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BSMC: Is there room for me?
An exploration of nursing leadership in primary health care

**A thesis presented in partial fulfilment of the
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Abstract

The unpredictability of health in a dynamic climate can result in a multiplicity of challenges. Indeed unpredictability has been referred to as the essence of creativity. Strong leadership in healthcare and importantly nursing is crucial to seeking solutions to organizational change especially when decision making will impact on the population's health. By influencing policy objectives through leadership, nurses have the opportunity to develop strategies that make a difference to future complex problems. With the implementation of the Governments *Better Sooner More Convenient (BSMC)* policy agenda and principles underway from 2008 onwards, to reframe primary health care services, a series of key principles emerged including: a more personalized primary health care system with services moved closer to home; reduction in demand on hospitals and a package of services centred on integrated family health centres, with nurses taking a key role in shifting services from the secondary to primary care needs of patient support.

From seventy health collective submissions positioning themselves to address these principles, nine were selected to move through to the next stage of development. The applications from all of the successful organizations referred to the need for improved multi-professional working and/or the importance of the nursing workforce to the BSMC agenda. Importantly, it would appear that a high quality nursing leadership function within the BSMC health collectives developing BSMC service configurations would be required to meet their goals.

The purpose of this study was to explore with nurse leaders how they were able to contribute to these evolving primary health care collectives and changes that influenced the development of new or reviewed services, in addition to gaining insight into their challenges and opportunities as nurse leaders. The literature suggests a move away from the post heroic model of leadership and refers more frequently to coalitions of experts or leaders as a collective intelligence. These emerging characteristics represent a distributed leadership model that is leadership shared across varying people, professions and roles. It is this distributed model of leadership that provided a conceptual framework and a clear point of reference for this study.

A qualitative approach derived from an interpretive perspective was the methodology chosen for this research. Eight out of nine potential nurse leaders involved in each of the regional health collectives participated in telephone interviews and communicated with the researcher via email networks. Theme identification was the essential task for the analysis process. Four key themes were identified with subthemes: politicization (power to influence), infrastructure (teams and education/training), coalitions of leaders (communication and relationships) and resilience (battling and visibility). The findings suggest on-going challenges to nurses leading in primary health care which include fragmentation among nurses, variable investment in regional nursing infrastructure, interdisciplinary relationship issues and limited training to develop future nurse leaders. Addressing these results requires clinical, strategic and professional nursing leaders to work within fora that are unified, cohesive and collectively agreed on their purpose.

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Chapter 1- Introduction

Introduction

Leadership is widely discussed in the health literature and is crucial to the development of the clinical, strategic and professional capacity of the nursing profession. By harnessing nurses' leadership potential the ability to influence may more readily be applied. Education and training, role development and the rapid growth of nurse clinics provide opportunity for nurses working in primary health care and the potential to influence patient care and service delivery (Alleyne & Jumaa, 2007; Wong & Cummings, 2007). In addition, leadership is reported to facilitate quality care and healthy workplace environments as well as supporting nurse recruitment and retention (McKenna, Keeney & Bradley, 2003; Marriner-Tomey, 2009; Halcomb, Davidson & Patterson, 2008).

Aims

The aims of this study could be seen to be twofold. Firstly this study aims to investigate the consideration given by New Zealand primary health care collectives of the need for quality senior nurse leadership in their organizations, as they develop new service configurations to meet the challenge of 'better, sooner, more convenient' care as per the expressions of interest accepted by the Government in 2009. Secondly to explore nurse leader's contribution to primary health care, to reveal the challenges and opportunities available to them and to provide recommendations on how further development of leadership in this context may be advanced from both professional and interdisciplinary perspectives.

Background

Primary healthcare reforms and the visionary change initiatives inherent within the Alma Ata Declaration (World Health Organisation [WHO], 1978) were reflected in the New Zealand Health Strategy (Minister of Health, 2000) and the subsequent release of the Primary Healthcare Strategy (PHCS) in 2001 (Minister of Health, 2001). The reforms potentially offered nurses and nursing significant opportunity to articulate and influence decision making processes through expert leadership and nursing contribution. The motivation to improve population health and address inequities, poor access to services through community engagement and interdisciplinary approaches to

healthcare were signalled by nursing and at the time viewed as an exciting change in direction. Central messages alluding to this opportunity and nursing involvement in developing a participative primary healthcare team were described in the nursing response document defined by the Primary Healthcare Nursing Expert Advisory group in 2003 (Ministry of Health, 2003). The vision at the time was described as one where integration and seamless care would be provided by primary health care nurses in a variety of settings and community locations. A definition of the primary healthcare nurse clearly demonstrated the breadth of working and the assumption that they were responsible and accountable for their evidence based clinical practice.

Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people, individuals, whānau, communities and populations, to achieve the shared goal of health for all, is central to primary health care nursing. (Ministry of Health, 2003, p.9)

Equal partnerships, collaborative practice, recognition and investment in a skilled and competent nursing workforce and positioning nurses at the heart of leading within the primary health care arena (Mackay, 2002) were repeatedly mapped as key ingredients to success (Minto, 2008). Almost a decade on and the implementation of the primary healthcare strategy has been superseded by the *Better Sooner More Convenient* manifesto (Ministry of Health, 2007) and the Ministerial Review Group Report (MRG) (2009) which provides a strong, clear directive toward clinical leadership. It is this leadership that is described as a key lever to ensuring quality health reforms in New Zealand. In a General Practice Leaders Forum (GPLF) meeting with the Minister of Health to discuss response to the MRG report, nursing leadership was noted to be a crucial component to the integration of services (T. Ryall, personnel communication, November 17, 2009). With the additional coalescence of primary healthcare organizations at this time, the potential opportunity for reframing nursing leadership

within the New Zealand primary health care environment appeared to be appropriate and timely to support the organizational changes envisaged. Reforms in health have been cyclical with each iteration of new Government assuming leadership over the health and disability system and the impact on nursing and the workforce has been significant (Donovan, Diers & Carryer, 2012). Past service reviews, the centralization of funding and the replacement of nurse leaders with managers or service personnel over time, has removed the expertise and insight offered through the skilled and knowledgeable senior nurse (Buchan & North, 2008).

Significance

The development of the nine health collectives and the integration of Primary Healthcare Organizations (PHO), provided a favourable environment for leadership within the New Zealand primary health care environment. The importance of nursing in delivering the *Better Sooner More Convenient (BSMC)* agenda has been emphasized and merged PHOs now have a potentially far greater number of nurses within their General Practices together with those employed by District Health Boards (DHBs) providing community services. These elements would seem to demand a high quality nursing leadership function within the organizations developing BSMC service configurations, however evidence confirming this realization is not apparent. Given the emphasis placed on the contribution nursing will make to the BSMC primary care agenda, and the increasing responsibility for services to be integrated, it is timely and appropriate to explore whether quality leadership at a senior nursing level is required, enabled and importantly, demonstrated to better serve the public's needs via an interdisciplinary approach to population health.

Context

The focus on leadership for this research grew from two premises. Firstly a personal journey into primary health care nursing and working within the area of General Practice. Whilst entering into an area with a wealth of knowledge and experiential awareness from intensive care work both in the United Kingdom and New Zealand, the journey to gain a degree of mastery in this new environment was both steep and challenging. Personal growth, development and subsequent interest in aspects of primary health care nursing leadership were gained by default through positive

interprofessional relationships and informal peer coaching, plus internal motivations to model excellence at work seen in colleagues and nurse leaders at the time. Needless to say this personal journey was ad hoc, unstructured and by chance; personal motivation and a desire to influence patient outcomes through a nursing lens that was based on current and evidence based care and intertwined with medical practices would seem to optimize service delivery. Secondly, despite the rhetoric that supported a call for leadership and nursing leadership to guide, direct, facilitate and steer change, the reality of the situation, the policy directive or clinical setting for nurses despite good evidence of its worth did not always seem to equate at the forum, advisory, or board table. The resultant and rising questions that the researcher contemplated, asked were nurses leading; were they being led, or were they simply on a lead?

Outline of thesis

This first chapter has outlined the background to the study, the significance and context in the current climate of change and reframing of health through calls for integration and delivery of services in the primary health care and community settings. The researcher's interest and early insight into the topic area is additionally noted.

Chapter two reviews the literature on leadership in health and specifically nursing. The literature is explored and examined in relation to definitions, pertinent models and theoretical perspectives. The leadership impact on the competency and capability of nursing is discussed alongside the constraints and opportunities that organizational contexts transpose. The leadership discussion is investigated with new trends and thinking in leadership emerging in the literature which will support the collective intelligence of leaders that may perform within professions or via an interdisciplinary approach. The chapter concludes with a review of global health directives that potentially could influence and effect structure and action to lead, in nursing nationally.

Chapter three describes the research methodology and theoretical underpinnings of this research. A qualitative, interpretive perspective is utilized to gain insight into the participant's experience and to understand the socialization of leadership for these nurses at the current time. Semi-structured telephone interview and email communications were used for the data collection process. A conceptual framework

incorporating a model of distributed leadership serves to situate the context of leading within a framework that befits the health collective environment of collaborative and interdisciplinary working; the opportunity for these leaders to work within this inclusive model approach is highlighted and explored as part of the project design. Project rigour is described and illustrated by using four criteria of credibility, dependability, confirmability and transferability. The general inductive approach to refinement, summarizing, merging and the revelation of themes is described.

Chapters four and five discuss the findings and presents the themes and sub themes that emerged as a result of data collection. Chapter six provides discussion of the key findings in relation to the literature and the conceptual framework, additionally identifying project limitations. Chapter seven proposes future learnings and recommendations, summarising with concluding statements.

Conclusion

The context of health is dynamic and ever-changing, so too is the approach to leading in health, and the significant role that nurses have to play clinically, strategically and professionally. This research has sought to examine the current climate and the perceptions of nurses leading through a period of change in health. The health collectives offer an opportunity to gain insight first-hand into how well nurses have been engaged in the health review processes, to determine if they have been able to contribute and how effective they have been in messaging the philosophical values and core principles that underpin nursing care.

Through sharing the valuable experiences and views of these nurse leaders, with regard to their leadership roles and positioning within the health collectives, a deeper understanding of the opportunities and challenges faced by nurses leading in primary health care are made evident. This research process has identified potential areas of focus for the future development of nurse leaders and the tools required to enable this. Findings will assist nurse leaders in working more collaboratively together to develop strategies for future proofing this key aspect of nursing.

Chapter 2 - Literature Review

Introduction

This chapter explores the literature on leadership in health with specific reference to nursing and primary health care. It was determined that a key focus for the literature was to understand how nurses are currently leading and to gain greater insight into how nurse leaders could potentially have increased influence in the future. The review begins with an exploration of leadership definitions. Leadership characteristics and behaviours along with the links to models and theories are examined, with specific consideration as to how competency and capability expectations for nurses from the perspectives of clinical, strategic and professional leadership, might be considered to be inextricably linked, with one potentially influencing the other. The constraints and opportunities of contexts are reviewed and the challenges faced by nurses when leading in teams will be considered. The consequence of leadership roles and positions in terms of outcomes for the patient, the workforce, professional relationships and nursing are also addressed. Finally a brief review of global health directives and their relevance to nursing leadership are explored.

A search of the literature reveals that there is a significant trend in the leadership discourse toward a revised thinking where individuals with diverse leadership attributes and expertise, whether in clinical practice or strategic ‘boardroom table’ type settings, are seen to integrate their contributions in a spirit of joint decision making. Further, it is noted that leadership is not always seen as a one-off responsibility for the few or the elite, rather it spans the many and requires engagement, adaptability and empathy (Heifetz & Laurie, 2001). This is important to note for nursing and primary health care nurse leaders as the current situation in health is one of change due to the drive for greater integration and a directive from the government to move services closer to home (Ministry of Health, 2008; Ministry of Health, 2010). Despite direct reference in the Ministerial Review Group Report (2009) to a need for greater clinical leadership, Mackay (2009) identified that established and clear leadership nursing systems are poorly profiled and inadequately developed. The challenges to promoting clinical innovation, gaining strategic input and achieving an impact professionally for nurse leaders remain an issue (Carryer, 2004; Murphy, 2009). The literature sourced and

referred to in this chapter spans predominantly New Zealand, United Kingdom, Canada, United States of America and Australia.

Literature Criteria

The literature contains significant information as to the change in thinking concerning leadership capability alongside the many challenges to progressing leadership specific to nursing and the primary health care context. The broad review of the health and nursing leadership literature suggests the need for increased awareness on the part of clinical, strategic and professional nurse leaders and organizations engaged in planning and developing services to ensure that responses are directed towards population health need. Further exploration of ‘grey’ literature (information produced by Government, business, industry or other) uncovered how policy directives have informed nursing leadership and whether nurses have been able to activate or respond amidst the challenges inherent within change and reform.

Journal articles, reports, thesis and commentaries relating to nursing leadership and roles relevant to the area of primary health care nursing since 2000 were searched via university libraries. Material for this review was accessed using the electronic databases, namely Web of Science; Scopus, Medline, Google Scholar; Ebsco host and CINAHL, together with salient documents from the Ministry of Health and New Zealand Government internet websites.

Defining Leadership

A collaborative approach

A useful starting point is to begin to unravel the many definitions of leadership and consider how they could be useful to the nurse leaders of today. Leadership definitions that have been explored in a variety of disciplines including health and nursing, return to the central principles of leadership as a process, incorporating influence, occurring within a group context and being involved in goal achievement towards a united vision (Northouse, 2007; Shaw, 2007; Haycock-Stuart, Baggaley, Kean & Carson, 2010). Davidson, Elliot and Daly (2006, p.182) construct a definition which incorporates these principles suggesting leadership is “a multifaceted process of identifying a goal or target, motivating other people to act, and providing support and motivation to achieve

mutually negotiated goals”. The concept and benefits of mutuality alongside those of influence and change are inherent within this definition. Whilst Cook’s (2001) study of nurses clinically leading suggested that the most influential people in improving patient care are the clinical leaders, Halcomb, Davidson and Patterson (2008) define the role of leadership in nursing as extending beyond clinical skill and knowledge to encompass strategic planning and responsiveness to the policy, fiscal and social responsibilities of health care that can influence service delivery. These authors however, saw leaders as enablers and pivotal in shaping innovation and alternative ways of working by supporting and coaching others, even if they did not possess the position title of leader.

Continuing this theme, the English Department of Health (1996) defined nursing leadership under the umbrella of professionalism, charging the professional leaders with a responsibility to work collaboratively earn respect of their colleagues and respond to change by influencing policy and service needs. Stanley (2006, p.22) also brings together a number of authors work considering the notion of collaboration and concludes with a working definition, “Leadership is seen in terms of unifying people around values and then constructing the social world for others around those values and helping people to get through change”. Taylor (2009) suggests this definition reflects a general overview of leadership incorporating interactive processes of bringing people or followers together, to forge a way through change. Roebuck (2011) comprehensively explored leadership with experienced United Kingdom (UK) health leaders and recommended that a new approach where leadership is a collective activity and an integral part of organisational culture and performance was required. A model of shared or distributed leadership explicated in many of the leadership reviews for the UK health service (The King’s Fund, 2011) build on this notion of collaboratively leading with coalitions of experts.

In Curtis, de Fries and Sherrin’s (2011) exploration of the nursing leadership issue, they suggest there is no one finite definition of leadership, however influencing the attitudes, beliefs and behaviour of teams, followers and others is a notable commonality. In line with this is the frequent reference to defining leadership through ‘followership’, being able to work with and empower others and activating a vision, these are further aligned in the literature to leading in primary health care or community nursing (Baileff, 2000; Bowles & Bowles, 2000; and Jooste, 2004). A leadership definition per se therefore can

be seen as an important determinant of any evolving leadership model and for nursing would therefore need to reflect the philosophical underpinnings of the profession.

Relational leadership

In reviewing Porter O'Grady's (2003a; 2003b) work and comprehensive writings on nursing leadership over a number of years, it is apparent that defining leadership in health is not easy. This appears in part due to the relationship of leadership to health organizations and the recurrent cycles of organizational and policy change that result from service demands and Government directives. He acknowledges the need for leadership consistency and structures for leadership modelling, to enable a leader to respond to the direction of an organization and support the needs of the workforce involved in systems change and restructure. O'Grady (2003b) also suggests that defining leadership and the leader is as complex as the role itself. He suggests that the leader as well as seeing a vision and the direction an organization needs to follow, requires the knowledge to build productive relationships, have insight into their own behavioural and emotional integrity and embrace a skill which re-engages the energy of the followers into any overarching intended goals.

Hanson and Spross (2005) also write comprehensively when defining the relationship of leaders to followers, through shared vision, empowerment strategy such as mentorship, and raising their ability to influence decision making, at a clinical, professional and policy level. Grint and Holt (2011) discuss followership extensively in the UK context and suggest leadership cannot be understood in the absence of followers; the followers also need defining and investment in terms of training, education and direction. They recommend that active engagement of these followers means the leader's relationship is defined by their ability to raise follower capability, responsibility and independence. Additionally they note that the leader-follower relationship is a term that extends to patient and family. The notion of patients as responsible followers is enhanced through reference back to the benefits of collectiveness when defining leadership, with leadership being provided by teams rather than one individual (Grint & Holt, 2011). In reviewing recent leadership trends, Hartley and Benington (2011) also take the focus away from a defined heroic leader to that of leadership practice amongst organizational networks, which favours partnership working and collaborative approaches. Further

attempts to define leadership through relationships are offered by Huber (2006) who supports that leadership is a process of influencing people to accomplish goals. Northouse (2007) concurs with others and again suggests that it is complex, but fundamentally agrees that it is a process involving influence and occurring in a group context to achieve goals. In defining leadership as a process, Kelly (2010) suggest this could be useful for nurses, in that the influence of leading towards goal achievement could be potentially more productive than a traditional power and control approach to leadership over followers.

Other authors report on how the relationship of the leader to the organization should be defined by values and beliefs that align with the organisational intent or vision and sound evidence base (De Groot, 2005). Buchanan, Addicott, Fitzgerald, Ferlie and Baeza (2007) suggest both formal and informal leadership roles can be defined through leadership practices and organizational interventions rather than just behavioural styles or competencies. These are key points for nurses when as leaders the challenge and pressures of change and conflict will require them to be flexible, adhere to their philosophical values, understand emerging priorities and continue to thrive in the dynamic environment.

A need for knowledge

Much of the literature recommends that a wide repertoire of knowledge is required to effectively perform and survive as a leader in these dynamic health environments. In-depth knowledge is considered to be beneficial and proposed by many as a way to achieve and influence goals of quality comprehensive patient care and improved staff satisfaction (Cook, 2001; Mahoney, 2001; Chinn and Kramer, 2008). In Antrobus and Kitson's (1999) research examining the socio-political factors impacting nursing leadership, they found that any nursing knowledge derived from a practice base or from the influence of practice was a key principle to any leadership philosophy. They go on to suggest that nurses tend to operate between domains of nursing leadership. These domains are described as clinical, academic, political, strategic, professional or managerial, and the knowledge and skills that are applied to each domain are drawn upon to enable the leader to influence. Linking to this idea of domains of leadership

influence is the relationship and the use of this knowledge from each domain which determines a nurse's sphere of influence.

Nursing knowledge required for a leadership position is often derived from Carper's (1978) fundamental patterns of knowing and includes, empirical, evidence based, aesthetic, personal, emotional, ethical, socio-political, emancipatory and unknowing knowing. Whilst knowledge and skill defines the competency requirements of the nurse leader, further development of capability to complement these attributes may serve to enhance the work of nurse leader roles (Gardner, Hase, Gardner, Dunn & Carryer, 2008). In Gardner et al's (2008) study, an exploration of the attributes of advanced roles such as the Nurse Practitioner sought to determine how capability could add value to the competent advanced nurse. The concept of capability appeared to link well to a leader's ability to build and sustain tangible relationships, to the application of knowledge in high clinical risk and complex situations and a person's confidence. In addition, adaptability and the personal attributes of self-awareness, self-efficacy or what is commonly referred to by Goleman (1998) as emotional intelligence, is considered critical to the concept of capability. Collective knowledge, 'concertive' action (Gronn, 2002) and organizational collaboration determines an alternative leadership approach which is integral to the practices of an organization, and fits again with the distributed model approach alluded to earlier.

Nurses as leaders in primary health care

Finlayson, Sheridan and Cumming (2009) offer a comprehensive research based review (2001-2007) of primary health care nursing developments in New Zealand and give examples of nurses both informally and formally leading successfully in their clinical roles since the introduction of the Primary Health Care Strategy (Minister of Health, 2001). Whilst this is crucial to the clinical reality, they further note that primary health care nursing leadership in New Zealand remains scattered, fragmented and disabled as no specific structure is uniformly visible. From their review therefore, it could be suggested that early descriptions and definitions of leadership in the literature are potentially redundant. A focus on leadership practices throughout health organizations may require closer attention and serve to highlight workforce potential from within. The impact on leadership definitions and the subsequent development of leadership for

nursing could result in greater clarity, direction of purpose, the facilitation of change and the achievement of organizational health goals.

Further reflection on nursing leadership presents two opposing views through the editorials by Chambers (2002) and Rolfe (2002) when reviewing definitions, leadership discussion and the nurse's engagement in the process of leadership. Chambers (2002) suggests that nurses are not without the opportunity to lead and they need to take up the challenge to turn the rhetoric into reality; essentially she suggests they need to take a lead and just get on with it. Rolfe (2002) interestingly responds to this by suggesting that the agenda that has been set is policy driven and as such nurses are being directed to act, without true consideration of how nursing could actually define and facilitate a leadership agenda themselves. Rolfe (2002) calls into question our response as nurse leaders to policy by using targets as an example; he suggests in reality we have had very little say in setting these targets in the first place but the expectation is that we will and do lead achievement of this work; our compliance is notable rather than our purpose as directors in setting the policy agenda.

In summary, the literature appears to be diverse and complex in its attempt to define leadership. Multiple definitions exist and offer solutions with or without a context. Historically leadership has recognized individuals with key behaviours and competencies. More recently the literature demands expansion of this approach to defining leadership within health. Identifying individuals with leadership potential is not enough due to organizational requirements, complex bureaucracies, multiple stakeholders, working across boundaries and localities. Sharing leadership is now considered essential for excellent health outcomes (Ham, 2008). Mechanisms for nurses to lead with clinical competence plus strategic and professional capability through networks and relationships can be interpreted as an enabler to influencing decision making and could affect the long term development of nursing leadership in the future. Further exploration of competency and capability is reviewed through the literature on leadership characteristics and theory.

Leadership Competency and Capability

Characteristics and styles

Hartley and Benington (2010) suggest that leadership characteristics will vary according to the context or the role an individual holds within an organization, and does not determine the leadership potential of a person. On reviewing the roles of nurse consultant leaders and their characteristics in the UK via an interview process, Woodward, Webb & Prowse (2005), ascertained that academic preparation to the level of Master's qualification supported the knowledge acquisition a nurse leader required; however personal characteristics which included experiential knowledge promoted confidence, determination, motivation and profiling. Buresh and Gordon (2000) have contributed significantly to the discussion around profiling a positive professional identity and insist that high involvement profiling or working across clinical, strategic, professional and inter disciplinary networks, aids and enables the nurse leader to capably challenge, practice, work with change and contribute collaboratively.

Cook (2001) used observation and interview to determine that effective clinical nursing leaders are identified through five key characteristics. These include the ability to highlight or look for new ways to do things; respecting and responding to individual and organizational need; the ability to influence; creativity for self and followers; and adaptability to support others through change both as individuals and organizationally.

This interaction with others and the ability to understand the self was further explore in a study undertaken by Zilembo and Monterosso (2008). They found that these leadership characteristics demonstrated by the nurse leader are crucial when mentoring or preceptoring and need to be adapted to individual situations. Key characteristics were associated with positive interpersonal relationships, mutuality, effective communication skill, compassion and supportiveness. Furthermore they identified that early fostering of leadership behaviour amongst students enhanced students ability to adopt and incorporate these qualities into their developing knowledge and skill sets. This is a crucial element to consider as our workforce ages and succession planning for leadership in the future becomes a priority.

Leaders as effective communicators

All the participants in Stanley's (2006) review of clinical leadership reported effective communication to be a central characteristic which determined a leader's degree of respect from followers. Nurses who listened, explained, and understood a viewpoint were considered leaders even if they were not positioned as such. Similarly, Jansen and Smith (2006) recommend that effective communication translates to care giving, resulting in a patient relationship they described as 'concordant'. An example of concordant communication is when discussion involves the patient feeling heard, where quality care and satisfaction is perceived, and negotiated plans of care are enabled. Conversely a non-concordant relationship is seen to potentiate reduced patient access, poor follow up, misunderstandings and decreased satisfaction (Jansen & Smith 2006).

In an earlier review of entrepreneurial leadership characteristics Ballein (1998) ranked communication as the most important for advanced nursing roles across clinical, academic, political and professional nursing environments. In expanding on the characteristic quality of being a good communicator more recently, Turnbull, James and Ladkin (2008) give further clarity by suggesting a leader needs to be able to understand and determine what kind of message and conversation is required in a specific context and who should be part of the discussion or conversation.

An emerging theme which explores the concept of communication further and emerged from a study reviewing policy and political leadership in New Zealand (Donovan, Diers & Carryer, 2012) was that of 'languaging', particularly in reference to messaging needs and positioning alongside other disciplines, politicians, public and media. The language and methods used to facilitate communication were considered important when seeking to be heard or gain attention in the political arena particularly. Hartley and Fletcher (2008) identify the need for those in health, particularly where multiple stakeholders are involved, to raise their political awareness. Huston (2008) likewise suggests that understanding internal politics within organizations and translating this to the wider political environment can both serve to influence and achieve goals alongside modelling the way for new nurses to manage complex organizational dynamics, and in turn raise capability.

Mentorship and coaching function

In Frankel's (2008) outline of leadership styles and characteristics a core function of nursing leadership is described as being a coach or mentor. Furthermore, structured mentorship is described as the key to the acquisition and mastery of new skills, with mastery giving rise to a skill that is practiced repeatedly in order to achieve perfection. Hughes (2004) suggests terms to describe this leadership function of mentor are interchangeable and include, teacher, supporter, coach, facilitator, assessor, preceptor, role model and supervisor. This leadership characteristic of supporting those less skilful and less knowledgeable, especially in situations of change and innovation was also considered a crucial component to supporting staff development by Nelson, Wright, Connor, Buckley and Cumming (2009). They found on evaluating innovation projects in primary health care, the success related to the nursing leaders with effective communication and relational role modelling skills. Their analysis was significant given that the review was commissioned as a direct response to assessing progress toward achieving the aims of the primary health care strategy (Minister of Health, 2001). In this instance the characteristics of mentorship, advocacy and advice were seen as positive and necessary in crossing the contexts of clinical work, policy decision making, administrative and business procedure. These characteristics were especially useful when nurses were faced with system and resource constraints in contracting environments. Thus, to become effective resource managers, primary health care nurse leaders were seen to benefit from skilled communication ability at all levels of service provision.

In their systematic review of leadership styles Cummings, MacGregor, Davey, Lee, Wong, Lo, Muise and Stafford (2010) suggested that leadership behaviours that focus on relational qualities result in leaders that inspire, coach and motivate followers to achieve, challenge and grow resilience. This is considered important if nurse leaders are to be more responsive to growing workforce shortages, fostering healthy workplace environments and promoting workplace productivity and commitment to quality care.

Styles and flexibility

Goleman (2000, 2004) has written extensively on leadership and lists six styles which he considers useful to deploy when developing strategy to navigate the leadership journey. Again characteristics of flexibility, openness to change and knowledge of self

and self-directed learning in a leader are identified as enabling and will likewise support a person to develop mastery, as defined earlier, in four or more of these styles. Goleman, Boyatzis and McKee (2004) suggest that effective leadership is moreover demonstrated by the ability to be versatile and move from one leadership style to another depending on the situation. For nursing leaders this may be a clinical setting, socially determined situation, political forum or professional gathering for example. The various leadership styles include visionary, coaching, affiliative, democratic, pace setting and commanding. In Goleman's (2004) review, however, his overarching message is to differentiate between what distinguishes a good leader from a great leader. He explains from research involving 200 global companies that the key factor in a quality leader is manifested when a leader can energize or deflate the dynamics between people within organizations through emotion. He refers to a style of resonant leadership as a term that amplifies the emotional impact of leadership, so that connections are positive and followers are inspired to excel. This, as opposed to dissonant leadership whereby people have a sense of being off the mark, they are less optimistic and creativity is quashed. He goes on to acknowledge, as already discussed, that skill and knowledge are crucial leadership ingredients but the mix is not complete without a leader heeding the components of emotional intelligence, namely: self-awareness, self-regulation, motivation, empathy and social skill, as discussed earlier.

An integrated review of emotional intelligence and nurse leadership conducted by Akerjordet and Severinsson (2010) found that the benefits of being mindful as a leader and having an understanding of emotional intelligence will essentially equip the nurse with a richer knowledge of self both personally and professionally. The implications of this for nursing leadership training and professional development are seen by Freshman and Rubino (2004) as more productive in that a leader with emotional intelligence improves organizational relationships and partnerships, alongside their own personal leadership qualities or characteristics. With an emphasis on the style of leadership determined by a characteristic or trait, whether innate or learned, others insist that this perspective does not acknowledge the context (Shaw, 2007).

It appears there is no finite style or characteristic for leadership and it continues to evolve. Cook, Macauley and Coldicott (2004) describe a leadership compass as useful in representing the balance that is required of leaders to factor in clinical, strategic,

political, spiritual and emotional intelligence priorities. Certainly it appears a mix of leadership ingredients is required and supported by Pearson, Laschinger, Poirrit, Jordan, Tucker and Long (2007) in their comprehensive systematic review on nursing leadership and its link to healthy workplace environments.

Models and Theories

Where characteristics and leadership styles can be informed by leadership definition, models and theories may serve to clarify and inform leadership development (Turnball James, 2011), however again the many models require some exploration as these have evolved and changed over time. Likewise the direction of thinking can be seen to be moving away from some of these earlier theoretical bases.

Leaders have variously been reported to have been born or adapted from learned behaviours. The 'Great Man' theory purports that leadership is innate; a person is a born leader with exceptional and unique qualities (Denmark, 1993) and fits the now questionable notion of the leader as a hero and a man, the latter emanating from military literature. Aside from this is the timing of this theory development; as noted by Jogulu and Wood (2006) women were neither factored into this conceptualization nor visible in employment. Leadership research at this time applied only to men, thus the relevance to nursing leadership with a predominantly female workforce might be presumed to be marginal at the very least. Trait theory grew from this early discourse and related to describing a leader as a person with specific ability or inherited traits based on their personal behaviours or characteristics (Grossman & Valiga, 2000).

Taylor (2009) discusses situational – contingency theories which assert that the situation, the leader and the followers are all significant and that different leadership styles are needed for varying situations. Thus again, it is evident that one style is considered by some (Shaw, 2007; Taylor, 2009) to be self-limiting and as such does not appear to encompass all the recommended qualities required to effectively perform as a leader. Additionally the situation, environment and organizational demands are purported by some to have a significant impact on any individual approach to leading (Bolden and Gosling, 2006) giving greater credibility to the notion of leading through a

collective intelligence approach. Vance & Larson (2002) suggest that leadership theory fits into one of two categories, transactional or transformational.

Transactional leadership is described as a structured, task based approach, informed by a process of exchange (Burns, 1978) on the assumption that people are motivated by reward and punishment. A transactional leader has been described by Huber (2006), as focused on the maintenance and management of on-going and routine work; in this descriptor the transactional leader appears to lean more towards a management style whereby the controlling and accomplishment of specific goals and objectives takes priority. Interestingly, views around transactional leadership theory are described by authors such as Alimo-Metcalfe & Alban-Metcalfe (2005) as being based on a formal power and control position where command and control form the basis of this theoretical which they also refer to as a male gendered and hierarchical model. These authors developed a transformational leadership questionnaire and ascertained from a comprehensive review of the literature in the UK National Health System that a new paradigm of leadership needed to focus away from the heroic leader and develop the individual within the organizational context. Further, Hartley and Benington (2011) discuss how formal or legitimate authority engendered in transactional theory often through positional power, can be reliant on instruction rather than influence and does not encompass the benefits of working within a collaborative environment.

Stanley (2006) discusses how transformational leadership grew from an attempt to distinguish between management (associated with transactional leadership) and leadership. Transformational leadership describes leaders as committed, with vision and the ability to empower through a value driven belief in the knowledge of followers (Marriner Tomey, 1993; 2009). In contrast to a transactional theory, the transformational approach discussed earlier and described by Alimo-Metcalfe and Alban-Metcalfe (2005) is one preferred by females, in favour of an interactive style and a shared process which provides encouragement through the enhancement of self-worth. This model of transformational leadership does involve planned actions, an understanding of change and risk taking where the leader acts as a trusted coach and role model. Lett (2002) saw this as relevant and applicable to clinical leadership or any area of nursing. Additionally in an earlier review of leadership, Sofarelli and Brown (1998) determined the empowerment of nurses via this approach to leadership was

important to support persuasive communication and facilitate decision making skills at times of organizational change. Furthermore Wong and Cummings (2007) supported a transformational leadership approach as beneficial to patient outcomes in their systematic review of studies exploring nurse leadership behaviours, styles and practices in relation to patient satisfaction. In a review of transformational leadership qualities however, Stanley (2008), suggested that being visionary does not determine why a leader is followed, rather their values, beliefs and principles lead to the respect and response they receive from followers and this aligns with an alternative model that he sees as more applicable to nursing, that of a congruent leader.

In combining a review of contemporary literature and a study of leadership, Stanley (2008) describes the theory of congruent leadership as aligning with the principle philosophies that underpin nursing inclusive of values such as care, compassion, honesty and integrity. He suggests that power is derived from unifying groups and individual followers around common values and beliefs. Leadership could be demonstrated at any organizational level and was identified through valued exemplifying and role modelling which resulted in influence. Additionally change was seen to result unintentionally when valued practice behaviours were seen, understood and adopted.

Stanley (2008) supports theory as vital to a common understanding of leadership. Hartley and Benington (2011) review the trends in leadership theory and its relationship to the current organizational demands in the UK health system, and suggest the great leader or superhero leader is ill suited to the current climate where a model needs to reflect co-operation and contracting environments. They suggest a cadre of leaders may be required from different organizations to address the needs of the population and offer innovative health solutions. Turnball James (2011) supports this notion and chooses to expand upon the former leadership theories which are inherently based around competency and behaviour. The development of shared leadership models, based on collective or distributed forms of leadership are considered by many to more readily deal with the contemporary organizational challenges with context as an important factor (Huffington, James & Armstrong, 2004). Enabling leadership development through a collective theory such as this is considered to be a challenge in itself, in moving individuals to a new paradigm or philosophy of leading which breaks free from

traditional hierarchical structures; this in itself requires flexibility and the ability to adapt as it can create unexpected emotional uncertainty for all parties involved.

Continuing with this change in thinking, Turnball James and Ladkin (2008) and Hartley and Benington (2011) suggest the capability of a leader can be illustrated through their adaptive skill in responding to a particular context. Adaptive leadership skills draw from work by Heifetz, Gradhow and Linsky (2009), and in the health change environment it is argued requires a mind-set shift of behaviour alongside recognition that emotional challenges will need to be confronted by leaders. The implications for nurses are worth considering in light of the organizational primary health care teams they work within and the change reforms they are expected to contribute to and lead.

Leadership Context and Challenges

The organizational context is discussed as important to leadership or leader development and an influencing factor on leadership form, relationships and the functionality of leadership (Porter & McLaughlin, 2006; Hartley & Benington, 2011; Finlayson & Raymont, 2012). Turnball James (2011) discusses how the UK health care context or organizational culture can potentially affect leadership development initiatives.

In examining the nursing leadership contribution to health service organization, Sorensen, Iedema and Severinsson (2008) clearly identify the challenges nurses face in the extent to which they are able to contribute, strategize and be part of decision making. Leadership context for nursing additionally involves variables of history or tradition, task assignment, personalities, relationships and group dynamics; these are closely aligned with teams, team structure and teamwork (Grumbach and Bodenheimer, 2004).

In New Zealand leadership roles and teams are identified as fundamental to the strategic direction put forward by the government in the Ministerial Review Group Report (MRG), (2009). Similarly, expert clinical, strategic and professional nursing leadership can influence and impact on organizational culture and the performance of a workforce as has been demonstrated through UK nurse consultant roles by Manley (2000) and Abbott (2007).

In a qualitative study of nurse leadership roles in the UK, Abbott (2007) found the roles of nurse consultants are paralleled with medical consultants, but notably not equal. With a focus directly on leading rather than managing a key focus of their leadership function is through networking with a multiplicity of stakeholders via collaboration, partnership and cross boundary working. This idea of boundary spanning brings with it a significant degree of autonomy and expectation that listening and negotiating through diversity is driven by a leadership responsibility that is taken back to nursing teams and interdisciplinary teams. As Abbott (2007) suggested this leadership approach fitted well with the political directive at the time, particularly in primary care and it also appears to resonate with the future direction being considered for New Zealand. However the aligned players in such a process need to invest significantly in ways to steer collaborative working, confront differences and enable partnered decision making if they are to overcome professional as well as organizational boundaries. Professional boundaries signifying the potential change to roles and role development pathways across the workforce as reviewed by Nancarrow and Borthwick (2005).

In Finlayson and Raymont's (2012) recent survey and interview study with primary health care staff, they found that translating teamwork for nurses means it remains hierarchical rather than equitable for the players involved. Leadership and governance within the General Practice environment, for example, resides predominantly with the doctor. In addition the context of the business structure, the employer-employee model plus the limited opportunity to formally be involved in decision making at Primary Healthcare Organisation (PHO) board level reduces real collaborative models of working. In conclusion these authors determined that teamwork in New Zealand General Practice settings was multidisciplinary as opposed to interdisciplinary.

In light of these findings, it is useful to examine the configuration of interdisciplinary teams and how nursing leadership may become more integral to this process. Orchard, Curran and Kabene (2005) define interdisciplinary teams as partnerships in which two or more health professionals collaborate in shared decision making to achieve patient centred goals. Teamwork similarly is seen as "a set of interrelated and flexible cognitions, behaviours and attitudes that are used to achieve desired mutual goals" (Day, Gronn & Salas, 2006, p863). Both authors report that these models of working rely on recognition of individual team member knowledge, and skill plus mutual respect

and trust amongst all the players. Social accountability and the creation of a positive group social identity are furthermore identified by Day, Gronn & Salas (2006) in helping to grow group leadership and to foster belief and resource within a group where goals are achievable. An interdisciplinary approach to collaborative care has been frequently acknowledged as a future imperative to delivering complex health, social care and teamwork, and as a model of delivery has become a key focus in much of the literature (Jansen, 2007)). Despite the rhetoric around the benefits of interdisciplinary working, challenges continue to pervade the literature (McCallin, 2001).

The historical or traditional challenge of the ‘doctor-nurse game’ was described by Stein (1968) over 40 years ago, yet still resonates today when relating it to more current literature. The ‘doctor-nurse game’ as described by Stein (1968) defines the unique and complex relationship between the doctor and the nurse and the assumption that the doctor holds total responsibility over decision making. However, to guide decisions that are made by the doctor, the interaction and communication with the nurse is pivotal in reaching a recommendation; much of which may have been derived from the nurses’ assessment of a situation or knowledge base. Interestingly the doctor-nurse alliance is maintained and reinforced through the belief from both parties that the doctor is presumed, as Stein (1968) suggests, as being omnipotent and omniscient. The issue is the hierarchy that prevails and stymies any possibility of respectful interdisciplinary relationships or nursing leadership that directly influences increased satisfaction to patients and the workforce.

Hewison and Griffiths (2004) highlight that although leadership is a key area for development, equally as important is for organizations, teams and professionals to create conditions which support innovation and change. They go on to describe how this again is not well defined and thus both leaders and organizations can become barriers to progress. In Mckenna, Keeney and Bradley’s (2003) study for example the environmental constraints of the General Practitioner (GP) fund holders and the lack of nurse consultant roles in this instance meant that the GPs were assumed the natural leaders; effectively limiting the potential to progress an interdisciplinary approach to patient care solutions advocated in the UK at this time.

Grumbach and Bodenheimer (2004) report on some of the drawbacks teams and subsequently teamwork, may present. The challenge of professional relationships,

personality and negative roles, along with these medical and nursing stereotypes described above, warrants careful planning, and consideration of a group mix to optimize group dynamics. The trend in the literature towards collective intelligence, leadership through coalitions of experts, negotiated goals and equity at the strategic table (Turnball James, 2011; Davidson, Elliot and Daly, 2006; Hartley and Benington, 2011) aims to bridge the contextual and organizational culture issues. A clear starting point might be for interdisciplinary professionals to acknowledge mutual responsibility for team effort and team results.

Way, Jones and Busing (2000) succinctly define seven elements of responsibility or accountability: coordination, communication, cooperation, assertiveness, autonomy and mutual trust and respect as successful to structured collaborative practice. The barriers to progressing teamwork that is equitable across the professions is not only due to historical or contextual circumstances, it may also include reticence and possibly lack of coaching, training and confidence for and from the nurse (Davies, 2000); plus a lack of understanding of nurse roles and their potential from the patient perspective (Pullon, McKinlay, Stubbe, Todd & Basdenhorst, 2011).

Jansen (2007) reviewed the readiness of health teams in adopting collaborative and team based models of working and highlighted some significant strategies for nursing leadership to consider. A strong nursing identity and professional autonomy needs to be developed through education and training and with specialist roles in primary health care and preparedness for conflict and the ability to work through this to help cultivate positive relationships and communications with medical colleagues. Knowledge and skill level extending to strategic and business planning alongside political decision making was considered crucial by this author if the roles and contributions of nurses to the team environment were to be taken seriously. In addition to this was reference to power and influence within a team. Nurses leading within this area were encouraged to have knowledge about hegemonic practices which could potentially influence a nurse's holistic approach to a caring and compassionate philosophy of practice.

Further work on exploring effective team processes in primary health care are considered by Grumbach and Bodenheimer's (2004) review and favour five characteristics: clear goals with measurable outcomes, clinical and administrative systems, division of labour, training of all team members and effective communication.

Team efficacy relies on transparent planning processes, workable group dynamics and positive professional relationships.

McCallin (2001) identifies in an early review of the literature surrounding interdisciplinary practice that new approaches to working did need consideration as one health professional could not continue to meet the complex and diverse needs of the patient. The ongoing and significant barriers to this way of working is highlighted by this author, such as poor dialogue and a need to change the current discourse; inflexible professional boundaries; and again the organizational approach to leadership within teams.

Freeman, Miller and Ross (2000) explored barriers to teamwork concluding that the directive, reductionist philosophy espoused by medicine in primary health care was based on a hierarchical approach whereby the lead was often taken by virtue of power and status. This was in contrast to the integrative philosophy of the nurse and as a result stifled and inhibited concordant communications between professionals, described earlier. This inequity in partnerships was further highlighted by the Ministry of Health (2003) when reviewing governance and leadership issues for primary health care nurses, in that many nurses were seen to contribute significantly to population health objectives, but not be party to decisions that would define their contribution, the resources they required and their financial contribution to the organisation.

Leadership Consequence

In order to determine how nursing leadership is informed through national and international reports, declarations and strategy documents further exploration is necessary. An understanding of global declarations and policy drivers may serve to identify a future direction for nursing leadership which can impact at a professional, interdisciplinary and organizational level. A review of the wider global health agendas may be useful when attempting to understand policy directives at a local level here in New Zealand. Additionally it is important that nurse leaders understand the international factors that can influence developments at a local level to gain a bigger picture view of the current situation and levers that could enable a change to maximize the potential of nurse leaders into the future.

Mckenna, Keeney and Bradley (2003) explored the perceptions of community nurses, general practitioners, policy makers and members of the public in the United Kingdom on nursing leadership. Whilst there was a consensus among research participants that nursing leadership equates to improved quality care and services; confusion remained as to whether leaders existed. This led to discussion around the current state of nursing leadership in the United Kingdom and the problems faced in identifying potential leaders. The study identified the importance of profiling nursing leadership so that it gains respect amongst community and influential stakeholders, such as politicians. Additionally it recommended the significance of not underestimating how useful nurses working together could be. With both aspects lacking, the authors recommended a shift in thinking was required if good leadership was to gain greater visibility.

Haycock-Stuart, Baggarley, Kean and Carson (2010) reviewed perceptions of leadership in Scotland by community nurses, via qualitative semi structured interview and focus group methods and concluded visibility was paramount in the community field especially when translating clinical leadership issues to the strategic and policy level and back to practice. Thus strong leadership was seen as significant in being able to address the invisibility of community nursing work and to illustrate this in 'real terms' at the strategic or board level. This focus again on the process behind sound primary health care leadership at clinical or practice level would then connect to policy agendas and ultimately would ensure adequate engagement with political health issues that impacted patient outcomes.

With reference to nursing leadership in the primary health care sector in New Zealand (Ministry of Health, 2003) the lack of a visible leadership structure was identified by Carryer (2001) as a barrier to succession planning for primary healthcare nurses. Reiterated also was the lack of a defined career pathway and the repeated restructuring in health which contributed to limiting opportunities for leadership development. The emerging role of the nurse practitioner was seen to offer hope to primary health care nurses as role models of the future with the potential to model expert leadership qualities.

Halcomb, Davidson and Patterson (2008) provide a commentary on Australian general practice nursing and identify multi-factorial reasons for the invisibility of this nursing

role in leadership and management. They see the acceleration of clinical leaders as fundamental to the advancement of the status of the nursing profession. However, in the general practice environment the facilitation of leadership development is not addressed. Of note the authors suggest the image of the practice nurse role requires direction in the form of a dedicated career pathway, additionally recommended as crucial by the professional body, the Australian Practice Nurses Association (Australian Practice Nurse Association, 2008). In this way a career pathway is seen both in terms of a workforce development framework and a way to address nursing shortages through succession planning by attracting new nurses into these roles.

Carrier, Gardner, Dunn and Gardner (2007), took a Trans-Tasman approach to examining the core role of the nurse practitioner (NP). Interviews with 15 NP revealed three components: dynamic practice, professional efficacy and clinical leadership. Clinical leading was indicative of a knowledge driven, evidence based approach to care delivery which again extended to informing and guiding local and national health policy. Interestingly this mirrors recommendations made by Antrobus and Kitson's (1998) work to utilize clinical leadership as a vehicle to impact both policy and practice.

Recurring themes in the international literature espouse strong clinical leadership as a benchmark for informing policy; supportive structures to nurture and grow new leadership and a career pathway to offer a frame of reference and enticement to nurses working or contemplating work within primary health care. Additionally, lone voices will not offer the strength and influence that will support primary health care nurses to present a powerful political position rather a visible, collective and unified standpoint is required.

It is interesting to note if international directives and movements have impacted on the practice and policy of nursing leadership and likewise the development of leadership in any way here in New Zealand. Furthermore it is worth considering how nurse leaders may appropriate international policy changes and use these as a frame of reference in order to inspire, generate, disseminate and activate future developments in nursing leadership.

In 1948, the World Health Organization (WHO) was established as the United Nations specialist agency for health (Al Gasseer & Persaud, 2003). Priority and policy directions are reviewed annually at the World Health Assembly (WHA) which comprises the WHO governing body made up of member states. This is important for nursing in that those resolutions, declarations and directives impacting at a global level have clear potential to resonate through to any national nursing workforce contribution and delivery of services in order to meet health need, and targeted outcomes.

One such seminal declaration is the 1978 Alma Ata declaration on Primary Health Care (WHO, 1978). Hanson, Van Damme, Van Dormael, Van der Roost and Songane (2009) suggest the declaration put the need for people orientated care on the international agenda for the first time. Bhatia and Rifkin (2010) concur suggesting that the comprehensive essence of the declaration shifted the focus of health improvements from mere provision of services to the wider context of health, social and economic development. In a critical review of primary care initiatives this declaration was described as a pivotal and visionary document by Kruk, Porignon, Rockers and Van Lerberghe, (2010). The challenges such as communicable disease, abject poverty and global inequality were significant universally, however the focus back to the principles inherent within this declaration are aspects nurse leaders need to consider and work with at an interdisciplinary level, if change and a shift in services is to result.

Early WHO recognition of the dynamic health climate and the need for international unity to achieve goals resulted in the development in 1987 of WHO Collaborating Centre's. Of the 1000 Collaborating Centre's worldwide representing all the major health disciplines, 36 in 19 different countries are dedicated to nursing and midwifery services, education, research and policy. Carty (2005) suggests for nursing the communications, and project work undertaken by these centres has impacted positively on the health of people throughout the world and illustrated the wide sphere of influence an international nursing leadership network such as this can have.

One of the key areas of work this nursing network was involved in alongside the International Council of Nurses, WHO leaders, partners and other specialized international professional nursing organizations was in 2001 when the strategic directions for nursing and midwifery services were outlined and passed by the World

Health Assembly as a resolution (Al-Gasseer & Persaud, 2003). A concern for the state of nursing and midwifery services around the world was identified and thus five key areas for action were identified. These included:

1. Health and human resource planning.
2. Management of health personnel.
3. Evidence based practice.
4. Education.
5. Stewardship and regulation.

The strategic directions yielded a plan or blueprint for nursing and midwifery leaders to obtain data around workforce issues, skill mix, education, and quality, organize and demonstrate evidence based outcomes at a local level to influence and support policy decisions at a national level. From a wider global perspective the strategic directions were seen to contribute to meeting both millennium development goals and priority goals of the WHO (WHO, 2002).

The eight international Millennium Development Goals (MDGs) developed in 2000 (United Nations, 2006) comprised a united partnership approach to eradicate extreme poverty, reduce child mortality rates and fight disease epidemics. The MDGs were intended to be broad and therefore not country specific. The World Health Report (2008) and the Report of the Commission on the Social Determinants of Health from WHO (2008) have brought primary health care vision into the present international world of healthcare. Globalization, the acceleration of technology communications and the enduring gap between rich and poor coupled with a need to consider multiple intervention rather than single interventions to care focus the challenges for primary health care today. Bhatia and Rifkin (2010) recommend three useful focus points to addressing these challenges within these 2008 documents and they include:

Consensus: (this meant partnerships, teams, collaboration and understanding the primary health care versus primary care dichotomy). Primary health care as a comprehensive approach to care incorporates equity and community participation plus the wider determinants of health whereas primary care is selective and reactive to need as it arises. This challenge to meet the underlying social, economic, and political causes of poor health was a central tenet to the social determinants of health commission titled closing the gap in a generation.

Equity: with market oriented reforms, the poor risk further neglect and the demands for efficiency at the cost of equity will only determine short term gains.

Community participation: a key principle of primary health care is focused towards community empowerment within the reports. These timely reports are notable in the call by WHO to governments worldwide to adapt services to people's needs and changing epidemiological patterns (Hanson et al, 2009). Universal coverage, people centred service delivery, public health policies and leadership at all levels is acknowledged, valued and recommended to take primary health care forward.

One further international document of note to primary health care and leadership is the Chiang Mai Declaration (2008). Again this declaration acknowledged continued worldwide health inequalities. With over 700 multidisciplinary health and allied health delegates from 33 countries endorsing this document at a conference dedicated to new frontiers in primary health care. Of significance is the emphasis towards nursing leadership. Three specific areas for nursing leadership were highlighted:

1. Successful leadership by nurses and midwives of primary health care teams was recognized as essential to achieving MDGs.
2. Primary health care policy decisions, at all levels, must involve nursing and midwifery leaders for effective and informed decision making.
3. Primary health care policy frameworks must explicitly recognize and include nurses and midwives as critical policy leaders in decision making.

Review of some salient international declarations and reports gives evidence of congruent concern internationally of inequality needs and a demand for health outcomes to be serviced from the appropriate philosophy to meet the holistic needs of individuals. The importance placed on nursing and nurses leading appear to be integral to positive outcomes, alongside collaboration and consensus. Activation of declarations and resolutions nationally will depend on an explicit understanding of these benchmark references and the conversion of rhetoric to reality both at a practical and policy level by New Zealand nurse leaders and their interdisciplinary partners.

Conclusion

The research aimed to explore the current positioning and potential of nurse leaders to influence strategic developments in the current primary health care environment. The literature reviewed examines the many available definitions, characteristics, styles and theories of leadership. The evidence suggests that the importance of leadership extends from the clinical, to strategic, political and professional levels. Individual nurse leader attributes remain important when defining leadership and characterizing the term; however the demands to lead are far reaching. The clinical expertise of a nurse leader serves as one vehicle for change and so too does the political aptitude and stakeholder engagement with other professionals that a nurse leader can demonstrate.

Studies explored reveal the many on-going interdisciplinary and organizational challenges to leading faced by nurses. The need for education and training investment required in New Zealand to support nurse leaders is highlighted through review of the literature and the more recent trend towards leading via a collective intelligence is noted. This in itself presents new challenges for nurse leaders within the current environment of political change, on-going interprofessional barriers and recurrent health reforms.

The importance and utility of this study lies in the knowledge gained from those nurse leaders positioned within the new health collectives and currently tasked with moving services closer to home, through leadership and interdisciplinary working. Whilst the policy directive demands a response that is regarded as permissive, the on-going historical, positional and professional chances and challenges confronting nurses at this time need to be identified so that the profile and visibility of nurse leaders is ascertained and comprehensively understood. This information may then be used to develop a pathway for the continued growth of new nurse leaders.

The following chapter describes the study methodology used to explore nursing leadership within the health collectives and amongst the participating senior nurses.

Chapter 3 - Research Design

Introduction

This chapter focuses on the methodology and theoretical underpinnings of the research. The methods used for this research are also described. A qualitative research design using semi structured telephone interviews with email communication was chosen for the study and data was analyzed through a process of thematic analysis. The ethical issues are addressed and the process to ensure rigour will be explained.

The aim of this research is to explore nursing leadership in primary health care. To examine this more closely senior nurses within the nine health collectives currently contributing to the Government's initiative to deliver a more personalized primary health care system were interviewed. By using a 'post heroic' or distributed model of leadership as a conceptual framework for this research the involvement and influence of those senior nurse leaders was examined. Senior nurse representation, the ability of the nurses to contribute and be heard and the challenges for these experienced senior nurses leading within the changing environment was explored. This research is specific to the context within which it is set and is therefore not generalisable. Themes that emerged, however provided the basis for thematic analysis from which reasoning resulted. Reasoning is described as processing and organizing knowledge for application to certain situations to reach a conclusion (Burns & Groves, 1987). Thus this study has served to add to the body of knowledge surrounding nursing leadership within primary health care in New Zealand. In addition, it has provided insight into how well senior nurses are represented within the nine health collectives, their contribution and the challenges of leading within this changing primary health care environment.

Conceptual Framework

Leadership quality and behaviour can have a positive impact on change (Caldwell, Chatman, O'Reilly, Ormiston & Lapiz, 2008). The opportunity for change has been identified by the nine successful 'Better Sooner More Convenient' (BSMC) health collectives. Improved coordination of services, transition of services to primary health care and the integration of services across organizations and professional groups signals a significant challenge for each of these health collectives. Specifically the key challenge surrounds the model of leadership of change utilized to plan and activate

these new service requirements. The importance of nursing's contribution cannot be underestimated in delivering the BSMC agenda and the rapid integration of Primary Healthcare Organizations (PHOs) demands a significant nursing contribution to inform new and developing health service configurations.

Chreim, Williams, Janz and Dastmalchian (2010) highlighted the importance of leadership and agency to enable change in complex and dynamic health care environments such as primary health care. They proposed a model of Distributed or Collective Leadership, whereby a coalition of leaders or agents each plays a lead role by pooling their resources and abilities to bring about change. This, as opposed to a single stand alone leadership model reliant on one individual leader's flair or charisma, is considered by Gronn (2002) as more likely to be successful in bringing about change. This is due to the multiple interests of different stakeholders or professionals who are involved and the requirement for all to contribute in a collaborative fashion. In this way they can complement one another and provide skill and resources that support productive change.

With emphasis within the literature on the benefits of interdisciplinary approaches to care and multi-professional working (Ministry of Health, 2010) and an international trend towards identification of leadership at all levels, this approach to examining the nursing position within the evolving organizations will provide a conceptual framework to inform and guide collection of data and offer a reference point for the findings that emerge. Further evidence of this model in action is provided by Turnball James (2011) and is referred to as a 'post heroic' model of leadership. The post heroic model makes explicit the idea of distributed leadership.

According to Chriem et al (2010) the notion of distributed leadership relates well to organizational change processes and as such suits a conceptual model framework to inform this research. Three specific factors on which a distributed leadership or post heroic model focuses, are taken from Turnball James (2011) paper commissioned by The King's Fund to inform Leadership and Management in the UK National Health Service. These three are:

1. Leadership that involves multiple actors who take up leadership roles both informally and formally and importantly share leadership collaboratively across

organizational or professional boundaries; it is not therefore about having more leaders numerically rather emphasis is on the richness of collective working.

2. Leadership can be distributed away from the top of the organization, and this distribution takes the form of new practices and innovations.
3. Leadership is integral to the practices of the organization not just based on behavioural style or competencies; the focus is on organizational relations, connectedness, intervention and change that relates to organizational practices and processes.

The impact of this approach to leadership for nurses in primary health care is that leadership attributes alone will not be enough to result in desired outcomes within the context of organizational change. Additionally the collective intelligence that is embedded in the culture of a group or organization will support the challenges that any change initiative requires; and finally the shared environment supports the notion that leadership is relational (Uhl-Bien, 2006). Organizations that support collaboration and people working together to activate new initiatives will likewise focus on roles, relationships and practices within an organization. The health context, the growing service demands due to an ageing population, requires conversations, understanding and learning with professionals who share the same context. Thus collaboration rather than competition becomes the premise for ensuring all the relevant information is obtained and sufficiently supports any decision making.

Methodology

The underlying theoretical approach of this research is derived from an interpretive perspective. The goals of interpretive research are to become part of another's world and to find out the practical wisdom, possibilities and understandings found there (Polit & Beck, 2008). The human experience is therefore, seen as a process of interpretation around meaning and actions, with participants or observers having their own social reality (Benner, 1994; Schwandt, 2000; Woods & Trexler, 2001). Therefore the social reality for one is not necessarily the same as for another and again this will differ from one situation to another. This is particularly useful to this project as potentially the situations experienced within each health collective will be different and individualized to circumstance and regional or contextual need and demand.

In addition, the meaning attributed to each situation will be dependent on those interviewed, their values, beliefs and the interactions they experience and have experienced in the past. This provides the researcher with an understanding of each individual's perceptions and reasons for certain behaviours and actions (Polit & Beck, 2008). Interpretive research generally relies on interviews with individuals who have experienced the phenomenon of interest, and some research understanding may be augmented by supplementary materials.

Qualitative research in general uses an emergent design (Polit & Beck, 2008). This is a design that emerges as the researcher makes ongoing decisions after reflecting on what has been learned. This process relies on discovery based on the realities and viewpoints of those taking part in a project. The focus is therefore, on understanding the subjective experiences of participants through language and expression of thoughts, feelings and experiences (Andrews, Sullivan & Minichiello, 2004).

It is hoped that by exploring with senior nurse leaders their experiences, they will provide rich responses and meaningful descriptions to add to the body of knowledge related to primary health care nursing leadership. Mays and Pope, (2000), add that by gaining insight into the participants worlds and identifying key areas, which might be both positive and challenging, research can further contribute, in this case, to the development of nursing leadership models in primary health care. They go on to suggest that the philosophy of qualitative researchers should be one of subtle realism, in that they are attempting to represent a reality rather than attain the truth. Therefore the views expressed by participants will depict their standing as a nurse leader and also their relationship within the health collective environment, both from a professional and an organizational perspective.

Ethical Issues

For this study, ethical approval was sought and granted via an expedited ethical review process with the Northern X Ethics Committee due to the minimal risk nature of the project (Appendix A). However, protection of the participants from harm remained an important factor. The maintenance of participant confidentiality was considered

essential so they were unidentifiable and importantly given the free decision and choice to participate, without judgment and at their own discretion. Polit and Beck (2008) cite three major ethical principles from the Belmont Report. The Belmont Report is a report utilised by the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1978). It is commonly used for ethics and health care research and it ensures the protection of participants in clinical trials and research studies. The three ethical principles to use with any human subjects in relation to research include beneficence, respect for human dignity and justice. Beneficence involves the desire to do good and protect the participants. The freedom to choose and maintain human dignity is a participant right which ensures self determination and voluntary involvement. Justice focuses on the fair treatment and privacy of participants.

Informed consent as a fundamental and ethical requirement, ensured participants had received an explanation of the project and gained the opportunity to raise and have answered questions related to any part of the research. They were asked to complete a written consent form if they were willing to take part in the project; this confirmed that they had made a considered decision to participate (Appendix B). Further informed consent was required for permission to audiotape the interview conversations. These would only be accessible to the researcher and the transcriber who had signed a confidentiality agreement (Appendix C). Participants were also assured that all procedures would be followed to carefully store all project materials within an information technology password protected format and a locked cabinet.

Email and telephone interview methods were used to obtain data. Participant's rights, including issues of confidentiality were clearly identified in all related communications by way of an information sheet (Appendix D). These will be discussed in more detail later. Aligned with this was assurance that no one nurse or their place of work would be identified in any future use of the information such as publication.

Māori were not specifically targeted for this research project, however, it is acknowledged that the method of recruiting participants through the nine health collectives would mean that some of the health collectives may have a specific Māori focus. It was possible that Māori nurse leaders may therefore be part of this project. In

this case participants were asked if any cultural issues needed attention. Te Tiriti o Waitangi and the four principles of participation, protection, partnership and self determination were acknowledged as integral to progressing this project; with particular reference to self determination as mentioned earlier in the context of the Belmont Report. Additionally a working knowledge of the Te Whare Tapa Wha model was considered to be useful and beneficial when working with Māori as it is respected as both a holistic approach to their needs and encompasses the reality of their world and their thinking.

Data Collection Methods

Participants

Patton (2002) identifies several strategies to determine the most appropriate sample to be used for a research project. Participant selection for qualitative researchers hinges on the ability to gain information rich cases to enable a deep and meaningful understanding of the topic under exploration. A purposeful sample using a homogenous sampling strategy to keep the focus of the inquiry centered on nurse leaders was the method used for this research. Burns and Grove (2001) support purposeful sampling which allows the researcher to consciously select typical participants for this particular study. Polit and Beck (2008) similarly suggest that homogenous sampling supports the understanding of a specific group of people.

In terms of the criteria for participant inclusion, the focus, is particular to nurse leaders represented on one of the nine health collectives. Thus selection is focused on the nurse as a leader situated in the appropriate setting at a time of political reorganization. The perceived benefit of sampling in this way as Minichiello et al, (2004) suggests is to explore each nurse leader's experience through the telephone interview process and gain insight into the similarities and diversities that exist across a homogenous group.

Once identified each nurse leader was contacted via email initially and invited to participate in a telephone interview. They were provided with an explanatory information sheet, giving a description of the project, the procedure and participant involvement, plus the time and commitment to the project that was involved. Attached

to the email was also a consent form, which they were asked to complete, sign and either scan and email or post back to the researcher. On receipt of the completed consent and acknowledgement from the participant, the researcher sent out a further e-mail confirming project involvement and incorporating some topics to guide the participant in the telephone interview (Appendix E). The telephone interview was scheduled at a mutually convenient time and recorded. It was assumed that all nine nurse leaders would have access to both email and telephone capability, so this did not hinder their ability to take part in the study.

Out of the nine nurse leaders approached all nine consented to telephone interviews, however one participant later declined to be interviewed due to the disestablishment of her position. The researcher carried out the telephone interviews at varying times to accommodate the participant need, this ranged from early morning to late at night, which highlights the importance of gauging a suitable time in terms of the nurse leader workloads and day-to-day busy scheduling. This approach to generating data was certainly enabling for both parties, in that geographical location and diversity was not an issue. It enabled discussion and connections to support the interview process and good communications were established in a relatively short period of time (Kralik, Price, Warren & Koch, 2006).

Email and telephone interviews

It is useful to explore how email and telephone interview methods of data collection were found to be useful for this project. Likewise their utility with this particular group of participants working in a rapidly changing environment. In this way email and telephone interview methods may be considered helpful and valid for further project work.

Carr and Worth (2001) discuss the increased use of the telephone as a method for interviews in research. They believe that this reflects general social change and technological advancements with currently, over ninety per cent of households having access to a phone. Added to this is the fact that mobile phones and the ability to access email via mobile phone technology creates the opportunity for personal and business communication at any time of day. The use of email prior to the telephone interview allowed the researcher to arrange interview times for each participant, remain available

and connected to each participant and to supply some pre preparation for the telephone interview in the form of the topic guide. For each participant there was a clear channel by which researcher communication and interaction could be enabled. With regard to the topic guide, this provided consistency for the proposed telephone interview format and it was hoped that the researcher would additionally be able to understand individual experiences, differences and commonalities to inform the project aims, despite using a generic topic guide.

In terms of research, Carr and Worth (2001) suggest that telephone interviews involve a process of gathering data whereby interpersonal communication is enabled without a face to face meeting. Earlier in 1983, Frey identified that telephone interviews, as a sequential event involved processes of interaction without visual cues. The use of telephone interviews is well supported in the literature (Barriball, Christian, While & Bergen, 1996; Law, 1997) as a cost effective and flexible method of data collection. An advantage of telephone interviews for this research project was the access it provided where there is a wide geographical spread of respondents which would have precluded face to face interviews. Carr and Worth (2001) report from a review of comparable studies of telephone interviewing and face to face data collection, that quality is not affected. Additionally the strength of telephone interviews is as comparable to face to face interviews where there is a high response rate and an understanding is reached between participant and researcher during the interview process so that communications are agreed and understood during conversation by both parties. Marcus and Crane (1986) consider safety issues and interviewer security, reduction of interviewer bias effects and a lower tendency for socially desirable responses as more important for some researchers than face to face interview techniques. Furthermore the prevention of the need to travel, the speed of data collection and cost effectiveness are considered major benefits to data collection. This mixed mode of collecting data and these factors fitted well with the busy participants involved in this research and their diverse localities.

The topic guide used for the telephone interviews provided a staged or loosely sequenced approach to questioning. Broad questions around the participants position and role moved to more narrow ones, namely nurse leader qualities, teamworking,

challenges and possible experiences or opportunities. Moving from general to specific discussion is recommended by Burns and Groves (2001). In particular when initiating the questioning around the nurse leaders' role and position the conversation needed to be brought back to the topic guide to ensure the follow on areas for discussion were not forgotten at the expense of a full history of the participants nursing to date. Further questioning techniques used to support good telephone interview communications, included clear paraphrasing of a segment of discussion, which enabled an understanding of the points raised to be checked and in some instances summarised, to minimise any misunderstandings and to note the end of one area of discussion and link in to the next stage. Likewise this gave participants opportunity to confirm the summary was accurate and representative of their key discussion points. Additionally they could contribute or add further detailing at this time if they determined this as appropriate thus ensuring a process of error reduction was incorporated into the interpretation of data obtained (Mays & Pope, 2000).

Reported drawbacks of telephone interviewing noted are potential for lower response rates, need for short interview duration, absence of visual and non-verbal cues and the possibility for limited telephone coverage in some areas (Novick, 2008). Although eight out of the nine interviews were completed it was felt that the email connection to participants followed by the telephone interview was a very applicable, user friendly and participant specific way of gaining data. The versatility of the telephone interview as a data collection tool is observed by Carr and Worth (2001) and as such this method proved effective in meeting the needs of the senior nurses interviewed who were easily engaged through email and responsive to booking time out in their schedules to follow through with the telephone interview. One participant had a personal assistant who organised the time for telephone interview and one other needed to organise a private room to ensure privacy. A late night telephone interview suited another participant best and certainly in terms of face to face interviewing this time would have been very difficult for the researcher. Hence the telephone interview proved to be enabling with participant and researcher needs and circumstances catered for via this methodology.

All participants had no issues with telephone coverage, and the duration of the telephone interviews was estimated as being between forty five minutes and sixty

minutes to allow participants to block out this time; this timeframe was honoured which alleviated any possible distraction or loss of focus from the topics under discussion. Conversations flowed well with no lack of discussion noted. The researcher was cognizant of the tone and accent of participant's voice and how this could potentially impact on the interaction. Finally of note, the occasional silence was experienced during the telephone interview. Mann and Stewart (2003) refer to this as 'non response in a virtual venue' and Novik (2008) suggested this can be more difficult to interpret in a telephone interview as a potential moment of discomfort, anger or simply a 'thoughtful pause'. Despite the researcher's relative inexperience it was not felt in these instances that the moment of quiet was anything more than a 'thoughtful pause' or if the phone connection had been lost at one point; by asking, 'are you still there' with the response, 'Yes, I was just thinking' which confirmed the reason behind the period of quiet and reassuring the researcher that this indeed was a 'thoughtful pause'.

Participants were offered the chance to come back to the researcher via email if they had any further input and also asked if they would mind follow up on any areas if the researcher required this at a later date. Telephone interviews were recorded and transcribed verbatim in a timely fashion. Recordings were rerun by the researcher to ensure understanding of each telephone interview was checked through listening and reflection.

Rigour

The need to evaluate quality within qualitative research is essential. The use of the term rigour is frequently debated, however, due to its association with quantitative designs and precise adherence to objective and generalizable findings (Polit, Beck & Hungler, 2001; Polit & Beck, 2008). Burns and Groves (2001) suggest that rigour represents striving for excellence, with detail and accuracy as important markers of a disciplined approach to research. In an attempt to ensure rigour and a valid and reliable study, the attention to detail and true representation of participant input was considered a critical component to this project.

Polit and Beck (2008) note that good qualitative work is both descriptively robust and interpretively rich and innovative. Rigour with qualitative work therefore, needs to be

demonstrated through a searching process of investigation which keeps at its core the true nature of events for the participants which is expressed in their language and acknowledges their circumstance. Lincoln and Guba (1985) recommend four criteria to illustrate this trustworthiness: credibility, dependability, confirmability and transferability.

Credibility refers to confidence in the truth of the data collected and how this has been interpreted (Polit & Beck, 2008). In this project care was taken to ensure the topic guide led into questions used in the telephone interview process which were open or free questions in contrast to closed or fixed ones (Hargie, 1991). This approach enabled participants to voice their own ideas in their own words, in order to minimize constrained responses. Similarly researcher bias could be mitigated by questions that generated discussion. Therefore the researcher had a responsibility to be cognizant of the questioning approach taken, to ensure this did not influence a response adversely. Polit and Beck (2008) talk of self correcting as a form of reflexivity. This is suggested by Mays and Pope (2000) as a way for researchers to remain sensitive to any possible bias, by continually verifying the accuracy of the information heard by checking at each step of the analysis.

Dependability relates to the reliability of data over time, and has to coexist alongside credibility (Lincoln & Guba, 1985). Mays and Pope (2000) expand on this criteria and suggest that to ensure the findings can be repeated with the same or similar participants in like conditions or settings, sufficient detail related to implementation is required. The process of reasoning, as described earlier, was ongoing and preliminary data analysis was augmented by a researcher diary used to record detail and factors that might affect the way senior nurses acted or interacted within a given situation or context. Summaries of each transcript were tabulated to include the headings, keywords or phrases, concepts and emerging themes, an approach supported by Minichiello, Sullivan, Greenwood and Axford (2004). By detailing and grouping together commonalities amongst all the transcripts a bigger picture of rich information gained was made evident. Braun and Clarke (2006) suggest this process of grouping with coded meaning supports a thematic process. They see this approach as useful in bringing together the information contained within the data, and also useful to identify distinct data differences to the themes that

begin to emerge. A systematic and consistent approach to the research process helped the researcher to organize the data in a manageable way to ensure quality information was not lost. Ongoing discussion with the researcher's supervisor to review this process supported a method of checking the direction the data analysis took, and contributed towards the stability and reliability of the data in this instance.

Confirmability is achieved through the participant's voice being truly represented, rather than that of the researcher. Face validity is a process whereby the researcher's interpretation is checked against that of the participants (Grbich, 1991). In this research, by revisiting the original topic guide question prior to moving on to the next question confirmation that the participants response had been clearly heard and covered in relation to the topic was achieved. Mirroring communication techniques were also used to ensure an area under discussion was fully understood (Egan, 1994) and captured accurately.

Transferability is an important aspect of rigour in determining to what extent the research can be taken to an alternative setting. A consistent and systematic process to this research was taken, an approach that could be used in other qualitative research work. The organization and processing of information in this way, ensured detailed descriptions could be made of the data obtained. Again this method could be utilized for other project work. The use of a conceptual framework additionally offers a point of reference for future exploration of leadership within any healthcare setting.

Data Analysis

Thomas, (2003) describes a general inductive approach for qualitative analysis which is straightforward and logical. Key aspects of this approach may be seen to include:

1. Refinement of raw data into a manageable format or summary.
2. To connect this emerging summary with the original research objectives.
3. To enable a renewed understanding of the subject matter via emerging themes to produce theory around the experiences gained from the raw data.

For the researcher, this matched the intent of the project which was to seek a richer understanding of the topic area and to find meaning which could add to the current

knowledge around nursing leadership in primary health care. Theme identification was the essential task assigned to the analysis process. This approach is ideally expected to report between three and eight key categories and offers a convenient and effective route to analysis that is widely used (Braun & Clarke, 2006).

The analysis process therefore started during the interviews, observations were journalled during the interview process, and key points of interest were marked on the recording device as conversations took place. This was useful to reflect on after each interview when listening back over the recordings; the tone of the participants voice, the expression in voice, the presence of emphasis, expression or thoughtful pause, (as described earlier) helped the researcher to gain greater insight into the strength in feeling of a certain point, its importance or not and the potential for impact. The journalling taken during each telephone interview, was revisited briefly after each interview had been completed, to mark early key points and impressions. This was additionally useful in relating the data back to the conceptual framework, both in terms of the impact on these individual leaders and their current organizational position.

The transcribing commenced after approximately two weeks and the completion of six interviews, whilst the further two participant interview schedules were completed. Transcripts were read and recordings reviewed again to refamiliarize the researcher with the discussions and to enable some organization of the material into categories in order to start identifying areas of repetition or patterns which would inform emerging themes. Minichiello et al. (2004) suggest the central purpose of thematic analysis is to identify themes raised through the interview process and find ways to clearly communicate data effectively. Each participant transcript was given a random number to ensure identification was nameless and abstract; the numbering range was between 49 and 63. Initial organization of the raw material gained followed. This took the form of categorising all of the eight transcripts under the areas of;

1. Keywords or phrases
2. Concepts
3. Emerging themes

Each descriptive label (above) supported the redistribution of data via an iterative process for each participant transcript. Detail was drawn from each transcript and slotted in to one of the descriptive labels. Transcript detail was colour coded so that the researcher could recall the specific source of the newly categorised content. Ryan and Bernard (2003) recommends pawing through texts and marking them with highlighters as a good starting point to find patterns in qualitative data. From this initial stage of organisation, categories began to emerge from the data, which then needed further examination and refinement.

Refinement and the merging of themes was developed as transcripts were read and re read. Additional to this was the recognition of word repetition or keywords and concepts which helped the researcher identify early themes. Ryan and Bernard (2003) suggest by simply looking at the words that frequently occur, understanding is gained and an indication that these words are important to the participant. The potential meaning and relationships between themes were written down and diagrammatically drawn to propose possible linkages. The data was revisited to ensure all possible theme variations had been deliberated upon. This approach to searching for relationships among data is described by Ryan and Bernard (2003) as connectors can serve as a quick way to identify themes.

The frequency of word repetition and the relationships identified between words and concepts helped when merging categories. An initial nineteen categories were identified and refined through the recognition of overlap and similarity of meaning. Consideration of the conceptual framework during the process of analysis, additionally provided a reference and reminder to the researcher, and gave some meaning to the many emerging themes. Whilst the process of breaking down themes or collapsing them through repeated revision was difficult, it was found that four broad themes with sub themes emerged. The complex nature of nurse leadership revealed that although individual experiences and organizational practices are important as the conceptual framework suggests; intraprofessional (between nurses) and interprofessional (between other colleagues) and organizational boundaries alongside working in a truly interdisciplinary manner have a significant impact on the four identified themes and their sub themes.

The four main themes are identified in bold with bulleted sub themes:

Politicization (this refers to the participation in political discussion or activity and political confidence)

- Power to influence (positional power and alignment to power/ powerlessness)

Infrastructure (this refers to the resource and foundations for nursing specifically, within health organizations or entities)

- Teams
- Education and training

Coalitions of leaders

- Communication
- Relationships

Resilience

- Battling
- Visibility

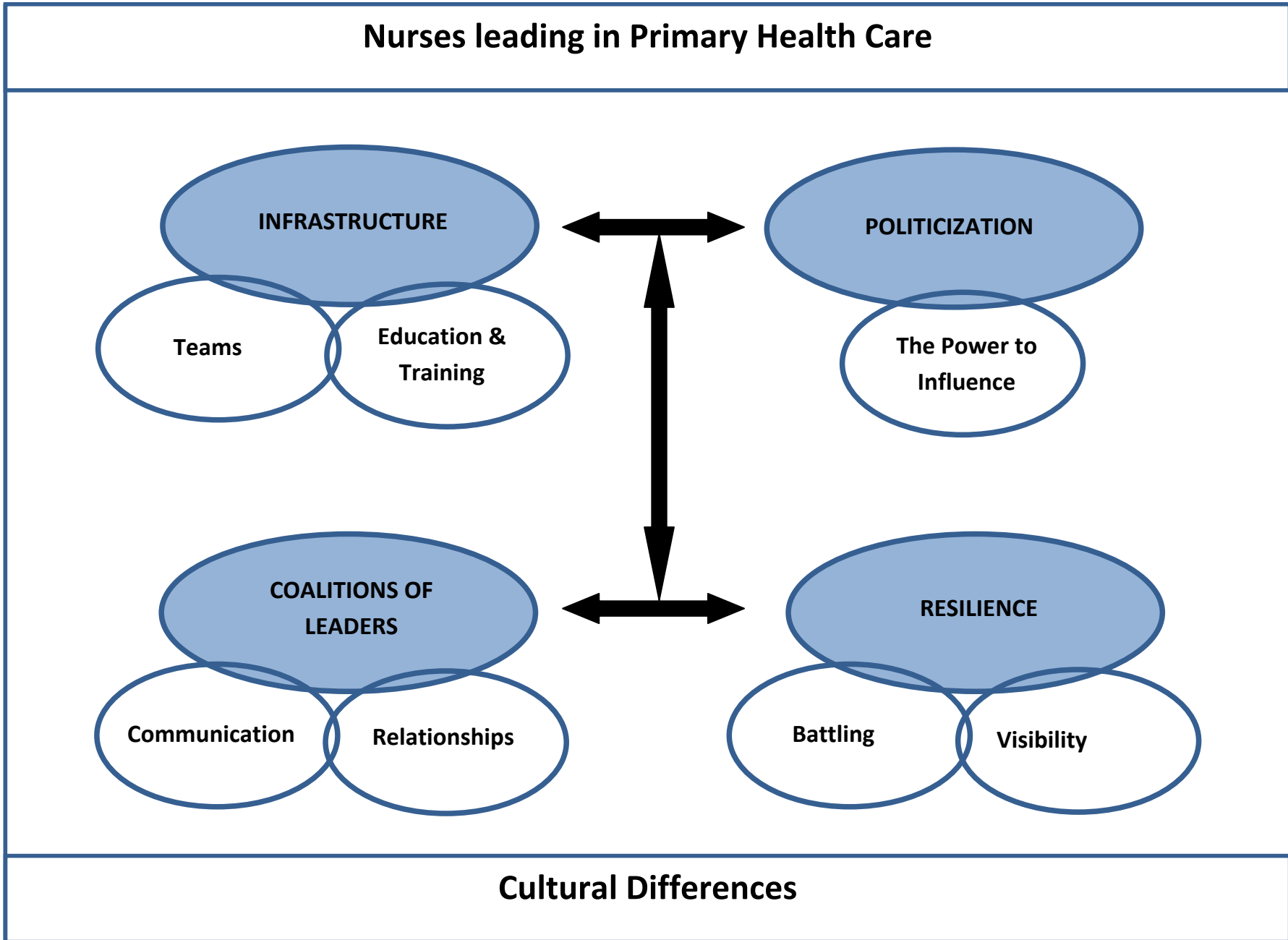
The themes and sub themes identified are discussed in the following two chapters, with reference to the conceptual framework.

Conclusion

This chapter has described the research methodology used in this project. A qualitative research design derived from an interpretive paradigm has been explored to understand the individual participant experiences specific to their environmental circumstance. A mixed mode of collecting data via email and telephone interview fitted the participants' busy schedules and geographically diverse locations.

A conceptual framework is described and supported the topic guide for telephone interviewing and the subsequent findings through data analysis. Ethical considerations and rigour are discussed. The iterative and time intensive process of data analysis reveals four themes, with sub themes. These are illustrated in figure one and presented in the findings of the study that follows.

Figure 1



Chapter 4 - Findings

Politicization and Infrastructure

Introduction

The previous chapter detailed the methodology, the process of data collection and subsequent analysis. A conceptual framework based on the notion of distributed leadership informed this study, as the context for the research was during a time of organizational change in the New Zealand health system. This framework offered the potential for nursing leadership to be activated by being a point of reference and a way of working as leaders. Additionally it helped the researcher to frame questions based on a dynamic model that supports leadership roles that are informal and formal, and seen at many different levels of an organization. Analysis followed a general inductive approach (Thomas, 2003) which resulted in theme identification.

The four themes presented in the next two chapters emerged as the central tenets to leadership for nurses in the primary health care arena. Each theme was significant in terms of supporting and enabling the participants to function as nurse leaders, however, each of the themes impacted on the participant's leadership journey given that they were manifest to varying degrees. The additional sub themes identified factors that influenced each of the main themes, both positively and negatively. Of note the negative aspects of influence were viewed and explained as challenges, in this way the perception is that negativity is never insurmountable, however long the journey takes. The themes and subthemes have additionally been chosen as they support the three specific factors that a distributed leadership model focuses on and it is proposed that without these themes it is unlikely that a true model of distributed leadership is likely to be implemented or realised either between nurses or between nurses and other professional colleagues or disciplines.

The two fundamental themes that emerged as essential elements to activating a distributed model of nursing leadership are 'politicization' and 'infrastructure'. The first theme politicization has one sub theme 'power to influence'. The second, infrastructure includes two subthemes, 'teams' and 'education and training'. The emergent themes serve to give insight into the current presence of leadership in primary health care and the challenges and opportunities acknowledged by the senior nurses participating in the

project. The representation of experienced senior nurses, the ability of these nurses to contribute and be heard and the challenges to their leadership potential within the changing environment was explored and is further informed by these theme choices.

Politicization

Political skill - the power to influence

“The ability to effectively understand others at work and to use such knowledge to influence others to act in ways that enhance one’s personal and/or organizational objectives” (Ferris et al., 2007, p.291)

All participants discussed the politics that existed within their organisations and how this had an impact on the decisions that were made. Nurses felt that having an understanding of how this affected change or decision making, was useful in terms of how they as leaders responded or dealt with situations. Additionally nurse leaders described the need to have an awareness of wider issues rather than those just within their immediate environment so they were up to date on any national clinical or professional policy issues that could have an impact on local level matters or decisions.

The term politicization has been used as an important theme due to the fact that it was strongly presented by participants as crucial to their role as nurse leaders. Participants stressed the need to be able to function as political operators. This importantly involved relating and responding well to other decision makers, and using leadership knowledge to understand a position or viewpoint even when it conflicted with that of nursing. This skill appeared to enhance their positional power and ability to influence both with colleagues and within changing organizations. Alongside this was the need identified by most participants to have a working knowledge of the political environment in order to influence policy and decision making by providing advice and engaging in political discussion.

I think that political acumen is really very, very important and building effective relationships would be my key ones. (51)

Mintzberg (1985) suggested that all organizations were political spaces and in order to survive or be effective, political skill was required. Blass and Ferris (2007) defined political skill as a way to accomplish goals through the management of interactions with others in an influential way and at times of change.

In the discussions that occurred during the interviews, participants shared their perceptions of themselves as politically skilled or activated leaders. Much of the time this depended on their ability to speak up and challenge as participant 49 illustrates:

Courage, I think courage is an incredibly important characteristic for a leader again. I guess it comes along with the whole resilience-tenacity, but the courage to be able to have your say..... to actually say I don't agree with that or this is a nursing viewpoint. The more you do it the easier it becomes and then I think people start looking to you or they're waiting for you to put your viewpoint forward (49)

Frustrations were expressed when participants discussed how despite being in leadership positions, the ability to influence was marginalised due to the fact that they did not have the power to direct thinking or behaviour due to financial constraints.

I'm not sure because as I say, they're hearing me. They're hearing so what's the issue? What's the issue here? I don't know what other challenges. Cultural challenges – no, I think I don't see any resistance. I'm Samoan but I get on really well with the rest of the nurses and doctors so it's not a challenge any way. Maybe funding. See nurses, here I don't have a nursing budget so who do I ask every time I want something to be done for the nurses. That's the other thing. (61)

Additionally nurse leaders talked of the responsibility of other nurses to step up to politicization, and this was seen by a number of participants as more than speaking up or having a place at the discussion table. To effect change or have influence on decision making nursing leadership was seen to be most responsive if it was positioned to lead change or new ways of working through the use of dedicated or available funds. Similarly where nurse leaders were included in discussions where innovation or change

involved financial investment and had an associated budget, then the leading was perceived to be integral to any change process and influencing decision making. This was a significant and valuable comment and demonstrated the potential for nursing to be viewed as an equal player in the business of healthcare.

You've got politics that govern how and where things go as well. If I think about what's been happening in primary care for the last say, seven-eight years, you went from having no nursing leadership to having established nursing leadership but from my observation from what I can see in nursing leadership roles, nurses have been put into senior leadership roles to manage nurses. They're not actually influencing funding and change and my view is that in order to gain true nursing leadership they need to be able to be part of making the financial decision around what happens in primary care. (55)

Some participants recognised that their nurse leadership positions were established as a direct result of responding to political strategy, namely the Primary Healthcare Strategy (2001) and the emergence of Primary Healthcare Organizations had created an opportunity to lead. For two participants the engagement in, and responsiveness to, a policy request, by their proactive organisations, resulted in nurse leadership positions being established with infrastructure in the form of a nursing team to support this; this is explained by one participant:

My current leadership role as employed within a DHB arose with pretty much a ten year history from Ministry of Health and nursing innovations right back in 2002, released expressions of interest to provide funding finally to support the development of primary health care nursing within the community after the release of primary health care strategy. (49)

Other participants described their position on the health collective as a result of networking and knowing others in the primary health care environment:

It was only limited nurses that got selected and part of that selection came about I think too because in the role in the PHO I had worked very closely with others in the sector... (52)

One participant had secured a leadership position with potential authority yet found little traction in finding solutions to identified issues. Another nurse leader (63) in a rural health setting conversely reported leverage and influence over organizational change due to her interest and persistence in being politically motivated. She was also able to describe how form followed function in that with the need for services and, the fact that there were no doctors available, plus the medical profession was supportive of nurse lead services, nurse input and integration was viewed as critical to outcomes.

So having that input right from the beginning and then in the key decision-making areas to ensure nurses are in there. And just keep plugging, say look, there's not the right mix of people in this group, we need to have – just ensuring there's nursing there the whole way through. The models of care – if we don't have nursing input it's not going to work. We just don't have the resources to solely go on a medical model. (63)

A further example from a participant of the positional power and influence held was attributed to teamwork and positioning specifically with medical colleagues. A decision by this nurse leader to strategically align with the profession that held the power at the time was perceived to be a way to progress the nursing agenda at the time:

...we gained the support and credibility amongst groupings [doctors] that actually were quite powerful and influential and remain so. (51)

A number of participants voiced their concern over nurse leadership appointments that were simply a token role. Leadership was viewed negatively and as exhausting when it was not recognised by other professional bodies that nursing could add value, views were not listened to nor were nurse leaders consulted. This appeared to result in an inability to make decisions and implement change which could be attributed to the poor positional authority afforded to that leadership role as described below.

Ever since this merge began, I don't see my role as having a lot of impact... I think they're listening, they're hearing but they're not doing anything. (61)

Leadership that might also be described as tokenistic was alluded to by one participant when discussing the struggles to influence change in relation to the level at which decisions were made. This was further felt when consultation was sought and given by another nurse leader in relation to improving service delivery and then negated or the point of view marginalised through inactivity. As these two participants noted:

I'm telling them when we have meetings. I say to them you want these practices to perform... I need a nurse for this practice so that these nurses will work together to meet the targets that you are giving, the MoH target, the DHB target, for all those performance targets. You need nurses because it's only the nurses who do the bulk of the work. So I mean, I stated this how many times.

I think we're not being heard. I'm not being heard. Not taken seriously. I'm not included in their decision-making. Are they under-valuing, undermining my ability, that sort of thing? (61)

I'm battling for nursing the whole time. What about nursing, nursing needs to be involved in this, you need to include nursing. It's like a tape recorder that's on continual play. It's the same and it's that whole five or six years in the PHO and I was saying the same and I'm still saying the same, sitting in the DHB. It's the same story so as much as it says nursing is part of it all, some of that is that just saying and it doesn't happen and so nursing is having to fight for that, to be part of that, to be an equal voice because I don't think we are, in reality, an equal voice. But I think we should be an equal voice. (52)

Leadership that appeared to have its origins in inflexible organizational processes and poorly defined infrastructure (which will be explored later) as well as through a lack of individual political skill in some cases might be explained through the concept of tokenism. Haycock-Stuart, Baggaley, Kean and Carson (2010) described nurse's views of leadership as negative when they were not listened to and change occurred following minimal consultation, this they also referred to as tokenistic. Ferris et al., (2007) described the four dimensions of political skill, i.e., social astuteness, interpersonal influence, networking ability, and apparent sincerity; each relates to one another and yet has a distinct purpose. In addition these dimensions would demand individual self-awareness, knowledge of self, and insight into the importance of relationships and how

other professionals or organizations may function; so crucial to the political acumen that defines this concept of nurses and politicization.

I just want these people to recognise and acknowledge nurse leaders. Not just nurse leaders, nurses! (61)

In addition to the four dimensions of political skill, was the perceived difference for nurses leading within Māori health and for Māori. One participant saw leading for nursing as quite different for Māori nurses, due much to the relationship with iwi, hapu and communities, plus the complexities of familial links. This participant described the interactions with multiple key stakeholders as doubly challenging, with nursing needs, patient needs, access and equity not always recognised as fundamentally dependant on the Treaty principles. To maintain a clear direction for Māori health and to ensure Treaty obligations were not negated proved to be difficult for this participant on a number of occasions. As this leader explained:

On top of that for Māori Health you also have the dynamics around iwi, hapu engagement and involvement and as tangatawhenua they see themselves as health being critical to their success. So it's a different dynamic you're working with again which you would not get in a mainstream organisation..... it's not embedded into the principles and philosophies of what they're delivering. (52)

This participant described how she needed to tailor the needs of the people to the political agenda of the time. This was very evident in the swift implementation of Whānau Ora, a political endeavour in terms of activating a policy for the people with an implementation process that required significant nursing and other professional input to enable it to meet the needs of the people. She went on to explain:

So there's the political arena. That brought about a different level of stress and that was really interesting. Working in that space in terms of how do you implement change i.e. in a population, when clearly you're driving a political agenda? That was a really interesting space to work in and it sort of brought me back down to okay, the priority for me has to be what will the best decision be for the population we service. (52)

Thus the vision for leading was based on Māori principles and was patient focussed despite a politically driven agenda. The participant had to be aware not only of her skill in ensuring the political priority was acknowledged but that also Māori engagement was thorough, broad and philosophically aligned to a service that could work for the people. The difficulties this participant felt in relation to leading for Māori health in the current environment were perceived to be greater than those faced in mainstream health.

Oh, it's way harder. The people that I work with that are Māori tend to be family, friends or people I've known a very, very long time so you have to be really clear about separating out things, what's work and what's not. (52)

The ability for nurses in leadership positions to respond to the political agenda of the day, to be politically self-aware and to seek politicization appears to be crucial if nurses are to influence and have a degree of power which impacts decision making. Alongside this one participant identified cultural challenges specific to Māori health as additionally challenging and perceived leading in this environment as 'harder' which needed to be considered with any New Zealand model of or development of nursing leadership in the primary health care arena.

Nursing Infrastructure

Teams and educational training provision

The second theme to be discussed is nursing infrastructure. For those participants interviewed who were part of an organizational infrastructure where primary health care nursing had dedicated leadership, a team supporting that role and the development of nursing and leadership planning, the power to influence appeared greater. Similarly where the primary health care nursing leadership was established and connected to the nurse leaders placed in the secondary or provider arm, this infrastructure was strengthened and so too was the leadership for those nurses situated in the primary health care environment.

...the existence of an established primary health care nursing infrastructure with credible leadership enabled us to link into the various areas of primary health care nursing...(49)

Infrastructure is described as the basic structure or system of an organization, and in the context of this project, this directly related to the nursing capacity which is defined by ways of working and the subtheme of teams. The second subtheme encompasses educational training provision, both formal and informal, and this refers to the data that was collected from participants and their access to available training and education. The subsequent capability of the nurses to lead and develop as leaders within the infrastructure of an organization, in particular when considering a model of distributed leadership, could be seen to be affected by these two subthemes.

Responding to the request for strategic plans around service redesign from the Ministry of Health was easier to engage in for those participants who were part of an established nursing infrastructure. The participants alluded to this as they had processes and systems in place and this was accepted as the norm. Their involvement in proposed changes was regarded as essential and valuable and, in fact, the nurses were able to lead some of the planning and implementation proposals. The data clearly illustrated how two participants were key drivers in their health collectives, which could be partially attributed to the established and accepted nursing leadership infrastructure within their particular organizational settings.

...as the nursing development team evolved and the expressions of interest came out in 2009 for the health collective then because we already had that, shall we say framework established around supporting primary health care nursing that certainly the PHO looked directly to the DHB nursing team for a large amount of input into both the development of the business case and then subsequent delivery..(49)

One other participant described the rapid organizational implementation of nursing infrastructure of which she was the key nursing lead and this was as a direct result of the strategic direction that her health collective took, which specified nursing as an important co-partner in the redesign journey. In the main however, nursing infrastructure was noted to be fragmented and ad hoc, with the nurse leaders seeking to lead similarly through no formal process and without a structured pathway to master their leadership journey.

Along with identifying the need for a solid foundation within the nursing team in terms of infrastructure, it was clearly articulated from each nurse leader that this time of change was the opportunity to have shared leadership. Shared leadership was referred to as distributed leadership by one participant, and in terms of interprofessional working seen to involve medical, nursing, allied health, Māori and business support to lead and implement service delivery in a changing environment, as noted below:

I think expanding that team focus is a real opportunity, with the broader allied health team. We've had opportunities to work alongside each other that we've never had before. I'm sitting at the table with the pharmacy leaders and the physiotherapy leaders and the community leaders and those are opportunities I've never had before. So we can understand each other's contributions much, much greater. (51)

The principle of shared working across organizational and professional boundaries as a core component of the distributed model is reflected in this comment and emphasises the richness that can be found through effective collective working. A number of participants saw this time of change as an opportunity to lead and establish better and stronger working relationships for the good of the community with other professional colleagues, as the participant below stated:

When they started choosing the committee and things like that for Better, Sooner, More Convenient that was a completely fascinating time because it seemed to me that for the first time we were actually breaking down the barriers between the secondary care hospital and getting that team of people to actually think about how it happens out in primary care. And there's quite a lack of understanding about the patient journey and things like through the secondary services and we were able to actually work together with specialists breaking down their own barriers between their own departments. (58)

The art in the efficacy of a distributed model is to have all leaders working in this collective fashion with equal partnering and commitment. Working effectively in cohesive teams in clinical settings was often described as the most productive approach

to working and at this time the team union appeared to be expanding to allied health. That is a team connecting in agreement for mutual interest and benefit.

The opportunities for nursing at this time and the development of leadership roles was perceived to be full of potential, however nursing was described as more effective when situated with the team. The structure within the teams was not always clearly defined, but the contribution from nursing was considered essential to service delivery and health gain. As three of the participants noted in three quite different ways:

What I see is that there is certainly a place for advanced nursing practice roles, nurse practitioner roles, nurses running services and running them really well but always with a team approach. (54)

The wheels often go around like that but what's fascinating now is – I'm probably going off the tangent a bit but what's fascinating now is that GPs are recognizing now that they're absolutely pushed for manpower, that more use should be made of practice nurses. So they're encouraging that now and encouraging the public to believe that the practice nurses can do more as well. It's quite a shift actually for them to actually promote nursing in that way. (58)

So we've got a way to go but I absolutely hand-on-heart believe that we must be embracing the team and not – it doesn't mean to say that you lose your individual professional focus or the loss of a world view but we need to be not working in an isolated manner and that's across the community and the hospital settings as well as within the different professional groupings, the tribes. It's not easy but you just have to make a commitment to do that and just keeping working at it at every opportunity. (51)

Despite the fact that this is not new information in terms of ways of working, what is interesting is that the climate of change was perceived to offer greater opportunity to model a collective way of working which was not reliant on a leadership model where one person called all the shots and securely held the power to influence. This is further exemplified in The King's Fund (2011) report which explores the types of leaders that are required to better meet the demands of health via different and diverse skill mix. The

focus is that of coalitions of expertise, which reinforces the concept of a post heroic leader, as discussed by Turnball James, (2011). This type of leader is not determined by attributes and characteristics alone, rather the skill and knowledge to fit the organizational purpose and objective in hand. Added to this was the perception that a fresh attitude towards working collectively was encouraged via the emergence of the health collectives, although the policy drivers and the management of this did not always mean the key players were leading the change initiatives, as one participant clearly verbalised:

But it's been quite an interesting change in the focus of how much easier it is for all parties to now sit down in the same room and get on with doing something.... I think it's going to have quite good achievements in the end but as it's evolved it's got a little bit more management driven than health professional driven. (58)

It was clear that despite the rhetoric around this leadership modelling, nursing and nurse leaders were still challenged when working within a team approach. For those working in the general practice setting this was explored further and participants were asked who they saw as the leader of the 'team'. This revealed varied responses, with some clearly stating the GP as the natural leader, due to the fact they are the business owner, often the employer and have the consistent relationship with a patient from cradle to grave:

I think undoubtedly at the moment the overall practice leadership role still, in the main, sits with the GP but in terms of patient care at any particular time I think the leader of that team changes. (51)

Within the team environment, this was further explained by service delivery or patient care being led by nurses in specific areas, this was described by one participant as delegated authority:

..so naturally that role [GP] is the leader but what we're saying is within that team approach that nurses might take responsibility for cardiovascular risk management, for example. So that we have a kind of a delegated authority to nurses to lead some service delivery because let's face it, nurses do do some things better within general practice than GPs do. (54)

Other participants described the leadership of the general practice team sitting currently with the owner due to the business model of the environment but also with anyone in the team who held the power base. Invariably this was with the GP, in one other case a Practice Manager. It was additionally acknowledged that leadership within the team remained hierarchical although leading by nurses who could demonstrate skill and expertise was considered a way forward, but described as, 'not an easy road' by participant 52. The emergence of Integrated Family Health Centres as one directive of the health collectives was seen to be a potential opportunity to develop shared clinical leadership, where at the very least medicine and nursing needed to be operationally and jointly leading. Again some participants were involved in activating this joint working approach, whilst others were only able to identify the benefits of such an approach, as the participant examples below suggest:

But very, very often in this model that we've got of GP ownership it's the GP owner that has the leadership role. It doesn't need to be. To me the leader doesn't have to be the GP. It could be anybody within that practice team. It could be the allied health person, it could be the nurse, it could be the practice manager. (52)

If this is the absolute opportunity that we get more distributed leadership within the development of the health care teams within places such as integrated family health centre's where we develop an approach that has shared clinical leadership, Māori health leadership and business admin leadership as well because there's no denying that you need all three aspects to successfully lead and implement, particularly service change in the changing environment. (49)

The fascinating aspect of these discussions was the diversity that was apparent amongst participant nurse leaders. Differences appeared to be framed largely by their professional interactions and experiences, past exposure to training and education, plus environmental influences. Whilst the nurse's role is acknowledged by all as pivotal to team working and clinical excellence in terms of good outcomes, a hierarchical approach to leadership could potentially be perceived as hindering decision making within this environment. The participant nurse leaders demonstrated differing

viewpoints both on the nurse as a leader within this specific primary health care setting and the nurses' potential to lead in the future.

Of significance throughout the interviews, all participants acknowledged the benefits of collectively working within a team union and with other experts. There was however the impression from some participants that there remains dominance amongst certain professional groups and that organizational collective working is not always equal in terms of representation and group activity.

It fascinates me that natural leadership is often assumed by profession other than nursing and to name an institution, it would be medicine and for some reason it's always deemed to be normal, natural and nice if you're going to have some sort of working group party or something that a doctor or a GP will chair it or lead it then we know that often those positions end up with quite a lot of positional power and then obviously if the positional power is with medicine then you will often get a medical viewpoint or lens... (49)

Therefore whilst team working was acknowledged as the way forward, the balance of power to influence and, therefore, make decisions appeared for some participants to sit firmly with the medical expert within the team. When considering the interdependent theme of politicization and the key ability for the nurse leaders to be able to contribute and model leadership behaviour, it seems this is even more crucial within the team environment. This is because each participant in this kind of model, needs to be taking part and seen as integral to a process, rather than becoming a subject or mute participant which would simply negate the position altogether on a group or within a team. As an associate leader or partner in any process whereby a collective group comes together, neither one should be or feel dominated or oppressed by the other. In this way there will be an assurance that decision making is appropriate for each participant leader that potentially could face different challenges and possess different resources despite their overall purpose being the same.

All participants explained the importance of maintaining a positive professional identity through teams, in order to demonstrate commitment and responsibility, this meant continuously speaking up and contributing as appropriate and where nursing was

concerned. Others such as participant 51 suggested that all nurses but particularly nurse leaders needed to assume this mantle more readily and not wait to be asked.

..we all have a responsibility to speak up, be prepared, know why you are there and play your part really and not just leave it to the old leadership structures that have served well, or not so well , in the past' (51)

It became clear that this responsibility was taken on by some through a learned behaviour approach or via role modelling and discussion led to the need for leadership education and training provision, which might raise the ability of nurses to operate as influential nurse leaders within a collective setting through academic preparation and educational training.

... so I think if it's nursing where opportunities are created that nurses do take every opportunity to actually contribute fully to the multidisciplinary team in an equal partnering way. I would expect collaborative practice around having equal partnership, equal perceptions of power and authority, equal ability to contribute to clinical decision-making, that actually we've got a responsibility there. (49)

Participants described the need for nurses to take opportunities and also to take responsibility to contribute to discussions and some suggested they needed to understand and express their decision making skills to be able to influence. This did not necessarily mean they had to be a leader with a title; this related to all nurses, and nurses needed to be encouraged to claim this part of their role.

I rely heavily, and my colleagues do on every nurse out there to understand that leadership is part of their responsibility as a health professional to assume leadership, not just if it is in their job title. Leadership with a small 'l' isn't it? (51)

One participant described how the general practice business model was noted to be 'stuck' and as such this created challenges both to the capacity and capability of nursing and its infrastructure. Implementation plans in this health collective sought to "unstick the stuck model of general practice that is currently and will continue to provide

challenges” (participant 49). This was in reference to the perceived restrictions placed on nursing by the business model of both general practice and also residential or older adult facilities. In order to facilitate a new platform whereby nursing’s holistic view of health could contribute to the redesign of services and ultimately patient care, the paradoxical situation of trying to lead and influence health activity and outcomes within the organizational context that was not publically funded, proved to be a challenge by some nurse leaders.

I think the initiative we managed to influence into getting into our business case was a really big step forward. Because to get written into business case we need to unstick stuck model of general practice, it’s pretty critical....We’re talking a culture shift, we’re talking about acute care management, we’re talking about what happens with chronic care with internal practice. (49)

Related issues of keeping people out of hospitals or emergency departments whilst working under fiscal restraint were also perceived to hinder innovation and creativity within teams. Alongside this were the challenges described around systems of the private purse and profit making versus the need to make the best use of health funds and ensuring patients are well supported to achieve optimal health outcomes. All participants stressed the ultimate focus for nurse leaders within any team made up of any professionals, sitting at high levels, strategic tables, boards or forums, was to continuously bring the focus back to the premise of the patient, to be the patient advocate.

So it’s like you go back to really basic priorities, the more you get into what seems to be what they call the higher level stuff. It’s almost like to me it goes more back to basics as to why I’m there. Because they miss that, completely don’t see that sometimes. Or most of the time. Yeah, we’re the patient advocate at the end of the day. (52)

The idea of layers of leadership and collective working fitted the environment of change. Leadership appeared to be a social process reflecting the need to work with others as opposed to one doing something to another; this is supported in the literature by Davies, (2000). Participants identified that there was an issue surrounding equitable

processes of leading within this organizational approach however, and the suppression of nursing to the dominance of medicine was exposed in some instances. McMurray (2007) and Brown, McWilliam and Ward Griffin (2006) discuss the expert hierarchical model of practice which holds the power and influence and is usually at the hands of the dominant practitioner and subsequently marginalises the nurse's ability to lead and articulate a professional perspective. Carroll and Edmondson (2002), and Golden (2006) also suggest that the call to replace hierarchical positions for leadership that is truly spread via coalitions, will result in greater capacity for learning and change.

Additionally some participants identified that nurses had a significant responsibility to be involved in decision making and to develop collaborative and team building skills, further supported by Huston (2008). The opportunity to be proactive at this time of change was acknowledged however, the education and training to support these requirements was noted as needing further exploration.

Education and its provision

Education and training provision emerged as a subtheme to nursing infrastructure in that the capability of the nurse leader and their effectiveness within the team of collective players or in an organisational setting was influenced to some degree by the exposure they may have had to education or training. Participants recognized that all nurses needed to assume the responsibility to lead but conceded that limited leadership training to guide the development and responsibilities of leaders was a key concern. Whilst some participants had experienced formal leadership training via one to five day courses, others identified post graduate study as the lever to taking on more senior leadership roles. It was clear that this had grown not only personal and professional capability for these participants but also had enhanced their confidence both clinically, politically and professionally. Two participants described this:

Oh, definitely it was an opportunity [working in the PHO]. Probably the biggest opportunity of moving into senior nursing was probably doing the Masters I think. I think that developed that whole different way of thinking and working. I would say that was more my trigger point. I probably didn't realize it at the time. It would be during that four years or whatever it took to do the Masters that I

changed over that time and I wouldn't have gone for the PHO role if I hadn't done that you see. (52)

Then some postgrad study, just a postgrad cert through Otago by external links and going down to Christchurch for block studies. That was the great thing that sort of set me off really, that made me want to keep nursing for a while. (58)

Whilst it was acknowledged by a number of participants that post-graduate education was crucial to their evolving leadership roles, it was evident that promoting and harnessing the post-graduate pathway amongst peers or other nurses was not always easy. Additionally, although distributed leadership was acknowledged as useful to primary health care, a lack of identifiable primary health care nurse leaders appeared to reduce the leadership visibility for new nurses or those wishing to grow their knowledge and skills. Processes around growing new nurses and nurse leaders were unstructured and therefore, limited the profile and potential for primary health care nursing leadership. An example of how this affected the workforce was given by participants in relation to both accessing funding and engaging in post graduate study; a key factor to progressing role development and a lifelong learning journey. Additionally another participant noted the need for improving peer support to those nurses working on further educational pathways:

Sort of getting them to do that and at the same time postgrad study, so that's the part that I think primary care really struggle with, is to develop....If you have a look across the country, very few of them are utilizing that funding to its maximum. If you look at secondary services, they often turn nurses down. They'll say sorry, we've already met the quota. With primary care we have to work really hard to try and get nurses to take the scholarships. (55)

I think we have to prove ourselves and what happens is that as nurses we let ourselves down or we let our profession down so nurses that aren't interested in perhaps moving forward or new ways of working and want to stick to the old systems, don't want to change. They let everyone else down I guess. Some of it's bringing along the rest of our peers I guess, bringing along the crowd. (52)

Where nursing infrastructure was established, whether in a DHB setting, a PHO, or health collective, formal processes for succession planning and growing new leadership was more likely to be enabled. This was also notable where a Director of Nursing for primary health care was positioned and identifiable. Commitment to a process for developing growth amongst the nursing workforce appeared to be more likely and systems in place. In discussing leadership development Edmonstone and Western (2002) suggest that both work and programme based education adds value but to be effective needs to be considered in a structured way if the impact is to be felt. This was further enhanced according to some participants, as illustrated below, if the organizational structure invested financially in training programmes for the nursing workforce. In this case the leadership extended to influence at a governance level.

I actually completed a Diploma in Strategic Leadership which is a two year Diploma course subsidized by our organisation in the development of leadership skills for not only our organisational staff but it's also open to our network as well. So we encourage – in fact the board have actually agreed to increase the number of nursing scholarships they offer for nurses working within general practice to participate in that course and they awarded one this year but they're going to award some more full scholarships next year. (54)

Informal training also appeared to occur in the organizations or health collectives that were willing to invest in the workforce and for those nurses keen to grasp opportunities. This was described by one participant as “a training of opportunities” (Participant 49) by another as “training through on the job experience” (Participant 52) and was more often than not dependant on solid mentorship, coaching or supervision. For all participants this varied, as nurse leaders they determined their role models, through their own drive and commitment, and the mentors or coaches ranged from nurses, nursing professors, nursing tutors, General Practitioners and Chief Executive Officers, (as exemplified below) but all benefitted where the infrastructure was strong and processes were in place that valued the contribution of the nurse leaders.

If you ask me about my opinion around personal training around leadership then there's a need for that experience as the apprenticeship model and actually being able to – you need the opportunity to sit at the table but then for myself

personally, I've had a couple of key mentors who have helped me to develop into my nurse leader role and all of those have been nurses. Nursing professors plus the key leads, the IPA GPs that have actually supported me on the journey and said no, you've got something important to say. (49)

I've always felt well supported but in fact more supported by my medical colleagues and other health professionals at times, than my nursing colleagues. (51)

Certainly specific leadership training and the scope of development available to nurses appeared to be lacking. From discussions with participants, there was no standard or formal leadership programmes and training at a consistent level that all nurses were able to engage in. Despite pockets of excellent investment in training and areas where post graduate educational uptake had improved, the general sense from participants was that leadership training was not formally encouraged.

...let's face it, there's not a lot available around developing leadership ability within health. (49)

Some nurses described how their work on professional groups and engagement in work outside of the health collective or their employment roles, plus their personal ability to see nursing's contribution through a wider lens and via a global perspective had contributed towards their learning and understanding of leading within nursing and health. Most described the relationship between primary health care nursing leaders and secondary care nurse leaders, especially those sitting in the planning and funding arms of District Health Boards as crucial.

...that positional power of the primary health care DON, Director of Nursing that is a critical link or linchpin between the funding and planning division which is what we're employed under and a PHO infrastructure and it's fair to say the PHO in our area which spans quite a large region was pretty light on primary health care nursing leadership. Because it seemed to be sitting in and resourced within the nursing development team so became a natural outcome that key members of the nursing development team and then had quite a lot of

input into developing the strands of the health collective and then subsequently in leading the development and implementation of the strength of work...(49)

This intraprofessional connectivity was considered a key factor in terms of allowing primary health care nursing care and service delivery to be maximized and financial investment in the workforce to be realized. Training and investment in rural nursing staff was not considered financially difficult by one participant, conversely retention of workforce members as a whole was a greater challenge. In some instances for nursing and specifically nurse practitioner roles ruralities provided greater training opportunities to grow and develop. This was considered a superb yet indirect way to model clinical nurse leadership to the wider health arena, and exemplify positive care outcomes based not so much on the provider but on the needs of the population.

Conclusion

Political acumen is identified as a key skill for nurse leaders and an organisational requisite and has been discussed in terms of the impact this can have on influencing decisions and policy from the board table to the clinical floor. Incorporating this theme into a distributed leadership model equips a nurse leader in the current dynamic climate to address, be engaged in, and contribute expertise to, decisions that could affect and result in health gain. Participants identified that nurse leaders need to take opportunities and raise their level of accountability in terms of being proactive, understanding the wider health environment and responding to policy changes. More importantly nurses needed to identify and negotiate policy change. There is still significant work to be gained in this area for primary health care nurse leaders.

The existence of established primary health care nursing infrastructure with identified credible leadership whether in a lead position or exemplified in a layered leadership model approach is described as enabling by participants. Those health collectives with structure in place were positioned well to respond to the change initiatives brought about by the Government at this time.

All participants described the value in the work of primary health care teams at all levels, although on further discussion, it is evident that team working remains

hierarchical and this potentially could impact on the ability for nurse leaders to truly lead, innovate and influence change. Within the framework of teams nursing leadership is not clearly identified and neither is a defined pathway. Added to this is the ad hoc approach to formal training and the informal training of opportunities identified by participants. Further education and training processes and direction to develop new nurse leaders could enhance the capacity and capability of future primary health care service delivery.

Chapter 5 - Findings

Coalitions of Leaders and Resilience

Introduction

In this next chapter data is presented which provides an insight into the principle idea of distributing leadership away from the top of organizations. It explores therefore the third overall theme of coalitions of leaders, as this emerged in discussion with participants, both between nurses, and between nurses and other health professionals. Two sub themes that emerged as significant factors important to coalitions are ‘communication’ and ‘relationships’. Consideration is given to the interconnectedness of these coalitions to the subthemes and the degree to which the participants were able to work effectively as part of a coalition group. Additionally the value added benefits of building relationships and productive communications is explored, in terms of how participants related to these subthemes in their roles as nurse leaders.

The final theme explores in more depth the principle of a distributed leadership model where leadership needs to be understood in terms of leadership practices. This theme of ‘resilience’ significantly highlights the limitations around this model for nursing or certainly for the nurses participating in this project. Sub themes of ‘battling’ and ‘visibility’ are explored from the data as they repeatedly emerged as having a considerable effect on the nurse leaders position, influence and overall on nursing leadership development. Both the positive and challenging effects are explored.

Coalitions

Building and communicating through relationships

Leadership coalitions are seen as variable, and could be a model where the lead is taken strongly by one or conversely shared among several different leaders which reflects more of a distributed model of seeking expertise to inform a process. The premise behind joint working or joining forces is to work towards a common cause. This cooperation results in coalition participant’s problem-solving to maximize an opportunity and to utilize all available resources in order to achieve an agreed goal. Where community or population health is the priority a shared leadership coalition approach tends to reap rewards alongside an approach where new leaders are developed.

Coalitions between nurses and between nurses and other professional colleagues has been identified as an overarching theme in this research as it clearly defines a way of working that was exemplified in some of the primary health care organization settings, in this instance, the health collectives. A range of opinions were expressed by participants about working either with nursing at the core of any approach or through an agreed or common goal that drove a partnership approach to working. One participant (49) described leadership in her organisation as distributed, with layers of leadership seen in the expertise offered by nurses within specialty areas, and says:

...our aim is for a distributed nursing leadership through key mechanisms like making sure we get nursing to each table and not only that we get nursing to the table, but actually that we support and grow and develop and coach each nurse when they are able to go and contribute to a steering group or a governance group or have input around service design or delivery but are able to articulate a clear nursing view. It's not just about having that person at the table but supporting those nurses to really contribute fully. (49)

This was not seen as hierarchical and provided a way to identify expertise throughout the organization, and was perceived to add strength to nursing leadership as a whole. Enabling, developing and harnessing strong leadership throughout an organization was again seen to reflect the strong infrastructure established within this participants organization. To ensure nursing leadership had an impact within the health collective the commitment of the employer was additionally significant if a tokenistic example (as described earlier) of leadership was to be avoided.

For nurse leaders who were working within the context of a coalition with other professional colleagues, having a profile at a local, regional and national level was described by a participant as helpful.

I think my work with the DHB has definitely helped my profile in an interdisciplinary manner... If you're looking at something in child health then you can't do that without involving paediatricians, pharmacies, nursing, community and Maori Health so it's probably fair to say that I've got a reasonable profile. (49)

The ability to build relationships and demonstrate capability towards achieving a goal was likewise beneficial and supported if the nurse was able to articulate a vision with an end goal in sight. For others who were developing their profile, partnering and communicating with colleagues to achieve a goal was seen to take time as there was an element of trust and respect that needed to be nurtured if the 'coalition' or joint working was to be successful.

It is the being consistent and staying involved, sometimes when it's tough and hanging in there and not just putting yourself forward but sticking at it. I think some of it's that, it's almost like earning the confidence and trust from people and some of that takes a bit of time. (52)

In terms of communication, participants conveyed that nurse leaders who were responsive and followed through on actions gained respect and trust from the partners they were involved with and the resulting joint working proved to be more productive. This often required working out of hours for some nurse leaders and it was suggested that it took time to develop a platform of trust. Additionally for leadership coalitions, both or all parties needed to be responsible for maintaining two way communications and investing in a relationship again driven by the common goal rather than an authoritarian professional preference. Likewise relationships needed to be inclusive rather than exclusive in that a range of relevant stakeholders ensured contributions were directed towards a common purpose rather than being self-serving. One participant explained how coalitions moved from larger groupings to small ones, and how it was the expertise that became the focus which served to inform the group goals:

...we were divided into groups like mental health, long term conditions and all of those sorts of things and IT, Manage My Health, all these sorts of things and we had massive groups of people all working and putting their ideas forward. And then that got shrunk back a bit to the final group and some of those people got sort of dropped out again. They weren't actually officially the leadership team but they were invited to participate because of their skills in whatever their area... (58)

For some of the nurses interviewed this approach to joint or cross working was extremely time consuming and emphasis was placed on this process as a ‘difficult journey’ in contrast to medical colleagues who were described by some participants as being able to assume authority within leadership coalitions just by the very fact they were doctors, as noted earlier. A positive aspect of this approach to working was the development of relationships and the opportunities to discuss key aspects of care that was enabled due to the changing environment as participants below described:

When I started out at the practices, if you say you’re going to do it the relationships are built on the fact that you either go back to them and say sorry, I couldn’t do it for this reason or you actually do it. Then that builds your credibility with that practice. I’d say the practices I’ve had intimate working relationships with have been practices that will continually come back to me. (55)

...that communication needs to be by communication both ways.... (49)

Interestingly, most participants clearly identified that leadership coalitions or working in a partnership approach both with nursing colleagues and medical and allied health was the most productive way to focus on health care development, especially as this mirrored the work of teams in the workforce. Some participants identified that nurses had a responsibility to lead and take on opportunities to grow and develop their leadership skill, however lack of structure or a framework to support this and ad hoc leadership training or profiling in primary health care from DHB to PHO to health collective, was considered a significant hindrance or barrier.

..If we’re talking within the general practice setting, clearly there needs to be medicine, nursing and we also need to be cognizant of partnering around allied health and also pharmacy. I know it’s very hard to say well okay, can we have a clinical leadership of ten people. Probably not but I think seriously, when we think about the makeup of the workforce that at least medicine and nursing needs to be at that table and provide that leadership. (49)

Participant 51 described the leadership coalition or joint working approach within her region as extremely well established across a variety of primary health care nursing roles. This was defined by a cross sector or cross working approach where nurse leaders interacted on a monthly basis. The strength in this unity enhanced each individual nurse leader's position and profile and was perceived by the participant to be a key lever to involvement in alliance groups as part of the health collective and indeed a critical stepping stone to working well with other professional colleagues. As the participant said:

We've had opportunities to work alongside each other that we've never had before. I'm sitting at the table with the pharmacy leaders and the physiotherapy leaders and the community leaders and those are opportunities I've never had before. So we can understand each other's contributions much, much greater.
(51)

A particular emphasis was put on developing positive professional relationships with medical colleagues to gain their support and understanding of nursing's contribution. It was additionally seen by some as enabling and a way to gain greater influence to raise nursing's profile. Interestingly not all participants held this view, whilst positive relationships with other professional colleagues was perceived by many as useful, some participants described that this was also a way to seize opportunities and expand the networking potential for future nursing developments.

We just forged ahead from that point on in terms of practice nursing development and we're able to have influence. So I think they just didn't quite get it at the time. I guess some people are quicker to see the importance of teamwork and that you're not necessarily selling your soul, you are still very much a nursing leader but within – it's part of that being politically aware and able to use your influence where you can really and seize the opportunities where you can. (51)

Similarly another participant strongly emphasized the benefits of building relationships with other professional colleagues and how being a nurse leader within the health collective had actually created opportunity to do this. Working as a nurse leader was

most productive when other professional colleagues were aligned and this was considered the only way for nurses to gain any momentum or sustained visibility in the primary health care setting.

I think one of the key learning's for me is that when I came into this role I thought I'd be one hundred per cent focused on nurses and what I've really learnt and I learnt really quickly, is that if I'd been one hundred per cent focused on nurses and not looked outside the nursing profession, we would have fallen at the first hurdle. (54)

This participant also talked of how a very specific change in communication within the General Practice setting, instigated by the health collective focus on coalition working, had a significant effect on professional relationships in the workplace. "Daily huddles" comprised of a multidisciplinary ten minute morning catch up (rather like a quick ward round) and "rounding" which was a 3 monthly review of progress according to health targets and quality with external support staff, created both set formal meeting time plus opportunity for nurses to contribute and influence service delivery in different ways. For all staff this was a new way of working that indirectly served to encourage talking, better communications and improved relationships, with the patient as the common goal. Policy to practice working with a distributed modelling approach could be seen to influence a system change by this participant.

...it's actually encouraging them to talk together more as a team, as a profession within the team, but also has given them an opportunity to start contributing towards the actual set up of clinics, the introduction of nurse consult models and other things like that which before, you know, for some practices was pretty alien (54)

Relationships for Māori nurse leaders was singled out by one participant as quite different from that termed as mainstream with a key rationale being the need to be connected to all relevant parties and not to overlook or neglect any potential stakeholder or whānau relationship. This additionally motivated the nurse to care as it was considered integral to the Māori philosophy or way of being and is exemplified by the participant below. The expectation for a Māori nurse leader was to be well connected

with community, iwi and hapu while additionally taking on the impact of the wider health care context on Māori. Added to this was the connection a Māori nurse leader may have in some way being related to many of those she may be interacting with on a day to day basis, both patients and professional colleagues. Communication of note was therefore considered to be doubly crucial in that responding to a situation or articulating a nursing need, had to include possible different iwi perspectives, a Māori focus, the policy and political agenda and the buy in from nursing and other colleagues alike.

But if you go to places like for example, [geographical location] where actually the nurse there, the people she looks after are cousins, aunties, uncles, the iwi/hapu, relationship there is a huge driver around making that practice succeed. (55)

On top of being responsive to the organizational context and practice population at the coalface, participant 55 noted that from a strategic point of view, that change could only be achieved over time and the investment taken in building trust and relationships with the practice owners or key stakeholders in certain primary health care settings.

I kind of worked out quite quickly, actually ninety per cent of what I needed to achieve needed to be done via relationships, like how well I knew GPs, how well I knew the practice, what would fit with what practice and basically all the practices were doing slightly differently and I couldn't go in and say right, you must (55)

Furthermore this translated to the clinical setting where to gain leverage and take responsibility for leading in a primary health care setting such as General Practice, a nurse demonstrating leadership ability could be seen to succeed if her interaction and communication could be fostered through building and sustaining these strong relationships with other professional colleagues. This was described to participant 55 in the following way:

She had to have a good – when I asked her what was the key driver, how she managed to set up her nurse led clinic, she basically told me it was because she

had a great relationship with the GP and the GP was open to doing that in his private practice. (55)

Interestingly for this participant working as a nurse leader, she identified that the power to influence as discussed earlier did not always result through just developing good relationships and communicating credible evidence based practice effectively, rather it depended on observing and identifying gaps in practice and sourcing the key professional who may have the power to initiate a change in behaviour, which may not be a nurse. Thus the nurse leader's skill was in capitalizing on her networking relationships with other professional colleagues to effect a change which ultimately would benefit the patient. This does however appear to demonstrate that within the context of General Practice, despite efforts to foster joint working approaches, hierarchies were embedded into the 'team' model, as described earlier, in most cases which appears to have directly affected the ability for nurses to make change, as noted by participant 55.

I also worked out that even if nurses were challenging practice, GPs were going to do what they were going to do anyway. Again, it depended on the GP. Some GPs would, some wouldn't. But if you put a paediatrician or a secondary clinician there that says the same thing, they will bring about the change. They won't argue with another senior clinician. I'd say that chain of command thing, it's held quite strongly in my view in primary care. (55)

From the perspective of relationships between nurses, some participants described concern over how primary health care nurses profile was not always strongly represented. This may have been again due to the lack of uniformity around formal primary health care nurse leadership roles, inconsistency in titles and differing levels of authority. For one nurse attending meetings at the local hospital with Directors of Nursing, the focus was not on matters specific to primary health care and likewise communication around leadership at a national nursing executive meeting was identified as needing greater primary healthcare input and presence. There was a clear desire and felt need amongst participants to make primary health care nursing leadership and its potential contribution more visible. The additional disconnect between primary health

care and secondary care needs appeared to demonstrate a requirement to fill the gaps and truly integrate.

It's different. If I go to a Nurse Director's meeting at the hospital, I find that not a lot is to be discussed because they're focusing on their clinical side of things. What happens in the hospital is just totally different to what happens in the community anyway. (61)

The ability of nurses to be able to communicate and network together was discussed by participant 63 as especially important in rural communities in order to gain a deeper understanding of any concerns and how this can be taken back through the various layers of leadership, to the policy table. Building relationships such as these was considered important in ensuring nurses were heard, supported and mentored through good communications and to make sure that the right kind of change was fed back to the 'Board' table.

I think it's just getting in there and working with the teams to help them change their models of care, listening to see what we can do to make life easier because it's busy and also taking their queries and things back and because I'm at a level of being able to influence some change, to be actually able to go and do some of those things. (63)

Coalitions can be between nurses and between nurses and other professional colleagues, and function most effectively when the common goal is agreed upon and this is often seen as in the patient's best interest. Relationship building is crucial to successful joint and cross working and also appears to be very complex due to the fact that within nursing and between nurses and medical and allied health colleagues, hierarchies remain strong and in some cases disabling, despite much rhetoric espousing the benefits of team working.

Communication that is understood by both parties, ensures each is heard and respected and can help to develop relationships and influence change. Interestingly the specific personal and professional qualities described in the literature as helpful to nurse leaders, do seem to raise the capability of the nurses. Their ability to contribute and influence

appear to be influenced by their knowledge and skill level and in some cases educational training and hence the dynamics within a coalition can be positively affected. This could potentially signal the difference between true distributed leadership working where individual experts are acknowledged and heard, as opposed to a model where a nurse leader is involved in discussion but denied involvement in a group's collective decision making.

Resilience

Battling to be visible

Common expressions that were noted from participants were 'battling' and 'fighting'. These terms were described most often as something that the nurse leaders had experienced over time, often years, in their leadership journey. It was commonly associated with continuous attempts to raise the visibility of nurses or nursing in the context of multidisciplinary forums or organizations, and one to one encounters with other professional colleagues, including nursing, medical and allied health. Dealing with these 'battling' situations demanded persistence and the ability to get back up or keep going despite facing challenges and blocks. Some, like participant 54 felt this persistence was having an impact and being heard, or for "people to take you seriously" took time and a degree of perseverance.

I'm saying that with a pinch of salt but actually sometimes it is hard. I still think there is sometimes a little bit of an attitude towards – if you're a nurse, you've got to work that bit harder to be heard amongst the other clinicians. But I think it's getting easier. I think there's a realization, particularly within this sector actually, that without the nursing workforce we just wouldn't be able to pull it off, our business case, so we're relying heavily on the commitment of nurses to get on board with that. (54)

Another participant (49) described resilience in terms of dealing with "difficult times" and being "shutdown" over the course of her leadership experiences. Having the courage and tenacity to disagree and pose a new perspective from a nursing viewpoint was considered essential and not something that could always be taught, rather it was an inner motivation, a passion and a commitment to the profession; as this participant said:

I don't think there's an easy place to be a nurse leader, part of that is definitely the need to have resilience, to actually be resilient. The journey's not always going to be easy if we end up in difficult conversations or inputting into service design delivery, governance discussions where what we put on the table is not always what other stakeholders want to hear or are interested in hearing. So I think resilience is important. (49)

In addition a number of the nurse leaders described the extra commitment that was required outside of scheduled working in order to be responsive and to maintain credibility by ensuring they kept up with the rapidly changing environment. Participant 49 went on to describe how this included putting in extra hours, being available and responding in a timely fashion to anything that was requested and to always be up to date and informed of issues whether clinical or professional.

It's not without considerable commitment and passion and a lot of voluntary, out of hours work to develop and maintain credibility with a profile. (49)

All participants spoke of nurse leader key qualities which mirrored much of the literature in that vision, knowledge, commitment, direction, self-awareness and integrity were achievable only through perseverance and the ability to keep going. Nurse leader participants saw the value in maintaining a voice and continuing to profile nursing with its commitment to patient health gains whenever the opportunity arose. Discussions provided insight into how nurses developed personal leadership characteristics including resilience due to the very nature of the on-going battles they described. This was perceived as quite a lone journey by some and with no formal primary health care leadership framework or career pathway often unsupported and certainly an area where nurses could improve by working in more collaborative ways with one another, as a participant summed up well:

Certainly presenting a public, unified approach is important. Behind the scenes working together and supporting each other is really, I think, important going forward. (51)

Additionally, and associated with a lack of support from both nursing colleagues and medical colleagues by some participants was a sense of isolation and a need to be resilient as any error of judgment was noted and criticized rather than the many gains being acknowledged or rewarded. This was duly accepted as part of the role although appeared to reinforce amongst participants the need to have direction and focus on how the patient may benefit. The lack of nursing collegial support was evident from some participant's discussion and certainly without the ability to have inner self belief and awareness of the goal or focus for leading, added to the fact that primary health care leadership frameworks of support were absent, this also meant that personal resilience was a buffer and a mechanism utilized by some to get through the difficult times.

I'm sure we've all got scars on our backs but that's okay. You've really got to believe in what you're doing and for me it is all about the patient, not necessarily all about nursing. (51)

Many of the participants described how being in a nurse leader position gave them an understanding of self and enabled growth of self-awareness through the realization that change took time and many areas had to be worked at, including relationships which could be challenging and trying on a number of occasions. An overriding sense from all participants interviewed was that to be effective as a nurse leader, everything took time and persistence. Resilience in terms of getting back up time and again following knocks, and resistance, both became the challenge and the expected. For Māori, leading was considered to be even more challenging by one participant and voicing the needs of iwi and Māori nurses in addition to the need for health gain was often referred to by others as 'being difficult'.

Formal leadership training was not commonplace and not uniform from participant descriptions, as has been discussed earlier, however individual participants, who had undertaken some training around mentorship and self-reflection reported that it enhanced their leadership capability, supported relationship building and enabled them to maintain a focus on nursing whilst being aware of collegial viewpoints. Despite this, participant disappointment was expressed when gain and success was not always an outcome, more often a compromise or 'letting go' was described as the only option, which created a sense of powerlessness and loss of professional value. The impact of

this added to the experience of on-going ‘battling’. Also, as was identified by participant 55 there was a notable lack of acknowledgement of cultural partnerships, which for Māori nurse leaders contributed further to the battling and perceived uphill struggles especially those faced by nurses in leadership positions. Self-belief and an awareness or ability to be mindful of collegial agendas was considered useful by participants as described by participant 51, although all saw the patient well-being as the central driver for their actions and input at a leadership level.

I think you’ve got to believe in yourself but also be focused on others. There’s no room for your own agenda. I think in nursing leadership to get to progress in a multidisciplinary environment you’ve got to be open and you’ve got to deliver to both your patients and your colleagues and be quite transparent and open. (51)

A further subtheme of resilience is visibility. Again this refers to the continuous efforts the participants described to keep the work of nursing and the potential benefits to the patient as central to positive outcomes and discussion. This was interesting as it took a number of forms. One participant described how she felt guilty for spending time representing nursing at various forums or meetings, despite the fact this was part of her job. Whilst identifying and believing that it was important to have nursing at the table and contributing to matters, she sensed her employers questioned or criticized her presence at various settings, which served to undermine her both personally and professionally, in that her visibility was marginalized.

I’m a nursing voice and I’m really clear that that’s what I’m there for because I think they question why am I at this, why are you going and spending time at this. I almost feel guilty sometimes that I’m spending time, because that’s how you’re made to feel – that it’s valuable yet my reason for being there, it’s vital really but they don’t see it. (52)

This aligned with a feeling of isolation and lack of support for the importance of a nurse leader to be visible and heard at health related meetings. Additional to this were the frustrations felt when through being away on leave for an extended period, the participant returned to her role, to find all efforts to ensure nursing was considered and factored into planning and service delivery, had to begin again. Having nursing

leadership available and present was a start and considered beneficial but securing and developing the leadership networks through infrastructure was deemed so much more effective. Due to the fact that nurse leaders in primary health care were often ‘lone rangers’ the benefit to working collectively if not locally then regionally or nationally was recognized as potentially beneficial, but again poorly defined or established in the current environment.

I think even in the position where I went away this year for three months and it was like I was just getting there and people were saying oh yes, we must include the nurse. I went away for three months and I came back and it was like I had to start again. It’s like you have to be there constantly to – it shouldn’t be. (52)

Two participants described how working with other nurse leaders was reasonably well established and served them well, but this had taken almost a decade to develop. The benefit referred to by most participants of greater impact through joint working, locally and nationally was described as far more compelling in terms of helping them to be heard and effecting sustainable change through a unified voice. However this was not available to all and not always activated.

I think probably one last thing is the importance of us all working together, certainly those who hold national roles. We’re getting better at that, we really are - so we can have much greater impact if we’re all – we can have our different areas of focus and our own beliefs. (51)

Participants described how nurse leaders needed to set an example by working better together, and communicating health needs by putting personal gain aside. The lack of any formal career pathway and structured process to develop leaders, both locally and nationally was evident, in that networking and engagement was considered to be piecemeal. As a result, when it came to the overall impact primary health care nurse leaders might have from a professional and political point of view, the presence and therefore visibility of these leaders was minimal and either unseen or unheard.

I think we have to not be divided because I think that’s what happens; nurses get divided against each other so it’s breaking down. It’s much more powerful if we

can be collective and when everyone else gets their stuff together like we have to, I think we have to set an example that we can work together and we can work across PHOs, across DHBs, across the country. I think we need to set that example. (52)

Unity and the acknowledgement of new nurse leaders were also noted as crucial to progressing nursing's visibility and influence. It was clear, however, that nationally there was no mechanism to support or grow new nurse leaders in career progression, which again could potentially lever the profile of primary health care nurses and their contribution to health gain particularly if driven through coalitions of nurse leaders. Added to this, some participants had either experienced or observed the 'tall poppy' phenomena whereby new leaders were seen as threatening or challenging rather than refreshing and enabling, which created an unhealthy environment and was counterproductive to nursing leadership development. Intraprofessional working between nurses was considered to be met with anxiety rather than embraced in some instances as participant 54 noted:

...we shouldn't feel threatened by new, emerging nurse leaders that are coming up with good ideas and new ideas. I think it's great. (54)

A lack of visibility was further described through the perception that primary health care nurse leaders had no formal national meetings with the secondary care nurse leaders and were not historically part of the national nurse leadership meetings, such as Nurse Executives New Zealand, as described by participant 54.

For such a long time now our nursing leadership has been seen to reside within the DHBs whereas what I think, and certainly somebody who said at NENZ, welcoming me to the group, this is great, we need more nurse leaders from primary care to step up and start leading the way as well (54).

Other participants identified that ideas and information relating to innovation was not always disseminated well or appropriately. It appeared that nurse leaders in primary health care were difficult to identify. Being able to locate these leaders might prove useful in mitigating fragmentation and by raising the profile of clinical and professional

work occurring within the current environment. This is exemplified below by participant 55.

So if you have a great idea for your primary care practice, how do you implement that and how do you share that that's your interest with others? I think that's really helpful and also too, having access to the right tools to have that happen i.e. having access to a senior nurse that might be able to help provide that support and guidance and direction. (55)

Participant 54 brought the discussion back to the political imperative and the policy directives which provided opportunity for nursing to clinically and strategically demonstrate excellence. One skill that participant 54 identified was to raise their political profile to showcase clinical successes and the impact of nursing as a crucial element to interprofessional working.

There's so much pressure, as you know, from the Ministry of Health to shift the focus away from secondary and tertiary care back into primary but it's about where are the leaders. There's some fantastic leadership going on in primary care but I just think we haven't had the opportunity to raise the profile for those leaders until now (54).

By sharing their experiences and innovation through joint working approaches, their political visibility and power to influence could be enhanced to present a stronger professional profile.

Conclusion

Coalitions were identified as a theme within the health collectives and expert nurse leaders described working alongside other health professional leaders. Coalition environments such as the health collectives were not always equitable and nursing input varied from significant to minimal. Key levers for the nurses were the development of strength, visibility and credibility through clear and articulate communications and building relationships. Nurse leaders described coalitions between nurses as beneficial and a way to enhance growth and development of nursing leadership, but connection

with secondary care nurse leaders was not always present and frameworks for progressing this in primary health care was considered to be underdeveloped.

Nurse participants clearly identified battling as an on-going challenge that the nurse leaders faced in the current highly dynamic environment. Again this is not a particularly new phenomena and the ability of the nurses to cope with this and quickly adapt is both crucial and significant as too is the concept of resilience. Positive imaging or profiling of nurses as leaders was seen to be helpful by some participants but not always communicated well. Whilst most participants felt nurses had made great inroads in having more of an impact in terms of contributing to decision making, it was clear the journey was not over and the environment continued to present as challenging.

Chapter 6 - Discussion

Introduction

The aim of this research was to explore with nurse leaders situated in primary health care at a time of health change and organisational repositioning, their role as leaders, their involvement and contribution to nursing leadership and their ability to be heard and face challenges relevant to nursing. A distributed model of leadership informed the project work by providing a conceptual framework to further explore the nurse leader's involvement and influence within the health collectives that were signalled by the Government to focus on the reforms at this time. With the rapid integration of Primary Healthcare Organizations (PHO) and the emergence of the nine health collectives, an opportunity was identified for nurse leaders to be involved in contributing to these policy changes through new approaches to collaborative working (Ministry of Health, 2010). An integrated approach to working would seem to support population health and potentially provide opportunities for nurse leaders to be part of the processes to foster the future development of new models of care delivery. Additionally a distributed leadership model lends itself to integrated working with contributing coalitions of experts. The successes and challenges in advancing as nurse leaders was explored through the theme and sub theme identification process, which are discussed in the previous two 'Findings' chapters.

The findings from this project suggest that nurse leaders continue to face significant challenges in primary health care as clinical, professional and strategic leaders. Nursing leadership is poorly profiled with supportive infrastructure only evident in pockets. Development of nurse leadership in primary health care is unstructured and there appears to be significant regional diversity and varied investment in roles. Associations with nurse colleagues and particularly medical colleagues have been described as both positive and challenging; in addition coalition working, such as team working via a distributed model framework appears to remain hierarchical and only workable where strong nursing infrastructure has been demonstrated. Coaching and mentorship for nurse leaders again appeared to be lacking, with no centralized programmes or structured opportunity to access support or training. The adoption of a distributed leadership model (Turnball James, 2011) by nurse leaders and interprofessional leaders potentially offers a process of partnership where each party could benefit from a joint working approach

where each is heard, contributions are negotiated and decision making is consensual. It appears that the current environment of health collectives has not fully enabled a process such as this to materialize and professionals in the business of healthcare need to pay closer attention to improving their inter connectedness for the purpose of positive population outcomes.

Strategic Positioning

As with the introduction of the Primary Health Care Strategy (Ministry of Health, 2001), the current Government's reframing of health services offered significant opportunity for nurses to lead and contribute to healthcare enabling greater involvement and promoting a mandate for nursing to be strategically and clinically involved and positioned to positively contribute to any envisioned or planned changes. The visibility of nursing and the ability to be involved in change processes has proved challenging over the last decade and appears to continue to be fraught with frustrations for nurses leading and nursing per se. This raises a number of leadership questions for primary health care nurses. These centre firstly around how well prepared nurse leaders are to strategically, clinically and professionally engage in change processes that are driven by policy. Secondly, what training and educational provision will support nurses to lead with influence and challenge in interprofessional environments? Thirdly there appears to be a need and importance for nurses to connect with other primary health care nurses, to provide peer support and work more collaboratively.

The ability to engage interprofessionally (between non nursing colleagues) and intraprofessionally (between nurses) is not only dependent on the quality and skill of the nurse leader in question but importantly their presence, their availability and their context or organizational environment. Hartley and Benington (2011) suggest that leadership is essentially shaped by the context, and within health the fluidity of the environment demands leaders who are not solely equipped with key characteristics, but those who can adapt and respond to the complexities of these systems. Early on in this study, identification of nurse leaders proved to be difficult, leading to the realization that primary health care nursing frameworks and structures were fragmented and poorly defined.

With the invisibility of primary health care nurse leaders identified early on the depth and breadth for nursing input into the health collectives was potentially threatened and indeed one of the nurse leaders identified for interview was disestablished and unable to continue through to interview for this project. Where there was an established regional team or organized nursing leadership infrastructure, nursing development appeared to be proactive. Nelson et al., (2009) similarly found that with organized effective nursing leadership, short and long term project development and innovation was more likely to achieve objectives. Also the contribution of nursing from the workforce level to the policy and strategy table was more likely to result in organizational change where leadership structure was visible.

Where clear titles identified the nurses who were leading either for a generic purpose or within a specialty, or for education and training purpose, the opportunity to gain additional support to undertake leadership training and further education was more likely to occur, which helped support individual leadership journeys. The legitimacy of nurse leaders so far as the type of leadership role they held appeared to also make a difference. This appeared to have an influence on their connectivity, both with nursing and medical colleagues. Formal authority exemplified through a specific position, such as a primary health care Director of Nursing position within an organizational infrastructure increased nursing visibility and enabled contributions to the health collective groups or fora. Leadership without formal authority or as Hartley and Benington (2011) suggest 'beyond authority', appeared to be represented by the nurse leaders in a mixed way. Persistence and out of hours working via voluntary roles with professional bodies served to legitimize authority for some leaders through their followers, peers and the organizational profile they gained. Others appeared to gain authority through continuously reminding managers and medical colleagues that nursing should not be negated when planning patient care, and service delivery. Formal authority however seemed to yield the greater access to power in terms of those nurses being able to play a part in the decision making. This ability to influence is seen by Heifetz, Gradhow and Linsky (2009) as part of the toolkit to leading where authority, power and influence serves as a purpose of doing rather than being. From this assumption it might be suggested therefore that the power to influence serves as a political tool to enable policy and decisions to be made. Conversely the political is power and an intimate understanding of political directives and agendas allows nurses

to be more actively persuasive within an organizational environment. Marquis and Huston (2009) suggest a key strategy for nurses is to learn to ‘read the environment’ alongside gaining insight into the informal power structures that may be evident.

A number of participants explained their route to influencing decision making as that of alignment with the dominant power sources within their organizations, planning and funding departments or the medical profession. It might be suggested that nurses need to guard against becoming medical refugees by seeking to ride on the coat tails of doctors. Others preferred to influence by seeking to lead with, rather than for, medical colleagues, which had the potential to result in disagreement and challenging situations. Both perspectives, raise the question of whether the political power and the power to be political results in nurses who are leading, nurses who are being led, or nurses who are on a lead.

In addition, where nurse leaders had influence at a governance level and the ability to impact planning and funding decisions, the ability to drive change with nursing impact was more likely to occur and be sustainable. This finding is supported by the Investing in Health document, (Ministry of Health, 2003) and Carryer, Dignam, Docherty and Lightfoot (2001) with central messages focused not only on developing participative health teams, but on nurses playing a key role in leadership and governance processes to advocate and influence decision making for healthcare provision. Good governance is reflected in the range and interest of primary health care stakeholders. Māori, nurses, and community representatives alongside other professional and business groups can provide quality representation at board level. This will ensure affordable and sustainable approaches to service delivery are considered and factored into population based healthcare practices. Conversely even where nurse leaders were able to identify issues and articulate them, with little influence over how funds were utilized to effect change, their power to make a difference was marginalized; in this instance tokenistic leadership only was communicated.

Persistent and on-going efforts to clinically, professionally and strategically lead interprofessionally with medical, allied and community colleagues were perceived to be beneficial by most nurse leaders in enabling better and more effective patient outcomes responsive to primary health care needs. This finding is supported by the international

literature (for example, Rosen & Ham, 2008; Ramsay, Fulop & Edwards, 2009), which highlights that the achievement of health gain results from strong clinical leadership aligned to community and business objectives to achieve integrated care working. Health collectives that involved nurse leaders and sought expertise from clinical nurse leaders in the redesign of services appeared to be more productive and efficient in progressing planning and implementation. Additionally when these participants could work with DHB and PHO nurse leaders the impact was even greater. Greenhalgh et al. (2004) explored collaborative working, and suggest 'simple rules' amongst those who are cross or joint working, can support the coordination of service development, a principle which may have better facilitated the work of nurse leaders within the distributed model approach, often espoused by the health collectives but not followed.

An additional question that is raised when considering the work of nurse leaders within these regional health collectives is the fact that each health collective presented a new primary health care structure, which appeared to either sit separately to current PHOs or form the body of merged PHOs. As another structure separate to DHBs and PHOs with the purpose of reframing services whilst current healthcare business continued from DHB and PHOs, duplication of planned services was highly likely. Unless clear principles and effective coordination as described earlier, plus cross working engagement and consultation could be demonstrated there was a significant risk of further management bureaucracy through these health collectives creating greater fragmentation and pocketed areas of working.

As a whole it appeared that policy drove the health agendas, including those of nursing. The reforms of the health sector have been described by Morgan and Simmons (2009) as potentially misguided or ill-informed when decisions that are made are driven by the desire for more votes. They suggest that by depoliticizing health and promoting a long term plan of health through cultural change and prioritising care rather than treatment, we will only then begin to address the significant issue of increasing disparity between what people expect and what services we as health professionals can ably deliver.

Where formal leadership authority was aligned to a robust nursing infrastructure with a remit specific to the needs of primary health care and community, influencing decisions had a greater chance of impact. This was well demonstrated by participants when either

secondary care links with funders or Directors of Nursing were enabled through strong relationships and clear communication. In addition whilst it was identified that formal primary health care nursing leadership positions were fragmented, in that they were not clearly identifiable; where there was a defined and formal role, the impact to profile nursing and influence strategic decisions appeared to be greater. Donovan, Diers and Carryer (2012) agreed with the notion that positional leadership contributed to the visibility of nursing and achieving momentum on key issues, although as a process they found leading did not always have to be demonstrated through defined leaders. In this study, nursing did not appear to drive a specific policy issue, rather be the contributor to an agenda, such as whānau ora or new models of service delivery. The ability to lead at a policy level was therefore identified to be lacking or invisible and the challenges for nurses in working together, organisationally, regionally and nationally across the sectors could be a reason for this.

The profile and visibility of primary health care nurse leaders is demonstrably different to those leaders working in the District Health Board or secondary healthcare setting. The links between the two remain segmented and consideration of further collaborative working to improve health gain is required. The ability of nurse leaders to cohesively facilitate a response to the care needs of patients, populations and their social needs, wherever they may be placed on the continuum of health, is the key factor. To enable this nurse leaders may need to consider more carefully the health gain that can be delivered through cross working with other nurses in a bid to break down the 'primary-secondary' divide. Participants openly discussed the benefits for nursing and other disciplines of cross working, and conversely the challenges to service delivery when nurses did not connect, locally, regionally and nationally.

The issue of stretched capacity, workforce demands, increasing disparity and the ageing workforce concerns (Morgan & Simmons, 2009), demand smarter solutions to care such as cross working or integration. It may therefore be proposed that if the medical lens alone continues to be the dominant influence then the view will be that of only fifty per cent capacity, leading one hundred per cent of the workforce. The resulting patient services will continue to be delivered in a non-sustainable fashion from one professional perspective alone. The Ministry of Health (2012) clearly supports clinical integration driven by effective clinical and professional leadership, and suggests success will be

determined through collaborative cultures, strong integrated governance and supportive systems as the key enablers. True appreciation of this integrated approach to service delivery continues to be a challenge for nurse leaders, as the clinical and professional power base seems to remain unduly weighted towards a medical model.

Calverley (2012) comments on the need for a shift in the way nurses respond to the needs of communities and how this requires strong leadership if this is to become a priority on the policy agenda. Additionally, as the public continues to take ownership of their health needs, nurse leaders may need to reframe the direction for nursing consistently with a focus on what can be delivered from the perspective of the consumer or those in receipt of care, right at the start of any discussion, any forum or any high level strategic meeting, ensuring goal objectives are focused on ‘...what are the community requirements?’ (Calverley, 2012, p.46)

Furthermore this raises a question that refers to the need for nurses to consider how they can step outside of their existing roles as educators, coaches and leaders to respond from a primary health care perspective and support social aspects of care so crucial to fully understanding the needs of the communities. In line with this is the need to find a way as nurses within the wider primary health care team, to work collectively and with our colleagues to deliver services that are meaningful to patients primarily and which fit policy directives. If nursing leaders are to engage in adaptive behaviour that works towards adaptive solutions, they may be more aptly placed to challenge and advise the policy makers on strategy that again has meaning for our communities (Calverley, 2012). This ability to be flexible and adaptable is strongly indicated in the literature and whether nurses are leading individually or collectively, Marquis and Huston (2009) suggest that the rapid and frequent organisational reform faced by nurses in the health arena, demands expertise and resilience that can be harnessed by the individual and conveyed to the workforce. It is understandable that the energy required to manage continuous change is often tested to the maximum, due to a desire to maintain balance and stability. Tan, Wen and Awad (2005) discuss complex systems and complex organizations and the behaviours required to adapt to situations of change which are not always predictable. The unpredictability of change or chaos can result in many differing reactions from the people involved on the change journey and more often than not, dynamics alter due to the disruption to balance. As individuals we all like to feel in

control to some extent as this creates a sense of calm. Disruption to this balance can result in people feeling uneasy, threatened, violated, fearful and often angry about the ambiguity that has been created. Response mechanisms include adaptation, resistance and resilience. Tan et al (2005) suggest the handling of these organizational challenges are essential and intelligent and effective leadership which engenders team support, strong communication via feedback loops, and coaching to encourage learning and improvement will enable adaptation and adjustments. The unpredictable nature of change in health that many of the nurse leaders have faced over the last decade has required them to master many, if not all, of these response mechanisms and continue with business as usual in order to survive; more often than not via internal resilience rather than training.

A critical component of minimizing this disruption to balance depends on how well individuals and groups can respect, trust and adapt to both the leader and importantly the style adopted by the leader. In this way their on-going relationships remain functional and productive. Porter O'Grady (2003) reinforces the importance of leaders understanding how to be adaptive and able to work through change that threatens to disrupt individuals and organizations from continuing to achieve goals. Moreover, Huston (2008) signals that the nurse leaders response to change and review, is a leadership competency that is required by nurses as we move towards 2020. Interestingly, Turnball James (2011) further develops the theme referring to this adaptive leadership as a practice rather than a leader style, and suggests this approach to understanding leadership needs expanding. What does appear to be clear is that nursing leadership as experienced by the participants is not only dependant on their skill and behaviour, but additionally their degree of connection with self, the degree to which they had been able to engage in training and their relationships with people and organizations as a whole.

The collective source of power for nurses leading is undeniably inactive and this was clearly notable with the frustrations verbalized by participants and the references to battling and fighting, plus the difficulties experienced to influence decision making for some. Legitimate or formal power structures and sources do not overtly support a distributed model of working through coalitions of expert leaders. However without this legitimate authority some nurse leaders in primary health care appeared to be

disadvantaged and evidence of leverage and the power to influence could only be demonstrated where positions of formal authority were located. For this reason and noting the current unstructured state of primary health care nursing leadership, the adaptive challenge is again an important part of leadership practice which nurse leaders are required to develop. It is suggested, by increasing the individual personal power of nursing through the reflective practices of peer coaching, mentorship and networking, individual nurse leaders will gain greater support and insight to develop their skills in leading, adaptation and change. Additionally building on the profile of nursing through effective clinical, strategic and professional nursing leadership partnerships the ability to influence may be aligned and informed. Formal leadership positions appear to currently offer greater potential to influence decision making and as such are therefore more likely to raise the visibility of nursing's contribution to the care and social needs of our populations.

Role Development

Little structured education and training on leadership for nurses is available, an ad hoc approach to nurses gaining experience in this field appeared to be driven by the individual motivation of the nurse leader. The importance of leadership however at every level of care delivery was verbalized clearly by all participants and is a key component of the New Zealand professional development recognition programme for nurses. For those nurse leaders working in organizations where nursing infrastructure was established, the opportunity for nurses, in terms of accessing courses, whether formal or informal, appeared greater. Additionally whilst clinical leadership was crucial for these nurses, a knowledge and understanding of strategy decision making, policy drivers and nursing professionalism was likewise essential when working in an interdisciplinary and political environment.

Despite the fact many of these nurse leaders were guided by personal and internal philosophies to care and lead nursing through the change, it appears that they face many interprofessional challenges. One significant difficulty is the lack of direction available to guide nurse leaders towards maximizing their role and career potential as leaders. Added to this is the lack of direction in terms of the political knowledge or experience needed to help shape nursing's position in the context of these Government reforms.

International recognition of the need for this developmental guidance for nurses was illustrated in 2006 when the United Kingdom Department of Health published, 'Modernizing Nursing Careers', which was closely followed in 2008 by a national consultation (Department of Health, 2008). This proposed that nursing careers fit into five broad pathways. Essentially leadership as a framework within nursing career pathways could be indicated through a lateral approach or an upward approach to career development. This both served as direction for nurses but importantly illustrated that the UK was willing to invest in reviewing leadership for nursing in order to strengthen the workforce.

Further international commitment to nursing leadership is demonstrated by Martin and Reid (2009) through the National Nursing Midwifery and Allied Health Professional (NMAHP) work programme for Scotland 2009-2011 which represents the work plan of the Chief Nursing Officer (CNO) Directorate. Each of the eighteen work programmes is supported and funded by the Government and delivered in partnership with NHS boards (similar to New Zealand DHBs), key stakeholders and academic institutions via a focused and collaborative approach. Each programme also has a policy lead within the Chief Nursing Officer Directorate. Two specific projects included; 'Early Clinical Career Fellowships' a response to 'Modernizing Nursing Careers' and an initiative where nurses choose a clinically focused Master's programme with mentorship and support. This demonstrates how coalitions of experts have united in a commitment to succession planning and is in direct response to the aging workforce challenges. The Development of NMAHP Leadership Framework programme looked at developing leadership capability and capacity to board level. This aimed to support leaders in developing their full potential to leading change and service improvements in Scotland for nurses.

With the considerable membership in the New Zealand Nurses Organisation (NZNO) and the examples of leadership profiled in the United Kingdom National Health Service (NHS) it is timely for New Zealand to focus energy on a centralized, accessible, practical and professional leadership training programme, as a matter of priority and investment in our future nursing workforce. Consultation with nurse leaders across the spectrum of health could be modelled to engage need, identify gaps and variability in service. Leadership training and career pathways for nurses needs further investment

and energy if the nursing workforce is to be able to professionally measure quality initiatives that are as the result of change and reform. Joint working and cross working can translate too to our professional nursing organizations such as NZNO and College of Nurses Aotearoa and the academic institutions. Energy and funds would be invested wisely into the future proofing of nurse leaders again from a central approach with a national endorsement to uphold standard, quality and a united objective of role development through further education and succession planning. Further identification of primary health care leadership training could be offered and activated via the New Zealand College of Primary Health Care Nurses, NZNO and the National Executive New Zealand (NENZ) group, by adopting a coaching model to enable both peer mentorship and succession planning for the future. Inclusive rather than exclusive examples of National leadership fora which embrace innovation and relationship growth with primary health care nurses are advocated both in nursing and interprofessional organizations. Further development of leadership networks is recommended by Mackay (2007) who sees the benefits in nursing alliances to support practice innovation.

The development of an understanding of self and self-awareness was highlighted by participants as important to achieving goals and maintaining direction; this appeared to be learned through role models or training courses attended by the individual nurse leaders. Whilst a distributed leadership model fits well into organizational change processes, the importance of behavioural styles and individual competencies should still not be underestimated. Relationships and communication featured highly, as crucial factors in leading in the current climate where interprofessional insight and awareness by a nurse leader contributed more effectively to their personal, professional and social competence. Participants referred to the benefits of being honest and transparent when stepping up to the responsibility of leadership. Given the challenges faced by nurse leaders as described earlier, this ability to demonstrate what is referred to in the literature as emotional intelligence (Eason, 2009), to reflect on the motivation of others and to critically appraise situations is seen as a key attribute for nurse leaders. Grint (2005, p.1473) refers to “wicked problems” as those where there is no consensus and those which may result from a problem that is viewed differently by different personnel. Understanding another’s frame of reference or perception is suggested by Hartley and Benington (2011) to be a key skill of leadership. Goleman, (1995) further identified how much more useful leadership can be when it is focused on goal based decision

making, where reactions are moderated, and motivation is maintained even when faced with frustrations. Self-awareness qualities were clearly identified by participants as crucial to their leadership journey and can be associated with greater resilience and positive organizational and personal outcomes (Akerjordet & Severinsson, 2008).

Relationship Competency

The distributed leadership model suggests that leadership is integral to the successful practices of an organization and that this approach is not just based on behavioural style or competencies; the focus is on organizational relations, connectedness, intervention and change that relates to organizational practices and processes (Turnball James, 2011). The importance of leading to support organizational change is acknowledged as crucial and applicable to the health collectives explored at this time in New Zealand. Additionally, it appears to be appropriate and fit the health environment as Ham (2008) and Mountford and Webb (2009) purport to take a shared leadership approach which involves all clinicians or experts in a collective leadership approach to really make a difference to patient outcomes. However it has to be noted that within health whilst the nursing role is pivotal to the safe and quality health care decisions made, this was described by some participants as unacknowledged and devalued or negated in the absence of a nurse leader. This clearly has significant implications for team working and the ability of nurse leaders to truly influence decision making. Thus it is suggested that interdisciplinary working either with or without a distributed model framework still requires further work in terms of equitable partnering.

McMurray (2007) admits that nurses are faced with significant challenges when leading, firstly to highlight the social care needs of populations or social determinants of health and secondly to address the primary health care-primary care imbalance. Again while there is a need to be responsive via primary care, which is predominantly centred on the business model of General Practice; the wider social benefits of a comprehensive primary health care response to patient need are more likely to achieve sustainable outcomes. In this way, patient self-care behaviours can be maximized and care-seeking traits minimized through the relationships developed by skilled nurses, and the knowledge of the wider issues affecting their worlds and lives.

Relationships with medical colleagues was identified as positive by some nurse leaders and indeed aligning with medical colleagues was seen to be instrumental and enabling to the development and growth of services and innovation for some participants. Despite the fact that all participants endorsed the work of nurses in teams and collectively with other professionals, some did allude to the hierarchical presence within a team as a flaw which left each level of clinical, practice or strategic leader in an unbalanced environment of power and control. Brown, McWilliam and Ward Griffin (2006) identified the need for nurses to challenge systems, organizations and personal barriers to practice which could hinder their potential to achieve best care outcomes with patients. They encouraged nurses to seek alternative ways to exercise their professional autonomy and overcome the constraints of controlling models of service delivery.

Working within organizations such as the health collectives at the current time and the steps all nurses took to be in their current positions, demanded fortitude and the ability to be able to bounce back. Nurse leaders fought hard to develop positive relationships, for some however this still did not have the impact they envisioned in terms of being able to influence decisions through nursing input, and the concern around the leadership role as a tokenistic one was mentioned on a number of occasions. Where leadership practices were focused on a solution or outcome, such as patient benefit the association or working within a coalition appeared to be more productive. Additionally where the purpose could be aligned with the collective interest, the utility of the nurse or doctor as an expert participant in the process was seen as important in that the achievement of the goal was the most important factor, rather than the leadership behaviour itself as has been historically espoused (Stanley, 2009).

Interestingly participants identified the crucial importance of being able to communicate well and build relationships. For most they had gained no specific training on knowledge acquisition, on how to politically engage or respond to policy change. Their abilities to lead in this sense were largely experiential in nature and depended on individual awareness, astuteness, learned behaviour, role modelling, personal interest and voluntary work on professional groups outside of individual roles. Role modelling clearly supported personal development in this area.

For some participants, it was clear they had not always gained support from their own nursing colleagues. With no clear direction for nurses leading in primary health care and fragmentation, in terms of succession planning, the tall poppy syndrome, where those seeking to achieve are negatively targeted, appeared to exist and had been experienced by some nurses.

Peer coaching and peer mentoring for others had provided the catalyst for change and development and along with this, acknowledgement and encouragement from peers to continue to grow. Parker, Hall and Kram (2008) describe peer coaching as a helping and reflexive process, where support is formal or informal. They suggest along with Siegel (2000) that peer assisted learning can provide important communication connections between colleagues, can reduce isolation and build self-confidence. Certainly this is an area for nurse leadership development that is worth exploring further and incorporating into both post graduate primary health care education papers plus leadership programmes as discussed earlier. Some participants had also observed a major shift in their growth as leaders from the post graduate education they had undertaken and in some cases this could be pinpointed to a specific tutor or academic lecturer, and through accessing reflexive support from colleagues. By combining and enhancing education programmes through reflexive processes such as peer coaching, a change towards improved leadership efficacy is likely to be more achievable (Wilson, 2007).

Limitations

Three limitations to this study have been identified and need to be noted when consideration is given to the findings. Firstly, the size of the study captured a snapshot view of the participants' roles as nurse leaders in the current fluid environment. The researcher has clearly indicated that the context is dynamic as is leadership itself, especially during change and health reform. As a result of this observation, participant views are also subject to change as the climate evolves and new processes emerge.

Secondly the distributed leadership model used to provide a framework in which to situate the research process, although useful and significant to providing a potential structure and model of leadership representation within this fast moving change environment, appeared to be too premature for some areas. Coalitions of experts

working in a partnership approach were more likely to be in established and functional organizations where nursing was afforded credibility and infrastructure. This was clearly not evident in some incidences and therefore, the model appeared to be challenging for some nurse leaders due to many relational variables already discussed.

Thirdly the researcher was situated in a voluntary, professional leadership position at the start of this project, and during the course of this work moved into a primary health care leadership position following organizational restructure. Therefore these personal exposures to primary health care leadership change and the social and care priorities perceived to be important by the researcher could potentially affect the way data has been interpreted and presented.

Whilst there appears to be some differences in the perspectives conveyed through the participant data obtained, there is consistency in the participant responses that have been collated. Most variation appears to be specific to organizational context and/or individual participant values and beliefs. The consistent, systematic and simplistic data collection and analysis process utilized within this research lends itself to transferability; additionally the use of the conceptual framework offers a point of reference for the future exploration of leadership within any health care setting and at a different point in time.

Conclusion

Nurse leaders demonstrated a number of significant challenges to their roles in the current dynamic climate. Clinical, strategic and professional leadership was affected by the context or environment, alongside the investment in nursing infrastructure and formal roles that legitimized authority. This authority appeared to be a determining factor in a nurse leader's power to influence. Intrinsic to this positional authority is the political intelligence of the nurse leader which at the present time appeared to affect the level of impact the nurse was able to have within the health collective change process.

Leadership programmes that are nationally consistent and are combined with academic preparation, clinical education, training and access to peer coaching or mentorship could better reduce the disconnect between primary and secondary care nurse leaders and their

roles; nurture improved networks and alliances; and facilitate a reduction in the currently fragmented primary health care nursing leadership placement and development. Surowiecki (2004) suggests decision making can be improved through the collective intelligence and wisdom of a group, rather than relying on individual brilliance.

A distributed model of leadership provided a conceptual framework to map out an approach to this research project which allowed for nurse leader positioning to be explored. The model's utility appears restrained as primary health care nurse leaders continue to face challenges around determining their place in the political system and their relationships with other disciplines which appears to significantly affect their power to influence, either positively or negatively. The opportunity to make connections and work with both nursing and interprofessional partners in an equitable way cannot be underestimated. If allowed to flourish, this successful blend has the potential to communicate an interdisciplinary workforce approach of best practice benefits for population health.

Chapter 7 - Conclusion and Recommendations

Introduction

The aim of this research was to explore with nurse leaders how their roles within the recently established health collectives might impact on nursing and health change. New Zealand and international literature focuses predominantly on the key characteristics and qualities leaders require to be effective, however increasingly new evidence is recommending a post heroic or a distributed model of leadership (Turnball James, 2011) to demonstrate greater collective leadership outcomes. By using a distributed leadership framework to review the position of leadership at this time a number of issues have emerged which suggests that adopting a model such as this, although potentially useful, remains particularly challenging for nurses. The literature review supported the need for qualitative research to assess and benchmark the roles and expectations of nurses currently leading in the dynamic primary health care environment.

The participants involved in this study demonstrated a considered commitment to leading in a variety of ways and despite significant challenges, their energy and capacity to work outside of their paid roles to promote nursing and be responsive to requests for nursing input or information, is noteworthy. An investment in future-proofing nurse leadership positions in primary health care at all levels of service requires a dedicated and systematic approach to planning and development, plus alignment with other nurses who are currently leading across the sectors. This is currently unavailable to New Zealand primary health care nurses.

Overview

In 2009, the selection by the Government of nine health collectives provided the avenues for reform and change within primary health care to begin. Clinical leadership was heralded as crucial (Ministerial Review Group Report, 2009) and the researcher chose to undertake a qualitative project to explore the nurse leaders positioned within these health collectives at the current time. With leadership described as an essential foundation for practice (McMurray, 2007) the researcher was keen to explore how well nurse leaders were engaged in the process of change and the implementation of new services. A conceptual framework based on a distributed model of leadership was used to help explore with the nurse leaders their role, their position, their interactions,

influence and relationships and the successes and challenges they experienced. This framework proposed a useful approach to leading which was responsive to the MRG (2009) mandate for disciplines to work collectively and would examine the potential of interdisciplinary models to leading in the new health collective environment. This approach relies on a coalition of expert leaders, nursing being one in this case, to influence change and collectively be involved in decision making.

For this study, purposeful participant engagement enabled the researcher to focus the inquiry on the nurse leaders represented in each of the nine health collectives at the time. All participants were swift to respond to requests to take part in the project and were open to discussion with a strong desire to be involved and be part of the exploration journey. This was exciting and supported the intent of the project to identify important knowledge, which was considered potentially beneficial at this time for future leadership development. From the discussions and areas identified by participants it was clear that the research process offered a way for their experiences to be examined and emerge. Furthermore, in order to understand the significant degree of ongoing work required to support the development of nurse leaders in primary health care, it was evident that the questions asked yielded rich responses to which these future issues could be identified and addressed.

It was clear from issues raised by participants that their ability to lead was influenced by both positive and negative factors and experiences. It is suggested that a number of these can be addressed through a commitment from the national nursing organizations, universities and professional bodies. A joint working approach which involved clinical leaders, academic and strategically positioned leaders and the aforementioned professional organizations may serve to profile a unified programme of leadership activity in New Zealand. This would include future planning that is considered and implemented by organizational and professional bodies working in unison with academic professionals and existing nurse leaders across all sectors. The current fragmentation of leaders and evidence of a primary-secondary leadership gap requires priority attention if nursing itself is to develop the infrastructure it urgently needs, to both raise the profile and credibility of nursing in primary health care to deliver services, and to support appropriate education and training around the development and growth of new nurse leaders for the future.

Other areas to focus on will help to determine a nurse leader's ability to more ably work in an interdisciplinary fashion with aligned colleagues in a productive and negotiated way. If coalitions of leaders, expert in their specific profession are required to build relationships with all professionals engaged in the business of health and in political discussion, the consistency in the language they use to message the nursing agenda could potentially be more effectively conveyed. A recent qualitative study by Donovan, Diers and Carryer (2012) acknowledged that the political language that links in with the policy agenda is a key skill for nurses to harness. In the first instance this may serve to strategically gain attention, and secondly the skill of communicating effectively may support nurse leaders through some of the 'battles' and difficulties that most participants described and commonly confronted. Additionally given current fiscal constraints and the perverse reality and demands to reduce costs but improve productivity and to likewise increase outputs through centralization and downsizing, if nurse leaders can demonstrate their ability to influence funding and planning decisions, their language needs to be tailored accordingly. The recommendations will take into account these factors based on the participant discussion and findings already outlined. Further consultation with the named organizations and networks would be required to activate these recommendations further.

Recommendations

The participants in this project conveyed commitment, energy and dedication to their leadership roles within the health collectives. They highlighted the importance of politicization and concurrently the development of relationships as significant when working with nursing colleagues but most importantly when leading in interdisciplinary fora. For those leading in organizational settings where the nursing infrastructure was established, training and education opportunities were easier to access, however there was no universal leadership coaching available for nurse leaders, and most had taken opportunities when they had arisen. With significant challenges evident and the strong need to be resilient identified, it is timely and significant that clinical, strategic and professional nursing leaders need to review planning for the growth of future leaders. Participants discussed a combination of learnings that had supported their leadership journey. Based on this the following recommendations have been identified:

- Nurse Executives New Zealand (NENZ) partners with the New Zealand College of Primary Health Care Nurses, NZNO and General Practice New Zealand (GPNZ) to actively scope current nurse leadership positions in primary health care which are situated in DHBs, PHOs, health collectives and NGOs to gain a clearer understanding of the available leaders able to contribute to nursing workforce development in New Zealand.
- For NENZ to ensure that a significant quota of their membership reflects the nurse leadership roles scoped in primary health care to enable input into policy issues and begin to bridge the primary - secondary nursing divide.
- The NENZ regional structures are reviewed and leadership across the regions becomes a priority review piece of work led jointly by these identified primary and secondary nurse leaders.

It appears that a blend of leadership preparation options would be required to comprehensively support nurses in the current changeable environment. Again whether they are working clinically, strategically or in a professional capacity the levers towards influencing change and impacting policy, are seen as threefold:

1. Academic preparation
 2. Training and education
 3. Coaching and mentorship
- The National Nursing Organisation (NNO), university nursing leaders and NENZ work in partnership with the New Zealand Coaching and Mentoring Centre to develop and invest in a leadership workshop programme through a formalized process.
 - A regionally and nationally consistent approach to leadership training and peer coaching is adopted and developed to model the way for future development of nurse leaders.

- The New Zealand College of Primary Health Care Nurses (NZNO) partners with NENZ to develop a principles document on negotiation, strategically influencing and politicization (engaging in political discussion) as a guiding document for ongoing leadership development in New Zealand.
- An apprenticeship model of training is considered between the Chief Nurse Ministry of Health team and university nursing leaders to allow placement and experiential learning in policy development and raise political acumen for nurses.
- The Chief Nurse team at the Ministry of Health invests in an inclusive 'careers in nursing model' to set the direction for role development and succession planning for future nurses working in the business of healthcare using the visual map design (Department of Health, 2009) (Appendix F) as a framework to inform the process here in New Zealand.

Conclusion

There is continued pressure on nurses to lead in a fluctuating primary health care environment with ever increasing demands on service delivery and patient need. Models of service are encouraging nurses to expand their roles, maintain currency in clinical issues, and lead nurse clinics and case management activities. Additional to this is the strategic and policy input nurse leaders are involved in, meaning they are expected to contribute to, and be involved in, decision making processes. All these activities demand appropriate training, preparation and ongoing coaching support. Enabling a consistent approach to clinical, strategic and professional leadership development through established organizations will refocus the lens of leadership on nursing to bridge the current divisions between primary and secondary nurses. A committed approach to establishing improved relationships and networks alongside programmes to raise the skill and capability level of nurse leaders working in primary healthcare will ensure they may be more responsive to the dynamic environment.

Clinical, strategic and professional leadership pathways appear to be poorly supported in terms of learning and likewise fragmented possibly due to minimal nursing

infrastructure and also the lack of nursing career direction or pathways available in New Zealand. In order to reshape the future for nursing, investment and energy into nursing career options and configurations may serve to support both career and leadership development in our future workforce. A design for nursing careers depicting the diversity in options and progression pathways available to nurses in England (Department of Health, 2009) (Appendix F) offers a visual depiction of potential to nurses not currently available to our New Zealand counterparts. This is certainly a model nurses could utilize to support the growth and maturation of nurse leaders which conveniently incorporates the academic preparation, educational and training requirements for nurses, plus supportive mentorship recommendations as benchmarking to support career planning.

Participants involved in this project shared their challenges and the energy they had invested into their roles as nurse leaders in not only the current dynamic climate but in relation to their leadership journey to date. If leadership is to be described as the bedrock of organizational change, practice and policy development (M. Jones, personal communication, 27 November, 2009) then harnessing the leadership potential for nurses is pivotal to population health changes. In order for nurses to lead effectively, they need to be equipped to respond appropriately and be at the core of healthcare discussions, rather than pulling on a lead to catch up with the play.

Finally in answering the question, BSMC is there room for me? The answer would have to be, maybe. A policy framework now exists within the New Zealand health system to support and indeed thrive upon well informed and effective nursing leadership. Yet some organizations still need to find room for such individuals, whilst some nurse leaders have to adjust their skill set and presentation to fit the gaps open to them. Our primary health care system has both the room and need for quality leadership from every quarter; we must continue to work collectively to meet the need and so provide individuals, groups and communities with the best possible access to timely care.

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Appendix A-Ethics approval

Northern X Regional Ethics Committee

c/- Ministry of Health
650 Great South Rd
Penrose
Auckland
Phone: (09) 580 9105
Email:

northernx_ethicscommittee@moh.govt.nz

30 September 2011
Rachael Calverley
30B Redwing Street
Browns Bay
North Shore City

Dear Rachael,

Ethics ref: **NTX/11/EXP/231** (please quote in all correspondence)
Study title: An exploration of nursing leadership in the primary health care setting
Principal investigator: Rachael Calverley
Supervisor: Annette Huntington

Thank you for your application received on 27 September 2011. This study was given ethical approval by the Chairperson of the Northern X Regional Ethics Committee on 27 September 2011.

Approved Documents

- Protocol [dated 2011-2012]
 - Information sheet/Consent form [undated, received 27/09/11]
- Please ensure you include a version number and date in the footer of your information sheet/consent form, eg Version 1, 27 September 2011
- Confidentiality Agreements [undated, received 27/09/11]
 - Authority form [undated, received 27/09/11]

This approval is valid until 30 November 2012.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by **30 September 2012**. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where

they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the [Operational Standard for Ethics Committees](#) and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the [Health Research Council Act 1990](#).

We wish you all the best with your study.

Yours sincerely

Sabrina Young
Temp Administrator

Appendix B – Participant consent form

An exploration of nursing leadership in the
Primary health care setting

PARTICIPANT CONSENT FORM – INDIVIDUAL

I have read the **Information Sheet** and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I wish/do not wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

Full Name – printed

Appendix C – Transcriber confidentiality

An exploration of nursing leadership in the
Primary health care setting

TRANSCRIBER’S CONFIDENTIALITY AGREEMENT

I (Full Name - printed) agree
to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than
those required for the project.

Signature:

.....

Date:

.....

Appendix D – Information sheet

An exploration of nursing leadership in the

Primary health care setting

INFORMATION SHEET

Researcher Introduction

My name is Rachael Calverley and I am a Registered Nurse currently undertaking a Master of Philosophy (Nursing) at Massey University. A component of my study is to undertake research and I have chosen to explore nursing leadership in the primary health care setting. I am passionate about primary health care nursing and the potential of nurses to make a significant and long lasting positive effect on people's lives. As many of you know this is not without its challenges; one of these challenges is ensuring we have primary health care nursing leadership that actually makes a difference.

Project Description and Invitation

I would like to invite you to participate in this research project which aims to explore the current positioning of senior nurses in primary health care. You have been identified as a senior nurse leader working on one of the nine BSMC health collectives I am interested in exploring your involvement and influence in the new and evolving primary health care environment.

Participant Identification and Recruitment

You have been identified as a senior nurse leader working in your regional health collective. This initial email invites you to take part in this research project and includes relevant detail for your information. Attached also to this initial e-mail is a participant consent form which you are asked to consider and sign if you are in agreement. Once you have agreed you are asked to e-mail or post back this consent form.

Your contribution is highly valued and considered crucial to gaining a greater understanding of the current situation with regard to primary health care nursing leadership.

Project Procedures

I hope to recruit nine participants in total to ensure representation from each health collective across New Zealand.

Once you have consented to taking part, you will then be supplied with some trigger questions via a follow up email, to consider for telephone interview.

A mutually agreed date and time will then be scheduled to carry out the telephone interview.

The telephone interview will last approximately one hour.

Data Management

All of the information you provide will only be accessed by me, my supervisor and the transcriber for the telephone interview; all will be required to sign agreements of confidentiality.

Your anonymity in the presentation of the results and or any subsequent publications relating to this research project will be preserved as any identifying details will be removed..

No information gained in this research project will be shared with your employer

You will be notified of the research project results and be able to access a copy of these.

Consent forms and recorded transcripts will be securely stored with the researcher.

Recorded interview tapes will be returned or destroyed according to your preference.

Participant's Rights

You are under no obligation to accept this invitation, however if you decide to participate, you have the right to:

Decline to answer any particular question.

Ask for the recorder to be turned off at any time during the interview.

Ask any questions about the study at any time during participation.

Provide information on the understanding that your name will not be used unless you give permission to the researcher.

Withdraw from the study at any time up to the end of data collection

Be given access to a summary of the project findings when it is concluded.

Your input into this research project is highly valued and much appreciated. I look forward to working with you on this further.

Please consider this information and if you are keen to participate, please complete the attached participant consent form and email or post it back to me (email and address supplied below). Do not hesitate to contact me or my supervisor for any further questions; details below:

Rachael Calverley

rachcalv@gmail.com

30B Redwing Street

Browns Bay

Auckland 0630

Cell-phone 021 163 4897

Dr Annette Huntingdon

A.D.Huntington@massey.ac.nz

04 8015799 Ext 62569

Ethics ref: NTX/11/EXP/231, 27th September 2011

Appendix E- Topic guide

Areas for discussion (to put in the second email, once a participant has consented):

Position

How you came to be in your current position.

How you came to be in a position to have input into the health collective.

Nurse leader qualities

What you think might be useful qualities and characteristics for a nurse leader

Development of the nurse leader role

Teamwork and leadership

How might the nurse leader fit into the Multi disciplinary team (MDT?)

Having influence within a MDT framework

Challenges and positive experiences/opportunities

Being heard

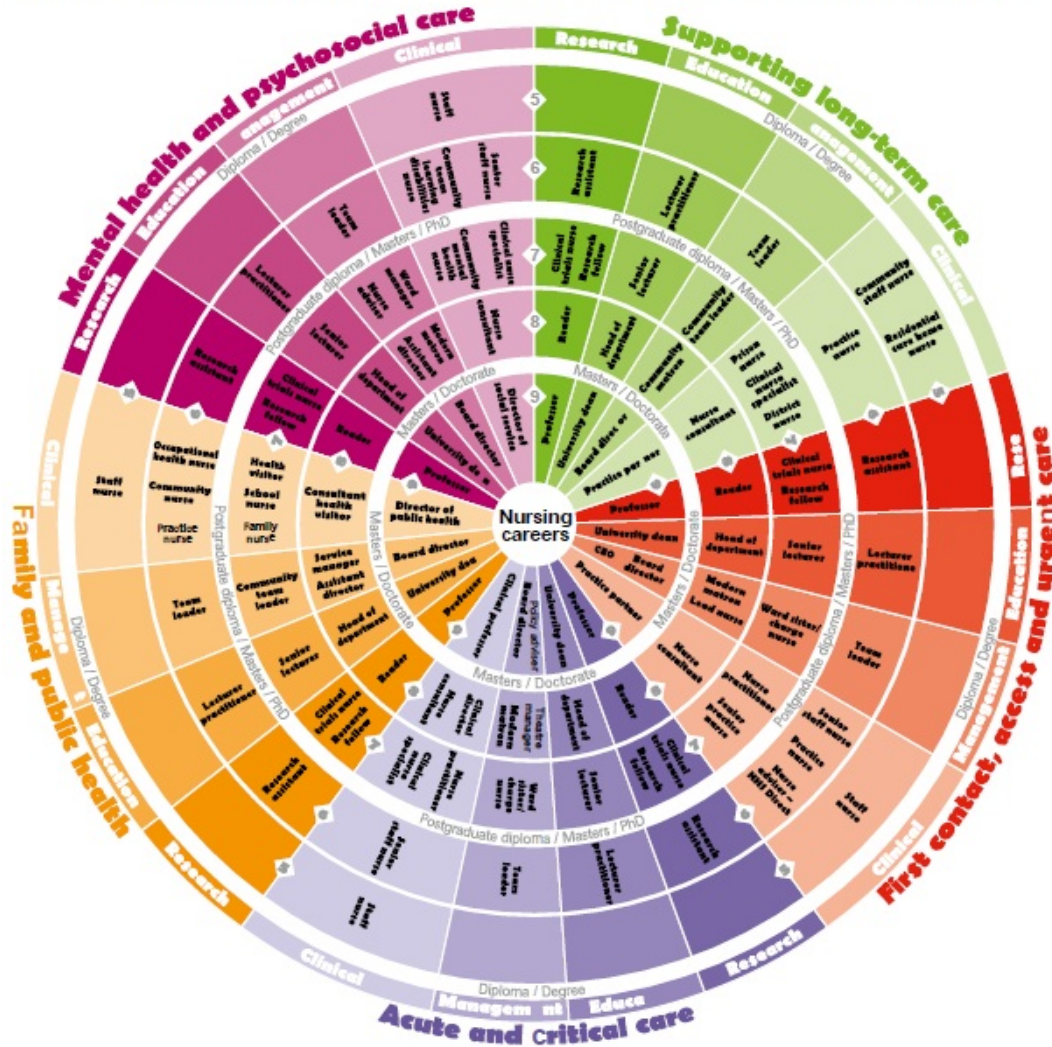
Having an impact

Activating progress from nursing input

Appendix F-Shape a quality nursing workforce

Shape a quality nursing workforce

Whether you're a service manager in a primary health care team or a workforce planner for a region, you need to get the most out of your nurses. The best way to do that is to understand the profession's wide-ranging potential. For more information, visit www.nhsemployers.org



Target resources more effectively

You may have to manage your nurses across settings, from hospitals to the wider community. Or you may have to think more about how nurses provide care in pathways from public health to acute and critical care. Whatever your exact responsibility, you will have to take an increasingly innovative approach to service design in order to deliver quality. Put the emphasis on prevention and help nurses to help children, young people, adults and older people to manage their health.

Get the best from each nurse

To design an effective nursing team, you need to consider more than just numbers of bodies. You also need to think about how much more value can be leveraged from nurses working at higher levels on the NHS Careers Framework. It's crucial to get a good mix of roles at the right level:

- Level 5 – Practitioner
- Level 6 – Senior practitioner
- Level 7 – Advanced practitioner
- Level 8 – Consultant practitioner
- Level 9 – Senior leader

Educate and develop

To deliver successful outcomes for your clients, you need to support your nurses in their professional development. Nurses given the right education and training (with early opportunities for postgraduate achievement) are better equipped to work with doctors, physiotherapists, pharmacists, radiographers and others – including healthcare support workers. They are also better able to support service users' smooth movement across the healthcare system, to ensure that they experience high-quality, safe and effective care at all times.

Balance the nursing skills mix

As nurses progress from their first job up to the executive board, they build on their skills as practitioners, partners and leaders. Each nurse can offer you these core competencies:

- Autonomy and accountability
 - Advocacy and negotiation
 - Assessment and referral
 - Decision-making and clinical skills
 - Managing complexity
 - Caseload management
 - Care pathway co-ordination
- For more details, visit www.skillsforhealth.org.uk