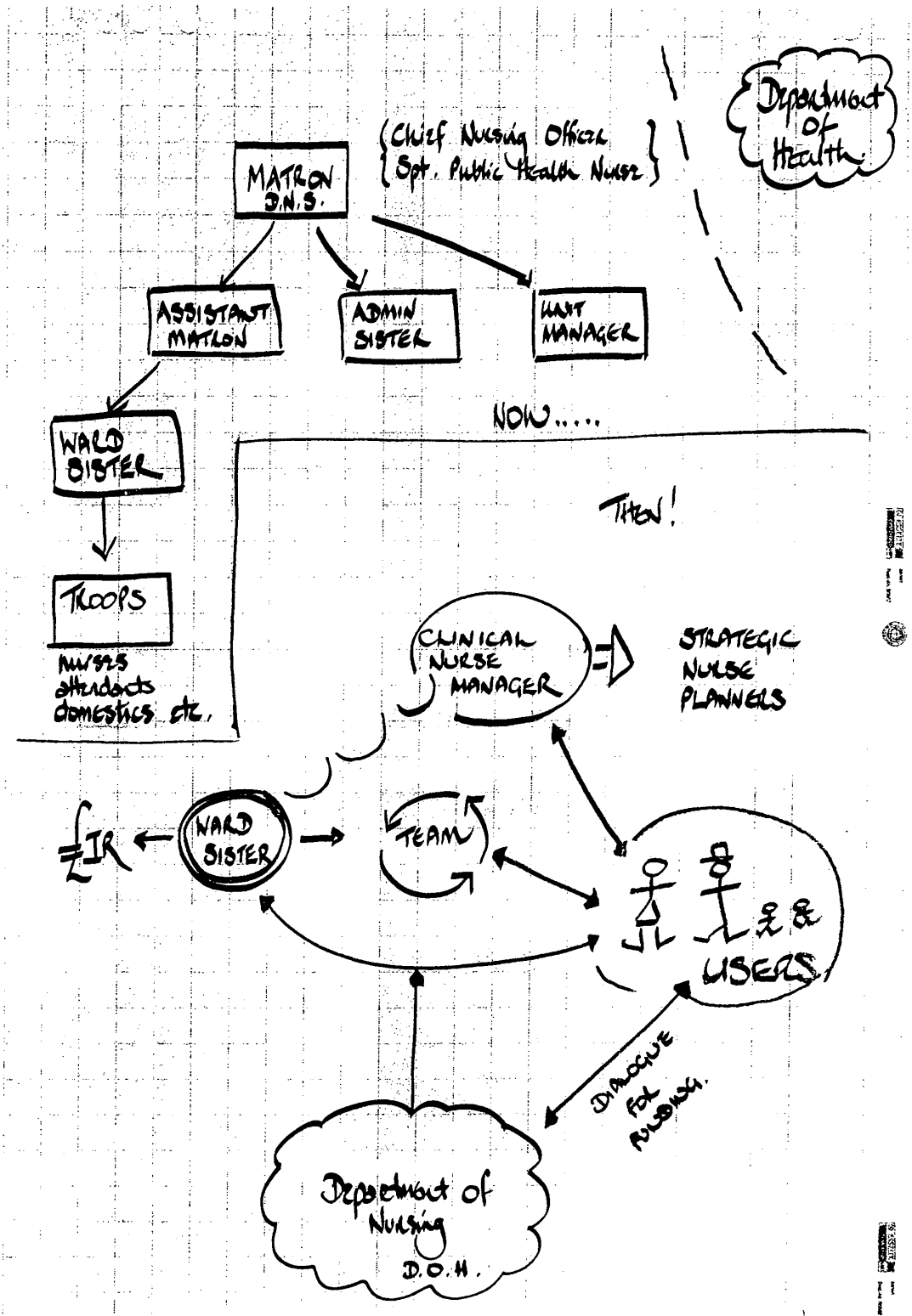
Nursing leadership 5 years later

There should be well-educated
— including management —
nurse-leaders who are enthusiastic,
have more consciosness, feel responsible for
their work and for their collegues.




insurance
politic
health care policy
users
education
recruiting potential nurses
nursery
coming nursing leaders


NURSE
HEALTH Policy
Families
Cities
ENVIRON
H. Services
Lifestyles
etc.

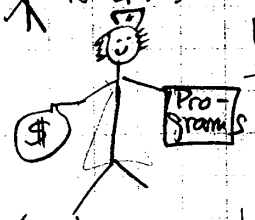


* CONCENTRATE ON CLINICAL CREDIBILITY *

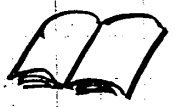
SPAIN

2001

* NURSES in the Political leaders
  - Administrad money
  - Coordination Programs
  - Planification Activities



* University
  - Near of the reality of the Health System
  - looking for young leaders.
  - Licenciated
  - Doctor?



* Hospital
  - competitive
  - quality
  - reseach.

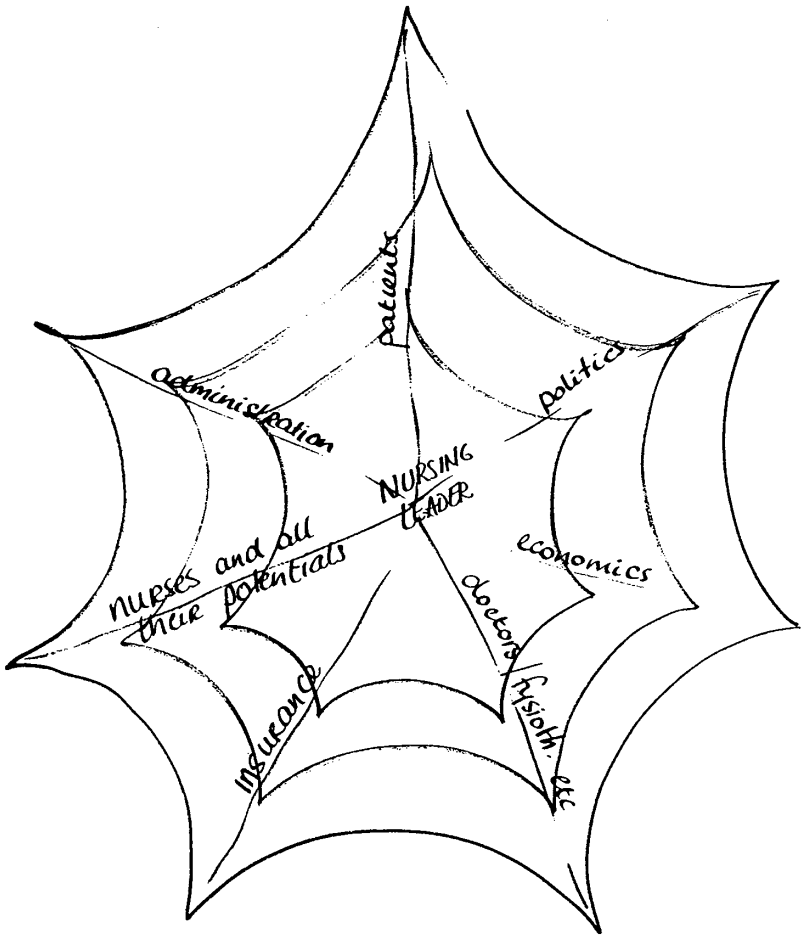
* Primary Health
  - Working with the Family
  - working with the comunitary association

1997 ⟶ 2001

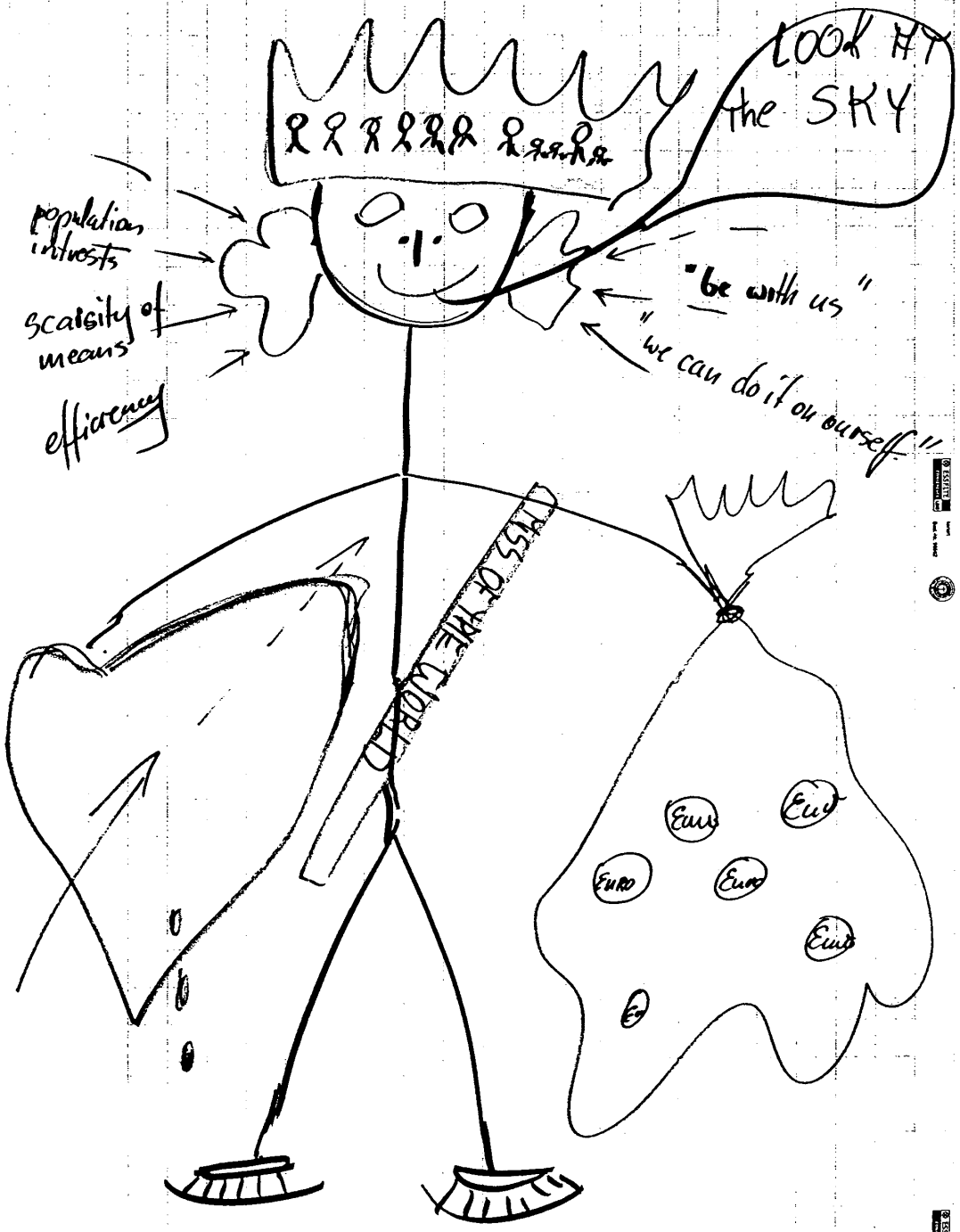
NEEDS

- to open (no closed) — multidisciplinary — INTERNATIONAL
- to listen to the young people (they have good ideas)
- to accept the challenges of the to be contemporary
- Don't be afraid to the news ideas
- to be in the mass-media — TV. — Programm — RADIO — Video.
- to prepare for a future who change quickly.

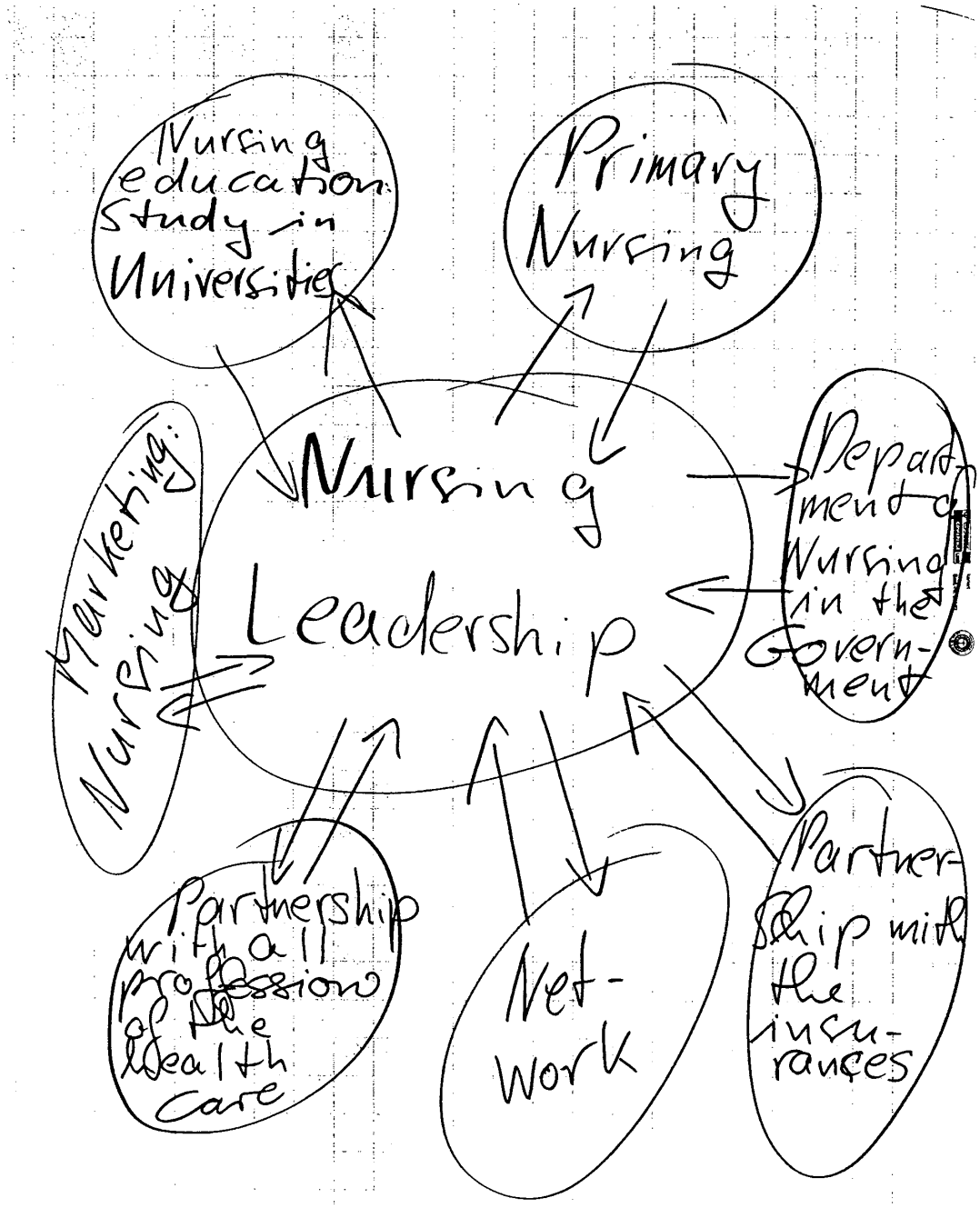
Spider in the web

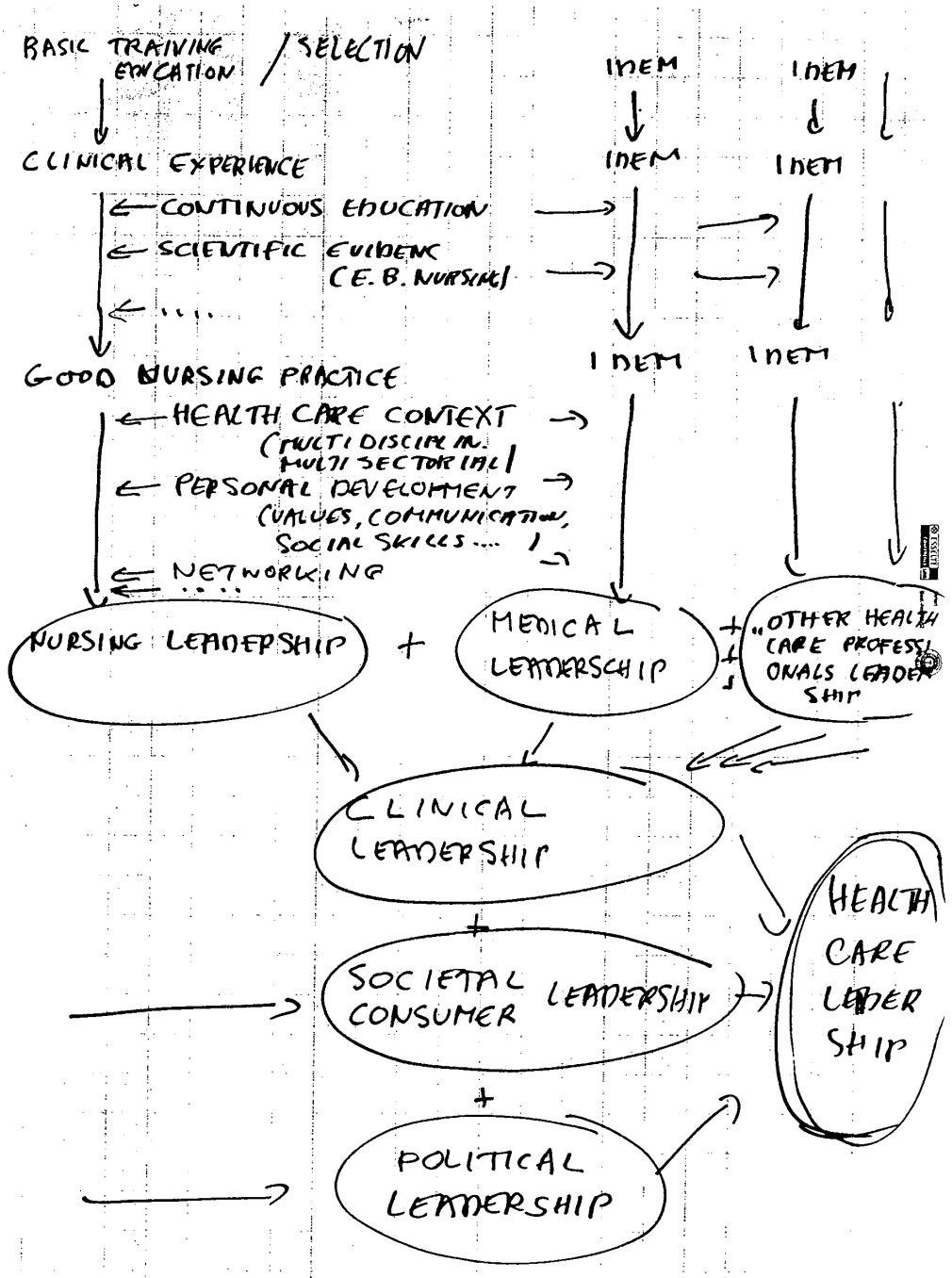


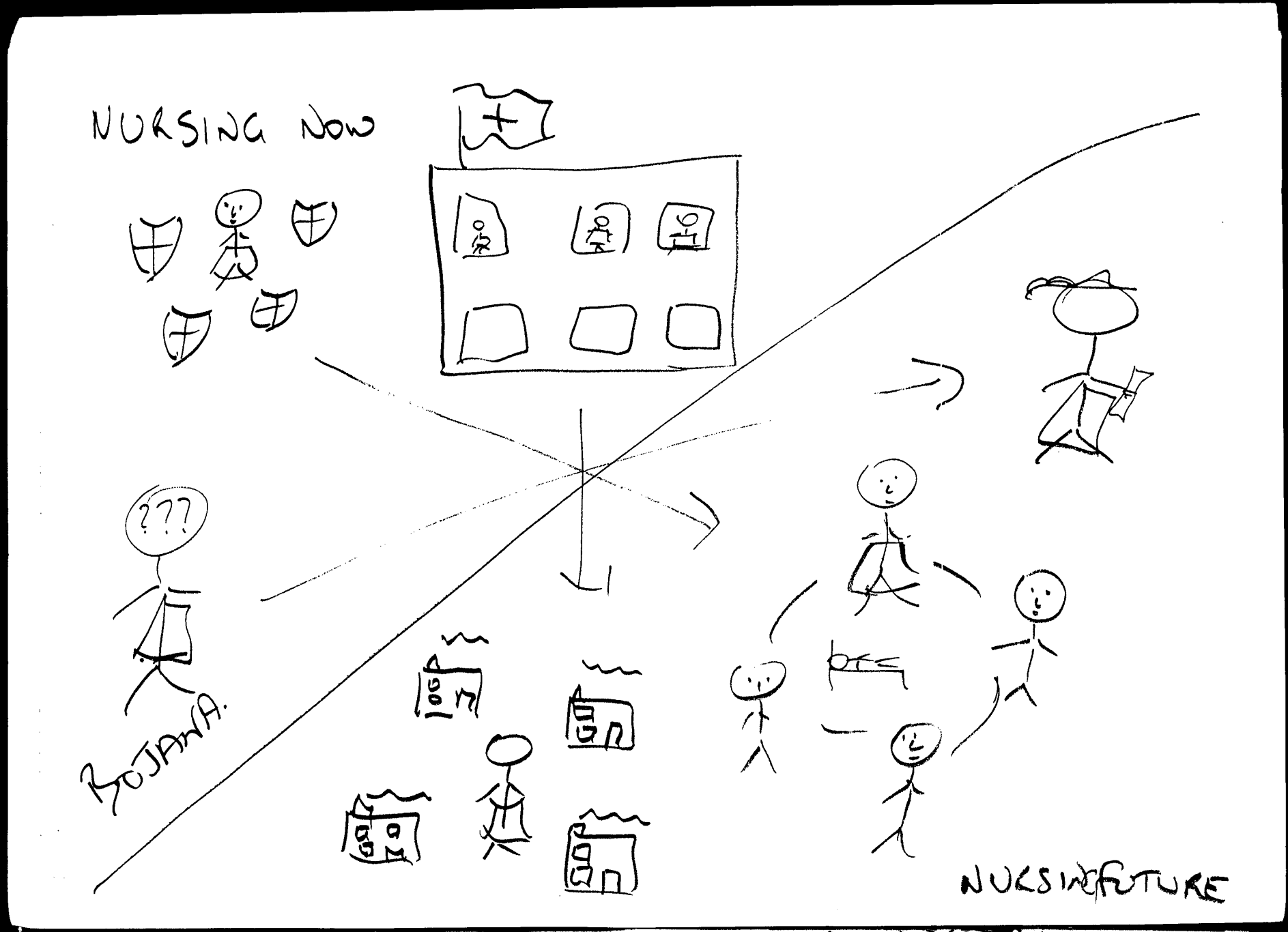
Nurses
Nursing
Patients
Doctors
Media
X



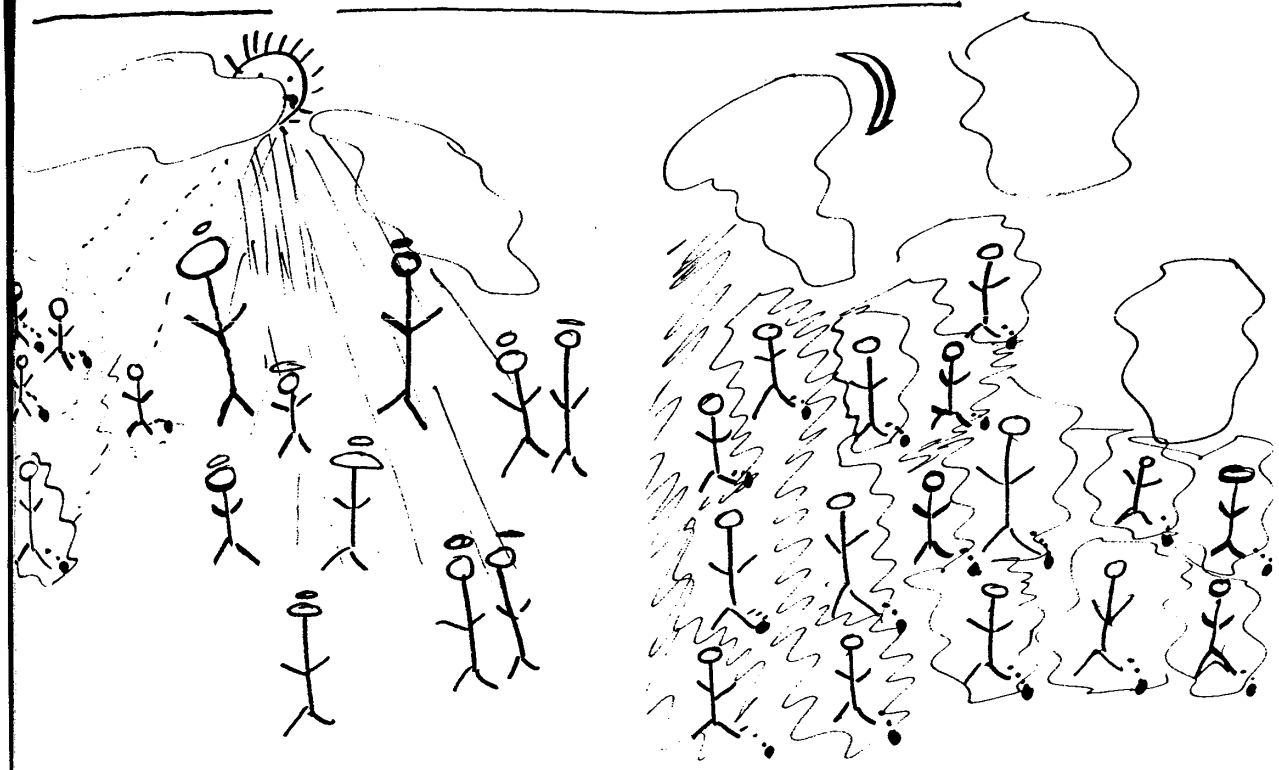
POLAND + ENG/SWED


Nursing education: Study in Universities
Primary Nursing
Nursing Leadership
Marketing: Nursing
Department of Nursing in the Government
Partnership with all profession of the Health Care
Net-work
Partner-ship with the insu-rances

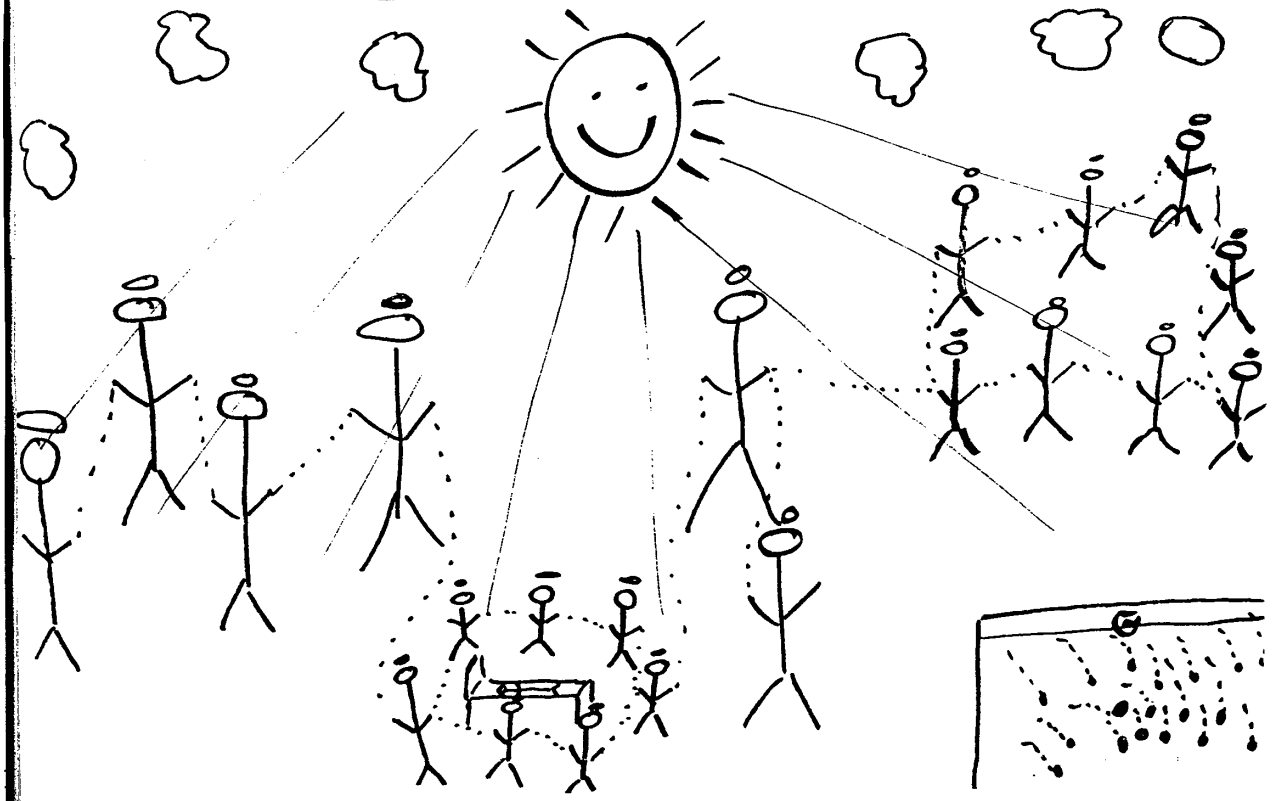

BASIC TRAINING / SELECTION
EDUCATION
CLINICAL EXPERIENCE
← CONTINUOUS EDUCATION →
← SCIENTIFIC EVIDENCE (E.B. NURSING) →
← ....
GOOD NURSING PRACTICE
← HEALTH CARE CONTEXT → (MULTI DISCIPLIN. MULTI SECTORIAL)
← PERSONAL DEVELOPMENT → (VALUES, COMMUNICATION, SOCIAL SKILLS ....)
← NETWORKING
INEM
INEM
INEM
INEM
INEM
INEM
NURSING LEADERSHIP
+
MEDICAL LEADERSHIP
+
„OTHER HEALTH CARE PROFESSIONALS LEADERSHIP
CLINICAL LEADERSHIP
+
SOCIETAL CONSUMER LEADERSHIP
+
POLITICAL LEADERSHIP
HEALTH CARE LEADERSHIP


NURSING NOW
???
NURSINGFUTURE

NURSING LEADERSHIP NOW. SHELLY H

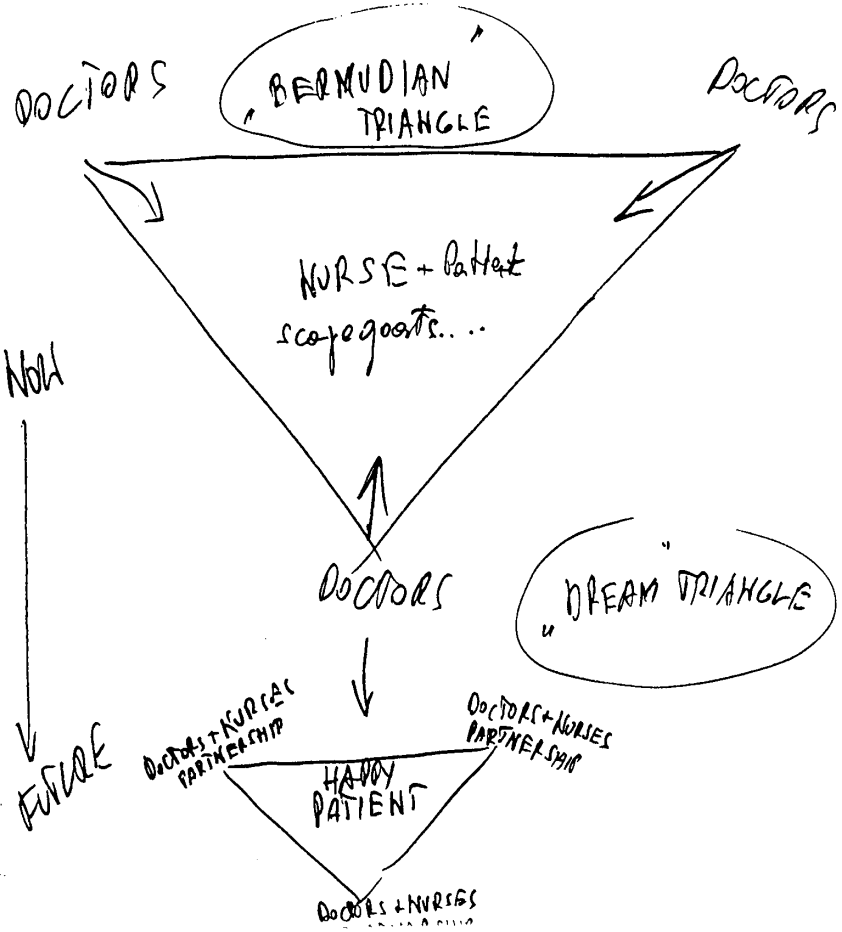


IN THE FUTURE




RESEARCH YES
YES EDUCATION
?
YES
PRAC-
TICE
!
YES
WE HAVE A PARTY!


RESEARCH
PRACTICE
?



All activity of nursing staff depend on medical staff

↓

physicians lobby

how future independent areas for the nursing activity

promotion of health

measure of health functionality

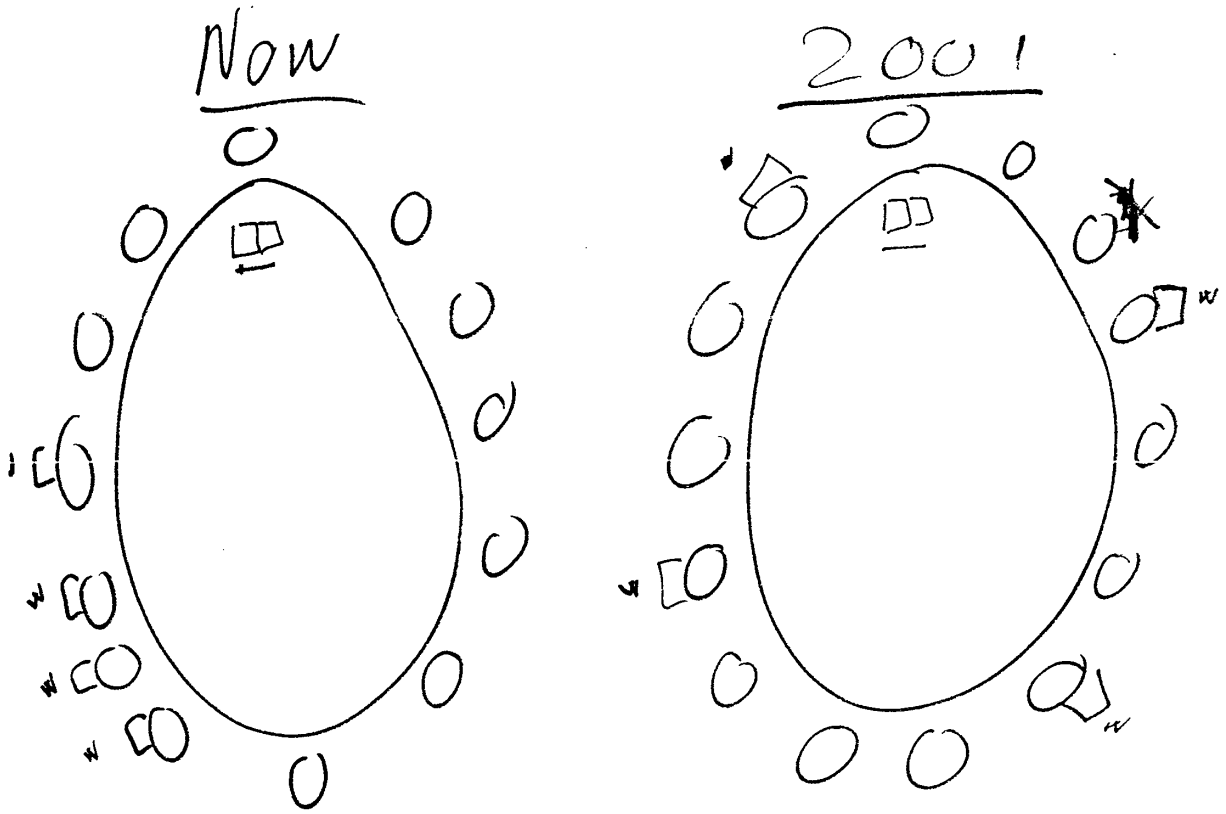
→ accounting costs of functionality

management of human R

management of change policy

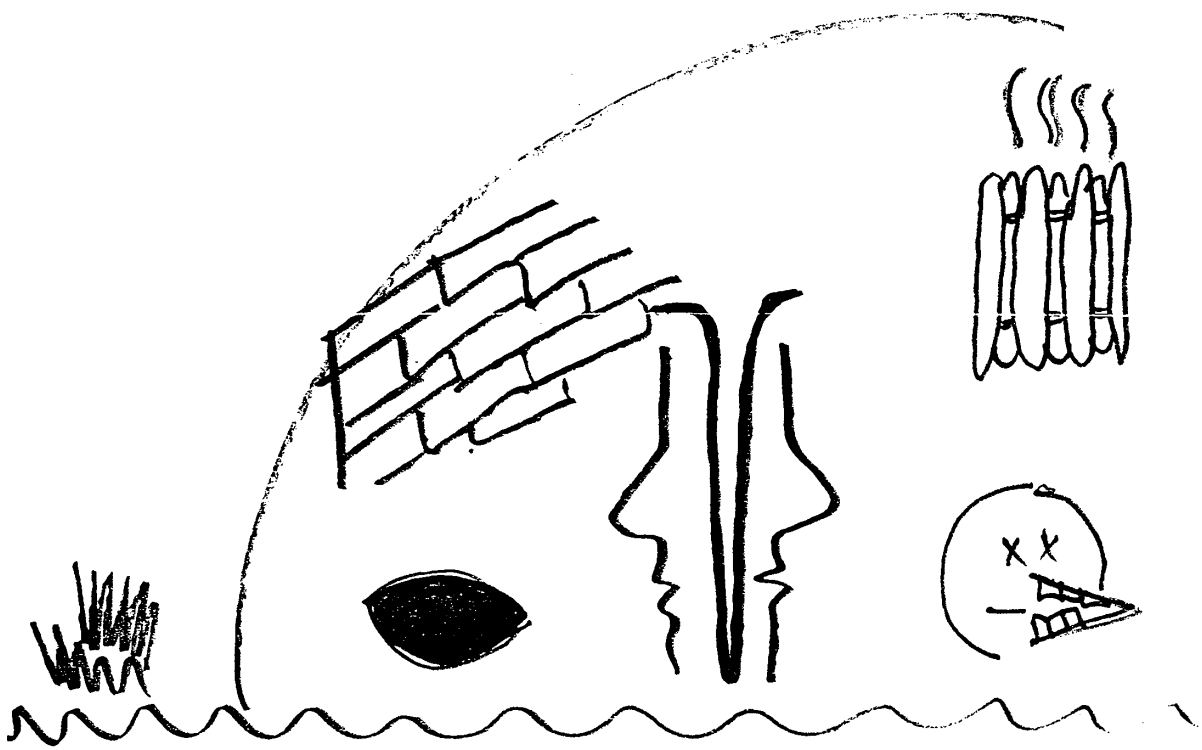
costs in PHC

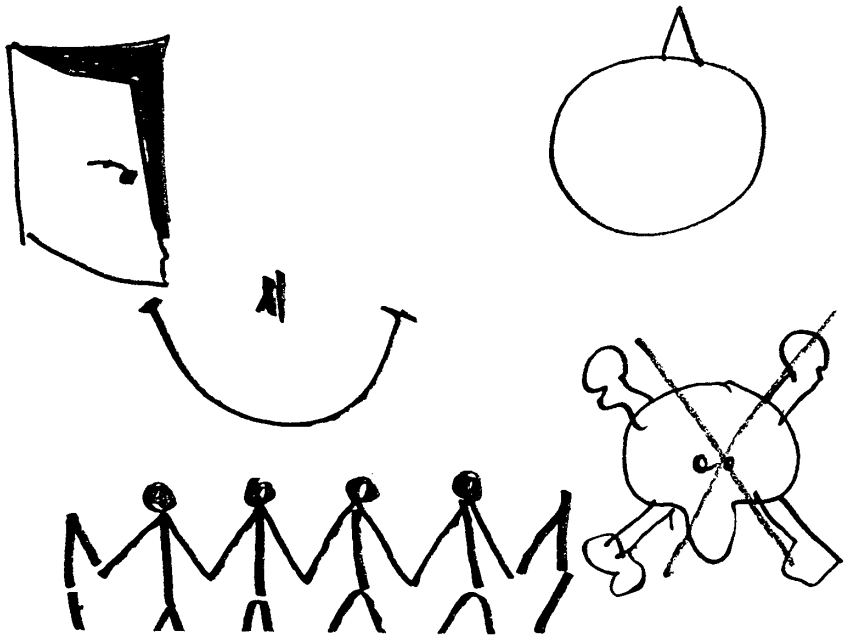
MARCH 25.


Now
2001

BEFORE

AFTER





King's Fund
54001000704737