ADVANCED HEALTHCARE PRACTICE

SECOND EDITION

Clinical Leadership in Nursing and Healthcare

Values into Action

Edited by

David Stanley

WILEY Blackwell

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Second Edition

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This edition first published 2017 © 2017 by John Wiley & Sons, Ltd
The first edition was published by Macmillan Education Australia in 2011

Registered Office
John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
9600 Garsington Road, Oxford, OX4 2DQ, UK
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Library of Congress Cataloging-in-Publication data applied for

9781119253761

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: ©Photo ephemera/gettyimages.

Set in 10/12pt Warnock by SPi Global, Pondicherry, India

1 2017

To my mum,
Marj Stanley (1926–)

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Notes on Contributors

Dr Judith Anderson, RN, BN, MHSM, MN, PhD. I have been a registered nurse for more than 20 years working in a variety of clinical, education, research and managerial positions. During this time I have completed a Bachelor of Nursing, Master of Nursing Education, Master of Health Service Management and my PhD, which was focused on change management in a small rural health service. I have been involved in translating research into practice in a variety of settings, including acute care, rural health, aged care and community health in both the public and private sectors. In these roles I have gathered knowledge and experience in implementing evidence-based practice in the clinical setting and currently work at Charles Sturt University as Courses Director.

Sally Carvalho, RGN, BSc (Hons), MSc, PG Cert HE, FHEA, RNT. My nursing career commenced in 1988 at Sandwell District General Hospital, in West Bromwich (UK), where I trained to be, and qualified as, an RGN (Registered General Nurse). As a qualified nurse I predominantly worked in Accident & Emergency (A&E) departments throughout the West Midlands. It was uncommon for nurses to study for degrees back then, but I did and I completed a Bachelor of Science in Nursing Practice and then a Master of Science in Advance Nursing Practice. The Master's degree course was very clinically orientated and it eventually led me to practise clinically in the (then) groundbreaking and clinically autonomous positions of an A&E Advanced Nurse Practitioner and Nurse Consultant. These advanced roles were a significant change in nursing culture at both local and national levels. Confident and effective leadership was required to break down barriers for a nurse to practise clinical skills, which were traditionally the domain of doctors and surgeons, particularly as I also studied and qualified as part of the first group of nurses in the West Midlands to register and practise as a Non-Medical Prescriber. A successful career in A&E also led to visiting lecturing opportunities, to teach within local universities. Eventually I took on the challenge of setting up and heading a clinical nursing team for one of the National Health Service Walk-in Centres. The leadership and management experiences from these roles led me to take a position as a Regional Lead Nurse organising and leading seven teams of nurses for a General Practitioner Out-of-Hours Service across a very large county during what was considered nationally to be a very politically sensitive time within the NHS as a whole. In all of these clinical positions I have maintained teaching links with local universities and eventually made the transition into full-time nurse education as a Senior Lecturer at the University of Worcester in 2005, where I still teach both pre- and post-registration nurses.

Linda Malone, RN, MHM, Grad Dip E Health, Gradt Cert Geront Nurs, Grad Cert Anaes and Rec Room Nurs, BN, Dip App SCi (Nurs), FACHSM, MACN. My nursing journey began in 1985 at a time when nursing training in Australia moved from a hospital-based system into the tertiary education sector. Initially, after completing my original qualification I worked in a variety of clinical

settings in both the public and private sectors, including medical, surgical, aged care, forensic nursing, primary and community healthcare, emergency and critical care and the operating theatre. During this time I worked as a nurse educator and clinical nurse specialist and then moved into nursing administration and management. Having a thirst for knowledge, I also completed a Graduate Certificate in Anaesthetic and Recovery Room Nursing, followed by a Graduate Certificate in Gerontology Nursing, a Graduate Certificate in Health Informatics and then a Master's in Health Management. With over 15 years' experience working at senior health and nursing management levels, I gained expertise in both strategic and operational management, organisational performance development, monitoring and reporting. I have considerable experience in facilitating change and the improvement and development of health services. I have a keen interest in Indigenous health and nursing workforce issues, and I am pursuing this interest by undertaking further studies at PhD level through Charles Sturt University (CSU). My commitment to the nursing profession in my current role as a lecturer at CSU is to facilitate a skilled nurse leader workforce for the future.

Dr Joanna Smith, RGN, RSCN, BSc (Hons), MSc (Hons), PhD. I am a lecturer in children's nursing and am passionate about ensuring that care is evidence based and delivered in a way that fosters effective collaboration and empowerment of the child, young person and family. I have worked in higher education for 15 years, with extensive teaching and learning experiences including curriculum development, programme management, interdisciplinary learning and supervising postgraduate research students. I have over 15 years' clinical experience, primarily caring for children with complex needs requiring surgery, which informs my teaching and research. I qualified as a Registered General Nurse in 1986 and a Registered Children's Nurse in 1987. My academic achievements began while working in clinical practice and culminated in achieving a doctorate in 2011. I am an ardent supporter of promoting and developing research skills among children's nurses and since 1999 have been an active member of the Royal College of Nursing Research in Child Health (RiCH) community, including being the elected chair of the national RiCH community from 2012–15. I am an Associate Editor of *Evidence-Based Nursing* and lead the journal's social media activities as a means of promoting evidence-based practice. I am also an Editorial Board member for the journal *Nursing Children and Young People*. My main research interests relate to the way in which health professionals work with and involve children, young people and their families in decisions about their care, in the context of children with long-term conditions. Although I have used a range of research methods, both quantitative and qualitative, I am particularly skilled in the application of thematic analysis and a framework approach.

Trish Smith, RGN, RSCN, ENB 136 (Renal Nursing), Dip Nursing, BSc (Hons), MSc. I completed my registered sick children's nurse training at Sheffield Children's Hospital in 1985 and worked there for 3 years developing an interest in renal nursing. Having completed a renal nursing course in Leeds, I crossed the Pennines and became the first nurse with both paediatric and renal qualifications to work in the children's dialysis unit at Booth Hall Children's Hospital. Over the last 28 years, based at the Royal Manchester Children's Hospital, I have developed the home-based dialysis service for children within the North West region, training over 400 children and families to manage dialysis within their own home. Advances in dialysis treatment now enable younger and sicker children to receive life-maintaining treatment within their own home with the support of specialist nurses. Having completed my Master's in Nursing in 2009, I have collaborated with colleagues in Manchester and Leeds Universities to undertake research exploring the learning and information needs of children and families with chronic kidney disease. Over the last 10 years, I have also had opportunities, along with

medical colleagues, to develop links with and visit hospitals in Sudan, Nigeria and Uganda. Teaching medical and nursing staff within their own clinical environment and with limited resources has been a challenging but valuable and educational experience.

Dr Karen Stanley, RN, BA, MSc, Post Grad Cert Education, Dip in Counselling, PhD. I am an experienced registered nurse and academic who has worked in the UK, China, Singapore, Perth, Western Australia and at Charles Sturt University in New South Wales. My latest position is within the School of Health at the University of New England in Armidale, also in New South Wales. I have worked collaboratively with a wide range of students and staff, including industry partners, and have provided support, guidance and leadership in relation to teaching, learning and assessment. In addition, I have worked within the Safety and Quality Department for the Department of Health in Perth as a Senior Project Officer. These experiences have enabled me to develop strong interpersonal skills, which I am sure have allowed me to support student and staff empowerment in the quality of their educational experiences. I have worked extensively in classroom environments and clinical education settings and have a keen interest in reflective practice and emotional intelligence. I have also recently completed my PhD, which focused on the importance of building interprofessional relationships within academia. My PhD aimed to promote a more collaborative approach to teaching, learning and research between professionals within higher educational institutions. I am committed to providing student-centred learning, as well as staff development that supports key attributes such as respect, collaboration, sharing good practice and having an appreciation of each other's roles. These are just a few of the qualities identified by professionals within my study that I believe are essential to building effective interdisciplinary relationships with staff and students.

Professor David Stanley, Professor in Nursing, RN, RM, Gerontic Cert, Grad Cert HPE, Dip HE (Nursing), BN, MSc (Health Sciences), NursD. I began my nursing career at the Whyalla and District Hospital, South Australia in 1980. These were the final days of PTS (preliminary training school) training and capping ceremonies and I entered nursing without much thought about its history or future. I completed my training as a Registered Nurse and midwife in South Australia and worked through my formative career in a number of hospitals and clinical environments. In 1993 I completed a Bachelor of Nursing at Flinders University, Adelaide (for which I was awarded the University Medal) and worked for a short time on Thursday Island before volunteering to teach midwifery for a number of years in Africa. Following this wonderful experience, I moved to the UK and worked as the Co-ordinator of Children's Services in York and as a Nurse Practitioner in the Midlands. I completed a Master's of Health Science at Birmingham University and after a short return to Australia, where I worked in Central Australia for Remote Health Services in Alice Springs, I returned to the UK to complete my Nursing Doctorate at Nottingham University in 2005. I undertook research in the area of clinical leadership. While I studied I worked as a Senior Lecturer at University College Worcester (now Worcester University). Returning to Australia in 2006, I worked at a number of universities in Perth and then Charles Sturt University, NSW, before moving to the University of New England in NSW in 2016. I am currently a Professor in Nursing, teaching undergraduate and postgraduate nursing and developing a substantial research profile.

I have had a wide and varied career in clinical roles, senior management positions and as an educator. My career has taken me to a number of countries (Thailand, Singapore, Tanzania, Zimbabwe and the UK) where I have worked in a range of different roles. My professional interests have focused on leadership and management, aged care, the experience of transition to university for first-year nursing students, physical assessment, the experience of men in nursing and the impact the media

has had on the nursing profession. I have also retained a long interest in international nursing issues and support the benefits of nurses and midwives learning more by exploring other parts of the world with clinically focused practice opportunities. I have arranged or been part of a number of international opportunities to the Philippines, Tanzania and Thailand, and have supported other international trips in a number of roles associated with international coordination.

Professor Veronica Swallow, Professor in Child and Family Health, RGN, RSCN, BSc (Hons), MMedSci, PhD. As a Registered Adult Nurse and Registered Sick Children's Nurse, I have worked in Acute Paediatrics in the UK NHS for many years as a Staff Nurse, Sister and Department Manager. I took a nine-year career break when my children were small and moved into academia mid-career, simultaneously as an undergraduate then postgraduate student and as a researcher and teacher. Having completed my PhD in 2006, I now work at the HE/NHS interface teaching undergraduate and postgraduate students about the application of research evidence to practice to promote optimum clinical outcomes for patients, and leading research in child healthcare. My research focuses on the ways in which families and health professionals work together to manage long-term conditions in daily life effectively. I currently lead the development and evaluation of complex, user-led interventions (e.g. web/smartphone apps) to promote optimum healthcare experiences for families and optimum outcomes for patients. I promote and support the active involvement of family members as co-researchers and advisers on my studies to ensure that the research is family relevant. I am a member of INVOLVE, the National Institute of Health Research Advisory Group for patient and public involvement in research, and for many years worked with the National Research Ethics Service. My multidisciplinary, international research includes a range of methods and systematic reviews. I am on the Editorial Board of the *Journal of Pediatric Nursing*. I regularly review grants for leading funders and am an active member of the International Family Nursing Association.

Foreword

In 1993 in my King's Fund–sponsored study and publication *Leading Questions*, I suggested that more attention needed to be paid to leadership training, management development and clinical leadership. It was clear then, and remains evident today, that more research related to nursing leadership and specifically clinical leadership is required. In particular, there is an urgent need to tackle the perceived leadership crisis in nursing and understand the reasons we have a gap between a talent bank of nurse leaders and a chasm in conditions under which leaders can flourish and even feel safe enough to do their job.

Leadership is not just something reserved for a few, an elite. It is within us all and distributed leadership is a vital part of what it takes to make an organisation work and succeed. We are all leaders in our own way, but we need to work in environments where the culture enables our leadership to find a foothold and thrive. This text, *Clinical Leadership in Nursing and Healthcare: Values into Action*, moves in the right direction to address my call for action. Stanley's text is based on five research studies undertaken in the UK and Australia that specifically explore the phenomenon of clinical leadership. Leadership happens at all levels and identifying who the clinical leaders are and attempting to gain an understanding of what clinical leadership means have become vital as the health service responds to the critical threats of the early twenty-first century. To address these threats, this text details what clinical leadership means and how it can be understood. As well, it offers a range of tools to enhance clinical leadership skills and places clinical leadership in the context of the challenges confronting contemporary health systems.

It is timely that clinical leadership is being re-evaluated and frameworks developed that support it, because it is clear that many health professionals have been unable to reconcile their role as leaders with their clinical expertise. Many health professionals have faced the dilemma of having to move further away from the core reason they first became health professionals, resulting in role and values confusion. These two need to work in tandem. Indeed, clinical expertise is the foundation for strong leadership in the health system. Realisation of the value that such expertise brings to the organisation needs to be given voice and made visible by nurses in a context that supports participatory governance. This text underpins an understanding of the vital place clinically focused leaders have in supporting better care, better health services and a greater focus on positive cultures within healthcare organisations.

Recent catastrophes of care and responses to them, in the NHS and across the globe, have signalled the need to foster and embrace values-based leadership as a means of enabling culture change. Stanley's text recognises the critical position that clinical leadership and clinical leaders have in all healthcare disciplines when addressing issues of change, innovation and quality initiatives in the health service. In addition, it supports and proposes a new leadership theory, *congruent leadership*, which links the leaders' values and beliefs firmly with the leaders' actions.

There is little doubt that leadership holds a central place in the facilitation of effective healthcare delivery for all health disciplines and across a wide range of clinical, managerial, educational and research-focused domains. However, it is also clear that getting the culture of care right, building greater responsiveness to patient and client needs and finding ways for clinically focused healthcare providers to develop ways to make care better relies on an understanding and application of clinical leadership. It is front-line, grassroots, clinical-level nurses and other health professionals who hold the keys for healthcare organisations to apply flexible, innovative change.

We need to think of a system of leadership within the organisation, one in which clinical leaders can use their talents and skills, feel these assets are valued and are given the time and space to progress and continually develop those skills in tune with their professional values and beliefs.

Anne Marie Rafferty
Kings' College London
May 2016

Preface

In the first edition of this book, Janelle Boston, an experienced clinician and educator in Perth, Western Australia, offered the following paragraph as part of her contribution:

> In today's rapidly changing clinical environment and ever increasing junior workforce, it is essential to develop and maintain strong nursing leaders who will be able to foster our future nurses for generations to come. As a Clinical Liaison Support Practitioner working with undergraduate nursing students, I believe it is important to lead by example striving for the best possible outcomes in clinical excellence by providing ongoing opportunities for professional growth in learning and development. For me outstanding clinical leaders are experts in their field, who share their passion and knowledge, who motivate and support their team members and provide positive direction no matter how challenging the situation.

I include this again here because I am sure Janelle is on to something and I too feel that it is important to lead by example and support the clinical leaders who are experts in their field, and who share their passion. This book is for them.

The book is the culmination of a considerable effort to understand clinical leadership (and followership) and reflects the authors' personal interest in this topic. The book is primarily based on a number of extensive research projects that considered who clinical leaders are, why they are seen as clinical leaders, what the characteristics of clinical leadership might be and the experience of being a clinical leader. It is also based on my years of involvement in clinical leadership as a senior clinician (nurse practitioner) and an academic, dealing with the issue of clinical leadership from a practical, applied position or as an educator and researcher. In each case my aim has been to try to understand and share my understanding with nurses and other clinically focused health professionals from a range of disciplines.

My interest is also firmly based on my own experience of being a nurse and midwife who can recall rejoicing in the pleasure of working with effective, wonderful and inspiring clinical healthcare leaders. A number of names come easily to mind: Sister Johnson and Paul Fennell, both of whom I had the joy of working with when I was a student and then a registered nurse at the Whyalla and District Hospital in South Australia; Sister Barbra, Sister Helen, Doctor Mike and Doctor Monica, from my days as a volunteer in Zimbabwe at the Murambinda Mission Hospital; and Christina Schwerdt and Penny Rackham from my short stay as an educator on Thursday Island. There are many, many others; but I also recall the depths of facing shift after shift with 'leaders' who were never at the bedside, always at meetings or only showed up on the ward to criticise and ridicule (I won't name any, but sadly their names come quite crisply to mind too).

I was drawn to investigate this topic because of my long association with the nursing profession, and now other health professional disciplines. As well, I have held a long and passionate interest in

nursing and leadership, particularly from the perspective of promoting better healthcare. I have sought to understand and promote greater clinical-level and healthcare empowerment and support the development of insight into clinical leadership that can have positive impacts on the quality of care provided to patients and clients in a plethora of healthcare environments.

Clinical Leadership in Nursing and Healthcare: Values into Action was written for nurses and other healthcare professionals who act principally in direct client/patient care. It will be useful too for students studying health-related courses at undergraduate and postgraduate levels, and for nurses and other healthcare professionals in roles of increasing autonomy, such as nurse practitioners and specialist health providers, health professionals studying leadership (or management) and anyone who wants to maximise their contribution to health care.

The purpose of the text is to motivate and inspire, as well as to offer guidance and support for clinical leaders (or aspiring clinical leaders) to take change and innovation forward and to initiate greater quality in care or therapies and treatments. There are many books about management (and leadership) for nurse managers or healthcare managers and, while their contribution to the health service is great, this book was not necessarily written with these professionals in mind. If you are a manager of some sort and you have this book in your hand now, by all means read on, as I am sure there are lessons and messages in the text for any health professional. However, my hope when I and my fellow authors sat to write *Clinical Leadership in Nursing and Healthcare: Values into Action* was to generate an understanding of leadership for clinical leaders: leaders at the bedside or who remain 'hands on' in their interaction with clients or patients; leaders who might not have the badge, or the title, or the confidence, or the realisation, but who are leaders in the health service nonetheless. These are leaders in the eyes of the people who follow them (their junior colleagues, their senior colleagues, patients or clients, other professionals, students and learners, qualified practitioners or yet-to-be-qualified practitioners), although they might not realise it themselves. These are the key leaders who can and will have a vast impact on the provision of quality healthcare, innovation and change within the health service.

The book presents the information in three parts. First it addresses the topic of clinical leadership and leadership in general. Much of what healthcare professionals know about leadership is based on insights and writings from the management paradigm. The first chapter redresses this by outlining why clinical leadership and quality or innovation are linked. It also discusses what leadership means by describing the theories that underpin what we know about leadership. As well, it describes the difference between leadership and management; looks at the attributes and value of followers; offers a description of the characteristics of clinical leaders; and sets out a new theory of leadership: congruent leadership. This theory, developed from research specifically undertaken with a range of health professionals, is directly relevant for bedside, clinical leaders to gain an understanding about what leadership means.

The second part of the book deals with the 'tools' for developing effective clinical leadership skills and insights. Chapters in this part offer information about organisational culture, managing change, decision making, team working, reflection, creativity, motivation and inspiration, networking, delegation, how to deal effectively with conflict, the relevance of quality initiatives and project management for clinical leaders and the use of evidence-based practice. These topics are all provided so that clinical leaders can orchestrate successful change and innovation and lead effective quality initiatives.

The final part of the book addresses issues that put clinical leadership into context. The topics relate to gender, generational groups, power, politics, empowerment, oppression and how clinical leaders can (using a *congruent leadership* style) have positive impacts on the quality of healthcare and lead their patients or clients, colleagues, team mates, co-workers, organisation and the heath service in general towards a better tomorrow.

David Stanley

Acknowledgements

I should like to thank all the students who have taken part in the clinical leadership courses and subjects I have been involved with in the UK, Singapore and Australia. Your enthusiasm and commitment to learning and improving care and clinical services have been an inspiration to me. I also thank all the paramedics, allied health professionals, ambulance volunteers and nurses who have contributed to my understanding of clinical leadership by willingly contributing to the five research studies that underpin this book.

I should also like to thank my educator colleagues who (over many years) have supported me and contributed their ideas, time and talents to the delivery of clinical leadership education: Jane Bahen (Australia), Alexandra Barnes (UK), Fiona Foxall (Australia), Helen Jones (UK), Karen Latimer (Stanley) (UK and Australia), Lina Ma (Singapore), Maria McNamee (UK), David Wall (Australia), Pippa Wharton (Australia) and I am sure there are others. I should also like to thank Phil Della, Janelle Boston and Rosealie Southwell for their contributions to the Foreword in the first edition of this book, and in particular Pippa Wharton and Fiona Foxall, who contributed chapters to the first version of the text: *Clinical Leadership: Innovation into Action* (2011).

Thank you too to Professor Anne Marie Rafferty for eagerly contributing the foreword and for supporting the direction taken with this book. I had heard of Professor Rafferty long before I met her. Her academic writing on leadership and research had significantly influenced my interest in healthcare-focused leadership and nursing scholarship. I first met her at the end of 2004 when she and others undertook to assess my doctoral thesis at Nottingham University. Her leading position in the world of nursing in the UK and her undoubted reputation as one of the most articulate and clear-thinking academics alive today promoted me to ask her to offer the foreword for this book. I am grateful and thankful that she accepted.

A special thank-you is extended to Stephen Stanley (my brother) for contributing the wonderful cartoons and illustrations used throughout the book. In Australia, Stephen is a nationally recognised cartoonist and it was a delight that he agreed to support this book with his talents and time.

Karen Stanley (my wife) deserves a second mention for proofreading the draft chapters and for her encouragement, support and understanding throughout the writing and development process.

The book could not have been developed without the initial support of Palgrave Macmillan and, although it was a shame they were unable to progress with the second edition, the book started with them and for this I am very grateful.

James Watson from Wiley took the submission forward and had the managers there take on the book's production. I am deeply indebted to the book production and procurement department at Wiley for their faith and support. In addition, Thaatcher Missier Glen for initial editorial support and Eswari Maruthu, the production editor, and the other editorial team members are to be thanked for

their wonderful work on editing the book on behalf of Wiley. particularly Sally Osborn, who undertook the final and most detailed edit to really bring polish to the text.

I should also like to thank the chapter contributors: Linda Malone, Judith Anderson and Karen Stanley from Australia, and Sally Carvalho, Veronica Swallow, Joanna Smith and Trish Smith from the UK. Each provided their respective chapters on time and with due care over the content. I could not have completed the book on time without their support and able advice. I should like to add that Fiona Foxall had planned to contribute again, but was unable to do so because of family issues. My condolences and best wishes go to Fiona during what has been a difficult and sad past year.

In the first edition, *Clinical Leadership: Innovation into Action* (2011), I neglected to acknowledge my doctoral supervisors Karen Cox and Linda Ellison (both from Nottingham University) and hope they will forgive this oversight. Karen Cox was an inspirational supervisor who prompted me to look beyond the end of my doctoral studies and keep asking the 'so what?' question, and Linda offered sound doctoral advice from an educational perspective that I found invaluable.

There are many others who have in many ways added to the completion of this project. Colleagues have offered support and encouragement, and undergraduate and postgraduate students have kept me keenly interested in the topic of clinical leadership. They have all fuelled my desire to do my best for them and remind me always that at the core of our learning is the client, patient, healthcare consumer – or person. Thank you all.

It is not only giants that do great things.

David Stanley
July 2016

Part I

Clinical Leaders: Role Models for Values into Action

Nothing in life is to be feared. It is only to be understood.
Marie Curie, Polish-born French physicist and chemist, famous for her work on radioactivity, first recipient of two Nobel prizes, first female professor, University of Paris

Clinical Leadership in Nursing and Healthcare: Values into Action suggests that clinically focused leadership or clinical leadership and administration-based or managerial leadership are not the same thing. The case for this view is set out in this first part of the book.

To support this statement, the book outlines a number of principles, frameworks, tools and topics describing how nurses and other health professionals can develop, lead and deliver effective clinical care – as clinical leaders, not as managers or as administrative leaders in the academic, political or managerial sphere. It also outlines a new theory of leadership, **congruent leadership**, which has been developed from a number of research studies exploring the nature and characteristics of clinical leadership from a wide range of different health professional disciplines, in the UK and Australia.

Congruent leadership theory suggests that leaders demonstrate a match (congruence) between the leader's values and beliefs and their actions. As such, clinically focused nurses and a range of other health professionals have moved decisively and clearly in the direction of their values and beliefs and can be seen expressing congruent leadership. They may simply have stood by their values, working not because they wanted to change the world, but because they knew that what they were doing was the right thing to do and that their actions were making a difference, if only in the life of one person.

It is timely that clinical leadership is being re-evaluated and frameworks developed that support it (Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Martin & Learmonth 2012; Mannix, Wilkes & Daly 2013; Storey & Holti 2013; Scully 2014; McLellan 2015; Rose 2015; West et al. 2015; Bender 2016), because it is clear that in attempting to climb the career ladder, many health professionals have faced the dilemma of having to move further away from the core reason they first became health professionals, resulting in role confusion and blurring of values (Stanley 2006c). Many have had to move into management or administrative positions or academic roles and leave their clinical roles further behind with each promotion. However, if leadership happens at all levels (Cook 2001; Stanley 2006a, b, 2008, 2011; Swanwick & McKimm 2011; Higgins et al. 2014), identifying who the clinical leaders are and attempting to gain an understanding of what clinical leadership means becomes vital.

Clinical Leadership in Nursing and Healthcare: Values into Action, Second Edition. Edited by David Stanley.

The first part of this book comprises five chapters. Chapter 1 deals with an exploration of the concept of clinical leadership. It explores the attributes of effective clinical leaders and outlines the rationale behind these attributes, then discusses why an understanding of clinical leadership matters now. The chapter considers what clinical leadership is and who clinical leaders are. Could a therapy team leader, who is busy telephoning staffing agencies in order to find staff to fill vacancies for a busy clinic, be the clinical leader? Could it be a nurse consultant, paramedic lead or nurse practitioner who is in the process of initiating a reform of clinically based practice on a recent research project? Could a healthcare assistant or physiotherapy aid who, day in and day out, has cared for sick and frail medical patients on a busy orthopaedic rehabilitation ward be the clinical leader? Could the bright-eyed, newly qualified occupational therapist who approaches work with enthusiasm and the hope that they are making a difference to people's lives on a busy rehabilitation day-case unit? Could it be the junior registered nurse who remains focused on essential bedside care and refuses to become drawn into the ward management issues? Or is the manager the clinical leader, as they keep staff focused on issues of quality, cleanliness and care?

Reflection Point

There are 'Reflection Points' throughout this book. These are to encourage you to pause and reflect on the topic or issues being discussed.

Start the book by pausing to reflect on who you think the clinical leaders are in your clinical area or practice location. Imagine that a relative or friend is ill and requires care in the clinical area you work in. Who are the people you would point to as clinical leaders? Who would confidently care for and lead the care for your relative or friend? What are your thoughts? Could it be any or all of the people described earlier?

Chapter 2 offers an introduction to the various definitions and styles of leadership. A spectrum of perspectives are presented to help health professionals get to grips with the concept of leadership. It is suggested that there are a wide range of views, beliefs and ideas about what leadership means, what types of leadership there are and how the types of leadership might be employed to build relationships, communicate more effectively, promote vision or values and bring about change or innovation.

Chapter 3 offers an insight into the important and often overlooked concept of followership. The concept of followership is defined, and followers' responsibilities and the attributes of effective and not so effective followers are explored.

Chapter 4 offers an insight into congruent leadership theory (Stanley 2006a, b, 2008, 2011, 2014). This theory of leadership was developed specifically from research exploring clinically focused leadership as it relates to health professionals, which is outlined in this chapter. Congruent leadership is promoted in this book as a valuable way to gain an understanding of how clinical leaders lead and why clinical leaders are seen as leaders. Examples of clinical leadership applied to congruent leadership are offered, as is a discussion about the strengths and limitations of the theory. Moreover, the relationship of congruent leadership to change, innovation, power and quality is considered.

Chapter 5 offers a discussion of the difference between management and leadership, suggesting that managers and leaders are driven and governed by a different set of values and beliefs, goals and objectives. The differences between management and leadership outlined here make it clear that

while a manager may be an effective leader and a leader may be an effective manager, their diverse drives, motivators and objectives may in fact make it very difficult for one professional to hold both sets of responsibilities successfully. Most significantly, the differences may be most evident in relation to the values that drive clinically focused health professionals, therefore attempting to combine these different roles may lead to internal conflict and ineffective care (Stanley 2006c, 2011).

So Part I aims to explore clinical leadership, leadership theory, followership, congruent leadership and the difference between leadership and management. It will outline the characteristics, qualities and attributes of clinically focused leaders and help identify what they are, as well as what a health professional might look for to become a clinical leader.

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1

Clinical Leadership Explored

David Stanley

Find people who share your values, and you'll conquer the world together.
John Ratzenberger, author of *We've Got It Made in America*

Introduction

Jesse Jackson, the American political and civil rights leader, has said: 'Change isn't about processes or structure. It is about courageous people who are prepared to act.' This book is about people in the health service who are courageous and prepared to act. For me, these are clinical leaders: women and men, across the spectrum of the health service, who explore the boundaries of their practice and who press for continual improvements in quality care, increased innovation and productive changes in practice. They are leaders because they put their values into action. Others see this and follow, because they hold or aspire to the same values and beliefs.

While nursing leadership and healthcare leadership are terms that have been evident in the nursing and health industry literature for many decades, clinical leadership is a relatively new term. However, what do we know about the concept of clinical leadership and what does the term mean? This chapter sets out to explore definitions of clinical leadership, the attributes of effective clinical leaders, and attributes less likely to be associated with clinical leadership. It will also consider who clinical leaders might be, and outline the implications for health organisations when understanding and recognising clinical leaders. It suggests that if an organisation – or indeed the health service as a whole – is to adapt and develop, there is an urgent need to identify who the clinical leaders are and to understand how they see themselves or are recognised by others (Mountford & Webb 2009; Jeon 2011; Storey & Holti 2013a; Bender 2016).

Clinical Leadership: What Do We Know?

Attempts to define clinical leadership, like insights into the concept, are relatively new. There were early contributions from Peach (1995) and Lett (2002), both from an Australian perspective, and US authors Dean-Baar (1998), McCormack and Hopkins (1995) and Rocchiccioli and Tilbury (1998) added to the dialogue. Berwick (1994) and Wyatt (1995) from a medical perspective, Forest, Taichman

Clinical Leadership in Nursing and Healthcare: Values into Action, Second Edition. Edited by David Stanley.

and Inglehart (2013) from a dentistry perspective and Schneider (1999) from a pharmacological standpoint have also added to the discussion. Most recently and also from a medical perspective, Stanton, Lemer and Mountford (2010), Swanwick and McKimm (2011) and Storey and Holti (2013a) have offered a summary of what clinical leadership may mean. However, in spite of this growing body of literature, a clear definition remains elusive (Mannix, Wilkes & Daly 2013; Jeon et al. 2015). Fortunately, more literature is evident each year that addresses Malby's (1997) suggestion that there has been limited agreement on a definition of clinical leadership.

Harper (1995) offered one of the earliest definitions, suggesting that a clinical leader possesses clinical expertise in a specialist practice area and uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care. McCormack and Hopkins (1995), Cook (2001b) and Lett (2002) support Harper's view, suggesting that clinical leadership can be described as the work of clinicians who practise at an expert level and who have or hold a leadership position.

Rocchiccioli and Tilbury (1998), writing from a nursing perspective, also cite excellence in clinical practice, but add that it also involves an environment where staff are empowered and where there is a vision for the future. Lett (2002) and Swanwick and McKimm (2011) suggest that a clinical leader is a clinical expert who leads their followers to better healthcare by providing a vision to those followers and so empowering them. Expert practice and a positive impact on quality patient care again feature, but each also links clinical leadership with vision, and this is at odds with the research results that support this book (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015). These publications suggest that clinical leadership and vision are seldom directly linked. Instead, clinical leaders are more likely to be followed because they match their values and beliefs with their actions in clinical practice; a perspective elaborated on in Chapter 4.

Stanton, Lemer and Mountford (2010, p. 5) offer the view that anyone who is in a clinical role and who exercises leadership is a clinical leader, before suggesting that a clinical leader's role is to 'empower clinicians to have the confidence and capability to continually improve health care on both the small and the large scale'. The UK Department of Health's (2007) definition is that the role of a clinical leader is:

> To motivate, to inspire, to promote the values of the NHS, to empower and create a consistent focus on the needs of patients being served. Leadership is necessary not just to maintain high standards of care, but to transform services to achieve even higher levels of excellence.
>
> *(DoH 2007, p. 49)*

Bender (2016) recently attempted to develop a theoretical understanding of clinical nurse leader practice and suggested that the core attributes of clinical nurse leaders rest on links to clinical practice, effective communication, effective interprofessional relationships, team working and supporting other staff.

Clark (2008) and Cook (2001a) suggest that clinical leaders are in non-hierarchical positions, with Cook adding that clinical nurse leaders are directly involved in providing clinical care that continually improves care through influencing others, with Cook and Holt (2000) supporting this perspective. Clinical nurse leaders also have a relationship with quality patient care and are able to influence others, implying perhaps that they may not need to be in positions of power or those that are hierarchically significant to lead in the clinical arena. The research that supports this book bolsters such views. These authors also imply that clinical leaders must be good communicators, and that they need effective team-building skills and respect for others.

The *McKinsey Quarterly* definition of clinical leadership is one that I particularly like (cited in Stanton, Lemer & Mountford 2010):

> Clinical leadership is putting the clinician at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and population, not as a one-off task or project, but as a core part of clinicians' professional identity.

In addition, the literature I have discovered points to a number of key elements in the recognition of clinical leadership:

- **Clinical expertise** (Berwick 1994; Harper 1995; Rocchiccioli & Tilbury 1998; Schneider 1999; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lemer & Mountford 2010; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Effective communication and interpersonal skills** (Harper 1995; Cook & Holt 2000; Cook 2001b; Stanley 2006a, b, 2008, 2011, 2014; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Jeon et al. 2015; Bender 2016).
- **Empowerment and respect for others** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lamer & Mountford 2010; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Team working or team building** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton, Lamer & Mountford 2010; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015; Bender 2016).
- **Drive change, make care better and provide quality care** (Berwick 1994; Harper 1995; Schneider 1999; Cook 2001b; Lett 2002; Stanley 2006a, 2006b, 2008, 2011, 2014; Ferguson et al. 2007; Clark 2008; Stanton, Lamer & Mountford 2010; Swanwick & McKimm 2011; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Byers 2015; Demeh & Rosengren 2015; Stanley, Hutton & McDonald 2015).
- **Vision** (Rocchiccoli & Tilbury 1998; Cook & Holt 2000; Lett 2002; Clark 2008; Swanwick & McKimm 2011).

However, it is my contention that there is much more to understanding clinical leadership than these definitions and views.

Reflection Point
Look around the area where you work. Who would you identify as a clinical leader? Why would you select this person or people? How does your choice of clinical leader fit with the definitions already offered in this chapter?

Attributes Less Likely to be Seen in Clinical Leaders

Not Controlling

Being viewed as 'controlling' was consistently seen as less likely to be associated with the qualities of a clinical leader. Table 1.1 indicates emphatically that in the five research studies that support this book (for more on these see Chapter 4), being 'controlling' was always the attribute identified as least

Table 1.1 'Being controlling': The characteristic least commonly associated with clinical leaders.

Percentage of respondents who identified *controlling* as the attribute least likely to be linked to clinical leadership	**Study 1**	**Study 2**	**Study 3**	**Study 4**	**Study 5**
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	78%	84%	80%	84%	83%

Table 1.2 'Being visionary' as associated with clinical leadership.

Percentage of respondents who identified *visionary* as an attribute likely to be linked to clinical leadership	**Study 1**	**Study 2**	**Study 3**	**Study 4**	**Study 5**
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	72% Ranking 27th out of 42	51% Ranking 37th out of 54	20% Ranking 33rd out of 54	40.9% Ranking 38th out of 54	34.2% Ranking 36th out of 54

likely to be linked to clinical leadership. Moreover, the percentages are remarkably similar across a range of professional disciplines, cementing a disassociation between being controlling and clinical leadership.

Not Visionary

'Being visionary' was also poorly associated with clinical leadership. As with Cook's (2001a) study, having a vision or articulating a vision appeared to be unrelated and unrecognisable as a dominant feature of the qualities and characteristics for which clinical leaders were recognised.

In Study 1 the term 'visionary' was identified by 72.3% of respondents as affiliated with clinical leadership, although even with this percentage it was ranked 27th on a list of 42 words to describe the qualities and characteristics most associated with clinical leadership. In each of the five studies, being visionary or having a vision failed to be rated highly in terms of a percentage factor, or as an attribute of clinical leadership. Table 1.2 offers data from all five studies to support this view. Interestingly, the percentages seemed to drop as the studies progressed in time (from 72% with nurses in 2005 to 34.2% with allied health professionals in 2015).

These results question the significance of 'vision' or 'being visionary' as a quality or characteristic sought or seen in clinical leaders. In each of the studies, respondents were invited to list their own attributes of clinical leaders and, as such, many additional attributes were offered. However, very few related to 'vision', 'being visionary' or 'being forward thinking' (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015). The lack of characteristics centred around clinical leaders being visionary was borne out by the results of the interviews or free-text comments, where 'vision' was hardly mentioned as an attribute looked for in clinical leaders, and rarely described as the motivation behind being a clinical leader.

This may be because respondents were drawn to or identify with clinical leaders who can lead them through the 'here and now' issues of busy and chaotic clinical work – who can cope with the

Table 1.3 'Creative/innovative' and 'artistic' as associated with clinical leadership.

Percentage of respondents who identified *creative/innovative* as an attribute likely to be linked to clinical leadership	**Study 1**	**Study 2**	**Study 3**	**Study 4**	**Study 5**
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals
	76.5% Ranking 25th out of 42	51% Ranking 32nd out of 54	60% Ranking 27th out of 54	59.0% Ranking 27th out of 54	56% Ranking 22nd out of 54
Percentage of respondents who identified *artistic* as an attribute likely to be linked to clinical leadership	13% Ranking 41st out of 42	24% Ranking 50th out of 54	0% Ranking 54th out of 54	42.5% Ranking 48th out of 54	8.5% Ranking 50th out of 54

demands of each day as it comes, rather than postulate and pontificate about how things could or should be. Clinical leaders were seen and selected if they had their values on show and stood on a solid foundation of care and compassion that governed and drove their practice standards. Clinical leadership is therefore defined in action, as clinical leaders mobilise their values and beliefs to guide and direct what they do when faced with challenges and critical problems in the clinical area (Clark 2008; Stanley 2006a, b, 2008, 2011, 2014; Edmondstone 2009; Stanley, Cuthbertson & Latimer 2012; Forest et al. 2013; Stanley, Latimer & Atkinson 2014; Scully 2014; McLellan 2015; Stanley, Hutton & McDonald 2015).

Not Shapers

Cook (2001a) saw clinical leaders as 'creative', identifying the typology of 'shapers' to describe them (see later in this chapter). In each of the five research studies that influence this book, creativity was rarely identified as a defining characteristic of a clinical leader. As indicated in Table 1.3, being 'creative/innovative' or 'artistic' was seldom ranked highly on the clinical leader attribute list.

Artistic was ranked second only to 'controlling' as the characteristic least associated with clinical leadership in the first study among nurses and was continually ranked near the end of the order in all the other studies. Higher percentages of respondents did still consider being 'creative/innovative' a feature of clinical leadership. However, this failed to be as strongly associated with clinical leadership as other attributes, and in interviews with clinical leaders or in other data sources, creativity and innovation were seldom expressed as an attribute worthy of note (Stanley 2006a, b, 2008, 2011, 2014; Stanley, Cuthbertson & Latimer 2012; Stanley, Latimer & Atkinson 2014; Stanley, Hutton & McDonald 2015).

I have struggled with this aspect of the results since my initial publications. Rolfe (2006), who wrote a commentary on the 2006 article (Stanley 2006b), was likewise unsure of the validity of the results, given that creativity was ranked so low. However, this feature of the results has been confirmed again and again with each subsequent study (see Table 1.3). I am sure that some clinical leaders are creative and that being creative is a substantial skill for clinical leaders to employ, but I am now sure that being creative is not something that others look for in their clinical leaders. Creativity does remain a key attribute that clinical leaders should aspire to, and it is of particular relevance if clinical leaders are to influence innovation or change or to find new ways to bring their values into practice. Chapter 9 elaborates on the issue of creativity and identifies a number of strategies that clinical leaders can employ to bolster their creative capacity.