



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Understanding leadership in community nursing in Scotland

Citation for published version:

Haycock-Stuart, EA, Baggaley, S, Kean, S & Carson, M 2010, 'Understanding leadership in community nursing in Scotland', *Community Practitioner*, vol. 83, no. 7, pp. 24-28.

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Community Practitioner

Publisher Rights Statement:

© Haycock-Stuart, E. A., Baggaley, S., Kean, S., & Carson, M. (2010). Understanding Leadership in Community Nursing in Scotland. *Community Practitioner and Health Visitor Journal*, 83(7), 24-28.

General rights

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.



Title: Understanding leadership in community nursing in Scotland

Key words: Leadership, community nursing, management.

Word count: 426 including tables and references-excluding the abstract

Abstract

There is limited evidence concerning leadership in community nursing. NHS policy also fails to clarify and define what leadership is although regarding it as key to developing safe and high quality care.

This paper reports the findings of a research study which aimed to identify how leadership is perceived and experienced by community nurses and examine the interaction between recent policy and leadership development in community nursing. Mixed qualitative methods were used involving individual interviews (n=39) and focus groups (n=3) with community nurses and nurse leaders in three Health Boards in Scotland. Findings indicate the leadership qualities valued by participants, including the importance of leaders' visibility. Team Leaders in particular were recognised for their visibility and clinical leadership. Strategic and professional leadership was less evident so acting as a barrier to the development of the profession. The strategic vision was often not clear to community nurses and they engaged in differing ways with the strategies and action plans of senior nurse leaders. New leadership roles, like change, need time to evolve and new leaders need space and the education to develop leadership. Future leaders in community nursing need to focus beyond clinical leadership ensuring that good leadership is a process requiring interdependence between leaders and followers.

Introduction

Nursing leadership in the United Kingdom is directly influenced by politics and policy¹ and is undergoing rapid change due to the impact of multiple reforms. Recent policies^{2,3,4} have the potential to drive change in the nature and functioning of community nursing teams emphasising quality improvement across all of healthcare, and a shift from hospital to community care.^{5,6,7,8} Developing the leadership role of nurses in community nursing is key to achieving both of these aims.^{5,7,8} Safe and high quality care is dependent on good leadership⁹.

In response to policy drivers and changing patterns of morbidity, community nursing has become more complex, as care shifts from hospitals to the community. Current policy signals changing roles and responsibilities^{2,3,7,8}, as primary care services are reconfigured. How nursing enacts policy to deliver quality patient care^{10,11} is redefining leadership within community nursing. Leadership skills are identified as being essential to this transformation of the vision of community nursing. Consequently new leadership roles have emerged within community nursing adding new dimensions so that clinical nurses have taken on increasing responsibility. Currently there is a lack of research about leadership in community nursing. Research from the acute setting indicates that it is the nurses' leaders values and beliefs that shape nursing leadership across different grades of nurses^{12,13}. It seems that acute nurse leaders require congruence between their activities and values and beliefs to be effective, this evidence is not yet available for community nursing.

Background

The publication of recent policies^{14,15,10} reinforces the importance of good leadership for quality care. However, there is little understanding of how this is being developed in

community nursing leaders and in frontline community nurses in Scotland. Despite an understanding that leadership matters and the policy emphasis on improving leadership, the quality of evidence around leadership in community nursing is limited. The current NHS policy fails to adequately clarify and define exactly what leadership is, although recent policy identifies the qualities and behaviours it expects of leaders¹⁰. The qualities and behaviours identified in recent policy reflect *transformational leadership* which is considered in some studies as particularly suitable to nursing leadership.^{16,17,18,19}.

For effective leadership it is necessary for the leaders to be clear about the conceptualisation of leadership within an organisation, otherwise leadership development might result in different leaders to those that the organisation is aiming for.²⁰ Leadership is complex whilst the following are considered central components:

- Leadership is a process
- Leadership involves influence
- Leadership occurs in a group context
- Leadership involves goal attainment.

As Northouse (2007:3)²¹ suggests 'Leadership is a process whereby an individual influences a group of individuals to achieve a common goal'.

Purpose

This paper reports the findings of a research study, which aimed to 1) identify how leadership is perceived and experienced by community nurses and 2) to examine the interaction between recent policy and leadership development in community nursing.

Method

This study used mixed qualitative methods involving community nurses and leaders in 31 individual interviews and 3 focus groups, with a total of 39 participants in three Health Boards in Scotland. Following written consent, all semi-structured interviews and focus groups were digitally voice recorded and then transcribed verbatim. The study was

approved by the Research Ethics Committee and the Research and Development Departments of the three Health Boards where data were gathered from April to December 2009. Participants were recruited by cascading information about the study through the Health Boards via the Nurse Directors. Data was managed within the Nvivo8 software. The research team undertook thematic analysis²² of the interviews and sought agreement on the key themes of the analysis. In the following section the key themes developed in the analysis are presented.

Findings and Discussion

Demographic profile of participants

The 39 community nurses, leaders and assistants interviewed and their KSF Banding are summarised in Table 1. Table 2 summarises the roles of the nurses interviewed. The interviewees had over five hundred years of experience between them of working in community nursing (Table 3) this data also indicates an ageing workforce. More members of district nurse teams were interviewed than those in HV teams (health visitors) (Table 2) reflecting the current profile of community nurse workforce in Scotland.

Table 1: Agenda for Change Band distribution of participants according to Health Boards

	Health Board 1	Health Board 2	Health Board 3
Band 2	2	0	0
Band 4	2	0	0
Band 5	5	4	3
Band 6	6	0	3
Band 7	5	2	1
Band 8	2	1	1

Executive level	1	1	0
-----------------	---	---	---

Table 2: Roles of the participants¹

District Nurse Qualified	14
Community Staff Nurse	12
Health Visitor Qualified	5
School Nurse Qualified	0
Nursery Nurse	2
Health Care Assistant	2
Acute Care Managers for Community Sector	1
Assistant Nursing Director	1
Director of Nursing	2

Table 3: Years of experience of working in the community

¹ Note: Team leaders have been assigned according to their qualification either as DN or HV. One lead nurse and both nursing directors have acute care backgrounds.

	Mean	Range	Number of respondents with over 10 years experience
Years in current community position ² (n= 37 respondents)	8.8 years	1 year– 26 years	14 respondents
Years qualified as a nurse ³ (n= 35 respondents)	25.85 years	5 years– 38 years	32 respondents
Years of experience in community nursing ⁴ (n= 33 respondents)	15.37 years	2.5 years– 30 years	26 respondents

Increasing the visibility and the importance of community nursing work

Community nursing has previously been considered invisible²³ and evidence suggests this is often still the situation, however strong leadership can help address the invisibility of community nursing work as this lead nurse indicates:

‘I think it’s that bit about trying to explain to people that we have very sick folk in the community, that you live in a community, we have huge health challenges because there’s a kind of feeling within health, I think, that all sick folk are sitting in the hospital and we’re doing all the, you know, cups of tea and they’re there stuff – and we’re not at all, are we? I mean, we’re doing real healthcare’. (Lead Nurse 1.2)

This Lead Nurse continued that at the Senior Health Board Management level it was sometimes necessary to explain to the Board that many people are ill in the community-one board member expressed to the lead nurse that they did not know a patient could have two long term conditions and a wound and still be nursed at home.

² Two Nursing Directors are excluded from this sample.

³ Two Health Care Assistants and 2 Nursery Nurses are excluded from this sample.

⁴ Two Health Care Assistants, 2 Nursery Nurses and 2 Nursing Directors are excluded from this sample.

The autonomy enjoyed by many community nurses is often seen as an attraction to working in the community. This preference for independence in the community workforce is pointed out by the following district nurse.

*'We tend to be (PAUSE) – we manage ourselves as much as possible, you know. We do manage, you know, our own caseloads, our own staff. It would only be if there was problems that the lead nurse would – she cascades information to us if things are changing in the CHP, if there's gonna be new ways of working or anything like that'.
District Nurse 3.1*

However, there can be a downside to this autonomy as it can contribute to the invisibility of the nursing work in community. It is also within this context that Team Leader 1.1 argued that *'there's not a culture of leading and managing in community nursing'* implicitly questioning the effectiveness of leadership in community nursing. There is indeed the question how a service that has 'no culture of leadership or management' can be lead effectively? It could be argued that it is exactly the lack of visible leadership in community nursing that has exposed the workforce to the demands of others, for example, policy makers, general managers in the NHS and recently social services, particularly in relation to health visiting work.

One district nurse explained her analogy of how she sees the distance and lack of visibility between frontline community nurses and senior nurse leaders as being akin the generation gap within a family tree:

'I've never worked at that level. I have very little contact. I see these people. [] I can only imagine that when you go to the next level, you're worrying about the level that's reporting to you, so it's different problems, you know. It's like having – probably having grandchildren, you know. At the moment, I'm just concerned about children, I don't have

any grandchildren level to worry about. So once I get to that stage, you know, you will have a bit of input but you don't have ultimate control, so it's the parents. So I think it could be just a bit like that, like a family tree'. (District Nurse 1.3)

Essentially the more levels between the nursing hierarchy the less likely people are to really know and understand the experiences and views of the nurses beyond their immediate level of the hierarchy. This reinforces the invisibility of both the leaders and followers work. This organisation of leadership is in sharp contrast to the leadership literature which frequently argues the transcendence of effective leadership on all levels.^{12,13,24,25}

Leadership in this study was very much experienced within the hierarchical structure of the NHS and either appeared to be running alongside the managerial hierarchy or was synonymous with management. A top-down approach to leadership was common with little interaction between senior leaders and front line nurses. While 'being visible' was one of the leader qualities often mentioned by participants, the organisation of leadership within a hierarchical NHS structure had implications for the visibility of their leaders. Data suggest that the leaders who did not have a 'visibility' problem were team leaders-a relatively new leadership role in community nursing. Where there were team leaders nurses felt that:

'I would say (name of team leader) definitely more – what's the word? – she's – she's there and we know she's there and she's around all the time. [] And she – you know, she is in and out – interact quite a lot, so – you know, although it's no specifically maybe been for me to go and do things, you know, it's probably been more for Band 6s. But she's definitely more around' (Staff Nurse District Nursing 1.4).

While this is a Band 5 staff nurse, she suggests that their team leader 'is definitely more around' and thus visible and accessible. This view is substantiated by other nurses across the sample but also by the team leaders, who understood the importance of their visibility and made efforts to be visible to lead the frontline community nurses delivering the direct

patient care. It can be surmised from the data that clinical leadership is developing well within community nursing with the new team leader roles. Strategic and professional leadership were not quite so evident.

It is evident from the current nursing leadership literature that the focus within nursing remains on developing clinical aspects of leadership²⁶. There is no doubt that the nursing profession needs clinical leaders but, as Antrobus and Kitson's (1999)¹ framework shows, leadership goes beyond clinical leadership to encompass political, clinical executive and academic aspects.

5.3 Barriers

Trying to introduce leadership at senior level into community nursing has been a slow process with some people in key positions blocking or sabotaging the leadership process. It appears that nursing still has a culture that tends 'to eat their young and doesn't celebrate success at all' (McKenna et al. 2004:74)²⁷. This nurse director explains the resistance she has had to overcome to strengthen the strategic leadership in the community nursing workforce:

*'It's taken me 3 years really to bring the senior nurses together and then to develop this, so it's been a slow developmental process but ahm – and I was often frustrated with the speed of while that was happening and would it ever happen but it certainly feels like it'.
(Nursing Director1.1)*

Interpretation of the data suggests that there is a lack of strategic leadership from within community nursing which, in turn, functions as a barrier to the development of the profession. This insight is supported by others studies which point towards a still existing leadership crisis and a lack of suitable nursing leaders.^{25,26,27}

5.4 Policy and leadership interaction

Policy had a direct impact on setting the goals, priorities and strategies for people in senior leadership. Leadership in community nursing has become very much focused on policy delivery. This is evident when a Lead Nurse explained:

'I think there is a lot of policy. I think it – there's – you know, I think it's – and the policy is national that needs to be translated and then there's the local policy and then there's the council policy. So there's lots of different policy directors (LAUGHS) coming in there and I think part of it really is kind of synthesising that really in some ways in taking it forward' (Lead Nurse 1.2).

There is a complexity to policy which is often overlooked. It became evident in interviews that 'policies' came from different directions, including national, local health board and local council policies, all of which have an influence on the delivery of community nursing services. The extent, to which different policies interrelated, complimented, contradicted or even counteracted each other remained unclear.

What was important was that leadership was seen to have a pivotal role in translating the policies into action plans for the frontline community nurses delivering direct patient care. As nurses moved into new leadership positions for example team leader role, they recognized the relevance of policy for practice and patient care, more so than they did when purely delivering direct patient care. In contrast, frontline staff seemed to have relatively little engagement with policy in their day to day work. Arguably not having a good appreciation for the policy context left many nurses weakened in the power struggles with senior nurse leaders around changes in patient care delivery. Some of the strategic changes were not welcomed by front line community nurses as they felt the changes were not in the patients' best interests, but the community nurses were unable to engage adequately with the political debate to advocate for the patients regarding opposition to some of these changes.

5.5 Leading and Following

Leadership was viewed as positive when leaders listened, consulted before implementing changes, respected and valued the contributions staff were making to community nursing, explained why things were changing, had an understanding of different policy agendas and motivated staff to develop the service with them. The following contribution was typical across the sample.

'What makes a good leader? Someone who has – is aware of obviously the national changes that are going on within community nursing. Someone who has got a vision for that and actually sees a way of taking that forward. Someone who consults with their staff and has consultation but also listens and takes on – listens and takes on board our concerns. And also someone who – I think someone who actually sees it from our perspective as well, you know. Someone who sees what it's like for people working in the community. That would be what I would say. Someone with vision and strong leadership qualities, you know' (Health Visitor 1.1).

Leadership was viewed negatively when the nurses described that they were not being listened to, consultations were seen as tokenisms, their views were not being valued, and the nurses felt they were being kept in the dark about changes and why changes were happening. When asked if nurses were consulted about changes the following contributions emerged:

'I always feel we're consulted but you feel as if the end decision's already made before – you know, it doesn't matter how much you say and what – there's been a lotta changes lately and a lotta things that have been quite major changes and so there's been a lotta consultation in that, you know, it's – it feels a bit tokenism' (Staff Nurse District Nursing 1.4).

Consultations as tokenism had been described as having happened in relation to several major service changes.

Analysis indicates that participants across the sample indicated that good leadership is a process, resulting from the interplay between leaders and followers. Some nurses were clear that they would not simply '*follow a numpty*' (*Staff Nurse District Nursing 2.4*) but rather viewed leaders as '*somebody that I would look up to and want to follow*' (*Staff Nurse District Nursing 3.2*). It was very much the choice of the nurse, the follower, to follow a particular leader. This perception correspond with Binney's and colleagues²⁹ view, arguing that leadership is not about knowing the answer but very much about the leader's ability to tap into the collective intelligence and insight of groups and organisations in order to collaborate and find solutions to challenges. This suggests that the relationship between leaders and followers is a key aspect of leadership^{30,31}.

Leading and Change

Good leaders are said to 'have a vision'^{32,33,34} and whether there was 'a vision' in all the Health Board areas was unclear. Data suggest that the vision was often not communicated to staff in such a way that staff knew either about the vision or where the way forward was. The future direction of community nursing was elusive to many community nurses.

Many community nurses and the nurse leaders explained the vast amount of change taking place in community nursing, but few of the participants were clear about how all this change would fit together and fulfill a vision.

Several nurses described change as being synonymous with leadership as opposed to management which was viewed as containment of the current situation or more of the same ways of working. Leadership was appreciated understood by many community nurses to mean change:

You need to manage the change but to actually move it forward, you need to lead it'. (Lead Nurse 3.1)

There were however a number of nurses working in the community who believed that the changes were really of little consequence, for some people the importance of change seemed to by pass them almost completely:

'I don't think there's really been much change actually. In the 10 years I've been here, it's kind of pretty static [] there's a few things get bandied about and everybody gets excited about but nothing really gets carried through, you know'. (Staff Nurse District Nursing 1.2)

These differing perceptions in the data suggest different ways community nurses are engaging with the strategic vision and action plans of the senior nurse leaders. Essentially there is a community workforce with a proportion of nurses engaging with change and all the challenges, rewards and emotions change can bring, whilst a number of community nurses are sticking to old ways of working, stagnating in a state of apathy as a consequence of the amount of change going on around them with which they have little or no engagement. A coping strategy is to stand still.

Arguably policy drivers which result in change which is too fast does not enable real change to happen, this is perhaps what some of the community nurses were reflecting on when they said there had been no change. As a consequence of too much change too fast the vision becomes unclear for leaders and followers. Community nursing does need change, but too much change too fast can equate with little or no change for some community nurses. As part of this change, new leadership roles need time to develop and new leaders need the space in which to develop leadership and this takes time.

Implication for practice and education

Community nursing needs to create 'space' for leadership to develop as leadership takes time and effort to become effective. Community nursing leaders and policy makers need to allow time for real change to happen at grass roots level. Essentially all leaders need preparation in change management processes. The evidence suggest leaders need skills in helping the community nurses understand and apply the changes in their practice to meet strategic directions.³⁵

There is a need for community nurses to be better prepared for leadership and engagement with policy through educational programmes pre and post- nursing registration. Such efforts should produce a greater number of nurses able and willing to undertake leadership roles from within the nursing profession and engage with the political agendas.

Conclusions

Leadership in community nursing needs greater visibility, which strong leadership can facilitate. Community Nursing needs a clear shared vision from which people can lead and follow. Future leaders in community nursing will need to focus beyond the clinical environment and need to develop a number of competencies which as Huston³⁶ suggests, include the ability to:

- develop a global perspective or mindset about healthcare and professional issues;
- integrate new technology which facilitates mobility and portability of relationships, interactions and operational processes;
- develop expert decision making; creating an organisational culture that recognises quality healthcare;
- understand and intervene in political processes;
- balance authenticity with performance expectations and
- be visionaries and proactive in response to rapid changes in everyday healthcare.

It must be remembered that leadership is a social process that happens *between* people reflecting the need to work with people as opposed to leaders doing things *to* people³⁰. In community nursing there should be more of a focus on the process of leadership, rather than the attributes of leaders. Leadership is a process involving many more people than the leaders.

Key Points

- Community Nursing needs a clear shared vision from which people can lead and follow.
- Leadership is a social process *between* people whilst leaders happen *to* people.
- Community Nursing needs conceptual clarity in defining leadership
- Community Nursing needs more political awareness in the workforce

References

1. Antrobus S, Kitson A. Nursing Leadership: Influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing*, 1999; 29 (3): 746-753.
2. Department of Health. *nGMS*. London: Department of Health, 2003.
3. Scottish Executive. *Visible, accessible and integrated care. Report of the Review of Nursing in the Community in Scotland*. Edinburgh: Scottish Executive, 2006.
4. Department of Health. *Knowledge and Skills Framework KSF*. London: Department of Health, 2003.
5. Department of Health. *Liberating the Talents: Helping Primary Care Trusts and nurses to deliver The NHS Plan*. London: Department of Health, 2002.
6. Scottish Executive. *Partnership for Care: Scotland's Health White Paper*. Edinburgh: Scottish Executive, 2003.
7. Scottish Executive. *Delivering for Health*. Edinburgh: Scottish Executive, 2005.
8. Scottish Executive. *Delivering Care, Enabling Health*. Edinburgh: Scottish Executive, 2006.
9. Donaldson L. Safe high quality health care: Investing in tomorrows leaders. *Quality in Health Care*, 2001; 10: 8-12.
10. Scottish Government. *Delivering quality through leadership*. Edinburgh: Scottish Government, 2009.
11. Department of Health. *High Quality Care for All*. Norwich: Department of Health, 2008.
12. Stanley D. In command of care: Clinical nurse leadership explored. *Journal of Research in Nursing*, 2006; 11 (1): 20-39.

13. Stanley D. In command of care: Toward the theory of congruent leadership. *Journal of Research in Nursing*, 2005; 11 (2): 132-144.
14. Scottish Executive. *Delivery through Leadership*. Edinburgh: Scottish Executive, 2005.
15. Scottish Executive. *The NHS Scotland Leadership Development Framework* Edinburgh: Scottish Executive, 2004.
16. Wong C, Cummings G. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management*, 2007; 15 (5): 508 - 521.
17. Thyer G. Dare to be different: transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management*, 2003; 11: 73 - 79.
18. McIntosh J, Tolson D. Leadership as part of the nurse consultant role: banging the drum for patient care. *Journal of Advanced Nursing*, 2009; 18: 219 - 227.
19. McIntosh J, Tolson D, Wright, J. *Evaluation of three Nurse Consultant posts in Scotland*. Glasgow: Glasgow Caledonian University, 2002.
20. Hartley J, Hinksman B. *Leadership development - a systematic review of the literature. Report for the NHS Leadership Centre*. Coventry: University of Warwick, 2003.
21. Northouse P. *Leadership - Theory and Practice*. Thousand Oaks: Sage, 2007.
22. Thorne S Kirkham S MacDonald-Eames J. Interpretive Description: a noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 1997; 20: 169-177
23. Low H & Hesketh J. *District Nursing: the invisible workforce*. London: Queens Nursing Institute, 2002.

24. Edmonstone J. *What is clinical leadership?* In: Edmonstone, J. (Ed.), *Clinical Leadership - A Book of Readings*. Chichester: Kingsham Press, 2005.
25. Goodwin N. *Leadership in Health Care - A European Perspective*. London: Routledge, 2006.
26. Cunningham G, Mackenzie H. *The Royal College of Nursing Clinical Leadership programme*. In: Edmonstone, J. (Ed.), *Clinical Leadership*. Chichester: Kingham Press, 2005.
27. McKenna H, Keeney S, Bradley M. Nurse leadership within primary care: the perceptions of community nurses, GPs, policy makers and members of the public. *Journal of Nursing Management*, 2004; 12 (1): 69 - 76.
28. McMurray R, Cheater F. Vision, permission and action: a bottom up perspective on the management of public health nursing. *Journal of Nursing Management*, 2004; 12 (1): 43 - 50.
29. Poulton B. Barriers and facilitators to the achievement of community-focused public health nursing practice: a UK perspective. *Journal of Nursing Management*, 2009; 17: 74 - 83.
30. Binney G, Wilke G, Williams C. *Living Leadership - A practical guide for ordinary heroes*. Harlow: Prentice Hall, 2009.
31. Kellerman B. *Followership - How Followers are creating Change and Changing Leaders*. Boston: Harvard Business Press, 2008.
32. Barker A. *Leadership practice: state of the art and recommendations for the future*. In: Barker, A., Dori Taylor, S., Emery, M. (Eds.), *Leadership Competencies for Clinical Managers - The Renaissance of Transformational Leadership*. Boston: Jones and Bartlett Publishers, 2006.

This is the Author's Final Version of © Haycock-Stuart, E. A., Baggaley, S., Kean, S., & Carson, M. (2010). Understanding Leadership in Community Nursing in Scotland. *Community Practitioner and Health Visitor Journal*, 83(7), 24-28.

33. Bass B, Riggo R. *Transformational Leadership*. Mahwah: Laurence Erlbaum Associates, 2006.

34. Kouzes J & Posner B. *The Leadership Challenge*, San Francisco: John Wiley & Sons, 2007.

35. McGill I and Brockbank A. *Facilitating reflective learning through mentoring and coaching*. London: Kogan Page, 2006.

36. Huston C. Preparing nurse leaders for 2020. *Journal of Nursing Management*, 2008; 16: 905 - 911.