

Who Cares, Wins

Leadership and the business of caring

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Foreword

There is extensive change occurring in health care, but despite that change the ability to provide care and compassion to every user remains a legitimate public expectation. However, different competing pressures have made this more an aspiration than a reality. The changing pattern of health care provision and commissioning provides unprecedented opportunities to redress the imbalance, but exceptional leadership is needed.

This report is particularly relevant in the light of the serious and much publicized problems in respect of the lack of leadership and influence brought to bear at senior levels with regard to the dignity and care of patients at Cornwall Partnerships NHS Trust and at Stoke Mandeville Hospital, part of the Buckinghamshire Hospitals NHS Trust. This quote from the Health care Commission's report on the outbreaks of *Clostridium Difficile* at Stoke Mandeville is particularly relevant to the findings of this report: 'Senior nurses considered that the director of nursing did not listen to her professional colleagues, that she did not represent the concerns of nurses to the board and did not have a focus on the care of patients.'

Any business will need a leader for its key product and I make no apology for describing care and compassion as such within the clinical work of acute and primary care. That leader has to be held accountable and have the authority to hold others, particularly the board, to account for how satisfied the customers (patients and carers) are with the service provided and how it can be improved. What a difference this would have made at Stoke Mandeville. This is not about the odd satisfaction survey but rather the competence, credibility and authority to performance manage on an ongoing basis the whole patient experience, wherever that is located.

The leadership of the marketing and delivery of new ways of caring for people's health will be central to the commissioning and provision of care outside hospital. I can think of no better ambassadors for this essential change than nurses equipped with the right leadership skills working at board level. However, if this is to happen and be effective the business of caring needs a higher profile on board agendas, properly supported by real time information for intelligent stewardship.

Critical to the success of patient care in the future will be the preparation of nurse leaders. This timely report, commissioned by the Burdett Trust for Nursing, points up the need for training and development that provide nurse leaders with:

- the skills, confidence and tenacity to 'bring the bedside to the boardroom' and keep this on the agenda against other competing interests;
- a sophisticated grasp of the organisational and political context in which they work and the consequent ability to tailor their leadership style accordingly;
- exposure to new ways of doing things outside health care; and
- a real understanding and belief in the advantages to the patient of the shift to care outside the acute hospital.

We have the opportunity to give a fresh impetus to capitalising on one of our best assets in health care by equipping nurse leaders to make care and compassion in the right setting a more consistent reality for the public. On behalf of the Advisory Group, I commend this report to you.



Sir William Wells

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Executive summary and key recommendations

Who Cares, Wins is a study commissioned by The Burdett Trust for Nursing about the business aspects of patient care and the implications for nurse leaders and their boards. Designed to trigger the actions that will take patient care 'from bedside to the boardroom', the report argues that **if a more market driven health system is going to deliver 'a new NHS', then patient satisfaction and customer care need equal ranking with finance, targets and outputs on board agendas.**

The business of caring is a whole board issue. Nurse leaders, because they have or can develop many of the qualities that will be required to deliver on this agenda, and as a result of the increasing breadth of their responsibilities, are well placed to lead the business of caring on their board's behalf.

There are examples of **exceptional clinical leaders** who have succeeded in making patient care a driving force in their organisation's strategy and operational processes, but they are in short supply. Two characteristics of these individuals stand out. The first is their skills, confidence and tenacity to 'bring the bedside to the boardroom' and keep this on the agenda against other competing interests. The second characteristic is a sophisticated grasp of their organisational and political context and ability to tailor their leadership style to it.

Exceptional clinical leaders are important in delivering improved patient care. But *Who Cares, Wins* makes it clear that there are also critical organisational factors that need to be in place: clear structures and accountability; valuing, seeking and acting on patient opinion and measuring its impact; and influential champions for patients at board level¹.

Who Cares, Wins makes recommendations on what clinical leaders, their organisations and those in the business of leadership development can do to create the exceptional leaders and boards that will place patient experience at the heart of health care commissioning and provision.

1. As with many of the other findings reported herein, this was one of the conclusions of a companion study commissioned by The Burdett Trust for Nursing, conducted by the University of Plymouth (2006): *An exploratory study of the clinical content of NHS Trust meetings in an attempt to identify good practice.*

Recommendations for clinical leaders as champions of care

Clinical leaders need to:

- recognise and rethink strategies to **put patient experience at the centre of their organisation's work** by capitalising on the new levers arising from the changing health and social care system
- **create a language and measures for the 'business of caring'** that will capture the interest and commitment of the board
- **ensure the improvements that matter can be measured.** Champions of care need to establish genuine and up-to-date intelligence about what patients and the public want, need and hope to get from their health care
- take opportunities to **learn from inspiring leaders inside and outside health care**
- **maintain a passionate commitment to making a difference** for service users and carers.

Recommendations for health care commissioners and providers

All PCTs are starting to rethink their approach to commissioning. The new opportunities of the market system are in place but will only work for the benefit of patients if commissioners allow these processes a free rein. Commissioners need to:

- **establish more rigorous ways of understanding patient needs and preferences** for different sections of the community, particularly minority groups
- **support and encourage patients to be more demanding** and explicit about their needs and preferences
- be prepared to **break the mould of traditional patterns of delivery** and commissioning in favour of improved patient outcomes rather than relationships with providers and institutions.
- use the freedom to **include locally agreed quality standards** within model contracts with providers to ensure that patient experience is reflected alongside clinical processes and outcomes.

Health care providers need to:

- **clarify how the 'business of caring' will be led and managed** in their organisation. Structures and processes for patient, carer and public engagement may need to be rethought.
- **be specific about the quality measures they will achieve at different stages of patient care pathways**
- **establish a conducive organisational culture** that puts patient experience at its heart. Important elements are: learning from patient and carer views; early warning systems for clinical teams to pinpoint and deal with poor quality care; horizon scanning to find new technologies and innovations that can be fast tracked to improve patient care; and investment in the skills and experiences of the workforce.
- **agree appropriate indicators** of how well they are performing in relation to patient experience and the links between this and other facets of organisational performance.

Recommendations for providers of leadership development

Leadership development for the business of caring may not require a complete reinvention but it does need greater focus on the context in which skills are applied and on the outcomes being sought. Providers of leadership development initiatives need to:

- offer leadership programmes, for established as well as aspiring leaders, that **focus on the specific context of the caring business** and help individuals to exploit the opportunities presented by the health care market.
- **prepare non-executive directors** to take their role in supporting and interrogating the business of caring through induction and ongoing development.

There are signs that health care regulators – both national and local – are taking increasing account of patient experience in the way that they discharge their duties, and this needs to continue. The recent national spotlight on the financial difficulties that the NHS has experienced presents a golden opportunity to rebalance the public debate. By stressing the central objectives of the reforms – improving people’s health and delivering a more personalised form of health care – managers, clinical leaders and politicians can rekindle public confidence in their health service.

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Nurses and the business of caring – an overview

Over the last few years public confidence in health care has faltered. Whilst patients love their NHS, public opinion has been more equivocal. The need to provide a more effective response to patient needs and preferences was one of the triggers to the latest round of health system reform in England. These changes look set to transform the health service landscape more radically and rapidly than all the rest combined. Although much of the discussion about the reforms has been couched in the language of the market – choice, contestability, competition, new systems of funding – the recent announcement that the Healthcare Commission will look at patient dignity in their assessment and regulation of health care providers is a reminder that it is patients and how they experience their health care that is the ultimate aim. Subsequent policy developments – the extension of patient choice beyond elective care, the revised quality strategy expected later this year, changes to the regulation of health professions and changes to the tariff system to include penalties for poor quality, to name but a few – suggest that this emphasis will become even more important over the next few years.

It was this interest in the quality of patient experience that led to *Who Cares, Wins*, a study commissioned by The Burdett Trust for Nursing into the business of caring and its implications for nurse leaders – executive nurse directors – and the boards of which they are members. The study is designed to raise the quality of debate and trigger the necessary actions that will take patient care issues ‘from bedside to the boardroom’.

The report argues that if Patient Choice is going to deliver the improvements in patient experience and better value for money – the policy’s original intention – then patient satisfaction, customer care, innovative approaches and risk management will need equal ranking with finance, targets and outputs on board agendas.

The report concludes that if nurses are to succeed as leaders in this changing health care environment and turn the tide of public opinion, they will need to be champions of new ways of delivering health care. A wider range of diagnostics, treatment and care delivered outside hospitals, tailored to individual patient requirements, combining a range of disciplines and clinical skills in innovative ways and all of this delivered in a way that offers better value for money: these are the characteristics of the health system of the future. As effective champions, nurses will need to bridge the quality and responsiveness of patient care on the one hand with the hard financial side of the health care business on the other. Executive nurses have a critical role to play in enabling their boards and organisations, whether they are commissioners or service providers, to view the ‘business of caring’ as much a part of their agenda as the financial bottom line.

How this work was carried out

The report findings are based on the views of over two hundred expert stakeholders, gathered through an online survey, interviews, workshops and a national stakeholder event.

In undertaking this study we looked at both the present and the future. We examined the roles of nurse leaders, responsibilities for leading the quality of patient care, the organisational factors which promote or inhibit quality care and how these and other pressures are likely to change the delivery of patient care and the way in which it is led and managed. We surveyed nurses and a wide range of other stakeholders inside and outside the health care system about these elements and the factors they felt would be of greatest significance in influencing patient care over the next 5 to 10 years.

Drawing on the findings from the survey and a literature review, we developed three plausible but very different **scenarios** about what the future might hold. These were used at a workshop for senior opinion leaders and practitioners who helped us think through what the future might hold for the business of caring. By identifying the common challenges which may occur under each of our possible futures we were able to identify some robust conclusions about how the business of caring can be given greater prominence in the evolving health system and about the leadership issues associated with that agenda.

In the appendices to the report you can find the terms of reference for the project (Appendix 1); details on the project methodology and profile of respondents to the survey (Appendix 2); the scenarios as used at the national stakeholder event (Appendix 3); attendees at the event and membership of the project Advisory Group (Appendices 4 and 5); and the findings of a review of the current leadership development opportunities available to care leaders (Appendix 6).

3

The changing health care system

Effective leadership is contingent on the context in which it takes place. In thinking about how the business of caring can be given a higher profile, we need to understand how the health and social care system is changing and what it will demand of its leaders. As a result of the current set of health care reforms the NHS in England will become increasingly diverse as a wider range of organisations – including private and voluntary sector bodies – become providers of health care, work in different ways with their local partners and make different choices about the way they use their resources and deliver care.

With the bulk of commissioning devolved to GP practices, priorities will be set locally and decisions about the pattern of care will be more closely tailored to individual patient needs. This does not just mean delivering better clinical outcomes, but also improving how patients ‘experience’ their health care. In the coming years, the NHS will be driven by a need to offer more choice: of when, where and how patients receive care; better and more supportive ongoing care to people who want to live at home; and a more responsive service, able to treat people as individuals and with dignity. These so called ‘softer’ outcomes are becoming important drivers for change along with the ‘harder’ (if not necessarily any harder to achieve) targets of reducing disease, reducing inequalities in health and access to care and improving overall health status.

Given that, across the country, nurses are the public face of health care locally, they are exceptionally well positioned to lead the change programmes necessitated by reform and, as trusted advocates of patient welfare, they have the potential to promote, champion and lead new patterns of care.

The future pattern of health care was recently summarised and re-emphasised in the White Paper *Our health, our care, our say*² and according to our survey findings, appears to have the broad support of executive nurse leaders. In 5 to 10 years time the health system will have:

- an improved focus on **prevention services, with earlier diagnosis and intervention**
- faster and **more convenient access to social and primary care**
- greater action to **reduce health inequalities** within and between regions and communities
- better infrastructure and services to enable people with **long term needs to manage their conditions**.

2. White Paper: *Our health, our care, our say: a new direction for community services* (Department of Health, 2006): available on the web at www.dh.gov.uk.

Given these general trends what aspects are likely to have the greatest impact on the business of caring? The survey findings indicate that there are five main pressures as outlined below (illuminated by direct quotes from research participants).

- **Patient choice:** is generally felt to be a positive pressure that will lead to improvements for patients, and the management of patient care: *“Choose and book - the choice agenda will start to reveal quality issues around standards of care as well as just patient convenience; this will start to impact on patient flows and financial flows”*. However, with greater choice and empowerment comes rising expectations. *“Patients expectations of ‘effective’ treatment for every condition are rising all the time. This increases demands on an increasingly thinly spread service.”* The ability to change the way services respond to patient needs and expectations, whilst also improving value for money, is going to be essential.
- **Changes in patient needs:** The major pressure on acute hospitals at present is from patients with long-term conditions. The ageing population is also likely to present greater challenges to health care providers, particularly as the availability of family and informal care may decline. *“Increasing elderly population with increasingly complex care needs as a result of multiple co-existing conditions”*. By exploiting technological developments such as remote monitoring, and improving care coordination (e.g. through new community matrons), more patients can be treated at home or in primary care settings. Nurse leaders will increasingly be developing integrated teams and patient care pathways that connect services horizontally at the local level and also vertically between community services with hospital-based settings.
- **The financial regime:** Not surprisingly, the factor that respondents thought most likely to affect the management of patient care over the next ten years was the availability of sufficient financial resources, coupled with the rising demand on those resources from an ageing population. The payment by results regime makes it increasingly important for trusts of all types to generate sufficient ‘headroom’ to weather changes in patient flows.
- **Competition and the plurality of service provision:** *“Greater competition between service providers will focus boards’ attentions on their key differentiators, including cleanliness, quality of outcomes, patient comfort and safety, responsiveness to patients’ needs (e.g. visiting hours that suit patients and their carers rather than hospital administration)”*. Alongside competition, commissioners and providers are expected to work in collaborative ways more frequently. Joint commissioning and the effective use of health care networks will be crucial to providing the most appropriate care for each patient, matching individual needs to the best centre(s) of expertise in the case of complex conditions. *“Cross-agency working will, after 10 years, be an accepted norm and break traditional barriers.”*
- **Workforce availability:** The recruitment and retention of skilled nurses has been a constraint on the delivery of patient care in many services. It remains to be seen how this will square with recent and continuing redundancies of nurses and other staff. *“I am confident that nursing will always be an attractive profession, but am concerned that the swings and roundabouts of workforce planners jeopardise stability in terms of the number of nurses available.”* The balance between trained nurses and health care assistants in delivering direct patient care was also highlighted: *“if the balance is tipped further toward the untrained workforce this may lead to ‘poor nursing, increased mistakes or lack of timely care”*.

4

Leading the business of caring – the implications for nursing

In parallel with the radical changes taking place to the health care system *Who Cares, Wins* found that the roles executive nurse leaders are playing in the health system are also being transformed.

The role of executive nurse leaders is changing

Nurse leaders are increasingly being given a **widening portfolio of responsibilities**. As well as leadership of the nursing profession nurses are increasingly found responsible for clinical governance, operations, financial issues, patient and public engagement, human resources and other functions. Many senior nurse leaders now have operational responsibilities for all clinical services. This continuing trend means that nurses, given their professional involvement in caring and care processes, are also well placed to influence the most critical business decisions their organisations will be required to make in the future. This trend is also a move away from the figurehead nurse – a board appointment by right – to leaders appointed for the breadth of skills and acumen which are a reflection of their nursing background.

Alongside these widening responsibilities, nurse leaders are finding they need to take a **whole business perspective** if they are to contribute effectively to board decision-making processes, whether as full board members or by providing advice. The sheer size of care budgets as a proportion of the overall budget for health care organisation means that nurse leaders have a significant role to play in helping organisations handle the complexities of the profit and loss account. With the emerging financial challenges for the NHS, despite unprecedented increases in national investment organisations will increasingly look to nurses and other clinical leaders to deliver more benefits within the same or diminishing resources.

Good practice example

“At our trust, the director of nursing (who is also deputy chief executive) is the key executive on the Risk and Clinical Governance Committee (a board committee). This enables him to play a key role in governance of patient safety and welfare, as well as health and safety of nursing staff. Our trust has been piloting a long-term patient-feedback project at a particular ward in the hospital, led by the director of nursing, which aims to obtain a high level of patient input into the level of care and comfort provided. The project is at an early stage.”

Nurse leaders now have more diverse and more challenging portfolios

High calibre nurse leaders are well placed to occupy the most senior roles in health care organisations in the future and some already do so. These roles go beyond the traditional focus of nurse managers and increasingly mean that executive nurses on the boards of PCTs, trusts and foundation trusts have quite varied portfolios. These wider roles are a double-edged sword. On the one hand nurse leaders have the opportunity for much greater influence. But on the other there are risks that the unique focus of nursing on caring risks being diluted or overshadowed by wider organisational concerns. *“It is difficult to promote the nursing perspective”; “Nursing used to be a role in its own right – now its often an ‘add on’.”*

Good practice example

“Because of my position as director of clinical services as well as executive nurse i have been able to influence and lead the development of the long-term condition agenda and also our intermediate care and rehabilitation service. These have been aided by nsfs and health act flexibility legislation.”

Nurses are leading service transformation and quality improvement as commissioners and as providers

A common component of these diverse portfolios is increased responsibility for setting and monitoring care standards for service design and development which embraces commissioning as well as service delivery. Nurses are *“Increasingly involved in setting care standards and monitoring those standards”*; *“They have been responsible for modernising services, improving the safety and quality of services and improving patient experience”*. Using the health care workforce in new and innovative ways is a further example:

- increased use of health care assistants;
- developing staff with multiple skills that straddle the boundaries between medicine, therapies and nursing;
- extending the specialist skills of some nurses.

5

Factors that help or hinder the business of caring

Organisational characteristics

As the role of executive nurse leaders is changing to embrace some of the wider facets of patient care – what role are their organisations playing in helping or hindering the business of caring? The three most significant factors which enable nurse leaders to promote the quality of patient care effectively are:

- **Clear structures and strong lines of accountability:** Where nurses can combine managerial responsibility and accountability with their professional leadership role they are more able to have a positive effect on patient care. This is enhanced where there are formal arrangements for reporting performance.

Good practice example

“In Medway we have developed the Medway Nursing and Midwifery Accountability System which ensures the matrons account for different aspects of the patient experience to the organisation’s nurse leader on a weekly basis. We are also working with the local university to see how both organisations can emphasise and improve the caring aspect of the student nurse curriculum.”

- **Patient views and opinions are given a high priority by and visibility in the organisation:** The business of caring is more likely to be promoted where patient views are given a key role in driving the organisation’s strategy and service development³.
- **Where leaders of the business of caring have credibility and influence at board level:** This is not simply a matter of the ability and competence of individuals on the board. Bringing the bedside to the boardroom demands a cultural shift. Chief executives and chairs need to play their part in making space for the ‘bedside’ in organisational strategy and Boardroom discussions⁴.

3. University of Plymouth (2006), *ibid.* 4. University of Plymouth (2006), *ibid.*

To an extent the inhibiting factors are the absence of these enabling elements, but there are three further points which emerged from our research:

- Whilst financial resources were frequently cited as an inhibiting factor to effective patient care, this was not the overwhelming view. This suggests that whilst the financial regime is important, **effective leaders in the business of caring find ways of delivering quality care within the resources available.**

Good practice example

“One instance is in a PCT where the role of the nursing director had been marginalised for reasons mentioned before. It came to crisis point when the district nurses indicated that they were being unfairly treated and cuts in establishment had brought the service to crisis point and therefore they felt they could not accept routine referrals. The director of nursing oversaw the introduction of a shared governance model and the creation and operationalisation of a nursing strategy aimed towards this goal. The nurses now have a structure to develop and showcase their contribution to the patient care agenda”.

- **Lack of experience and skills:** As portfolios have widened and the health care system becomes more business like, nurses are finding that their lack of experience and skills in some facets of their work prevent them from delivering enhanced patient care.
- **Inadequate monitoring of patient care at board level:** Despite many central policy initiatives which are linked to patient care, it is the case that many boards fail to turn these into systems and processes that are regularly audited and receive the attention of the board. For example, it has taken media attention for some to take responsibilities for infection control up the agenda long after it was a government priority.

Leadership development

Given the point noted above about skills and experience, the way in which nurses are supported and developed for their widening portfolio is particularly important. *Who Cares, Wins* looked at existing opportunities for nurse leadership development and how these link to the business of caring.

We found a vast array of leadership programmes and development opportunities which are increasingly available to all sections of the workforce, not only those in the most senior positions (see Appendix 6). Most programmes seem to focus on leadership behaviours, developing skills of individuals and supporting personal aspirations. In general, however, there does not appear to be a wide range of programmes specifically designed for nurse leaders, although there are many generic programmes which do cater for nurses in senior management and on boards amongst their participants.

With most executive nurse leaders having already completed some form of postgraduate management development and/or leadership programme, the current challenge for those leading the business of caring is in applying these skills to the specific context and culture in which they operate. Influencing skills, networking and political aptitudes, research methods, lateral thinking and creativity, risk management and commercial 'nous' are all increasingly important – but with a heavy measure of application in practice.

This focus on leadership in context is demonstrated in the increasing emphasis that some organisations are placing on workplace learning and development.

Good practice example

“There are a range of very different developments with which I have been involved:

Moving a university based post-graduate school of nursing back into an NHS hospital under the management of the trust’s chief nurse. This was difficult to achieve but has been an outstanding success.

Implementation of weekly ward rounds by the trust chief nurse and the senior nursing team.

8 weekly, full day team building meetings for sisters and CNS’s from throughout the organisation and from all divisions and directorates.

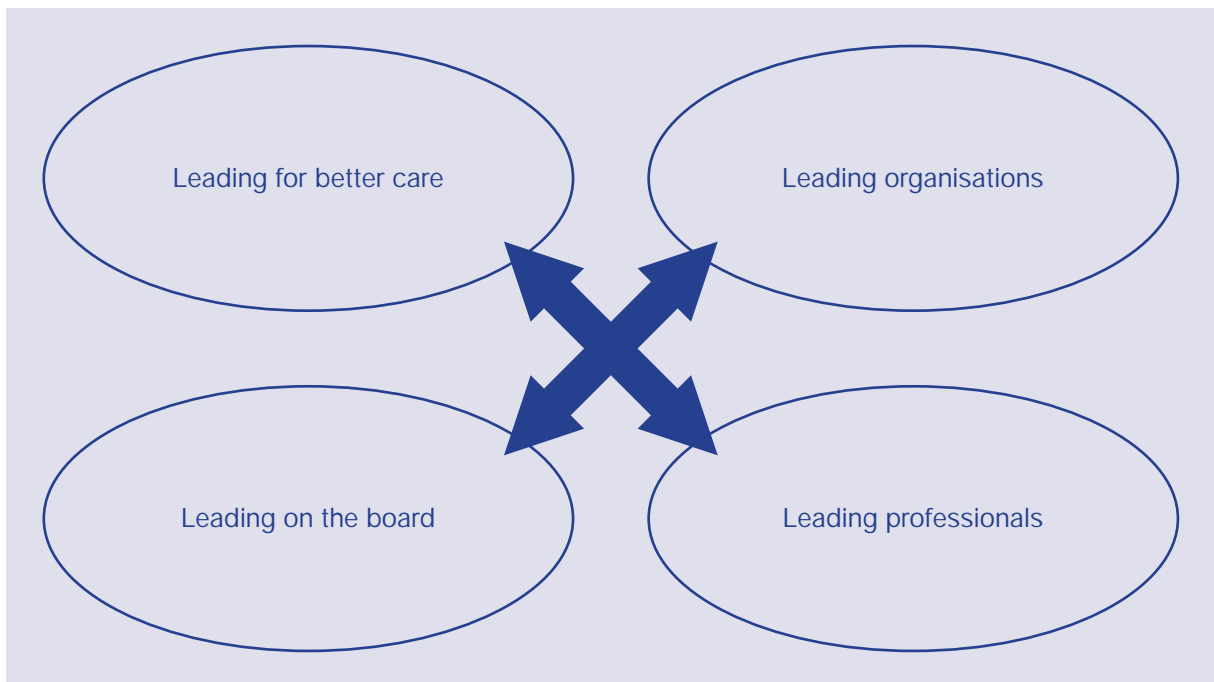
Once a year an ‘away day’ and dinner is also provided.

The senior nurses now see themselves as a corporate body with a foot in their division or directorate and a foot in the corporate nursing directorate. Our discussions are often about the ‘essence of nursing’ and reflections of patient care experiences including a Nursing Grand Round where patients are presented using Nursing Diagnosis”.

6

Leading the business of care in the future

Who Cares, Wins has highlighted that there are four areas of leadership challenge faced by nurse leaders – all of which need to be addressed over the next ten years if nurses are to grasp the full potential of their emerging role.



In this section we bring together our analysis of the changing NHS context, the roles and responsibilities for nurse leaders and the factors which promote or hinder the business of caring to consider what this means for the type of skills and qualities that nurses as leaders in the business of caring will need in the future.

Leading for better care

Key Messages

Leading for better care means nurse leaders will need skills which enable them to:

- re-shape services to respond to the changing demographics of the population
- build trusting advocacy relationships with patients and carers and enable all professionals within their sphere of influence to do likewise
- ensure that the patients' perspective influences board decisions
- link all facets of their portfolio to the impact on patient care and experience
- encourage creativity and innovation within organisations
- develop their clinical skills where appropriate to their changing role
- harness technological developments to support their practice
- understand the evidence base for alternative approaches to care
- market analysis and social marketing skills to understand and promote significant elements of patient experience
- deploy effective techniques for public and patient engagement.

Enabling patients to express their needs and responding to them

Patient choice and experience will increasingly be hallmarks of responsive and quality health care provision. This is changing the relationship between patients and professionals. Nurse leaders in the future will be advocates for those groups of patients less able to represent their own views. For those who can represent themselves nurses have a role in *"empowering patients to have realistic expectations and to take increased responsibility for their own long term health"*. In this new relationship between patients and professions the role of empathy, compassion and respect are likely to assume greater importance. *"Being able to make patients feel we have all the time in the world within a few minutes."*

Promoting innovative solutions within available resources

To respond to patients' individual needs and preferences, nurse leaders will keep up to date with and test out alternative ways of providing care, making best use of emerging technologies. As a wider range of providers of care emerge, the ability to integrate supply chains of increasing complexity and diversity will also be significant. Managing relationships between patients, the wider community and health care organisations will become even more critical and nurse leaders must have the skills to balance the interests of all stakeholders. With increasing pressure to find new solutions and responses to patient care, leaders in the business of caring will need to promote creativity and innovation in their organisations and balance this with clear processes for identifying and managing risks. *"Being able to challenge traditional solutions and create structures to permit innovation."*

Good practice example

“Working with our learning and development department I have been able to embed the patient experience as communicated by real patients, in all of our in-house development programmes. This is now crossing multidisciplinary boundaries even to the medical undergraduates and is having a very powerful effect upon staff attitudes.”

Broader clinical skills

Leading for better care increasingly means encouraging nurses to broaden their clinical skills including diagnostics, prescribing, and case management.

Leading organisations

Key Messages

Nurse leaders will need skills which enable them to:

- broaden their portfolio of responsibilities whilst maintaining close engagement with patient care
- manage change in an increasingly complex landscape of provision
- engage effectively with commissioning processes
- deliver efficiency improvement strategies
- contribute to meeting organisational financial, service and marketing targets
- be business orientated as well as patient focused (business skills in costing, pricing and activity modelling)
- accelerate the pace at which improvements in care and resource utilisation are delivered
- understand the new pattern of incentives and disincentives and how these will impact on stakeholder behaviour
- consider new organisational entities in running public services
- demonstrate leadership skills for partnerships (these may be slightly different in emphasis to those required within a single organisation or team).

Managing change and its impact on patient experience

As the portfolio for senior nurse leaders expands nurse leaders are increasingly required to move from a professional focus to a whole organisation perspective. Managing change both internally and through partnerships with other bodies becomes critical as does building organisational leadership and management capacity. This requires a degree of flexibility in the face of changing requirements, regulations, organisational culture and the ability to understand and respond to the impact of changing incentives on stakeholder behaviours. *“The ability to live with constant changes and to lead staff through them.”*

The ability to develop clear and effective long term strategies will be balanced by a grasp of performance management across the dimensions of the balanced scorecard. Finance, quality of care, human resources and business processes will be vital areas of knowledge and skill. Using information to understand the impact of services on patient experience is likely to be particularly important given that more nurse leaders are removed from their role as a front-line nurse: *“Most board nurses no longer have a clinical case load, so how will they understand the needs of patient care?”*.

Good practice example

“One colleague sets aside a day a month to go out with clinical staff to observe, listen and learn. She works in a small PCT which does make this easier but the key point is making and maintaining contact with the shop floor.”

These broader portfolios present more complex delivery challenges. Leading organisations will require greater political and influencing skills. *“Keeping pace with change and having an influence on changes and developments within an increasingly politically driven Public Sector.”*

Working through commissioning

With the increasing focus on effective commissioning by practices and by PCTs, the business of caring will require nurses and other clinical leaders to engage with commissioning processes both directly and indirectly. The ability to understand costing, pricing and activity trends and effective negotiation and persuasion skills will be as important as specification of quality standards. Commissioners will also need to *“have business acumen for service delivery and contract negotiations”*. Alongside these hard elements however, commissioners need to ensure that their specifications tie back to patient experience and provide them with the data they need to monitor the impact of the care they commission.

Business, marketing and financial skills

The need to develop good business skills – particularly financial and marketing abilities - was raised by research participants as an important skill needed for the future. One respondent predicted a shift in emphasis from *“touchy-feely nursing to tough financial institutions”*. Whilst this is most likely to apply to board members, it is increasingly likely to be a skill set needed of all clinical leaders. The ability to deliver far more benefits for the same resources in the tightening financial environment will be key.

Leading on the board

Key Messages

Nurse leaders will need skills which enable them to:

- balance financial and business responsibilities with providing quality care
- operate at board level as a 'custodian of care'
- understand how boards and corporate bodies function
- effectively influence decision making both within the board and with stakeholder organisations
- operate at a strategic level
- command respect
- contribute to their boards rethinking the appropriate measures of performance that will be needed to function effectively within the changed context of the NHS.

Raising board awareness of, and commitment to, the quality of care will be balanced by an appreciation of the links between this and the financial bottom line. Traditionally, board level nurses have been considered relatively marginal to the core decisions boards are required to take. In the future they will find themselves at the heart of key debates on the business of health care organisations. The confidence and ability to influence at this level will be a critical success factor, as will a detailed understanding of the financial aspects of alternative ways of improving patient experience. Boards of health care organisations will themselves need to change the way they have traditionally functioned to fully benefit from new-style nurse leaders.

Balancing finance and care

A key challenge for Executive nurse leaders is *"to remember that we are a patient based company and that this is as important as financial balance"*. There is likely to be increasing pressure on nurse leaders to ensure that even where budgets are shrinking, care remains at the heart of the nursing and health care agenda: *"Maintaining a quality service in light of higher expectations and limited budget"*. In this context more illuminating measures of performance may be needed to enable boards to measure the impact of the organisation on patient care, experience and outcomes.

Credibility and influence

Clarity about accountability and responsibility of the 'custodian of care' on the board is important. The individual must also have *"respect, credibility and be fully engaged in the 'corporate' role of the board"*. This will require being able to 'hold their own' with other board members, and ensure that patients' opinions and needs are 'championed'. The skill set required goes beyond generic influencing skills to include political awareness, perception and ingenuity – as one respondent put it: *"nurse board members need to be diplomats extraordinaire"*.

Good practice example

"Within our trust the director of nursing implemented an award winning Nursing & Midwifery Accountability System where matrons report weekly on issues including MRSA / C.Diff / pressure sores / cancelled operations/sickness. This has allowed us to identify and improve our care where required."

Strategic insight

In leading on boards, nurse leaders increasingly need to have strategic insight into where business opportunities lie. *“To really understand and know the health needs of the population ... be brave with some of the decision making and be fully informed to be able to challenge the ‘norm’ and ‘what we have always done’.”* For those in commissioning roles, this may require *“an ability to challenge tradition and be unafraid to destabilise organisations whilst ensuring stability of service provision”*.

Leading professionals

Key Messages

Nurse leaders will need skills which enable them to:

- motivate and engage staff across disciplines
- recognise and publicise success
- manage both recruitment and retention strategies whilst contributing to the wider workforce development agenda
- communicate with a wide variety of professional groups
- build leadership capabilities and capacity amongst health care professionals
- understand how to create and develop effective teams
- communicate effectively and build trusting relationships with all disciplines.

Nursing professionals at all levels will face challenges and opportunities as health care changes and as patient expectations rise. Nurse leaders of the future will be adept at leading across professional boundaries and building support from a wide range of professions, from nurses with highly developed specialist skills to the growing workforce with caring responsibilities but no formal professional qualifications. Handling resistance and challenge, using evidence of best practice, valuing diverse perspectives, understanding the languages of the professions and consensus building will be essential attributes.

Designing an effective workforce

The ability to look ahead at organisational and service requirements and ensure there is an appropriately trained workforce will be critical if organisations are to have capacity and flexibility to deliver innovative responses to patient needs. This means understanding trends in recruitment and maximising opportunities to retain those with valuable skills. It is also vital that these varied skills are efficiently deployed for the benefit of the patients. The professional development and educational needs of all health care professions may increasingly figure on the agenda of those nurse leaders who take a wider role in the development of the health care workforce – getting the balance between multi-disciplinary training and development and respecting the specific needs of individual professionals will be key.

Support, motivate and empower nurses and other professionals

As demands on the health care workforce increase the ability to motivate and maintain morale in a climate of uncertainty will be a significant factor in delivering effective patient care. In championing the business of caring, nurses will increasingly be leading a range of professions and disciplines, but ensuring that the contribution of nurses is valued and supported at board level will continue to be important. Managing the balance between having a leadership role for nurses and also for a wider set of clinical professionals will present particular challenges.

Communication and listening skills

Advanced communication and listening skills are seen as increasingly important attributes for nurse leaders and board members. The ability to tailor messages to different audiences and organisations is an especially important component of this particular skills set.

Leadership, vision and management skills

All of the above will demand a strong sense of vision on the one hand; and leadership skills to gain support for this vision on the other. This was recognised by participants in the research, who emphasised: *“Vision coupled with strong and courageous leadership, determination and resourcefulness”*; *“Having a vision of where they want nursing to develop, not being led by others”*.

It is important to stress that the business of caring is not the preserve of nurse leaders as of right. Nurse leaders have and can develop many of the qualities that we have set out in this section. And the increasing breadth of their portfolios puts them in a strong position to take a lead in this field. What is important overall is that health care commissioners and providers put patient experience and care at the heart of their strategies and plans and that there is clear accountability and responsibility for that agenda at board level.

7

Leading the business of caring: recommendations

The earlier sections of this report have outlined the changing context for the business of caring and some of the challenges that nurses and other clinical leaders face in bringing the 'bedside to the boardroom'. In this final section we make recommendations about the next steps that boards, individual clinical leaders and those in the business of leadership development can take to help put the business of caring back at the heart of health service reform.

Recommendations for champions of care

The skill set for champions of patient care is relatively easy to define – many of these qualities have been described in the previous section. There are already examples of clinical leaders who have succeeded in making patient care and experience a driving force in their organisation's strategy and operational processes (as illustrated by many of the 'good practice examples' contained in this report). These leaders are exceptional and in short supply. Two characteristics stand out. The first is their skills, confidence and tenacity in 'bringing the bedside to the boardroom' and keeping this on the agenda against other potentially competing interests. The second characteristic is a sophisticated grasp of their organisational and political context and the ability to tailor their leadership style accordingly.

For aspiring champions of care the messages are:

- Find opportunities to learn from these aspiring and contextual leaders – as mentors, coaches or peers.
- Think carefully about the new incentives and disincentives introduced by the changing health and social care system. Delivering the 'business of caring' needs to be planned within this new context – effective champions of care rethink their strategies and tactics and make best use of the new levers of change available in the health and social care system.
- Create a language and measures for the 'business of caring' that will capture the interest and commitment of the board.
- Ensure that they can measure the improvements that matter. Champions of care need to establish genuine and up to date intelligence about what patients and the public want, need and hope to get from their health care. This means differentiating what needs to be measured and reported on a regular basis, what existing information can be draw on and interpreted and what ad hoc data collection or research needs to be undertaken or commissioned.
- Maintain a passionate commitment to making a difference for service users and carers.

Recommendations for health care commissioners and providers

All PCTs - whether reconfigured or retaining stable boundaries – are starting to rethink their approach to commissioning. The basic building blocks of a market system are in place but will only work for the benefit of patients if commissioners allow market processes a free reign. Commissioners need to:

- Establish more rigorous ways of understanding patient needs and preferences for different sections of the community, particularly minority groups who might be more difficult to engage in standard consultation processes. It means combining clinical and epidemiological information with a broad range of intelligence from the new Local Involvement Networks (LINKs) and other data sources about what patients and the public want from health care providers.
- Support and encourage patients to be more demanding and explicit about their needs and preferences and enable them to take full advantage of the choice regime as it starts to open up new possibilities for patient care.
- Be prepared to break the mould of traditional patterns of delivery and commissioning for improved patient outcomes rather than relationships with providers and institutions. Market processes and the levers presented within the tariff or other payment system offer considerable opportunities to encourage new as well as existing providers to generate effective responses to patient needs.
- Use the freedom to include locally agreed quality standards within model contracts with providers to ensure that patient experience is reflected alongside clinical processes and outcomes.

Health care providers need to:

- Be specific about the quality measures that they expect to achieve at different stages of patient care pathways and being honest about where others can do the job more effectively.
- Develop a thorough appreciation of the costs of alternative ways of delivering services and how they compare with the likely income that they are likely to receive under the new pricing regime.
- Develop flexible and efficient ways of linking with other providers in the supply chain in order to give patients a 'seamless experience' in their care.
- Consider flexible approaches to workforce management and deployment and alternative ways of recognising and rewarding innovation and care.
- Pay attention to establishing a conducive organisational culture – one that values the partnership with patients and carers and uses their views alongside those of clinicians to improve services. This might include: formal processes for organisation development so that services can learn from patient opinions and experiences, early warning systems for clinical teams to spot poor quality care and deal with it swiftly and effectively, horizon scanning to find new developments, technologies and approaches that can be fast tracked to improve patient care, and investing in staff to develop and apply the necessary skills, qualities and experience.
- Consider how the 'business of caring' will be led and managed within their organisation. Structures and processes for patient, carer and public engagement may need to be rethought, particularly when organisation's become Foundation Trusts and appoint their Board of Governors or in the light of the new proposals for strengthening the patient voice
- Agree appropriate indicators of how well they are performing in relation to patient experience which should enable them to assess the impacts and outcomes of patient care and understand the relationships between these and other dimensions of organisational performance.

Recommendations for providers of leadership development programmes

Whilst some champions of care may appear to be born to successfully undertake their roles, most of us benefit from investment in leadership skills. Leadership development for the business of caring may not require a complete reinvention but it does mean bringing together existing elements in new ways and a change in emphasis in how skills are developed.

Providers of leadership development initiatives need to:

- Put greater emphasis on business thinking, perhaps by establishing closer partnerships with academic bodies or training providers who already offer commercial skills development programmes
- Provide opportunities for senior leaders who may have already undergone conventional leadership development programmes to reassess their ways of understanding and responding to their environment and relationships. Experiential learning focused on the workplace or parallel organisational contexts, for example secondments or shadowing may be helpful here as would be opportunities to see how organisations outside of the health care sector make customer a priority.
- Ensure that leadership development programmes are focused on the specific context of the caring business and the new opportunities and challenges that the health care market presents.
- Prepare non-executive directors to take their role in the business of caring through induction and ongoing development.
- There are signs that health care regulators both national and local are taking increasing account of patient experience in the way that they discharge their duties and this needs to continue. The recent national spotlight on the financial difficulties that the NHS has experienced presents a golden opportunity to rebalance the public debate. By stressing the central objectives of the reforms – improving people’s health and delivering a more personalised form of health care – managers, clinical leaders and politicians can rekindle public confidence in their National Health System.

Appendix 1

Terms of reference

The terms of reference for *Who Cares, Wins* were to:

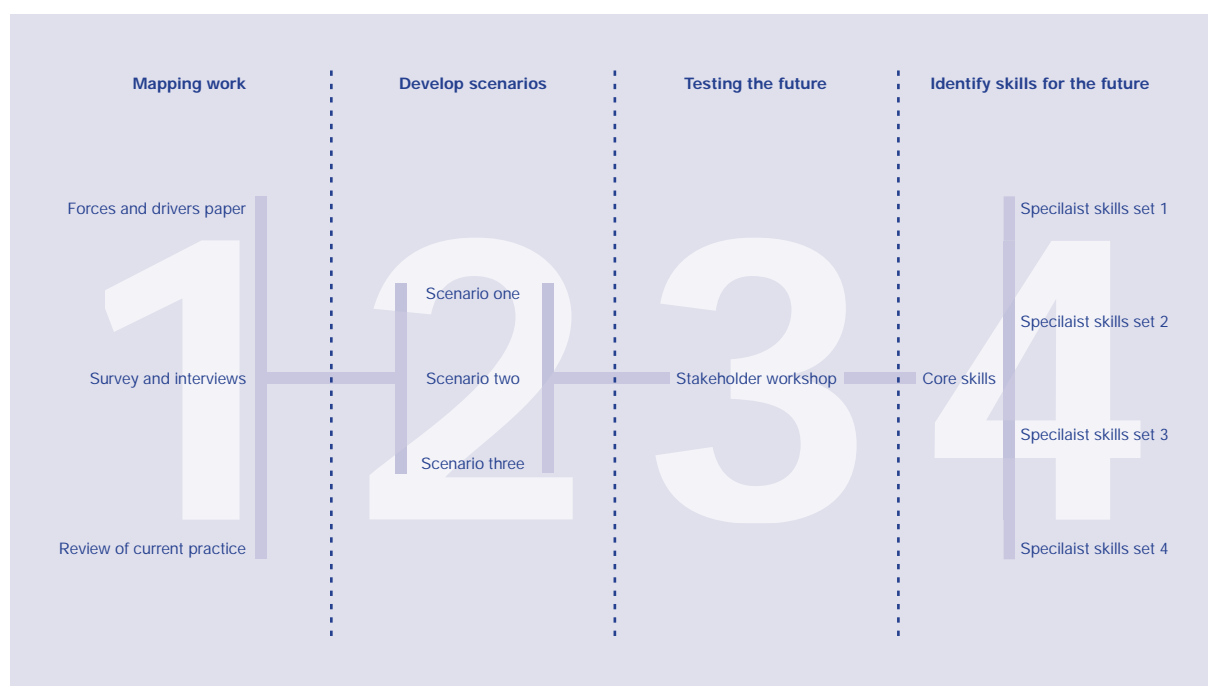
- Explore the implications of changes in the NHS and in other sectors on boards, and how executive and non-executive members assure themselves and their stakeholders about the quality of care that is being commissioned and provided
- Make recommendations about the future kind of preparation and development that will be required for executive nurses with specific board responsibility for, and custodianship of, the quality of patient care in the new health care system, taking into account what development support is already on offer and gaps in current delivery
- Recommend ways in which health care organisations might create a leadership culture and what processes would ensure business objectives and the provision of quality care are fully integrated
- Highlight what sort of programmes of preparation and development, for individual executive nurses and the boards of which they are members, might address the points noted above.

There are signs that health care regulators both national and local are taking increasing account of patient experience in the way that they discharge their duties and this needs to continue. With the recent national spotlight on the financial difficulties that the NHS has experienced there is an opportunity to rebalance the public debate and rekindle confidence in health care provision through stressing the central objectives of improving people's health and health care.

Appendix 2

Methodological details

In order to achieve the objectives of the scoping study, the project team adopted an innovative, future-focused methodology, as illustrated in the diagram below. Steered by an expert project Advisory Group (see Appendix 5), the OPM project team designed an online web survey, which stakeholders from a wide variety of sectors and backgrounds were invited to complete. This survey asked for participants' views both on current issues affecting the leadership of care, and perceptions concerning challenges and opportunities for the future. Running alongside the online survey were telephone interviews and workshops, as well as a programme of desk research to uncover existing evidence about the forces and drivers impacting upon nurse leadership specifically and current practice (including in leadership development – see Appendix 6).



The findings from the survey and other fieldwork concerning what the future might hold were used to develop three **scenarios**. These scenarios describe England in 2011 and focus specifically on what the health and social care system might look like and some of the possible challenges for nurses, nurse leaders and boards in prioritising patient care. In developing these scenarios our aim has been not to predict the future but to provide a tool to encourage debate about the robust actions that should be taken now and which fit in all possible future states. The scenarios are included in Appendix 3.

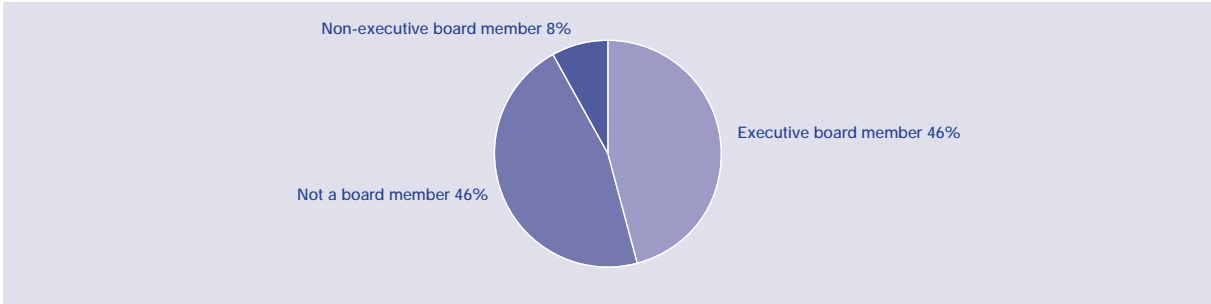
These scenarios were used as the basis for a **national stakeholder event** held on 30th March 2006. This one day interactive workshop brought together a wide range of participants from the NHS and independent sector, from commissioning and service delivery, acute, primary care and social care backgrounds. Participants worked in groups to identify the challenges and opportunities posed by each scenario, and then considered the actions that would have the most impact on patient care and the ability of nurse leaders and boards to prioritise care needs across all of the scenarios.

The remainder of this appendix provides some of the detailed findings from the national survey, to which 150 individuals from a range of backgrounds responded.

Profile of survey respondents

Respondents were asked to state whether they were an executive or non-executive board member, or not a board member. The results are shown in the pie chart below.

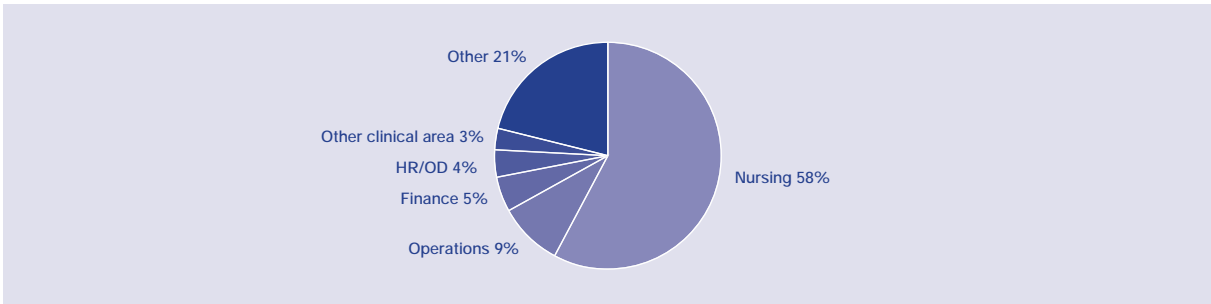
Respondent profile – all respondents



Base: 150

The respondents that classified themselves as a board member (both executive and non-executive) were then asked to specify which remit most closely matched their role - the results of which are shown below:

Profile of directors

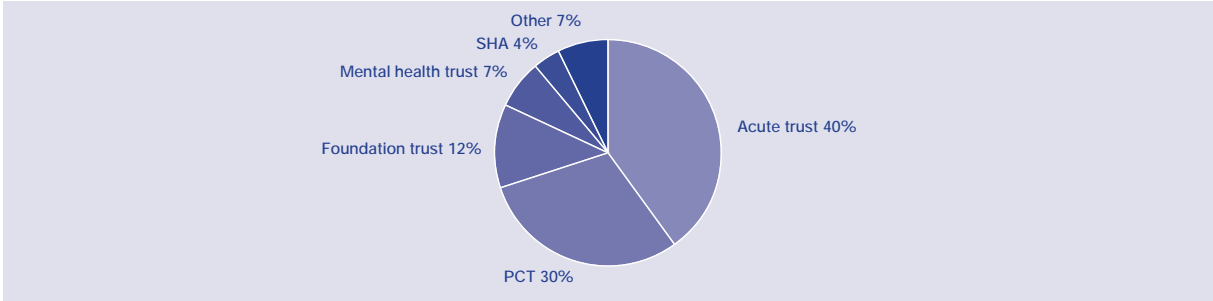


Base: 75

A large proportion of respondents in the 'other' category were trust chief executives.

Those board members that worked for the NHS were then asked to specify which NHS organisation they worked for, the results of which are shown below:

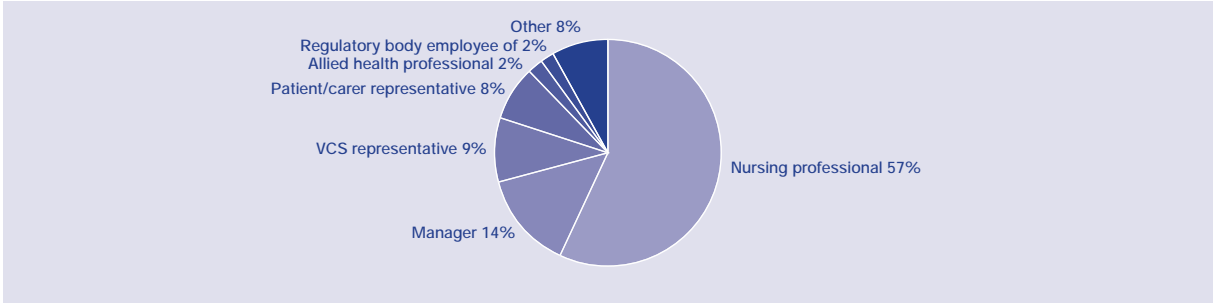
Profile of NHS board members



Base: 73

Finally those respondents that were not board members were asked to specify the job that most closely matches their current role from a list of options:

Profile of non-board members



Base: 65

Changing roles

Survey respondents were asked what they considered, broadly speaking, to be the main changes to the role of nurse leaders over the last 5 and 10 years (in two separate questions). The responses to both questions, which were open-ended, have been grouped into thematic categories, and the results are shown in the tables and graphs below.

How the care leadership role has changed in the past five years⁵

	N	%
Broader role/portfolio – need to take a ‘whole business view’	63	33
Impact of financial constraints/considerations	16	8
Role has been diluted/eroded	16	8
Changes in workforce management	14	7
Developing new nurse roles (e.g. modern matrons)	13	7
Increasingly responsible for patient involvement	13	7
Increased accountability/role in performance management	10	5
Increasingly responsible for setting and monitoring care standards	9	5
Politicisation of role	8	4
Increasingly responsible for risk management	5	3
Responsibility for promoting the nursing profession	3	2
Increased importance of marketing/reputation management	3	2
Other	17	9
Don’t know/not in a position to respond	3	2

Base: 193 Missing: 7



5. Figures shown in both this table, and the tables below relate to the number/proportion of responses rather than respondents, as in many cases survey participants cited more than one type of change.

How the care leadership role has changed in the past ten years

	N	%
Broader role/portfolio – need to take a ‘whole business view’	41	33
Role has been diluted/eroded	18	14
Changes in workforce management	11	9
Increasingly responsible for setting and monitoring care standards	6	5
Increasingly responsible for patient involvement	5	4
Complexity of working environment/pace of change	4	3
Impact of financial constraints/considerations	4	3
Increased accountability/role in performance management	4	3
Developing new nurse roles (e.g. modern matrons)	2	2
Responsibility for promoting the nursing profession	2	2
Politicisation of role	1	1
Other	5	4
Don’t know/not in a position to respond/nothing to add to response to ‘last 5 years’ question ⁶	22	18

Base: 125 Missing: 7



6. Please note that a significant proportion of the ‘don’t know’ responses indicated that respondents had nothing to add to their answer to question asking for the main changes to the nurse leader role in the past 5 years. This may be indicative that some respondents find it difficult to differentiate trends or have poorer recall of previous developments.

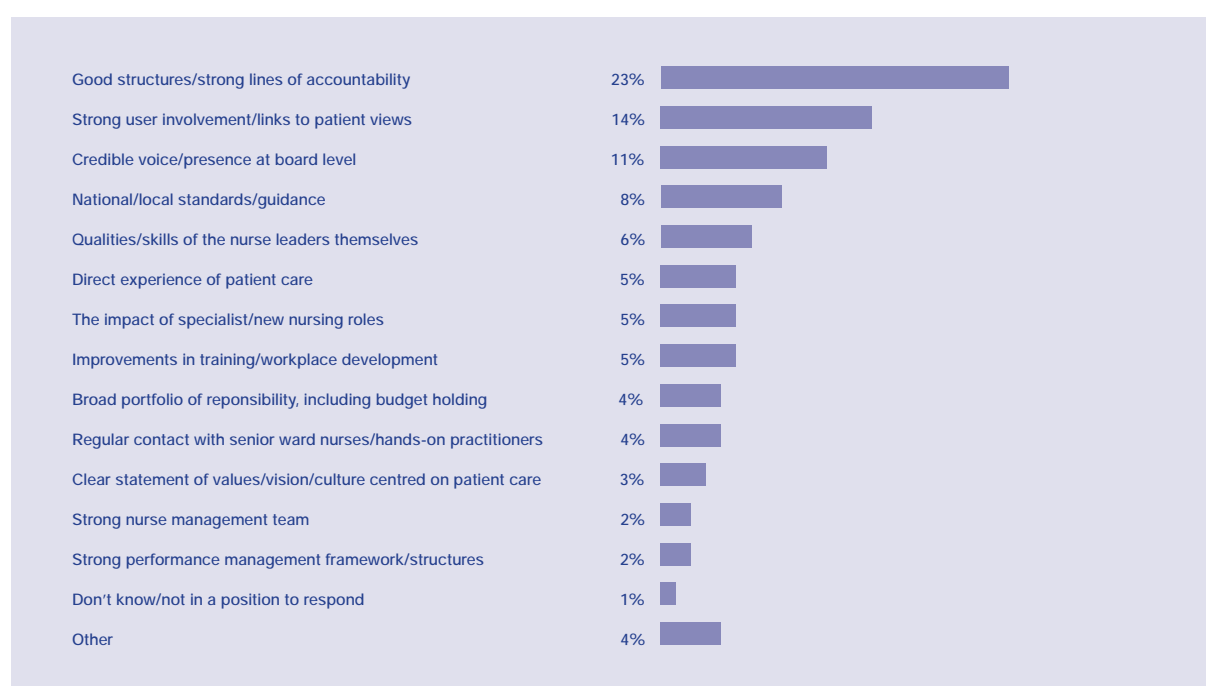
Current roles: inhibiting and enabling factors

Survey participants were asked to describe the processes, protocols and structures that in their view enable, or restrict the ability of nurse leaders to have a positive impact on caring. The responses to both questions, which were open-ended, have been grouped into thematic categories, and the results are shown in the tables and graphs below:

Factors that enable nurse leaders to have a positive impact on caring⁷

	N	%
Good structures (e.g. clinical governance)/strong lines of accountability	47	23
Strong user involvement/links to patient views	28	14
Credible voice/presence at board level	23	11
National/local standards/guidance e.g. Essence of Care	17	8
Qualities/skills of the nurse leaders themselves	13	6
Improvements in training/workforce development	11	5
The impact of specialist/new nursing roles (e.g. modern matrons)	11	5
Direct experience of patient care	10	5
Regular contact with senior ward nurses/hands-on practitioners	9	4
Broad portfolio of responsibility, including budget holding	8	4
Clear statement of values/vision/culture centered on patient care	6	3
Strong performance management framework/structures	5	2
Strong nurse management team	4	2
Other	8	4
Don't know/not in a position to respond	2	1

Base: 204 Missing: 7

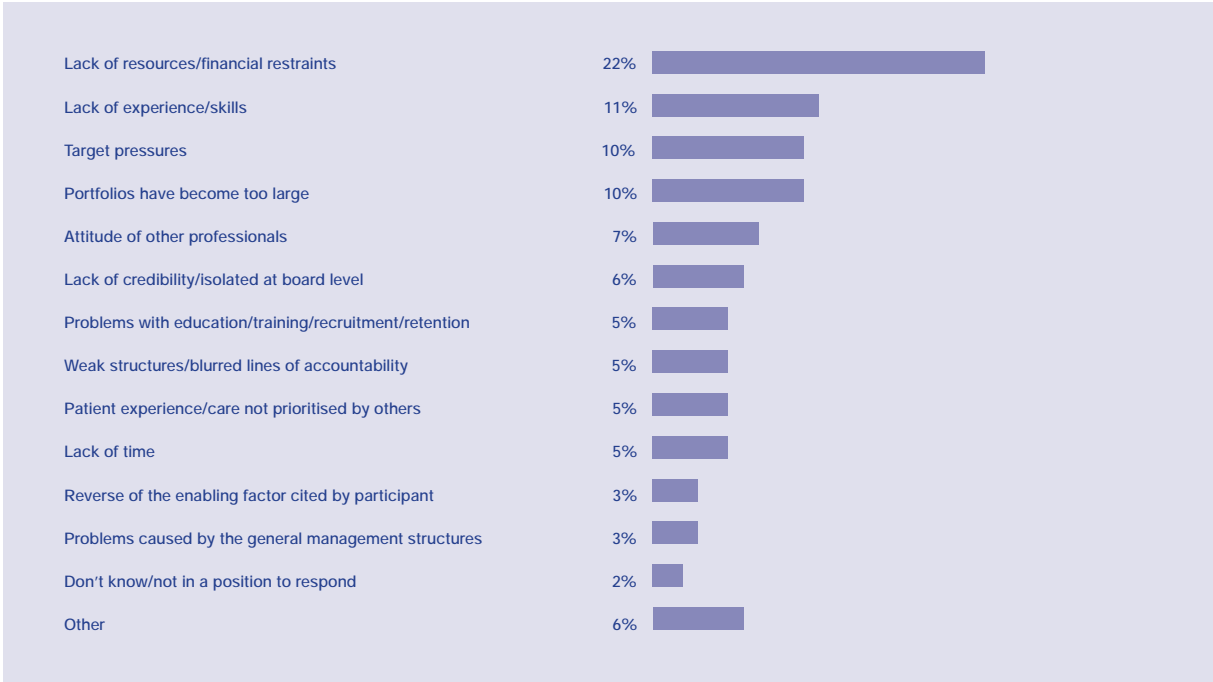


7. Figures shown in both this table, and the tables below relate to the number/proportion of responses rather than respondents, as in many cases survey participants cited more than one type of factor.

Factors that restrict nurse leaders to have a positive impact on caring

	N	%
Lack of resources (including staff shortages)/financial constraints	39	22
Lack of experience/skills (e.g. leadership)	20	11
Portfolios have become too large	18	10
Target pressures	17	10
Attitude of other professionals (e.g. doctors)	12	7
Lack of credibility/isolated at board level	11	6
Lack of time	9	5
Patient experience/care not prioritised by others	9	5
Weak structures/blurred lines of accountability	8	5
Problems with education/training/recruitment/retention	8	5
Problems caused by general management structures	6	3
Reverse of the above (i.e. reverse of the enabling factor cited by participant)	5	3
Other	10	6
Don't know/not in a position to respond	3	2

Base: 175 Missing: 7



Appendix 3

The scenarios

This appendix includes the three scenarios developed for use at the national stakeholder workshop. They represent distinct clusters of expert opinion about what the future may hold for the leadership of care. Each contains both opportunities and challenges for care leaders.

Scenario one: 'Equity, access and control'

The political context

As many predicted, the accession of Gordon Brown to the premiership has brought with it social policies that pull back from the market based approaches pioneered under Tony Blair. The central message of the Brown regime is "efficiency within an equitable social contract." Continuing the themes that characterised his chancellorship Gordon Brown has focused his government upon economic stability and prudence – an approach necessitated by a generally stagnant economic climate and poor growth.

Characterising the overall policy of the government is difficult, given its essentially reactive thrust. Whilst its policies are generally left-leaning, even verging on socialist in places, the focus on efficiency and prudence gives them a unique character. Autonomy and contestability, hallmarks of previous government policy, have not disappeared from the scene but their role and importance has been heavily reined back. The main emphasis is on equality of coverage, strong communities and equity in response to individual needs. There is far less emphasis on individual choice.

The flagship policies are being promoted by Office of the Deputy Prime Minister. Under the policy mantra 'a fair Britain for everyone', the ODPM is leading government policies on social housing, poverty, and community building, as well as contributing to lead the education and skills agenda which has significant implications for inclusion. The influence of the ODPM has even spread as far as the health and social care arena – in the form of its Healthy Chances policy programme designed to impact upon health inequalities. This has led to major initiatives targeting those areas performing poorly on the indices of multiple deprivation; and a drive on further and higher education provision.

Health policy

Pressure continues to be exerted upon the health system, driven by public health issues. Obesity is rising. Smoking, while continuing to gradually decrease, remains at troublesome levels, particularly amongst low income groups and young people, for whom cigarettes now have an additional rebellious allure stemming from the ban on smoking in public places. The levels of sexually transmitted infections and substance misuse are growing rapidly.

Increased demand for health care has not led to massive overspends however. The budget deficits that grew under the Blair regime have resulted in finances being tightly controlled by the centre. Some health authorities have introduced compulsory means testing for all but a tightly defined core NHS which mainly focuses on emergency care. Patients earning over a certain threshold have to make a compulsory contribution to their health care costs on top of their national insurance, or opt to go private (as many do). Whilst government ministers have done everything they can to deny it, this is seen by critics to be the end of health care being 'free at the point of access'. Despite the criticism, the additional revenue that this policy has created has prompted (or forced, rather) the government to look into rolling the policy out across England.

The focus upon equity and equality are now the driving forces for change in health and social care. The equity theme has been the driver to target resources at those with greatest needs and least ability to pay. The equality theme has been the driver for specifying a core NHS and for the independent sector being frozen out of the choice agenda. Patients can choose, but from a more limited menu, and from a more restricted range of treatment options. NICE treatments are increasingly being targeted at patients who fit nationally specified eligibility criteria, ending the so called post-code lottery.

Payment by Results (PbR) and practice based commissioning (PBC) also remain in place, but the government has taken back much of the control of health spending. All NHS bodies are now subjected to highly demanding performance management and financial probity regimes that specify which services are provided and funded, and the ways in which care is undertaken. There is limited autonomy granted to commissioning bodies. National strategic commissioning plans are in place and all PCTs are required to produce plans for their area which closely direct and performance manage the work of general practices and other health care providers. The terms of contracts with providers are set nationally, as are many of the prescribed pathways of care and treatment approaches. Providers not able or willing to provide those pathways to tariff do not receive contracts.

National tariffs are increasingly in place for all types of care as the Treasury utilises crude national average costs to drive efficiencies. The voluntary sector plays a crucial role in the provision of some services, successfully competing against the NHS and independent providers in a number of areas including care for patients with long-term conditions and mental health problems. Not surprisingly, given the focus on value for money, the successful voluntary organisations are national players with established track records in delivering health and social care.

The introduction of compulsory means tested health care contributions have provided additional sources of income for some health authorities, as patients paying the top rate of tax are forced to pay up to 20% of their health care costs. The introduction of charges has also led to increased numbers of disillusioned patients opting out of the NHS and previous trends in private health insurance appear to have been reversed.

Overall, patients have a limited voice in the system. Brown's is very much a state led health care programme, and there are few effective forums through which patient experiences and complaints can be heard. Stretched resources in the NHS have meant that nurses and other medical staff often have to work in difficult conditions, having to fulfil many different roles. Patients are becoming increasingly frustrated both with the standard of care available on the NHS and with the lack of avenues through which to pursue grievances. This is not helped by the recent changes to the choice agenda (i.e. leaving out the independent sector) which has resulted in many people feeling that their 'choice' is somewhat illusory.

However, for those people with long-term illnesses, the standard of care has generally improved. Through the use of community matrons, the majority of patients with long-term conditions are managed at home. This has resulted in a dramatic reduction in hospital admissions, surgery visits and home visits, and increased levels of customer satisfaction. However, in line with national guidance, only the most vulnerable patients are targeted, and this has received some criticism from patient advocacy groups, accusing the government of failing to see the bigger picture in terms of patient care.

Nursing and the health and social care workforce

Perhaps unsurprisingly in this difficult national context, the nursing profession is in something of a crisis. A lack of resources in the system has meant that the number of health care professionals working in the public sector has dramatically fallen. Low pay, poor working conditions and a lack of professional respect has resulted in large numbers of doctors, but especially nurses and therapists, seeking employment outside the public sector. Furthermore, large numbers have been made redundant with the centre insisting that the NHS balances its books. Up to 10,000 qualified nurses a year have left the UK to find work in other countries, and a significant number each year are being lured by the independent sector. Many NHS nurses are forced to take on a second job to make ends meet.

The scarcity of qualified health care staff is not limited to nurses – the shortage is also strongly felt amongst doctors, resulting in an acute shortage of GPs in the UK. Consequently, the health service has had to survive with what resources it does have, with the resulting effect of huge demands being placed on nursing professionals, as they are forced to take on a number of different roles, including prescribing all medicines and conducting the bulk of outpatient follow-up work.

Training has also suffered under stretched health care budgets. Nurses are forced to pay for some of their own Continuing Professional Development as Trusts are no longer able to find the resources. As one would expect, most nurses are unable or unwilling to fund their CPD, resulting in a shortfall in specialist nurses, and stagnation in the skills of the existing workforce. While the CPD offered by the independent sector is not considered dramatically superior to that offered by the NHS, nurses are reported to feel more valued in the private sector, which is said to have a big impact upon their decision to work there. “Return to Practice” courses have also been slashed, making it harder for nurses to return to work, and further shrinking the already dwindling workforce.

While initially nurses welcomed the additional responsibilities bestowed upon them by the government; poor training, coupled with a shortage of qualified nurses has resulted in the profession being severely overworked and underpaid. Furthermore, there have been a number of high profile scandals where over-stretched and poorly trained nurses have been held to account for providing an inadequate standard of care.

Governance and accountability

The strong state role in health care provision, coupled with a command and control, target-oriented approach brought about by lack of resources, has created and reinforced strict hierarchies both within organisations and in the system as a whole. Due to the low esteem in which public sector nurses are held – both in terms of popular opinion (given the various scandals involving NHS nurses) and within the profession as a whole, there is little opportunity for NHS nurses to make their voices heard in health care organisations and get the issues that patients really care about to board level. The demise of modern matrons, noted above, has removed one of the key avenues by which nurses on the ward could channel issues upwards. Nurses are constantly held to account for the quality of patient care, but do not have the resources, and are not empowered to carry out this function. Given the very heavy emphasis on financial control by health boards most non-executive positions are filled by those with a financial background and those with an accountancy background are most likely to be appointed to CEO and other key senior executive posts.

Scenario two: 'Lost in the supermarket?'

Political overview

It is 2011 and the new Conservative regime, elected thanks to its massively popular 'Government By The People' campaign, is pressing ahead full throttle with radical modernisation of the public sector. The message from No. 10 is that market forces must drive efficiency, quality and choice in public services. In the health sector, many commentators believe that David Cameron's Government has simply been able to reap the benefits of Labour's Community Health care Bill, which the previous administration was unable to implement due to an (at the time) ever deepening financial crisis in the NHS.

According to EuroHealth, an independent health monitor, the UK now has the most competitive health care market outside of the US. The new government has increased the emphasis on encouraging independent sector involvement in health care delivery on a level playing field with public services. Frustrated at the lack of progress that PCTs made in demonstrating the value for money from their provider services, the Government has replaced them with 32 Regional Health Agencies. These new bodies, which are co-terminus with the new local government regional bodies, have no provider functions and are charged with managing and overseeing the health service within their area. The vast majority of commissioning (almost 90%) now occurs at the GP practice level and the only involvement the health bodies have in this is in performance management, and the strategic commissioning of gap or problem areas.

The independent sector has greatly benefited from this policy with many patients preferring private and voluntary providers to NHS organisations. Citizen choice has proven extremely popular with large parts of the population and the demands this places on services are great. In order to compete, to attract patients and funding, providers have to offer increasingly comprehensive, innovative and flexible services. 'Front of house' services and the ability to deal with patients are all important. Public and Patient Involvement structures have been largely discarded with the government emphasising market mechanisms as the means for ensuring service users receive what they want.

Resources and the health and social care market

One of the government's major health policies has been to introduce price competition into the national tariff system. No longer are tariffs to be set at a specific level, rather providers will now be free to compete on price. The government believes this is an essential move towards greater efficiency within health and social care. This move has been welcomed by private providers who have long been arguing that the lack of price competition has pushed down quality and pushed up costs. The pressure on providers to compete means that they not only have to develop care packages which appeal to patients, but have to develop innovative approaches which keep costs down and compete with other providers on price.

The new practice based commissioning arrangements, after suffering teething problems, are beginning to settle down. In most areas large primary care practice collaboratives have been established either as mutuals or limited companies. – Some of these larger groupings now cover significant populations and are starting to make a real difference to the design of clinical services. Senior nurses, in particular nurse consultants and specialist nurses, have an important part to play in these new ventures. Critics of the approach argue that this has led to an even more prominent postcode lottery with markedly growing differentials in the standards of care and health outcomes between the different GP 'platforms'. Several large US based companies have started to enter the market by taking over large GP commissioning organisations. One such company, Freedom Health care, recently declared that they expect to see significant growth in the market with a bright future for companies like theirs. These bodies are introducing highly systematised approaches to management and service delivery.

As a provider of services voluntary organisations are expected to compete as any other provider would. The social enterprise fund set-up by the Labour government has been terminated and though such bodies are continually encouraged by Tory ministers to offer services, they are given no support for doing so. Many have complained that a lack of support, combined with the more volatile commissioning arrangements, and price competition have made it very risky and difficult to undertake provision. Recent years have seen a trend towards large scale aggregation of third sector bodies. Health care is increasingly a big business operation and many of the smaller nursing service providers that were offshoots from PCTs have either folded or been taken over.

Patients and models of care

In both health and social care, the policy focus is on delivering ‘what the user wants, where they want it.’ Consequently there has been a massive explosion in the numbers of community based treatment and diagnostic centres. There is an increasing use of technology to support remote care and continued growth within the domiciliary care market, alongside consolidation on the provider side (4 large providers now account for 85% of the market). Institutional care has become increasingly unpopular with both users and commissioners and is fast becoming the reserve of the “mad, bad and poor”.

The most striking manifestation of consumer-focused community-based public health care in 2011 is the long anticipated widespread emergence of GPs and nurses in large retail outlets, particularly supermarkets. Like many of the rest of Health Secretary Oliver Letwin’s ‘innovations’, this new model of care was mooted by ministers in the preceding Labour government, but was never actually implemented: leaving it to the Conservatives to forge a more-or-less coherent policy package out of the remnants of a dying administration. Whilst supermarket-based primary health care has been generally popular with voters and indeed with many health care professionals (in particular nurses, for whom this initiative offers further public visibility and standing), it has also led in recent months to a number of high profile scandals. Over the last year six GPs and three nurses practising in clinics housed in FoodMart supermarkets have been accused of only prescribing drugs manufactured by FoodMart’s parent company, the global conglomerate VigaCare. This is despite the fact that VigaCare’s drugs – in particular for the treatment of certain conditions – have been shown to be less effective than rival products.

Nursing and the health and social care workforce

The major changes described above have had a massive impact upon the shape of the health and social care workforce. More and more organisations are relying on generic skills and the ability of their people to work across roles. The use of care managers whose role is to oversee and direct care rather than deliver it has introduced a significant demand for community matrons and even non-professional customer care managers. The focus is heavily upon skills and the ability to undertake several roles, which has placed particular strains on nurses and those expected to deliver in-home care to a variety of users. Many have complained that they are feeling isolated, increasingly working alone and in peoples’ homes, rather than feeling part of an organisation.

Pay and rewards however have been increased in response to much greater competition for staff. NHS organisations have complained that many of their staff are being drawn away from them by better paying independent providers. There are large numbers of individual care freelancers who are enjoying very lucrative times working for a range of different organisations simultaneously. State providers have had to relax “moonlighting” restrictions in order to prevent a massive shortfall of qualified, experienced staff. Turnover is chronic at all levels of staff and management.

Amidst all of this, nursing as a profession is gaining an even higher status and level of professional respectability than it enjoyed previously, as nurses show themselves able to adapt to new roles with great success. In particular, the emphasis on good customer-facing skills in the new ultra-competitive marketplace has served nursing practitioners well. Competition for nursing staff has also in general led to an improvement in the quality of training on offer to nurses, with employers recognising the importance of good continuing professional development. The extent to which providers take a holistic view of professional development needs (over, say, the skills needed for the marketplace) is in doubt, however, and training for new nurses has not received the emphasis many feel is necessary for the long-term sustainability of the profession.

Governance and accountability

The free market, aligned as it is with a system of finance where the money follows the patient, means that providers from state, independent, and third sectors alike fall by the wayside if they cannot supply services at sufficient levels of quality and efficiency. Government sponsored regulation is as light touch as it needs to be – with the emphasis on providing the information necessary to help patients make their own decision about where to get their care. Boards of all health care organisations have had to rapidly adjust to this new regime, or face extinction, and the result of this has been real prioritisation of patient care issues. Because nursing has such a high status as a profession in this new health care environment, senior nurses are headhunted for the top board positions – from Chief Executive downwards. Whilst seen as a generally positive trend, a number of key nurse leaders are beginning to express concerns about how to manage the apparent conflict between delivering challenging business objectives and maintaining a professional set of values that places the needs of the patients at the heart of their work. In a recent Nursing Times survey, some have reported significant pressure from their boards to compromise quality of care to enhance profitability.

However, as the supermarket drugs scandals show, accountability is in another sense much looser, and more complex than ever before. Many critics complain that the preponderance of large independent sector providers of care over voluntary sector or practitioner-owned organisations has limited the choice for the patient – big business means uniformity with little to differentiate the larger providers.

Whilst nursing as a profession has grown in prestige, it has also become far more fragmented: nurses rarely work in one organisation for the length of time necessary for the foundations of collective action to establish themselves, and there is a concern that nurses, as other practitioners, are concerned more with their own benefits package rather than their colleagues or even the needs of the patient.

Scenario three: 'The local National Health Service'

Political overview

The new Labour government, having secured a slim majority of 14 seats at last year's 2010 election, has found itself less able to counter the pressure coming from the opposition parties, both of whom are seeking to portray Gordon Brown as the 'haggard old economics professor' in the face of their 'young guns' – Cameron and Huhne. The government's weakened position has led to clear concessions in policy. Whilst Gordon Brown campaigned on a platform somewhere to the left of the policies of the Blair government, he has found himself having to make concessions that have pulled the policies to the right and centre.

The net result is that the so-called radical localism agenda has come to the forefront of almost every field of public policy. Local public service boards, which require citizen involvement in the planning of local services, are being piloted in over 50 local areas. The effect this policy platform has had on delivery of public services has been increasingly significant. The focus upon community engagement and public involvement has become even more demanding. Public service bodies are required to demonstrate increased levels of public engagement in decision making and rising satisfaction with services. A model of public sector governance (based on school and hospital foundation trust), with public membership is being promoted for all public services.

Health and social care

Local provision and local control are now the driving forces behind health and social care, as with other public services. Involving all of the community and ensuring all needs are met is key to the agenda. Whilst the stated aim of reform in this area is ensuring equality and demonstrably good local outcomes, a recent Health Service Journal survey of health care professionals revealed that over three-quarters (77 per cent) of those in the field felt hamstrung by the pressure placed upon them by patients and patient boards. Whilst in the last years of the Blair government, targets focused around safety, clinical cost effectiveness, public health governance, and health care environment and amenities, today patient satisfaction and accessibility of services dominate boards' agendas. However, many front-line staff (particularly nurses) argue that the wrong indicators are being used to measure progress against these targets, with a serious mismatch between patient satisfaction targets and the things that really satisfy patients.

Resources and the health and social care market

National tariffs are in place for a large number of services, but these are generally the easier to package elements of health care. Whilst they are promoting local control, the government has signalled something of a pull back on Payment by Results (PbR) and choice. Previous attempts to ensure universal coverage have been truncated and plans to expand tariffs, PbR and choice into other areas have been scrapped. The mixed system is to outsiders quite difficult to fathom and the future direction remains unclear.

The commercialisation of care continues to expand, but not at the pace many expected and is restricted to planned/elective care and hospital services. There is renewed support for public-private partnerships, particularly PFI, which showed signs of a pause toward the end of the Blair regime. Preferred (longer term) strategic partnering arrangements have been adopted by many local authorities and are increasingly being used by PCTs as a means of contracting services. Using the Local Area Agreement framework, there are also stronger incentives to pool budgets across local health organisations and local authorities.

Primary care commissioning arrangements are less settled, and show considerable variability. In some places proactive consortia of GPs (including nurse consultants in some cases), have taken control of local budgets and are commissioning to effect better outcomes. But in other areas PCTs remain the commissioners of services, with few GPs willing to take-up practice based commissioning (PBC) and only limited services falling within

PBC budgets. The government is not pressing areas on this, they are perfectly happy for the PCTs to retain commissioning, so long as it does not adversely affect outcomes, or deliver a return to a postcode lottery of ends, but not means. The mantra of regulatory and inspection bodies is “what matters is what works.”

Where PCTs do retain principal commissioner status, there is nevertheless a trend for senior nurses to set up and operate successful nurse-led businesses. Roughly half of these receive funding from private health care companies (the largest being VigaCare and the US-owned J.B.Goode Health Enterprises), whilst a substantial proportion of the remainder are employee-owned limited liability mutual organisations, a company type whose legal status is still not entirely clear, despite its prevalence. Alongside these comparatively ambitious ventures, the last few years have seen a rapid rise in the number of nurse specialists setting up in business on their own. For example, diabetes nurse specialist Beth Foster works as an independent contractor in Durham providing clinical and patient education services under contract to local GPs.

Some larger provider groups and campaigning organisations are lobbying that this “mixed bag” of PBC, choice and PCT control of services means there is no clear approach in place, and is a “nightmare” to work with. Some argue that this has led to an increase rather than a fall in the level of equality of provision, but that this evidence will take time to show. User groups also report that the bewilderingly complex and inconsistent commissioning arrangements are creating difficulties for many in navigating the system.

Patients and models of care

One of the major themes of health care policy is improving care for older people and those with long-term conditions. Apart from being something of a vote winner, the government has taken the line that the single most significant group for health and social care is older people, and that improvements delivered in that area will pay for themselves in coming years due to an ever-ageing population. Consequently, they have announced initiatives to raise the basic state pension, alongside a raft of care initiatives aimed at the well being and active ageing of older people. Pilot funding is now in place for older people’s advocacy services within which advocates will be paid to help older people manage individualised budgets, direct payments and patient choice in order to manage their own care. The government has raised funding for residential nursing care for the most in need whilst concurrently announcing new funding for domiciliary care services for older people.

Whilst there are no ‘standard’ models of care (given the focus on meeting the needs and preferences of local people), the previous Labour administration’s flagship initiative to increase the number of community matrons has been placed by the current government in the broader context of an even more radical shift to care in community settings. ‘Supported self-care’, made possible across the board by substantial advances in telemedicine technology is proving increasingly popular as is the rapid increase in the number of Remote Diagnostic and Treatment centres (or RemDiTs, as they are commonly known). Whilst these centres are available for the treatment of patients with a variety of long-term conditions, they have been particularly successful in the field of specialist cardiac care. Patients have their blood pressure, pulse and breathing rate, oxygenation levels and blood sugar levels monitored at home. The information is transmitted by phone to a 24 hour monitoring centre staffed by specialist cardiac nurses and doctors, who analyse the data on computers. Within minutes the nurses can have a video phone discussion with the patient and the GP to decide on treatment.

The 2010’s are seen by many to be the ‘dawning of the age of the patient’. Health care professionals across England have come to fear the impact caused by the firing of a patient trigger, one of a tranche of initiatives introduced as a parting shot by Blair’s government. . As long as a patients’ organisation or a local councillor could muster the 5 per cent of a district’s population (in the form of their signatures on a petition) necessary to constitute a ‘community call to action’, the health care commissioner in question (whether a PCT or GP) would have to conduct a comprehensive, open and transparent review of provision. In the early days these reviews typically resulted either in a new provider being brought in, or the existing provider having to radically rethink the care it offered.

Nursing and the health and social care workforce

Whilst support for the patient trigger is widespread (particularly amongst patients, unsurprisingly), critics point to the rigor mortis they claim a 'trigger-happy' population has brought about amongst the ranks of health care professionals. In places claims have been made that irresponsible action has caused providers to be deeply risk averse. As evidence for these claims, the nay-sayers point to the number of documented cases where the threat of a patient trigger has been enough to cause a private backer to pull the plug on much-needed health care facilities. Campaigns to raise the number of signatures required for a call to action have, however, fallen upon deaf ears given the central place that the patient trigger occupies in the radical localism policy platform. On top of this, nurses interviewed as part of a Nursing Times feature reported that they were reluctant to suggest departures from standard care practices, for fear of incurring the disapproval of powerful 'expert patients'.

In general terms, however, nursing practitioners, particularly those working in the community, enjoy unprecedented levels of independence and control over the way they work in comparison to five years ago. With the diversification of care (in terms both of setting and mode of operation) has come a broadening of the range of career options open to those within the nursing profession, and the national career framework for nursing has been credited with adapting to meet and facilitate this change. Nurses are increasingly employed as high level clinical specialists with leadership of local commissioning bodies, as core members of community health teams, and as para-professional care managers – helping patients to navigate the health system. The shifting balance of care from the acute hospital to the community means that the patients who do reach hospital are far more debilitated, and nurses who remain in acute settings are therefore required to deal with a more challenging caseload. There are, however, significant downsides to this increasing independence – not least in the form of isolation and lack of professional challenge/support for community-based nurses. The quality and availability of training on offer to nurses also varies quite considerably, in line with the lack of a cohesive national approach to the (supposedly) 'National' Health Service.

Governance and accountability

Regulation and inspection regimes have become much more robust with the merger of agencies to form a 'super care' inspectorate. The use of multi-dimensional 'balanced scorecard' approaches which require strong stakeholder engagement and satisfaction measures within self audit and inspection are the hallmarks of a very joined up approach to whole system assessment. This is particularly relevant for those contracting to provide social care services as they are assessed within the same balanced scorecard, and poor performance in one area has been demonstrated to limit opportunities elsewhere. Commissioners increasingly share information through sub-regional and regional arrangements, which emerged as a result of sub-regional commissioning arrangements driven by Gershon.

From the perspective of the nursing professional, accountability has become increasingly blurred. Whilst independent and powerful in one sense, the community matron can also be seen to be under the sway of a number of different 'masters': ranging from the local public service board, to the general commissioning practice who pays for his or her services. Professionally, he or she will have to report to both his or her clinical practice manager, as well as any one of the local implementation teams set up to meet the objectives in one of the strands in the Community Health care Bill. In acute trusts the typical pattern is for nursing board members to occupy 'figurehead positions' – the focus is on (often merely symbolic) leadership rather than operational management. This has been compounded by the relative inexperience and lower status of nurses now appointed, usually on a 12 month rotational basis, to provide the nursing perspective on boards.

Appendix 4

National stakeholder event attendees

The Burdett Trust for Nursing and OPM are grateful to the following individuals, who generously gave of their time and expertise to attend the national stakeholder event on 30th March 2006.

Daljit Athwal	Head of Nursing	Leicestershire, Northamptonshire & Rutland SHA/WDC
Jean Bailey	Management Adviser	Royal College of Nursing
George Baker	Chairman	Patient and Public Involvement in Health Forum
Pam Barnes	Dir. of Nursing, Patient Care & Public Involvement	North East London Mental Health NHS Trust
Prof. Veronica Bishop	Professor of Nursing	De Montford University
Louise Boden	Chief Nurse	UCHL
Lindsay Boxall	Locality General Manager	Mansfield District PCT
Rosemary Cook	Director	Queen's Nursing Institute
Linda Dell'Avvocato	Head of School Nursing PEC	Croydon Primary Care Trust
Jackie Eades	Leadership Development Manager	Derby Hospitals NHS Trust
Katherine Fenton	Director of Nursing and Quality	Barts and the London
Debbie Graham	Midwifery Lead Nurse	NE London
Ray Greenwood	Director & Trustee	The Burdett Trust for Nursing
Jill Jarvis	Chair of Council	Royal College of Nursing
Dr Roger Moore	Chief Executive	NHS Appointments Commission
Bernice Newman	Information Officer	Wellchild
Jeremy Nobes	Head of Nursing, Specialist Medicine	Queen Elizabeth Hospital
Sue Norman	Director & Trustee	The Burdett Trust for Nursing
Helen Page	Area Service Manager-North West	Newham PCT
Julie Pearce	Chief Nurse	Hampshire and IOW SHA
Tina Pollard	Clinical Service Manager	Addenbrookes Hospital
Carole Ribbins	Deputy Director of Nursing	Leicester Royal Infirmary
Margaret Richardson	Health Strategy Consultant	South West London SHA
Janice Sigsworth	Deputy Chief Nursing Officer	Department of Health
Paul Trevatt	MacMillan Nurse Director	North East London Cancer Network
Mary Watkins	Pro Vice-Chancellor	University of Plymouth
Katy White	Head of Nursing - Surgery	Medway NHS Trust
Jane Wilshaw	Director of Nursing & PPI	Isle of Wight HCT and PCT

Appendix 5

Project advisory group

The Burdett Trust for Nursing and OPM are grateful to the following individuals, who provided guidance and support throughout the project:

Sir William Wells (Chair)	Chairman, NHS Appointments Commission
Baroness Audrey Emerton	Peer
Sue Norman	Director & Trustee, The Burdett Trust for Nursing
Ray Greenwood	Director & Trustee, The Burdett Trust for Nursing
Katherine Fenton	Director of Nursing & Quality, Barts and the London
Jacqueline Geoghegan	Director of Nursing & Operations, The Medway Maritime Hospital
Ken Jarrold	Former Chief Executive, County Durham & Tees Valley SHA
Baroness Rennie Fritchie	Commissioner for Public Appointments

Terms of reference

The terms of reference for the Advisory Group established the Group's purpose as follows:

- 1) Offer views and perspectives on the remit of the study.
- 2) Contribute to the development of ideas.
- 3) Act as a sounding board for the OPM project team.
- 4) Recommend/access individuals and networks who might participate in the study.
- 5) Provide feedback and challenge on the material/ideas developed during the course of the study.
- 6) Offer guidance on the content of the final report.
- 7) Give profile and credibility to the study.
- 8) Advise how best to share learning which emerges from the study, and make recommendations to The Burdett Trust for Nursing regarding the next phase of work and how it might be progressed. This will involve:
 - a) Considering and putting in place the systems and measures necessary to evaluate the success of the project and any future work.
 - b) Identifying and prioritising key stakeholders/stakeholder groups for targeted dissemination of the project findings, and assisting in promoting the messages contained in the final report to these stakeholders.

Appendix 6

Leadership development overview

This appendix places the subject of nurse leadership in the context of broader trends in the provision of leadership development. The range and complexity of leadership development services on offer appears, from the desk research, to be growing. This growth is unsurprising as this is a highly competitive market with lots of different players from within the NHS and higher education sector to commercial companies offering leadership development programmes and other offerings.

Given the breadth of approaches it was agreed for the purpose of this study to focus on the following approaches or interventions, as defined by Warwick Business School in its study of leadership development⁸. These are:

1. Competency frameworks
2. Appraisals
3. 360 degree feedback
4. Mentoring
5. Coaching
6. Networking
7. Action learning
8. Formal programmes
9. Fast-track cohorts

8. Hartley J, Hinksman B; *Leadership Development, A Systematic Review of Literature* (NHS Leadership Centre, 2003)

Our desk research indicates that much leadership development is targeted at specific sections of the workforce, with the vast majority of providers offering courses targeted specifically at senior managers. However, a large number also provide courses for middle and junior managers, providing a progression of leadership development opportunities.

Interviews provided evidence to support these observations, with respondents citing a notable increase in specific leadership development programmes, aimed at a wide range of roles within organisations. It is not only the supply of different development initiatives that has increased – providers themselves reported increased demand for more targeted programmes than in previous years, with many highlighting development tailored to new managers and middle managers. Many respondents felt that this trend was influenced by the increased recognition within the public sector that leadership must occur across whole systems and between organisations. Research suggests that public sector purchasers of leadership development activity are more mindful of the need to manage talent and ensure effective succession within organisations as driving the increasing emphasis on developing more junior staff members.

Another reason for this trend is the emerging consensus that leadership effectiveness is a whole organisation issue, not something that is resolved at the most senior levels. As a result, the groups for whom leadership development is provided now range from the senior executives through to frontline staff, with junior and middle managers increasingly being targeted for leadership skills development.

There is also evidence of a 'cascade approach' to leadership development, in which successful programmes provided to senior leaders are subsequently rolled-out to more junior tiers within the organisation. This approach has the benefit of ensuring ownership and engagement from the top of organisations, which is perceived to be a crucial factor in success of development interventions.

There is a strong focus in current leadership development for public services on the following elements:

- Enabling leaders to lead across systems and partnerships
- Building the capabilities of leaders to scan for and respond to future challenges
- Enabling leaders to negotiate with, and influence others
- Building leaders who can develop customer focused organisations
- Creating leaders focused on delivering social outcomes and results
- Supporting people facing major challenge and pressure, through coaching, mentoring and informal support
- Enabling leaders to be self aware, aware of others, and able to respond to personal development needs

There has been a steady increase in the number of leadership development opportunities made available for senior nurses, particularly since the need to improve nursing leadership was so clearly highlighted in the NHS Plan. Many of these have been made available through generic programmes for senior managers and Directors, some of whom are nurses. Whilst we have been unable to establish a comprehensive picture of what is on offer, it is our impression that there are rather fewer opportunities for leadership development specifically targeted at nurse leaders. Those which are targeted either wholly or partially at nurses include:

- Clinical leadership programme
- Develop yourself, inspire others
- Modern matrons and nurse consultants
- Health foundation leadership fellows award scheme
- Successful nurse leader programme
- Strategic leadership and expert practice (Nursing practice development).

In general, there does not appear to be a wide range of programmes specifically designed for nurse leaders (or even the leadership development of nurses), although there are many more generic programmes which do cater for nurses in senior management and on boards amongst their participants.

Clinical leadership programme

The Royal College of Nursing is responsible for one of the longest running, and largest leadership development programmes for nurses called the Clinical Leadership Programme. Set up to run for 12 months, programmes vary in terms of their exact content/structure, but focus in general on improving the capacity of participants to undertake transformational leadership, focused on five core areas:

- learning to manage self;
- building and managing effective relationships with other staff;
- developing patient focus;
- enhancing internal and external networking ability, and
- increasing political awareness.

The programme is run in partnership between a trust, which seconds a facilitator to lead the project for 18 months, and the RCN Clinical Leadership Team. The local facilitator has three months intensive preparation, during which time they attend workshops, develop their leadership skills, and have one-to-one sessions and a monthly facilitated action learning session which continues throughout the programme.

Key stakeholders in the trust are involved to ensure the programme is effective locally and in line with strategic objectives, and the course leaders emphasise the importance of locating the programme organisationally: both to reflect a trust's strategic aims, and to find a 'home' within trust structures (for example, by setting up a steering group including a board member). In the main, participants on the Clinical Leadership Programme are ward leaders rather than board-level nurse directors.

Develop yourself, inspire others

More recently, the RCN has established a twelve-month programme called *Develop yourself, inspire others*, for individual health and social care practitioners who manage and lead a team and who want to maximise their own performance and that of their team. This includes modern matrons, nurse consultants, team leaders, senior therapists, ward managers (or their equivalents in other settings), senior nurses, district nurses, health visitors, clinical nurse specialists, senior midwives, nursing and midwifery managers, allied health professionals, radiographers, pharmacists or other health and social care practitioners in similar roles.

Modern matrons and nurse consultants

A large scale national programme for Modern Matrons and Nurse Consultants developed by the NHS Leadership Centre, the aim of the programme is to promote the modern matron and nurse consultant speciality, develop visible, vocal and effective leaders, and raise standards of care for older people.

The course ran over a period of six months, and combined courses and master-classes run by the Leadership Centre. The aim of the programme is also to bring together participants from different parts of the health system to foster partnerships between primary and secondary care and the independent sector as well as extending services for older people with mental health problems and learning disabilities.

Health foundation leadership fellows award scheme

This scheme offers personalised leadership development to individuals who have “demonstrable potential to make an outstanding contribution to improving the quality of health care in the UK”, and is for health care practitioners, health improvement practitioners (including public health professionals), health services managers, clinicians and policy makers. The scheme runs over almost two years, and comprises coaching, learning sets, workshops, seminars, a professional development budget (to be spent based on decisions made during coaching). Each participant identifies a suitable mentor within their own profession.

Successful nurse leader programme

Provided by the Kings Fund, this programme provides nurses with a unique learning experience designed to help them develop the skills, awareness and confidence they need to maximise their leadership potential. The programme is designed for both new and established senior nurses working at ward manager level up to assistant director level in health or social care, or in the colleges of nursing.

Successful Nurse Leader aims to support nurses who wish to take this step, empowering them to overcome the personal and professional obstacles to achieving career success and to take an active role in shaping the health and social care services of the future.

Skills upon which the programme focuses are:

- self-awareness and emotional literacy
- communication skills
- presentation skills
- the ability to give and receive supportive yet challenging feedback
- the ability to facilitate group processes and make effective interventions
- the capacity to inspire and influence others
- strategic and political awareness
- awareness of your organisation as a system and your role within that system
- understanding of how to build leadership capability through strategic alliances and networking across disciplines, responsibilities and management levels.

Successful Nurse Leader uses a variety of formats to encourage learning on several different levels. The formats include presentations, group discussions, role plays, and a range of experiential, creative and peer-review exercises.

The programme also includes a number of action learning sessions in which participants can ask for feedback from your peers on challenging personal experiences that you are struggling with at work.

Strategic leadership and expert practice (Nursing practice development)

This course aims to develop the strategic leadership and practice development skills and expertise of nurses, midwives and health visitors in a range of health care settings. The learning outcomes for the programme have been designed to enable nurses, midwives and health visitors to study their own unique, professional practice, in order that personal, team and organisational goals can be achieved. Students undertaking this course will benefit from the opportunity to be able to apply for professional accreditation from the RCN as clinical leaders, facilitators, and, for some, expert practitioners. The programme comprises the following elements:

Core Units	Pathway Units	Elective Units
Research Methodology and Strategy	Practice Development	Disseminating Learning from Practice
Knowing the Context of Professional Practice	Exploring ideas and concepts	Professional Development through Contract Learning
Knowing Self in Professional Practice	Practice Development	Facilitating Learning in the Practice Setting
Research Philosophies and Methods of Enquiry	Making it Happen	Evaluating Learning in Practice Based Environments

The programme content reflects the complexity of the clinical environment and acknowledges that practitioner's experience. The teaching strategies are chosen to facilitate: adult learners need to be equipped with life long learning strategies; to build on their previous learning; and their need to work and learn collaboratively in teams and as independent practitioners. Teaching methods include: lead lectures, discussion groups; student led sessions and debates; problem based learning; peer and unit leader facilitated tutorial groups and professional supervision groups.

Assessment is part of the learning process and a variety of methods are used to reflect the programme's academic, clinical and professional nature. These include: written assignments; portfolio development and reflective commentaries; practice development project proposals; project evaluation reports; production of a research proposal and a research dissertation / thesis (MSc/Doctorate only).

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