

Public health nurses perception of clinical leadership in Ireland: narrative descriptions

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Aim The aim of the study was to identify how clinical leadership skills are perceived by Public Health Nurses' in the course of their everyday work and the effectiveness and consequences of such skills in primary care delivery.

Background Public health nurses deliver primary care to children and adults as part of small teams or in individual situations. Leadership skills are needed to fulfil their many roles.

Method Rigorous analysis of narrative interviews with public health nurses working in primary care environments in Ireland was undertaken. Narrative information was obtained by having conversations with 20 public health nurses relating to their perceptions on what clinical leadership meant to them and how their leadership skills influenced effective primary care delivery.

Results Analysis of conversations identified the tensions existing between the various roles and responsibilities of the public health nurse and other primary care workers. This tension was perceived by the nurses as being the main barrier to effective primary care delivery from their perspective.

Conclusions Clinical leadership is viewed narrowly by public health nurses as management skills rather than leadership skills were mainly identified. Education for the role was identified as a critical success factor.

Relevance to nurse managers Public health nurses are well placed to shape and influence health service culture through effective clinical leadership.

Keywords: clinical leadership, cost effectiveness, health service organizations, professionalism, public health nurse

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Introduction

During the last decade, the hospital sector has undergone changes in its organization that has centered on making health care delivery more efficient and effective. The management structure of the public health nurses (PHN's) workplace has remained largely unchanged

over the past two decades (Markem & Carney 2008). Nurse management is vested in the Director of Public Health Nursing (DOPHN) with, in recent years, the assistance of assistant directors. Each DOPHN receives reports from up to 40 PHN's. The health care needs of clients are covered by Public Health Nurses working mainly autonomously from health centres with in some

instances the support of registered nurses. The clinical leadership skills of PHN's are largely unknown.

Background

Leadership means providing health care through a collaborative and ethical process that uses advocacy to effect change for the benefit of patients. Education for leadership includes the wider aspects of management that are currently part of master's degree programmes for health care professionals. In Ireland, Public Health Nursing is experiencing significant change which encompasses the agenda that Public Health Nurses (PHNs) provide quality care in the current contemporary healthcare environment (Department of Health & Children 2001a,b). The role and scope of Public Health Nursing has evolved over time to incorporate societal changes, technological advances and the delivery of an evidence based service responsive to need (Marr 1997). The fundamental principle underpinning public health is the provision of a comprehensive, integrated, multidisciplinary service to individuals, families and communities (Hanifan *et al.* 2002). This care is delivered by the primary care teams, including PHN's. The government health strategy, *Quality and Fairness A Health System for you*, (Department of Health and Children 2004) introduced concepts for health and social gain. In the health strategy, health gain is concerned with the health status of the individual and is related to quality of life. Social gain is concerned with the provision of community services (Department of Health & Children 2001a). The need exists for innovative, proactive and highly skilled PHN's capable of delivering a high quality service. The Commission on Nursing (1998) acknowledged the changing healthcare environment for staff and made recommendations that PHN's receive greater support in their role and that their professional autonomy is supported by the management structure (Hafford 2002). Previous research has demonstrated factors that support teamwork, commitment, morale and clinical governance (Mc Sherry & Haddock 1999), all of which have wide organizational influence (Schneider & Bowen 1993, Schneider *et al.* 1996). Clinical governance advocates that organizations must ensure the provision of quality clinical care by making individuals accountable for standard setting, maintenance and monitoring performance (Campbell *et al.* 2002).

Aim of study

The aim of the study was to identify how clinical leadership skills are perceived by Public Health Nurses'

in the course of their everyday work and the effectiveness and consequences of such skills in primary care delivery.

Method

Sample

Conversations were held with 20 public health nurses attending a professional development programme, run over a period of 12 weeks by a university in Ireland. Programme content focused on professional areas, human resource management, general management, legal and ethical issues, communications and leadership. Candidates for this programme were either selected by the Health Service Executive or were self selecting in a ratio of 50 : 50. All participants were registered public health nurses working in health centres in urban and rural areas. The average length of time since qualification as a public health nurse was 8 years. The majority, 16 (80%) had not undertaken such a programme since qualification.

Data collection

Data were collected during the period January–April 2006 through narrative conversations with participants. Approval was obtained from each participant in advance of the interview process and an appropriate sheet explaining the purpose of the study was given to each participant. Participation was deemed to signify approval to participate. Participation in the study was voluntary and anonymity of participants was preserved as no identifying data were collected.

Public health nurses narratives

Narrative interviews typically start by asking the respondent a general question that is intended to elicit a story in that person's own words. For example, in this case as the interview is about perceptions of what clinical leadership means to them and how they perceive it in practice. Respondents were asked what has happened to them since they first commenced working in the role as a public health nurse and if they felt their leadership skills had evolved and if they felt they had, in what way. The benefit of this very open-ended method of interviewing is that it is possible to identify what is important to the respondent in their practice role. Their own priorities and meaning of the role from a clinical leadership are identified, rather than the researcher's pre-conceived agenda (Mischler 1991).

Following this telling of their story the researcher then asked additional questions about relevant components with a clinical leadership focus: such as why they might believe that problems or issues might arise in clinical leadership in their field of nursing and explored their perceptions on how best to address leadership problems or issues. Finally, the researcher asked the respondent to discuss leadership issues facing public health nurses in their areas of practice. The interview could typically be construed as being in two parts—the narrative part and the researcher's part in asking semi-structured questions (Ziebland & Herxheimer 2008).

Data analysis

Data analyses, utilising qualitative data, were completed in September 2007. Narrative analyses, a type of qualitative approach that focuses on the story as the object of the inquiry, were utilised (Polit & Beck 2006). Thus, rich narrative descriptions of participants' perceptions of clinical leadership in public health nursing were obtained. Following the interviews transcripts were analysed utilising N6 software which helped the researcher to organize and analyse emergent themes (Pope *et al.* 2000), using the method of constant comparison. This method was used to ensure that all the perspectives emanating from the narratives were captured in the analysis of each theme. Six major themes and approximately 45 sub-themes were identified. Analysis of such qualitative data is a labour intensive process as all conversations are written up. Themes emerging from these individual conversations were then grouped and presented in a collective manner. Two independent university lecturers were asked to examine the coded material and to relate conversations to findings and to confirm that they were able to follow the decision trail of the researcher. Agreement was high with convergence on overall coding categories and on narrative analyses results. This process ensured confirmability. Ethical considerations, confidentiality, transcribing, rigour, audibility and credibility issues were addressed. To achieve rigour a homogenous sample was sought in order to establish applicability in overcoming bias in sample selection.

Findings

This section examines the evidence obtained from the analyses of the narrative responses to the conversations. The following six strategies emerged: inter-professional collaboration; leadership principles and practices;

inappropriate management styles and processes; management functions; structural organizational issues and futuristic models of healthcare. Themes and their primary strategy and constituent components are presented in Table 1.

Theme 1: Clinical leadership in public health nursing

Respondents defined clinical leadership as inter-professional collaboration. They identified this as having the ability to facilitate good practice through the use of evidence based practice in care delivery and in abiding by codes of professional conduct. Clinical leadership to them also involved the ability and opportunity to mentor students and co-workers, and in being able to utilise clarity in decision making.

Typical comments around what clinical leadership meant were:

'It's facilitating good practice and recognizing, encouraging others to perform their jobs effectively and efficiently, using co-mentoring and evidence based practise' (Ref 3)

and

'I believe it [clinical leadership] to be able to acquire knowledge, be adaptable, clear in decision making with students and colleagues and being professional, demonstrating ethical behaviour and abiding by codes of professional conduct within my scope of practice' (Ref 6).

Theme 2: Leadership principles associated with public health nursing

Leadership principles and practices were the primary strategies emerging from this theme. Components included the need for building, directing and leading a team and in having good client interactions and relationships. Respondent's spoke of the necessity to make decisions on personal goals and in knowing how to go about achieving those goals with the involvement of their own team members. They felt that having interest in practice and in professional development in order to facilitate good practice was their goal and led to competent practitioners. They spoke of competence as specialising in areas of practice, pushing standards to excellence, having evidence-based knowledge of their area and being able to apply knowledge to safe practice. They spoke of the need to recognise, motivate and encourage

Table 1
Thematic content

<i>Themes</i>	<i>Primary strategy</i>	<i>Constituent components</i>
Theme 1: Clinical leadership in public health nursing	Inter-professional collaboration	Facilitating good practice in patient care delivery Mentoring of students and co-workers Utilising evidence based practice in care delivery Clarity in decision making Abiding by codes of professional conduct Leading a multidisciplinary team Effective use of communication skills
Theme 2: Leadership principles associated with public health nursing	Leadership principles and practices	Interaction with clients Relationship building Team empowerment Managerial and leadership skills Goal setting Having a vision for the future Need for empowerment Personal & professional development Competence to practice Motivational skills
Theme 3: Why problems/issues arise in clinical leadership in nursing?	Inappropriate management styles and processes	Inappropriate management styles Lack of delegation skills Poor communication skills Nurses exceeding scope of professional practice Poor conflict resolution skills Unreasonable expectations of role Non acceptance by managers of the role Non alignment of goals Competence not recognised by management and other professionals
Theme 4: How best to address leadership problems/issues	Management functions	Setting realistic goals Identification of problems Assessing need Team inclusion and management Evaluation of strategies employed Change management skills Involvement in care planning
Theme 5: Leadership issues facing nurses working in public health in community areas	Structural organizational issues	Organizational structural change Organizational hierarchy Lack of resources Poor working relationships Lack of co-ordination of work Discord in primary health care teams Erosion of qualifications Need for political awareness and political acumen Need for patient advocacy
Theme 6: Future models of care delivery	Futuristic models of care delivery	Need for education in clinical leadership Development of futuristic models of relationship building New health service organizational forms Ability to identify leaders of the future in public health nursing Need to feel empowered in the role

others through involvement. Having a vision for the future was seen as important. A typical comment was:

‘I need the ability to motivate staff to attain a goal which would benefit my patients and clients, and that also would be implemented within a framework which is workable’ (Ref 14)

and

‘I believe public health nurses need to be competent in their role and to continue to develop their

competencies through personal and professional development-programmes such as this one’ (Ref 5).

Theme 3: Why problems/issues arise in clinical leadership in nursing?

One participant appears to sum up the perceptions voiced by the majority in relation to why problems/issues arise in clinical leadership in nursing? She said that problems arise because:

'of autocratic management styles, nurses exceeding scope of practice, delegation of tasks inappropriately vis-à-vis competence or interest. Failure to assess for risks/hazards. Failure of team building are also causes' (Ref 10).

Respondent's spoke about poor communication skills amongst different grades of nurses, and of PHN's being unable to communicate with some management and colleagues in a meaningful manner. They identified resources as contributing to poor leadership. A typical comment was:

'I believe there are not enough resources in place. There are unreasonable expectations due to cost cutting, and this has become a regular feature of everyday working conditions and has resulted in low morale' (Ref 8).

They spoke of poor leadership being caused by poor visionary skills in relation to patient needs and in staff and patients having unrealistic goals thereby leading to difficulty in alignment and agreement on goals. Management style was discussed. A typical comment was:

'management is mainly autocratic up to now and in trying to change to democratic models a need for more realistic expectations [by managers] in attempting to gain co-operation of PHN's is needed' (Ref 11)

and

'I think that autocratic management style is often present in primary care structures [and this] has resulted in lack of motivation, job satisfaction and low morale' (Ref 11)

and

'Managers [are] not taking into account the competence and interest of some staff, in particular specialist areas of practice, and this leads to a lower standard of patient care than would otherwise be delivered' (Ref 1).

Theme 4: How best to address leadership problems/issues

Setting realistic goals that met the needs of clients and staff was mentioned as well as identification and assessment of problems. Respondents discussed the need for inclusion by all team members in communications and in having the opportunity to evaluate new strategies and of the need to negotiate change rather than forcing change through. There was the expectation

that PHN's must move on and accept change as this was seen to be beneficial for the patient. A typical comment was:

'Resistance to change by all grades of staff is contributing to difficulties in clinical leadership' (Ref 5)

and

'Inadequate staffing levels leading to lack of time to implement [the] process of change and not enough feedback for efforts made are problems for nurses' (Ref 4).

Theme 5: Leadership issues facing nurses working in public health in community areas

Structural change with inadequate communication was perceived as the main concern. Respondent's spoke of structural changes in setting up primary health care teams aligned with lack of resources and staff, all leading to stressful working conditions. They believed that inadequate structures were best addressed by good teamwork and peer support, whilst having individual consideration for others. There was a strong belief that management needs to accept nurse specialists and RGN's and to encourage good working relationships between all grades of nurse and assistants working in the community. They spoke of the problems associated with large health centres where poor coordination of work existed between grades. They believed that the introduction of primary health care teams led to improved standards and best practice procedures and to enhanced team building, but conversely that different practices and procedures were present in each community area and that this led to confusion. They believed that large clinics should have a director of public health nursing appointed. They were also concerned regarding the authority of the PHN and of the PHN qualification being eroded by the removal of midwifery from the entry requirements for public health nursing. A typical comment was:

'I think that PHN's on the one hand are not anxious to give up what they already have and on the other fear the consequences of this qualification being removed. Financial constraints, erosion of role, lack of knowledge and time contributed to stress and fear' (Ref 13)

and

'I think that there is a need for us to become more politically aware and to develop greater political acumen in achieving our goals and those of our clients' (Ref 14)

and

‘patient advocacy is one of our primary functions’ (Ref 12).

Theme 6: Future Models of care delivery

Identified in Theme 6 was the recognition that new models of care delivery would be needed in the future. Respondent’s expressed the need for education in clinical leadership in order to prepare them for their new and future roles. They identified the need for new ways of ‘seeing’, ‘doing’ and ‘evaluating’ care delivery in new health service structures. They spoke of the need to identify leaders of the future in public health nursing. They also spoke of the need for new networking structures that had a professional and social dimension, and this view was typified by this comment:

‘We need to get out more, meet and talk with other professionals and take our heads out of the community for a while. We would learn a lot from this’ (Ref 12).

Discussion

Findings from this study highlight the perception that if healthcare interactions between professionals are collaborative and strategic in nature that positive benefits will result for all involved (Theme 1). Collaboration is defined as clinicians from different disciplines working together co-operatively through sharing responsibility for decisions made and in co-ordination of activities (Carney 2002b). Carney (2002a,b) in her research undertaken in 65 acute care hospitals in Ireland found that collaboration amongst professionals in strategic management occurred with positive care delivery outcomes as a result. A study by Boyle and Kochinda (2004), undertaken in two ICU units in the United States, reported that positive benefits accrued from purposeful intervention techniques that resulted in greater levels of collaboration between physicians and nurses in care delivery. However, intervention techniques remain relatively rare in enhancing collaboration amongst professionals in health care settings. The positive benefits of collaboration are often negated or reduced by the presence of power groupings and by inter-professional rivalry and discord (Carney 2002a,b). The collaborative model used by Boyle and Kochinda (2004) incorporates the dimensions of leadership, communications, problem-solving, conflict management and teamwork. It is deemed important that inter-professional collaboration occurs in

all settings in which clinicians work and not just between nurses and doctors/physicians (Knaus *et al.* 1996; Carney 2006; Baggs *et al.* (1999).

Empowerment

In Theme 2 empowerment was frequently mentioned in the context of the need for PHN’s, their clients and colleagues to achieve a sense of empowerment. Public health nurses in this study reported a loss of empowerment in their role and often non-recognition for their work at individual level. Faulkner and Laschinger (2008) suggest that respect in the workplace is a key to nurses feeling empowered and that workplace empowerment is a complicated concept that involves not just respect but also structural and psychological dimensions. Empowerment is the transfer of power, from the self to another person, in a manner that allows for the development of positive self-esteem and value in the other, and where authority is delegated and power is shared (Rodwell 1996). The qualities of the empowered nurse have been identified; these include moral principles that are based on respect and personal integrity, acknowledged self-esteem self-esteem and expertise (Avolio & Gibbons 1988, Bass & Avolio 1990, Jasper 2008). Team disempowerment also occurs due to the make up of various teams, such as project, management and work teams that demonstrate different performance drivers (Cohen & Bailey 1997). Team empowerment is defined as the increased task motivation due to the team members’ collective, positive assessments of their organizational tasks (Kirkman & Rosen 2000). Empowerment in teams arises because team members perceive that the team is effective, that the work being undertaken is meaningful and that they have the power to make decisions and to contribute positively. Respondent’s spoke of the sense of not being recognized for the work they do or of their roles being devalued as a result of a new skills mix being introduced into primary care teams (Theme 3). The more highly empowered team members are the more likely the members are to make complex decisions without waiting for managerial approval, whereas teams that meet infrequently become passive and are more likely to refer to their managers for direction. It is recognized that face-to-face interaction and regular meetings are important factors in influencing empowerment in teams (Kirkman *et al.* 2004).

Conflict resolution

Conflict resolution was mentioned in Theme 3 as causing difficulties for PHN’s in terms of the need for an open and transparent communication process to be in

place between PHN's and their managers, colleagues and the daily wider multi-professional teams they work with. Communication practices or interaction patterns between professional clinicians and patients will determine the success, or otherwise, of individual patient health goals and health outcomes. It is through interaction patterns that public health nurses are in the important position of making a difference to the lives of individuals (Thorne *et al.* 2004). The PHN's role is largely concerned with assisting patients in primary care settings to achieve stated goals.

Conflict of interest may arise if interaction patterns between the public health nurse and manager are deemed inappropriate. This often led to conflict and a spiral of silence as a result. Scott (2004) talks of the 'spiral of silence' that is common in today's health care organizations and argues that silence allows deviant behaviour to become the norm. This results in unresolved issues and unstable system processes resulting in resentment and loss of trust in management amongst the silencer and the silenced professionals (Carney 2004a, Scott 2004). Therefore, leaders who are not afraid to speak out when conflict presents must emerge from the health service ranks through encouraging communication, involvement and collaboration amongst the organization's members (Carney 2002a). Magnet hospital staff perceived collegial nurse-physician relationships as the key to quality patient focused care (Porter O' Grady & Malloch 2002).

Managing change

Respondents reported difficulty in managing change and in resistance to the many Health Service Executive changes being introduced (Theme 4). They worried about the effect of change on their patients. Clinicians need to be involved in the process of change from the start, and patients' rights should be protected throughout the process. Multi-professional team working is necessary in order to ensure cohesion across the system and to exploit the potential for networks of care (Audia *et al.* 2000). Regular communication and feedback between clinicians will maintain momentum and enthusiasm for the change (Office for Health Management 2003). A study on the management of major structural change in the NHS (Office for Health Management 2003) found that local training and development programmes that place emphasis on action-oriented approaches, are needed to assist staff changes being introduced (Currie 1999). Outcomes expected from the introduction of change need to be consistently reinforced, otherwise the focus remains on

the process of change, rather than on desired outcomes (Pettigrew 1977).

Involvement

Respondent spoke of the need to be involved in decision making and also of the need for their patients to be more involved in setting health care goals (Theme 4). Patient and client involvement is growing in significance for all health care professionals who deliver care, particularly in the NHS in the UK, and in the HSE in Ireland, where involvement has become a plank in reforms being introduced (Department of Health & Children 2001a,b). The NHS Plan (Department of Health UK 2000a) states that too many patients feel 'talked at' rather than 'listened to' and advises that involvement must include positive and effective relationships between patients and the clinicians providing their care. Care management models ensure that health professionals work together with service users (Department of Health UK 2000b). A study undertaken by Abbott *et al.* (2001) involving four groups of service users living in the community found considerable dissatisfaction with the care management provided. Whilst two groups were prepared to take an active role in their care and were satisfied with the service provided to them, the remaining two groups were dissatisfied and unclear with the care provided, with some having to take proactive action in order to obtain the required services. Thus, what is required is regular contact with clients. The most cost-effective skills mix of qualified and less qualified staff may provide regular contact, not substituting for, but rather complementing, the public health nurse (Abbott *et al.* 2001).

Management and leadership concepts in managerial effectiveness

Public health nurses in this study appeared to confuse management roles with leadership roles even though respondents expressed the need to lead and they saw leading as part of their role (Theme 4). Participants discussed the Health Service Executive structure in primary care delivery as one of constant change, perceived as causing confusion. Hoggett (1996) describes the new management changes being introduced in Britain as 'simultaneous centralization and decentralization' and argues that this is an apparent combination of bureaucratic and non-bureaucratic organizational structures. Others argue that this structural combination succeeds by controlling the work processes of health service professionals (Harrison & Pollitt 1994,

Webb 1999) through tight control on their work practices (Pollitt 1993). Practice protocols, that provide step-by-step detail on how nursing tasks should be carried out, are in evidence in one UK Trust hospital and appear to indicate that, in this particular hospital, managers and not health care professionals control the day-to-day activities of care delivery (Bolton 2004, Department of Health UK 2001), and that the essence of nursing, the caring role, can easily be broken down into quantifiable tasks. This is not possible. Participants in this study did view their roles as being diminished through the introduction of non specialist nurses into their community areas.

The focus on nurses' work has resulted in an attack on the nurses' occupational autonomy (Douglas & Ryman 2003, Scott 2004). However, it is also acknowledged that the nurses' work involves rapid, autonomous decision-making that puts the nurse firmly in the work role of *knowledgeable doer* (Carney 1999, Robinson 1992). Even so the success of management in controlling the work processes of nurses and other health service professionals is difficult to define or quantify, particularly when structures and management strategy vary across hospitals (Grimshaw 1999, Adams *et al.* 2000) and community care areas. Therefore, the hospital management of the future is likely to rely on the traditional autonomy of nurses in relation to how health care is delivered by them and even though nurses may resist some of the management demands placed upon them in their roles, they are likely to accommodate many of these demands (Bolton 2004). Carney (2006) argues that this compliance results from the nurses' professional sense of putting the patient first and their perceived conciliatory role in health care partnership. This professional sense has allowed nurses to develop their own ways of interpreting the wishes of management. It is important that co-operative relations are maintained between management and health care professionals, as the objective of both groups is the same – the provision of quality care to patients. Specialist public health nurses are needed to ensure those standards are maintained.

Developing political acumen

Participants reported difficulty in interpreting policy changes (Theme 5). This was manifested through a perception of knowledge gaps in relation to the many policy papers and changes being introduced in primary care and the need to become more politically aware of the health service changes that are being introduced. Health service managers have a professional responsi-

bility to develop new ways of becoming more knowledgeable about health care policy. In addition, PHN's have a responsibility to become more involved with the policy issues that affect their patients, the wider population and their professions (Bradshaw & Brown 1996, Murphy 1999, Carney 2006). Collectively, health care professionals are the largest hospital and community groupings holding a critical voice in the development of patient services and in patient outcomes and, as such, should develop political skills so that they may influence health policy (Faulk & Ternus 2004) This includes involvement in health policy discussion at all levels and involvement should include meaningful participation in the development of strategy and in the implementation and evaluation of policies (Bradshaw & Brown 1996).

There is nothing new about the importance of health care professionals developing political acumen. However, health policy, as a separate entity subject, receives scant attention at college level (Bradshaw & Brown 1996) and consequently professionals do not view politics and public policy in health care as their responsibility (Faulk & Ternus 2004, Carney 2006, Bradshaw 2008). Public policy needs to be introduced early in the undergraduate curriculum for all health care students and professionals need to think policy and politically in order to act as patient advocates (Reutter & Williamson 2000, Oxman & Smith 2003). Participants also mentioned their fear of exceeding their scope of practice through lack of knowledge relating to changes in new regulations being introduced. Bradshaw (2008) discusses the recent policies that seek to extend the role of health service users in England and he queries if this policy is directed towards genuine user participation or a 'dogma-driven folly' that is aimed at providing a more individualized service to individuals. He argues that this is difficult to achieve as care is still far from being user centered.

All health care professionals have a duty of care to their patients and play a vital role in involving patients. Organizations are required to acknowledge the expertise and professionalism of health service staff and to involve them, early on in the process and, not as is often perceived, too late to have any real meaning (Carney 2002a,b, 2006; Calpin-Davies 2003, Moss Kanter 1994). Moss Kanter (1994) suggests that this relationship building is more effectively developed through ongoing professional education. A Canadian study, which explored the process of partnership, concluded that the nurse-patient partnership embodies power-sharing and negotiation and leads to patient empowerment, because empowerment allows the patient to act on his or her own behalf (Gallant *et al.* 2002).

Identifying leaders for the future

Choosing the 'right' leader was identified by respondents (Theme 6). This is not an easy task for the organization, because superior decision-making capabilities or the 'halo effect' can mask a deficiency in strategic thinking or in long-range conceptual thinking, and may indicate over-reliance on policies (Henneman *et al.* 1995). To assess leadership potential requires skill and confidence. Thus in order to assess leader capability, senior managers need to consider a range of leadership criteria including evidence of knowledge and skills, including so-called 'soft' skills, such as trust and integrity. Managers should not be fearful in choosing a leader who may be different, if the role requires, and not feel threatened by a new leader who is more skilled and has more experience than themselves (Carney 2006). The leader needs vision and be able to function in a team but equally, the leader must be capable of acting and standing alone, and of making unilateral decisions when required, thereby possessing risk-taking ability (Burns 1978).

Effective leadership is associated with more ethical behaviour, job satisfaction and, in a climate of organizational change, effective leaders produce desirable outcomes for employees (McNeese-Smith 1995). Effective leadership also leads to patient satisfaction and is a requirement for effective care delivery (Chan & Cheng 1999, Chen *et al.* 2005). Leadership behaviour that focuses on the five behaviours identified by Kouzes and Posner (1995) is appropriate for effective health care management; these are *challenging the process, enabling others to act, inspiring a shared vision of the mission, knowing the goals and objectives of the organization, modeling the way* and *encouraging the heart*. Professionals require leadership skills that include vision, charisma and collaborative and co-operative forms and that are multi-dimensional in orientation and innovative in change (Porter O' Grady & Malloch 2002). As a result, followers of outstanding leaders become committed to the vision of the leader through shared values (Burns 1978).

Futuristic organizational forms

Futuristic forms of organizational communication structures that PHN's need to embrace are emerging and alluded to in this study, although not recognized as such by respondents (Theme 6). These forms include informal networks, network-mapping, boundary-spanning, central connectors and social network analysis. Cross and Prusak (2002) analysed informal networks in

the United States and found that hierarchies function through personal contacts and informal networks, and that work progresses through such contacts. As informal networks are powerful political tools, managers need to develop ways of managing communication emanating from and entering such groups, by focusing on key internal group leaders (Krackhardt & Hanson 1993).

A powerful technique, known as 'social network analysis', was developed by social scientists to recognize and manage informal networks (Cross & Prusak 2002). PHN's should identify the network function and the process or the activities where connectivity is required. This information identifies sets of relationships existing within key areas, such as employees and other personnel that they talk to regularly.

A further extension of the informal network is boundary-spanning. Boundary spanners are roving ambassadors who communicate with the wider community (Floyd & Wooldridge 1997) and can be invaluable to the organization in terms of the information, specialised knowledge and contacts they make. This is particularly pertinent within external professional networks in maintaining professional knowledge and research related to best practice. Managers with personally-satisfying networking and boundary-spanning roles are more satisfied in their work, remain more committed to the organization and stay longer than managers not in these roles thereby boosting organizational productivity and knowledge generation (Cross & Prusak 2002). Knowledge workers require the mentoring of their managers in order for the employees' knowledge-based capital assets to be realized (Krackhardt & Hanson 1993, Hertting *et al.* 2004).

Conclusion

As a result of health service restructuring and re-organization, significant changes have occurred in health professionals' perceptions of their work and their organizations. Futuristic communication forms are emerging as a consequence. Whatever form of structure the organization chooses to adopt in the future, it should have as its central philosophy, the recognition and development of its employees' core competencies. Core competencies reside in its employees and are built on the knowledge and expertise of the employees. Therefore, the delivery of health services should be built around the core competencies of its employees, who then deliver the required services desired by its patients and clients. Thus, leadership and relationship skills are essential to the future of health service organization in

order to ensure successful outcomes for its patients it serves. Public health nurses, in order to preserve and enhance their community care focus, need to adapt to new ways of thinking and of delivering care and would benefit from new forms of social networking interactions. Public health nurses are well placed to shape and influence health delivery and therefore should be included in decision-making processes affecting them and their practice, and to have their expertise and specialist knowledge accepted by management and by their peers.

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