Nursing leadership: bringing caring back to the future

Alison Kitson

Abstract

Leadership, whether it is nursing, medical or healthcare leadership, is about knowing how to make visions become reality. The vision that many nurses hold dear to their hearts is one where patients are treated with dignity and respect at all times; where systems are designed for the benefit of individual needs; and where the work performed by nurses and other carers is valued and respected. Achieving such a vision will require a paradigm shift in the philosophy, priorities, policies, and power relationships of the health service. Fundamentally, it will require the rhetoric of patient centred care to become a reality. The following scenario is set in the UK in the year 2012 and describes a health service that is on the pathway to achieving this vision. It tells the story from a nursing perspective and outlines the three key foundation stones that helped nursing achieve the vision of a patient centred health service: (1) development of patient centred care measures as part of performance management and the clinical governance agenda; (2) leadership based on personal growth and development principles; (3) new clinical career and competency framework for nursing.

(*Quality in Health Care* 2001;**10**(Suppl II):ii79–ii84)

Keywords: nursing leadership; patient centred care; career framework

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Vignette

Tuesday 25 October 2012. A bright sunny day. The Secretary of State for Health and Wellbeing is about to celebrate the launch of the opening of the 100th care complex in the UK. She can hardly believe it herself. An initiative that started only a few years earlier has had such dramatic impact.

She approached the microphone.

"*Prime Minister, Honoured Guests, Ladies and Gentlemen. It gives me great pleasure to open this latest and largest care complex here in Grimsby. Who could have believed that in such a relatively short space of time we have been able to transform the health needs of the citizens of this country. Not by investing yet more and more funds into medical technology and hospital buildings but, by having the courage of our common sense and convictions to place* **caring** *at the centre of all we plan and do in the National Health Service.*"

"*This shift in our thinking and in our policies has rewarded us richly. Today we celebrate the opening of this flagship care complex. Exemplary in that it demonstrates true partnership working between the local community, the health professionals, private industry and the arts. We can celebrate the fact that within this care complex we have not only the latest medical technology delivered to us via the Internet, but we have the whole range of caring support services that any community might need. In addition, and in keeping with the philosophy of the care complex, we have also integrated services to support individuals and families in many life events that cause stress and anxiety. Our counselling service draws on the best services both locally and internationally and our creative arts suite enables those in the community who are feeling disempowered and disenfranchised to regain their self-esteem.*"

She continued.

"*We wish to pay special thanks to those health care leaders who have transformed the services in this local community. To the nurses and doctors in particular who worked on how they could shift their traditional ways of working and delivering medical services to developing a fully integrated patient centred service. Your excellence will be carried far and wide by the interest and enthusiasm evident here today.*"

The story unfolds: how did it all start?

The vision of a care complex emerged from the watershed health reforms of the Blair Government of the early 2000s. Entering their second term, New Labour had embarked on a radical or "modernising" agenda of reforms for the NHS. Essentially, they were tackling two fundamental problems or impediments to modernising the Health Service: one was the NHS culture and the second, which flowed from it, was the rigidity of the systems, process and working practices, particularly of the professional groups.

Key messages

- Improvement of health services is dependent upon the way patient centred care is understood.
- Traditional healthcare culture and roles need to change if service delivery is to improve.
- Leadership that promotes the values of patient centred care—respect, dignity, compassion caring—will lead this transformation.
- For nursing three key features have been identified that will help this transformation:
  - patient centred care measures developed as part of performance management and clinical governance;
  - leadership based on personal growth and development principles;
  - new clinical career and competency framework for nursing.

Despite a plethora of initiatives, the first 5 years of the Blair Government saw few improvements. Indeed, public expectation had been raised to such an extent by the hype in the newspapers that a lot of negative publicity was emerging. Horror stories just wouldn't go away. Demand for services was rising, staff were feeling more overworked and demoralised, and generally everyone was dissatisfied.

Then, almost by accident, things started to change. Strictly speaking, it wasn't an accident but more a surprise of what actually became the driver for real sustained change and improvement. As far as we can work out, it turned out to be that overused phrase "patient centred care" that held the key to the transformation. The sceptics at that time secretly thought that the phrase "patient centred care" was a device conjured up by the spin doctors as a vote catching ploy. So, you can imagine their surprise when the rhetoric began to metamorphose into reality.

The first signs that patient centred care was becoming more than just a catch phrase came in early 2000. A couple of big public enquiries had highlighted the deep seated problems with the way the health services were organised. Too much protectionism and secrecy, too much fear, too little trust, empathy, and information. Those who worked in the system as well as those whom it served were the victims. Of course, the natural and programmed cultural reaction was to find someone or something to blame. But, after that futile and rather pointless exercise, common sense prevailed and healthcare leaders began to look for the real causes that needed to be addressed.

In parallel to this was growing disquiet from the caring professions, particularly nursing. Evidence collected by the Royal College of Nursing and other prestigious organisations showed a widespread disillusionment in nursing. Nurses were leaving in ever increasing numbers and, more worryingly, fewer potential recruits were identifying it as a preferred career choice. Reasons cited for leaving included pay and conditions, inflexible systems but, more importantly, significant numbers identified frustration at not being able to care properly for patients, compromising standards, and having to risk patient safety.

Increasing numbers of patient groups and influential media personalities also "went on the record" to talk about the inhumane unacceptable service that many hospitals were having or choosing to deliver.

The breakthrough didn't come with a ministerial announcement. It sort of slipped through. It happened when the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) at that time were launching a policy document on *Leadership and Quality*. Part of the "double act" involved a question and answer time. One of the questions from the press was: "Which did they value more, getting patients better (i.e. curing) or making them feel better (i.e. caring)?" Together and publicly the CMO and CNO both responded that caring and curing had to be held in equal respect, that patient centred care was based on the ability of individual professionals and whole healthcare systems to be able to keep that intricate balance between caring and curing. They reminded the press that it was that same sensitivity and wisdom which had started the hospice movement and such integration of caring and curing continued to be the essence of good nursing and medical practice.

Following this event, civil servants were charged with the task of ensuring that patient centred care criteria were included in the performance monitoring and clinical governance returns to the Departments of Health. Work started by a modernisation team (as they were called then) on essentials of nursing care—which included measures on areas such as patient dignity, privacy, comfort, safety, information, hygiene, nutrition, and elimination—were scrutinised to see how they could begin to be used as national performance measures of patient centred care.

Clinical teams from medical specialties as diverse as gerontology and paediatric oncology were invited to develop sensitive measurse as to how they would evaluate their ability to provide patient centred care. And, while much work had been done in their clinical areas to measure many of the technological interventions, it was soon realised that much more creative, intellectual, and organisational energy had to be devoted to developing reliable measures for patient centred care.

From the investment in this benchmarking activity in the early part of the 21st century, a number of other patient centred initiatives were set up which eventually led to the development of the concept of care complexes, including:

(1) Extension of the national service frameworks to all major healthcare interventions and, from their work, creation of a network of interrelated services spanning the four countries of the UK. Using telemedicine and telenursing technology, practitioners in one locality could call on the expertise and experience of practitioners in other parts of the country. Thus, a consultant nurse managing a stroke rehabilitation unit in Southampton was able to ask advice from a colleague in Aberdeen on a particularly complex case via the Internet. Patients and relatives were also able to use the same facilities to communicate with each other.

(2) Evidence from the intermediate care initiative demonstrated that one of the most sensitive predictors of effective recovery from acute episodes of illness was the quality, appropriateness, and intensity of expert nursing care. Over the next few years more nurse led centres (otherwise called care and recuperation centres) were established. Fashioned after the old style cottage hospitals, these centres provided expert nursing care supported by telemedicine and other appropriate services. They also tested out the complex boundaries between health, social, and personal care—definitions that had been profoundly complicated during this time.

(3) In tandem with the nationwide initiative to set caring values at the heart of the delivery of the health service as evidenced through the

essentials of nursing care initiative, healthcare policy leaders also invested in widening the range of holistic care opportunities. Such innovations were placed under appropriate scrutiny of the relevant national service framework, so proper dialogue and clinical evaluations were carried out. One of the most exciting outcomes was in the management of pain in labour; after many years of struggling women actually got what the majority of them wished for—a skilled midwife whom they knew to stay with them during the second stage of labour.

(4) Another initiative that paved the way towards the care complex was the innovative work carried out in many of the new primary care trusts and health action zones. With a new freedom to define health care as both contributing to cure and care, the investment decisions, priorities, and power relationships between many of the key stakeholders began to shift. For example, elderly people suffering from chronic arthritis began to feel that, despite the lack of cure, they could begin to expect more creative ways of helping them to care for themselves more effectively. Ideas from groups hitherto silent began to emerge, facilitated by the health team, brought together to create a vibrant community committed to health gain. The specialist centres for gerontology, cardiology, and other national service frameworks began to come together under the direction and leadership of the local primary care team. Together with the care and recuperation centres and the range of support and counselling services, the foundation stones were being set up for the care complex to emerge.

How did the nursing profession deal with the shift towards the philosophy of patient centred care?

Morale had reached an all time low—not just for nurses but also for many doctors, particularly general practitioners, allied health professionals, and health service managers. A frenzy of activity in the late 1990s merely accentuated the problems and, while individuals were willing to believe the rhetoric of the Government's modernisation agenda, few really expected to see the radical changes that were needed. That, indeed, was the heart of the problem: without belief there could be no vision of how things could be transformed.

So where did the belief come from? In nursing the gradual transformation happened through a number of national leadership initiatives, most notably the RCN clinical leadership programme and the Leading Empowered Organisations (LEO) project. These programmes emphasised the importance of investing in oneself as a leader before being able to effectively lead teams or organisations.

While this may be a relatively straightforward message for many people—that is, that you cannot be an effective leader if you have not invested in your own personal development—it was a message poorly understood and rarely experienced by many nurses at that time. Whether it was the prevailing culture of the day which implicitly prioritised technology and cure over caring and non-technological interventions that led to nurses feeling undervalued and virtually invisible within the decision making areas of most health facilities is hard to say. But, whatever the reasons (and there were many), nursing and nurses were suffering. Their own feelings of victimisation sometimes manifested themselves in unpleasant organisational behaviour such as bullying and other types of discrimination.

The leadership initiatives within nursing were part of a national programme coordinated by the leadership centre. Based on transformational leadership theory, the RCN clinical leadership programme concentrated on unlocking the potential of individual nurses, working with them over a 12 month period to develop their leadership capacity to improve patient care.

Many clinical leaders benefited from these and similar programmes during these early days and what each nurse experienced set the framework for how they would deal with patients, teams, and organisational change. Many nurses on these programmes had to go through a "refining process"—letting go of the anger, stress, guilt, and anxiety they had experienced in their working lives. Often the build up of frustration and resentment blocked their ability to be able to innovate and change the systems in which they were working.

Other initiatives around service improvement and clinical governance, working with whole clinical teams, also focused on similar areas of personal development, value clarification, team work, and the development of a range of skills and techniques to increase the team's confidence in managing change. Whichever method or approach was used, the basic ingredients that unlocked the potential and re-engaged practitioners included the following:

(1) Investment in personal development

- this included working up some sort of personal development profile supported by a trained facilitator who would go through with each clinical leader their perceived strengths and areas for development, areas of influence and control, and areas for development;
- techniques such as action learning sets were used to enable individuals to learn from each other;
- personal goals were related to overall quality improvement objectives for patient care.

(2) Coordination of individual empowerment and development of leadership potential

- value clarification exercises were fundamental to checking out what practitioners believed they were trying to achieve and discussion of values underpinning effective leadership and effective healthcare delivery ensured explicit discussion about such principles as respect, dignity, autonomy, justice, compassion, honesty, humility, service. The sort of leaders nurses and doctors wanted to become were laid out as were the parameters of the patient-practitioner relationship. This was where the rhetoric of patient centred

care began to cut into the reality of many practitioners' minds.
- clarifying roles and boundaries: effective teamwork and change management is related to the ability of team members and leaders of those teams to clearly understand each others' roles and responsibilities. With the changes in professional roles and the blurring of boundaries that happened at this time, it was up to many local groups of professionals to decide what was best for the patient and then decide who would do what according to who had the most appropriate skills. Thus, teams had constantly to readdress their objectives and work roles. Individual members were given opportunities to lead particular projects so everyone had experience in managing change;
- clarifying accountability: personal development and leadership development helped explore the complex areas of professional, team, and individual accountability. It was always a topic that needed to be discussed within any new team or project and leaders began to learn how to explore it in relation to patient advocacy, transparency of information giving, shared and individual accountability, and consequences of accountability within the emerging clinical governance frameworks;
- leadership skills "tool kit": in addition to the broader value based governance and interrelationship dimensions, leaders were given support in developing skills in fundamental areas such as teamwork, effective communication, resolving conflict, risk assessment, and quality improvement techniques. Skills were developed by active involvement in projects, all centred on improving patient care. Individuals and teams were mentored and supported by facilitators, either working on one of the nursing leadership programmes or with one of the many modernisation or clinical governance teams.

Impact of the leadership investment
The transforming effect of this work began to be evident by the end of 2004. Within nursing over 100 000 clinical leaders had had the opportunity to go through a leadership programme. Each clinical leader was now working with his or her team—either nurses or interdisciplinary, or both. The mood within nursing had certainly changed. Gone were the days when nurses complained about not feeling valued or involved in strategic decision making.

Partly as a result of the essentials of nursing care initiative and the investment in the leadership programmes, clinical nurses found themselves with opportunities for transforming patient services they had hitherto only dreamed of. But it was a quiet revolution rather than a big bang. What patients began to notice first was that order and calmness (and cleanliness) began to re-emerge in healthcare facilities. There was a sense of calmness and control in outpatient clinics, labour wards, or primary care services. You would be greeted and politely asked what you needed. You would be dealt with respectfully and courteously. Gone were the days of frantic, chaotic, undignified activity. And even when things did get like that, there was always the return to the normal state which was a sense of order and control.

New roles and new clinical career pathways
When reflecting on what had brought about such change, many nurses identified three key factors: (1) the patient centred care initiative with the benchmarking of essentials of nursing care; (2) the leadership initiatives; and (3) the new clinical career pathways that developed during this time.

Again, the seeds were sown in the late 1990s with a Prime Ministerial announcement of a new role called "consultant nurse". Amid much confusion and a certain amount of hostility from some quarters, this new breed of "super nurse" was developed. It took a while for the profession and the service to know what to do with them but, particularly with the push towards patient centred care, the role of the consultant nurse began to flourish.

Consultant nurse
Between 2001 and 2006 the numbers of consultant nurse posts went from around 500 to 5000. They became key leaders within the national service frameworks, innovating and setting up the care and recuperation centres in the community and led many of the service development initiatives to refine the patient centred care measures.

The role of the consultant nurse was distinguished by its focus on patient empowerment and advocacy. In setting up new services the focus was on how patients could benefit in terms of their coping skills and overall improvement in their quality of life. Education, self-help, and development of supportive networks were essential elements in the consultant nurses' armoury of clinical skills.

This orientation towards providing an integrated care package for different groups of patients helped to demonstrate the complementarity between consultant nurses and medical practitioners. Consultant nurses also became role models for expert clinical leadership and service development, taking up joint and honorary university appointments where they ensured that students coming through training programmes were exposed to the very best clinical nursing and innovative patient centred practices.

Many of the service developments, particularly in ensuring that the health services became more patient centred, were led by consultant nurses. A big multicentre project on exploring the concept of comfort as a therapeutic intervention to reduce postoperative pain and anxiety helped to transform surgical practices and reduce inpatient stay, and a further innovation around understanding the role of hope in aiding recovery and compliance with therapeutic regimens had a profound effect on the provision of services to patients with chronic heart failure.

Other roles

What also emerged from the reforms in the early 2000s was the beginning of a much simplified integrated career and competency framework for nursing (fig 1). At that time there was a lot of discussion about whether traditional professional roles would disappear altogether—would patients' interests be best served if we were to do away with terms such as doctor, nurse, therapist, manager and call everyone a practitioner? In having to face this question, what began to emerge was the profound importance of knowing how to balance the therapeutic (or curing) interventions with personal support (or caring) activity. Integrated curricula reinforced the importance of this balance of therapeutic and personal support services. Much useful work was done on how health and social care services could develop more evidence based systems, processes, and interventions that would demonstrate the effectiveness of both therapeutic and caring interventions.

The gradual refinement of the roles in nursing developed from registered nurse to senior registered nurse to senior specialist nurse, after which one could become a consultant nurse or executive in a practice role (fig 1). The clamour for "bringing back matron" was finally put to rest at this time, the curious title of "modern matron" being replaced by senior registered nurse. Senior specialist nurses emerged from the new clinical specialist roles and by 2005 it was the generic title for what used to be called district nurses, school nurses, health visitors, and the plethora of other specialist roles.

For the first time in its history, the nursing profession was seeing the realisation of many of its dreams and aspirations—a health service that was committed to caring as well as curing; proper recognition of the importance of delivering patient centred services; enabling nurses' knowledge and experience to be used to develop much more integrated and humane services; focusing on empowering and enabling individuals and local communities; and a commitment to individual growth and development for all healthcare workers.

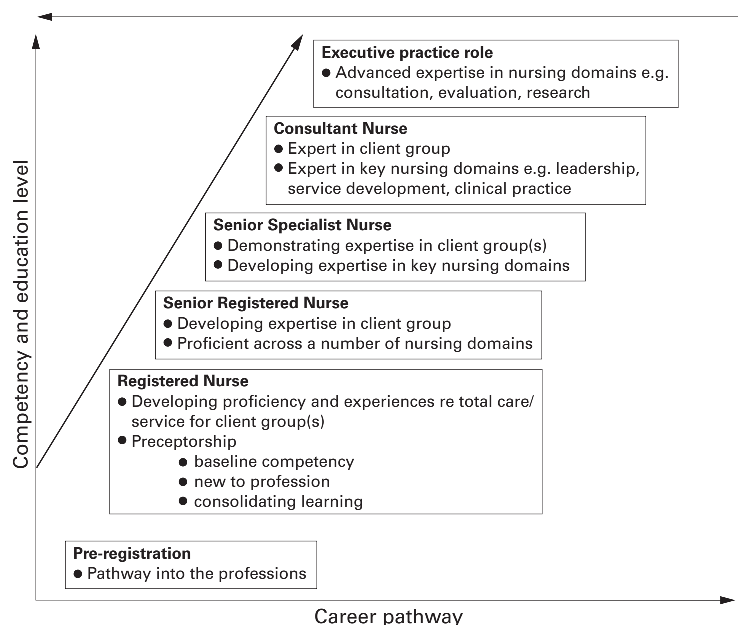

Figure 1 Integrated career and competency framework.

The modernisation of caring services also embraced nursing home and social service organisations. The force for change was the commitment to providing safe, humane, and dignified health and support services for vulnerable members of the community. The narrow protectionist boundaries of many professional groups evaporated away during this time—not by force of government policy but by teams of committed workers coming together to find better solutions to providing integrated systems of personal care to members of their community. Innovations in technology helped to transform services; instead of replicating expensive medical technologies, networks were set up through which centres of excellence could diagnose, treat, and monitor complex interventions with the main resources going to ensuring the right people with the right attitudes and skills were delivering care locally.

The birth of the care complex concept

At one level the care complex concept was not so radical but, on the other hand, it did represent a watershed in the thinking and strategic development of health services in the UK. There had been a gradual movement towards democratisation of health services—moving health to the local community, integrating health and social care, enabling health improvements to be central to the whole regeneration of local communities. But it wasn't until policy makers began to see the profound effect that the patient centred care initiative had on service reconfiguration that they were able to believe they could deliver a truly modernised health service.

The steps were relatively simple. Using a shared governance model, local community leaders together with health professionals and other key stakeholders began to explore how they could deliver a patient centred service in their area. Three main sorts of service were identified—medical/technical intervention services; care and recuperation services; and preventative and counselling services. Services locally were coordinated through the care complex which also took responsibility for coordinating the initial contact and health assessments from members of the community. The care complex was built on a federal model—groups of services connected together according to their primary role. Services were both real and virtual; more and more information, advice and technical interventions were being delivered via the internet and other technologies.

But there were also the real sanctuaries to which people in need and distress were able to come for help, support, rest, and comfort. Different groups were able to get help—single parents; elderly frail carers; people with mental health problems in need of support and space.

Much of the planning and development of the care complexes came from the huge energy

and vision that was unlocked from health professionals during the early 2000s, especially nurses. In the spirit of the new philosophy for leadership in the NHS at that time, the investment was in unlocking individual potential, respecting contributions, and working towards a common vision for patient centred care. Power bases did, of course, shift, the biggest shift being the move from professionals to members of the local community. However, this turned out to be another release of hitherto untapped energy.

It would be naïve to think the changes didn't have their protractors. Major battles were fought and won over the cost effectiveness of investing in care rather than continuing the huge investment in technological and pharmacological solutions. But, within a climate of evidence based practice and service evaluation, the many gaps around the effectiveness of patient centred care services began to be filled in.

Postscript

By 2010 over 50 local communities had opted into the care complex concept, 20 of which were led by consultant nurses and their interdisciplinary teams. A real spirit of optimism had entered the health service. Local communities were taking much more interest in health; it was no longer something separate from one's own lifestyle. Professional roles were much more about education, support, and empowerment. Of course there continued to be the spectacular scientific breakthroughs, but this was balanced by the ability of the service to provide safe, humane, and dignified care. Gaining that balance was indeed the most spectacular breakthrough of the Blairite years.

I would like to thank the following colleagues for stimulating certain ideas in this paper and for drawing on current projects and work: Geraldine Cunningham, Gill Harvey, Sue Antrobus, Sabina de Geest and Jean Faugier for evidence of what works in clinical and political leadership programmes; Kim Manley, Rob Crouch, Gary Jones, John Humphreys and those involved in the RCN faculty project for informing the contents of the integrated career and competency framework; the many clinical nurses and particularly those consultant nurses who have a vision for a patient centred care service; health care colleagues, particularly Jenny Simpson, Paul Dieppe and John Langan, whose vision for a truly integrated patient centred health care service has been and continues to be inspirational.

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