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Strengthening Nursing, Midwifery and Allied Health Professional Leadership in the UK: a realist evaluation

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Abstract

Purpose

This paper shares the findings of a realist evaluation study that set out to identify how to strengthen nursing, midwifery and allied health professions (NMAHP) leadership across all health care contexts in the UK conducted between 2018-2019. The collaborative research team were from the Universities of Bangor, Ulster, University of the West of Scotland and Canterbury Christ Church University.

Design

Realist evaluation and appreciative inquiry were used across three phases of the study. Phase 1 analysed the literature to generate initial programme theories (IPTs) about what works, tested out in Phase 2 through a national social media twitter chat and sense making workshops to help refine the theories in Phase 3. Cross cutting themes were synthesised into a leadership framework identifying the strategies that work for practitioners in a range of settings and professions based on the context, mechanism and output (CMO) configuration of realist evaluation. Stakeholders contributed to the ongoing interrogation, analysis and synthesis of project outcomes.

Results

The study generated 3 initial programme theories and five Guiding Lights of leadership that enable and strengthen NMAHP leadership across a range of contexts in addition to a leadership impact framework, and 360 feedback and reflection tool to aid leadership development in the workplace.

Originality/value

The realist evaluation with additional synthesis from key stakeholders has provided new knowledge about the principles of effective NMAHP leadership in health and social care, presented in such a way that facilitates use of the 5 guiding lights to inform future practice, education, research and policy development.

Classification of Article: Original Research.

Keywords: Transformational leadership, nurse, midwifery, allied health professions leadership, realist evaluation, appreciative inquiry.

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Introduction

This paper presents the findings of a three-phase study which aimed to strengthen nursing, midwifery and allied health professionals' (NMAHP) leadership practice in the UK across a range of practice based contexts. The study, funded by The Burdett Trust, intended to identify what NMAHP leadership strategies work, why and for whom. The outcome was five 'guiding lights', a metaphor describing the salient features of leadership that reflect a strong relationship and value-based approach relevant to contemporary health and social care. The term 'guiding lights' has been coined in preference to 'simple rules' used by other researchers when translating complex insights or findings into principles based on realist reviews undertaken by Best *et al*. (2012) and Plsek and Wilson (2001). The project also created a vision for the future of leadership through a narrated visual presentation at https://hml.helix.uws.ac.uk/Play/17172, a leadership impact framework and 360 degree feedback tool to facilitate practitioner self-reflection and assessment.

Over the past couple of years there has been a noticeable philosophical shift in understanding about how leadership impacts on culture, quality, safety, staff and patient experience in health and social care (Cardiff *et al.,* 2020; Manley and Jackson 2020; Manley et al., 2019). This shift has prompted debate about the need to identify what works well in both formal leadership programmes as well as in workplace teams and organisations. It is especially important in a pandemic world that NMAHP leadership contributions are visible and valued in all international contexts and literature (Duignan *et al.,* 2020; Bell and Colleran, 2018). UK evaluations of leadership programmes (Hocking *et a*l., 2020; University of Manchester 2017) are heavily weighted towards the NHS, exclude social care and do not identify i) what difference they make in practice longitudinally, ii) whether there is any cost benefit for system investment, iii) what impact they have on reducing workforce inequalities, or on improving patient and staff outcomes. The purpose of this paper is to contribute to this debate by presenting the principles for strengthening nurse, midwifery and allied health professionals' leadership distilled through the lens of a realist evaluation and appreciative inquiry approach.

Aim of the Study and Research Questions

The study aimed to identify the enablers, processes and indicators that nurse, midwife and allied health professional leaders use to achieve and demonstrate impact and embed innovative practices across different contexts (clinical care, environment of care, social care & education, organisations, communities and multi-professional teams), addressing four specific research questions:

1. What are the enablers required for NMAHP leaders to achieve impact and embed innovation in different contexts?
2. What are the processes that NMAHP leaders use to achieve impact and embed innovation in different contexts?
3. What are the indicators of effectiveness of leaders in different contexts?
4. What are the indicators of outcome that demonstrate impact and embed innovation in different contexts?

1
2
3 128 The research team had expertise in realist review methods, appreciative inquiry, practice
4 129 improvement, practice development, clinical and systems leadership and were based across
5 130 the UK with a link University in each of the four countries. An advisory board comprising
6 131 national nursing, midwifery and allied health professional leaders from England, Northern
7 132 Ireland, Scotland, Wales and Eire provided additional expertise across practice, education,
8 133 research and strategic contexts and acted as a peer review group auditing the development
9 134 of the guiding lights framework and associated tools.
10 135 In this study, the literature was interrogated as a data set to generate tentative programme
11 136 theories to evaluate and synthesize what leadership strategies work, as opposed to identifying
12 137 what the gaps are. We briefly outline here our contemporary understanding of leadership
13 138 theory in order to make our assumptions and definition of leadership clear in the theoretical
14 139 framework section below. It is important for us to distinguish here that our study focused on
15 140 contemporary theories of transformational leadership as opposed to management practices.
16 141 Management we identify as having a focus on the delivery of organisational tasks carried out
17 142 in the best possible way to achieve organisational goals that are appropriately resourced
18 143 (finance, human resources) and meet the needs of the organisation. The main aim of
19 144 management is the achievement of order and consistency (stability), through planning,
20 145 organisation, directing or guiding, and supervising and monitoring activities (Gopee and
21 146 Galloway, 2017). Kouzes and Posner's theory of transformational leadership (1987) on the
22 147 other hand, defines leadership as a set of five observable, learnable practices: challenging
23 148 familiar processes, inspiring a shared vision, enabling people to act in accordance with their
24 149 vision, modelling the way through living shared values, and encouraging others by recognising
25 150 and celebrating success. For our team, transformational leadership is a relationship-based
26 151 leadership approach associated with positively improving the workplace and its culture at
27 152 different levels across the system, with impact on quality and safety outcomes for both
28 153 healthcare users as well as staff (Bogh Andersen *et al.,* 2018; Boamah *et al.*, 2018; Manley *et*
29 154 *al.*, 2019;Tomlinson 2012; Manley *et al* .,2011; Wang *et al*., 2011; Mullen and Kelloway; 2009).
30
31 155 **Literature Review**
32
33 156 Health and social care systems are complex because of dynamic changing inter-relationships
34 157 characteristic of open systems (Greenhalgh & Papoutsi 2018). The pandemic poignantly
35 158 demonstrated this, with every part of the system experiencing unforeseen consequences due
36 159 to change in other parts (Jackson *et al.,* 2021). A great deal of the published literature
37 160 assumes that leadership happens within *'a stable, albeit complicated, arrangement of*
38 161 *individual elements '* rather than a dynamic, ecological system that is multi-facetted and
39 162 complex' (Cohn *et al*., 2013, p40).
40 163
41 164 The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery
42 165 of continuously improving high quality, person centered, safe and compassionate care (West
43 166 *et al*.,2015). Leadership is the most influential factor in shaping organisational culture so
44 167 ensuring the necessary leadership behaviours, strategies and qualities are developed is
45 168 fundamental (Manion *et a*l., 2005). The literature cites three contemporary views of leadership
46 169 needed for the 21st century which move away from focusing on the individual qualities and
47 170 skills of leaders:
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i) greater emphasis on collective leadership which embraces collective capability and endeavour when acting and learning together to shape the culture (Manley *et al.,* 2019; Sharp 2018; McAuliffe *et al.,* 2017; West *et al.,* 2014 and West *et al.,* 2015);

ii) distributed leadership with a shared distributive and adaptable focus, not just across organisations but also across boundaries and systems (Endres and Weibler, 2020; Beirne, 2017;West *et al*., 2015); and,

iii) social leadership which recognises that social capital is embedded in people with different expertise working together through social movements, connected relationships and networks (Stodd, 2016).

There is clear evidence of the link between leadership and a range of important outcomes within health services, including patient satisfaction, patient mortality, organisational financial performance, staff well-being, engagement, turnover and absenteeism, and overall quality of care (West *et al.,* 2015). Using theory to guide research into leadership in health care is vital to ensure the concepts and constructs the research seeks to address are both appropriate and the most relevant. However, there is a reported preponderance of weak study designs in health care leadership research (Wong *et al.,* 2013), which include small sample sizes; lack of underpinning theory; survey instruments with inadequate reliability and validity; failure to measure important control variables; cross sectional designs; reliance on self-report (e.g. for measuring patient safety); and poor measurement of leadership (not systematic), all of which make it difficult to draw more wide-ranging conclusions about the processes by which leadership affects key outcomes, in terms of moderators or mediators.

Wong *et al.,* (2013) conducted two systematic literature reviews of nursing leadership and patient outcomes, which identified 20 articles of good methodological quality (research design, sampling, measurement, and statistical analysis). Of these, only nine were based on an explicit leadership theory. Transformational leadership theory is to date the most influential theory guiding health care leadership research. In their review Wong *et al.* (2013) found six out of the nine articles were influenced by transformational leadership theories (Bass & Avolio, 1994; Kouzes & Posner, 1995). Other theories identified included authentic leadership (Wong *et al.,* 2013), and servant leadership theories (Nagel & Andenoro, 2012). Positive effects of transformational leadership are cited as work-life balance, staff well-being, positive nursing outcomes, patient safety, openness about errors, and patient and staff satisfaction (Kvist *et al.* 2013; Wong *et al.,* 2013). Authentic leadership emphasises the importance of building leader legitimacy through honest relationships which foster trust with followers by valuing their contributions and behaving ethically and transparently. Trust then leads to engagement and improved individual and team performance. Wong *et al.,* (2010) found nurses who reported higher levels of authentic leadership in their managers also reported a greater level of trust, work engagement and perceptions of quality of care. Wong *et al.,* (2013) found positive relationships between authentic leadership and managerial trust, working life, and patient outcomes. Moreover, authentic leaders supported and encouraged nurse empowerment in their roles and this empowerment led to improvements in job performance.

Leadership types, styles and experience impact on teamwork and team culture (Cardiff *et al.,* 2020; Manley *et al*., 2019; Manley *et al*., 2011). The use of different leadership styles continues to be recognised as relevant to different situations, particularly when creating the conditions through relationships for enabling individuals, teams, organisations and more widely, communities to become empowered or in situations that require a more transactional style, for example in the context of emergencies and safety (Fynes, *et al.,* 2014).

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Theoretical Framework of Effective Leadership underpinning the Study

Our theoretical framework of effective leadership is informed by four key theories. Firstly, complex adaptive systems theory that explains the interrelationships and interdependence across systems and the few simple rules that guide local development of the 21st-century healthcare (Plsek, 2001). Secondly the theory of transformational leadership and the importance of developing leadership expertise and skills at every level of the health and social care system to support transformation (Manley and Jackson, 2020; Manley *et al*., 2019; Manley *et al.,* 2018; Martin and Manley; 2017). Effective leadership is embodied in compassionate relationship centred values, key to enabling empowerment of bottom-up teams and creative solutions to sustainable system change that is person-centred (Manley and Jackson 2020; Dewar *et al* ., 2017; Dewar and Cook, 2014). Leadership expertise in the form of authentic enabling relationships is required for developing collective direction across boundaries, to grow others as leaders, and to enable transformation to happen in every part of the system as well as across it. (Dewar *et al.,* 2017a; Dewar and Cook 2014). Leadership skills for supporting sustainable person-centred transformation are recognized at three levels: micro, meso, and macro (Manley and Jackson, 2020). Transformational leadership across these levels characterize quality clinical leaders, facilitators, and reflect the tenets of Kouzes and Posner's (1995) model of leadership practices modelling the way; inspiring a shared vision; challenging the process; enabling others to act; and encouraging the heart. Transformative leaders are compassionate, collaborative, visible and use positive language, building trust and recognise good work – this changes how others around them behave, react and respond (West *et al.,* 2015). Through learning from and building on what went well, leaders nurture a safety culture that minimises the occurrence of harm (Hollnagel *et al.,* 2015). Finally the theory of relationship centered practice (Dewar and Cook, 2014) emphasizes that appreciative approaches build on what works, and are a powerful strategy for countering the negativity that impairs readiness to change supports self-organising change processes that generates new ideas, new ways of thinking and collective ambition. (Cardiff *et a*l., 2020; Dewar *et al*., 2017; Sharp *et a*l., 2017; Watkins *et al.,*2016).

These four leadership theories were based on our paradigmatic/underpinning philosophy /epistemology/ontological stances. The focus on transformational and facilitative leadership informed a movement from individual leadership behaviours to collective action and co-creation, but also a focus on adaptability and complexity further endorsed by complex adaptive systems theory. There is very little published evidence of systems approaches to leadership and transformation so this study offers important insights into how NMAHP leaders can be more influential in supporting and leading system integration for the future to meet the health and social care needs citizens globally.

There follows an explanation of the study design, methodology and methods used.

Study Design

Methodology

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The study design was based on principles associated with realist evaluation methodology (Emmel *et al.,* 2018; Wong *et al.,* 2016; Dalkin *et al*., 2015; Pawson and Tilley, 2004; Pawson, 2006) and appreciative inquiry (Cooperrider *et al.,* 2008; Dewar and MacBride, 2017; Sharp *et al.,* 2017. Appreciative inquiry (AI) aims to create new lenses (knowledge, models and/ or theories) for looking at old issues (Bushe and Kassam, 2005). It is a move away from traditional 'problem-solving' approaches (problem identification followed by solution implementation). The focus is on stakeholder engagement and dialogue, identifying strengths and positives through provocative questioning so that 'what might be' can emerge; these are considered more powerful generators of momentum and sustainable change (Cardiff *et al*., 2020). This basis for the research implied a need to engage with NMAHP leaders who were willing to share their experiences and ideas in helping to shape a contemporary practice driven view of what works and does not work in different practice contexts. The appreciative focus framed the questions asked in the study design and in the realist evaluation methods used in Phase 2 and 3 of the study.

Realist evaluation is a theory-based approach to evaluation enabling the use of mixed-methods to explore the research question of interest. It is being increasingly applied to the evaluation of complex social programmes that involve human decisions and actions as it seeks to provide an in-depth understanding of what works, for whom, in what contexts and why things work. A central tenet of realist methodology is that programs work differently in different contexts therefore taking account of contexts is important (Wong *et al*., 2016). Realist evaluation enables the generation of initial programme theories (IPTs) that provide more detailed explanation and insight into strategies that work in practice. A realist programme theory specifies which outcomes are linked to the intervention, what mechanisms generate the outcomes and what features of the context affect them (Emmel *et al*., 2018). The realist approach explores the relationship between the context, mechanisms and outcomes and the configurations ('CMOCs'; i.e., C + M = O) that are uncovered become part of an explanatory initial programme theory (IPT) to be tested and refined. The function of the IPT is to describe and explain as far as possible how and why the programme (NMAHP leadership) may be working for some people and not others, depending on which mechanisms are or are not triggered in specific contexts (De Brun and McAuliffe, 2020). These chains of inference enable the exploration of generative causation, by explicitly linking the triggering of mechanisms to contextual conditions and specific outcomes (Davidoff *et al.,* 2015). Through elicitation of the patterns of CMOCs that are evident across settings it is possible to establish the NMAHP leadership CMOCs that operate as the common thread across various contexts (De Braun and McAuliffe, 2020).

The realist evaluation process starts with the construction of an initial programme theory (or theories) on how and why an intervention/programme/policy is thought to work. These are then (repeatedly) applied, reviewed and refined to (eventually) produce a realist programme theory that describes which contexts, combined with which mechanisms, produce particular outcomes for specified groups (Wong *et al.,* 2016). The Rameses II reporting standards for realist evaluation research (Wong *et al.,* 2016) guided the conduct of our work. Since programmes work differently in different contexts and through different mechanisms, programmes cannot simply be replicated from one context to another and automatically achieve the same outcomes. Theory-based understandings about 'what works, for whom, in what contexts, and how' are, however, transferable (Wong *et al.,* 2016).

Figure i illustrates the relationship between Context, Mechanisms and Outcomes in the research process.

<Insert Figure I>

To our knowledge, this is the first study of NMAHP leadership that combines realist evaluation with appreciative inquiry to explore why and how NMAHP leadership interventions operate to trigger mechanisms that lead to certain outcomes. Recent publications have used qualitative mixed methods evaluation to explore clinical academic careers for the NMAHP workforce (Miller *et al.,* 2020; Coad *et al.,* 2019) and realist evaluation has been used to evaluate the impact of collective leadership on team working and safety culture in health care teams (De Brun *et al* .2020, De Brun and MacAuliffe, 2020).

Methods

The study comprised three interrelated phases using mixed methods of data collection (Table I). At the start of the study, terms of reference, definitions, inclusion and exclusion criteria were discussed and agreed to ensure a shared understanding within the team to inform the literature review and research processes.

<Insert Table I: Study Design>

Ethical approval

Ethical approval was achieved through University Ethics at Canterbury Christ Church University (Ref 17/H&W/24C). A full application through the National Health Service's Integrated Research Application System (IRAS ID/2234444) was additionally completed but was deemed unnecessary by them when reviewed. Informed consent for participation in the social media twitter chat was provided through a nomination strategy and participants were advised that we would be thematically analysing the data for research purposes to generate initial programme theories.

Phase 1: Interrogation of the literature to generate tentative programme theories

Phase 1 involved interrogating the literature using a realist evaluation approach to generate insights between contexts, mechanisms and outcomes that would inform the development of initial programme theories about what works, in what context and for whom, regarding leadership in NMAHP contexts. Realist evaluation recognises the restrictions with a fixed search protocol and instead utilises an iterative approach which begins with a broad aim which is progressively refined during the review of the literature (Pawson *et al.,* 2005; Pawson, 2006).

The search strategy was collaboratively discussed, developed and refined by the study team. Two members of the study team focused on searching, sourcing and identifying relevant literature and in collaboration with the team refined the search strategy using an iterative approach for the lifetime of the study. In addition, working in partnership with the team,

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identification of key authors in the field of leadership, seminal papers, secondary sources and grey literature informed and shaped the review of the literature. In the realist review literature value is placed on all types of evidence that can answer any part of the review question – then using this evidence to corroborate or refute emerging programme theories

The search strategy (Figure II) included:

- Literature published in English within UK, Europe and International.
- Range of papers including research, theory, practice, discussion, policies.
- Grey literature.

<insert Figure II Literature Search Strategy>
Date parameters were set from 2010 - 2018. Databases searched included Cinahl, Medline, SocIndex, and Health Source: Nursing/Academic Edition databases. Search terms included nurse leadership combined with impact, culture, practice, education, organisation, policy and education.

Due to the vast amount of literature retrieved on an initial search using the terms health professionals and allied health professionals, a decision was made to confine the search to nursing only and to build on this through seeking contributions on relevant allied health professional literature from the advisory board members and other stakeholders from the social media and workshop elements of this study. Following removal of duplicates; titles, abstracts and reference lists were reviewed and pertinent secondary sources added to the review. This is an important process as premise of realist review is to err on the side of inclusion to avoid omitting data that could contribute to programme theory development (Rycroft-Malone *et al.,* 2012). This process generated a total of 132 papers to be included in the review which were then subjected to three levels of iterative analysis to develop some tentative programme theories about leadership strategies that work. Wong *et al*. (2013) discuss the necessity to 'contain' a review as it has potential to go in many different directions. The review was therefore 'contained' in the sense that it focussed on nursing leadership in all contexts as exploring other midwifery and allied health professional contexts was not practicable within the given timeframe. However, grey literature for midwifery and allied health professional contexts was additionally reviewed at the end of this phase. The themes emerging from the review were analysed thematically to generate a refined CMO table linked to the literature themes.

In the first level analysis of the literature a framework was developed to support data extraction focused on identifying the context, mechanisms and outcomes (CMO) that described what leadership strategies work, in what context and for whom in every context from each of the 132 papers identified. An example is provided in Table II.

<Insert Table II: Example of Framework Constructed for first level analysis of the literature>

Often outcomes were implicit, with very few studies presenting theoretical insights to the relationship between contexts, mechanisms and outcomes. Most papers highlighted factors that could tentatively contribute to insights across different contexts, mechanisms and outcomes of NMAHP leadership rather than specific middle range theories. Middle range

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theories focus on a narrow dimension of the leadership practice reality and often attempt to describe, explain, or predict certain phenomenon in clinical practice (Smith and Liehr, 2008).

The synthesis of the literature from the CMO tables for the 3 broad cross-cutting themes and hypotheses identified the contexts and mechanisms that contributed to both process outcomes and ultimate outcomes for different stakeholder groups. Using the idea of developing “simple rules” from the emergent findings (Plsek & Wilson, 2011; Best *et al.,* 2012); the analysis of the CMO configuration identified common cross cutting themes which informed the basis of broad principles which nurse leaders may use to achieve impact and embed innovative practices across different contexts. At this initial stage, the three cross-cutting themes reflecting three initial programme theories for testing were identified as: 1) Authentic relationships and connections (C1), 2) Transformational leadership linked to collective leadership and social capital (C2,3,4), and 3) Supporting everyone to have a voice in complex and changing contexts (C5,6,7,8,13).

For each of these themes the context mechanisms and outcomes were identified at micro-meso and macro levels of the health and care system to identify what works, how it works and for whom. This distillation was intended to identify the essence of what the themes were about in a way that would help nurses, midwives and allied health professionals to easily remember and apply general principles of leadership practice in their everyday work. This process was informed by a large reputable Canadian study which used realistic evaluation to explore large systems transformation (Best *et al.,* 2012). This approach had previously been identified as a way of focusing on middle range theories that can inform ways of thinking and being, where these were referred to as ‘simple rules’ and a way of working with complexity to aid decision-making (Plsek, 2001; Plsek and Wilson, 2011). To strengthen the quality of a review, Wong *et al*. (2013) emphasise the need to have a detailed audit trail of iterative processes and draw upon external stakeholder expertise. Whilst the **supplementary literature table** identifies the CMO factors distilled from the full literature review, here we present an excerpt of the second level analysis of the literature, to illustrate the audit trail for the development of CMO relationships for cross cutting theme 1 authentic relationships and connections (C1).

<Insert Table III: Illustration of second level analysis CMO relationships in relation to NMAHP leadership derived from interrogating the literature for cross cutting theme Authentic Relationships and Connections>

In Table III it is possible to see that the literature identified that contexts that develop NMAHP leaders who can build and nurture authentic, caring & successful relationships with individuals, those important to them, staff and stakeholders (C1) enable staff to feel valued and supported (O1), experience an increased self awareness, sense of empowerment (O2) and self confidence to speak up (O3), as well as strengthened more compassionate and respectful relationships (O4). This in turn impacts on outcomes that improve staff wellbeing, reduce stress and emotional exhaustion (O5), improve staff morale and satisfaction (O6) and improve the quality of leadership so that it is more compassionate, inclusive and valued by others (O7). At a team and service user level, this impacted on enhanced team effectiveness and learning culture (O8), staff engagement and healthy safe workplace cultures (O9). The following mechanisms were identified from the second level analysis of the literature as being crucial behaviours for creating these outcomes:

- Facilitating caring, compassionate civil conversations, caring reflections and practices (M1).
- Leaders are authentically present building ethical, trusting relationships where people feel safe to speak up (M2).
- Leaders develop appreciative, mutual learning relationships with all and nurture these in others (M3).

Further the literature identified the importance of leaders being able to connect emotions (M4), using different opportunities through powerful inquiry-based questions to promote conversation-based change (M5). Their ability to enable self and situational awareness in others through self assessment, inquiry, self motivation, self-compassion, self-reflection for learning and role clarity (M6).was a powerful mechanism for enabling others to learn, grow and flourish.

Each of the three cross cutting themes were then distilled into a more condensed version as CMO configurations that separated out intermediate and ultimate outcomes, using all the theme titles for CMOs from the second level analysis (any embellishments in the titles (in green) came from a second round of literature analysis F1-F32. This was relevant literature that previously did not come up in the first literature review which focused mainly on nursing , explained earlier, and embraced AHPs (including what was suggested by advisory board) and more general research and theoretical insights. Table IV provides an illustration of the further development of cross cutting theme 1 authentic relationships and connections which was later shared with workshop participants.

<Table IV Illustration of Cross Cutting Theme 1 Authentic Relationships and Connections further refined in preparation for presentation to workshop participants>

As part of the study, there was a planned and comprehensive approach to test out theoretical development with external stakeholders. Leaders from a diverse range of health and social care contexts within the four countries of the UK were invited to workshops from social media events on Twitter (#Strengthening, the hashtag used for the twitter chat) and through professional networks and an advisory board. These activities also asked leaders to consider the cross-cutting themes which had been developed and discuss the processes and indicators they use to achieve and demonstrate impact and embed innovative practices. These are described in Phase 2 and 3 below. The stakeholders (advisory board and workshop participants) were invited to contribute to the ongoing refinement of three tentative programme theories arising from the integrative literature review and reflected in three sets of CMO relationships.

Phase 2- Social Media Twitter Chat

Phase 2 was used to test out and add to our initial programme theories and themes generated from Phase 1 with senior NMAHP leaders and practitioners across the UK. Twitter was used to help support nomination of NMAHP leaders in practice, education, research and strategy/policy contexts who we could invite to the sense making workshops and/or have further dialogue around our emergent analysis. Additionally, this phase served to generate other insights about leadership, particularly in the midwifery and allied health care professional

contexts to complement the lower inclusion of these areas in the literature. This process was informed by a recently developed UK-wide Social Media research strategy for health care research that draws on the unique selling points of 'rapidity of access' and 'scale of consensus' to engage health professionals and key stakeholders. (https://hartsofthepossible.wordpress.com/about/).

Two one-hour twitter chats were advertised through all professional bodies and networks in each of the four countries of the UK. Across the 2 twitter chats held on the 11th and 19th July 2018 there were 199 participants sending 998 tweets with 4.035 million social media impressions. Of the 199 participants, 26 were AHPs holding senior leadership positions as Professors, Professional Leads, Clinical Fellowships in University, policy, workforce, government departments, professional bodies and practice contexts. Twenty-one participants held senior nursing leadership positions as Professors, Policy Leaders, Directors of Nursing, Senior Advisors, and Consultant Practitioners in University, government departments, global think tanks and practice settings. Thirty-one participants held Midwifery leadership positions as Professors, Lead Midwives and social entrepreneurs in University, global think tanks and practice settings. The remaining 121 participants were front line NMAHP practitioners from across the UK. The two transcripts of each twitter chat were printed off and turned into a manuscript. Each line of tweet entry was numbered and retweets highlighted as repetition of a key message that participants felt very important. The transcripts were then subjected to a content analysis drawing out the key words and phrases that could be used to test out and interrogate the language used in the guiding light document to ensure that language used was practical and grounded in the real world so that it would be readily understandable and used by practitioners in practice and others less familiar with professional leadership terms. The analysis was completed by two members of the research team independently. Table V illustrates an excerpt for Guiding Light 1 of how the themes generated from the Twitter Chat were used to populate a table testing out our IPT and guiding lights, and providing supportive evidence from practice for:

i) Identifying leadership attributes useful for developing a 360-degree assessment tool.
ii) Impact of leadership experienced by them that had a significant impact on their own leadership behaviours and practices.
iii) Leadership processes perceived as most influential in working with others.
iv) More general impacts on developing followers, teams, evidencing impact in practice and on strategic thinking.

<insert Table V example of national twitter chat for guiding light 1>

Table V illustrates that Guiding Light 1, focused on working towards or building authentic caring relationships was a core finding from the literature review and the data generated through the workshops and twitter chat. Leadership attributes identified as most influential in the twitter chat were themed as:

1. Approaching, personable, compassionate and generous.
2. Sparkle, authentic, relaxed and passionate.
3. Are able to observe, listen and are non-judgemental.

For twitter chat participants the impact of this kind of leadership on themselves was identified as being encouraged to follow their own passion and in thinking about modelling the way, that they are a real person. The leadership processes identified as being most influential were

connecting in a way that makes everyone feel special and being authentic and true to your values. These twitter chat comments and themes helped to reinforce the findings from the workshops and the literature review to inform development of Guiding Light 1 and the other guiding lights in the framework.

Phase 3- Exposure of IPTs and Guiding Lights for further critique and/or validation

National Sense Making Workshops

This phase focused on bringing a range of key stakeholders together for sense making workshops. The work was complemented by the professional networks known to each UK country lead in the project team. The workshops in each country focused on presenting and getting further critique of the three IPTs , generated from the CMO relationships as well as engaging with future perspectives through participants' shared leadership stories and collaborative critique**.** Participants were self-identified from the twitter chat complemented by professional networks known to each country's lead in the project team. Table VIII summarises the number of participants involved. In total there were 61 participants of which 28 were nurses, 9 midwives, 18 allied health professionals and 6 University of the Third Age reflecting a citizen contribution.

<Insert Table VI Summary of Participants in the National Workshops>

The workshops used the creative methods of appreciative framing and dialogue in order to promote collaborative sensemaking of the data presented as the draft IPTs, CMOs and Guiding Lights. In this context, *sensemaking* is understood as a social process where meaning is 'negotiated, contested and mutually co-constructed' (Maitlis and Christianson, 2014, p 66). This can springboard action that might otherwise be impeded (Hultin and Mähring, 2017). The use of symbolic representation or imagery can help to deepen inquiry, to unleash latent, tacit or unconscious knowledge (Dewar, 2012; Sharp et al., 2018). A collaborative sensemaking tool developed by the LIFE programme (Sharp et al., 2017; Dewar, 2012) was used consisting of 12 images with words to promote generativity. Words are provocative prompts and thus have generative potential, provoking reflection or stimulating alternative dialogue, leading to new insights or thinking (Bushe and Marshak, 2016). The intention was to add a playful and experimental dimension to the workshops as this is at the heart of AI (Sharp et al., 2018). Each person explained why they had chosen a particular image or images and what feelings or thoughts that image had provoked in them in relation to NMAHP leadership. Figure III provides the composite of images chosen by participants and the conversations this sparked about leadership. Generally the feedback from the workshops endorsed the CMO configurations and promoted creative conversations that illustrated these.

<Insert Figure III> Composite of images chosen by participants and the conversations this sparked about leadership

Analysis of the Data and Development of the Guiding Light

A requirement for realist evaluation research is that data collection and analysis takes a "retroductive" approach (Gilmore *et al.*, 2019) . Retroduction refers to "the identification of hidden causal forces that lie behind identified patterns or changes in those patterns" (The RAMESES II Project, 2017, p. 1). Retroduction uses both inductive and deductive reasoning

and includes researcher insights to understand generative causation, by exploring the underlying social and psychological drivers identified as influencing programme outcomes. For retroduction to occur, it is important to have multiple data sources and incorporate one's common sense to test and refine programme theories (PTs), (The RAMESES II Project, 2017, p. 1).

The analysis phase comprised a synthesis of the data from Phases 1-3 and a purposeful discussion around which key theories influenced our synthesis based on our past experience and applied research as researcher-practitioners. This is an important principle in appreciative inquiry that requires researchers to be curious in asking questions of the data to focus on what is emergent in relation to what matters most to NMAHP leaders. These substantive theories were based on our values and beliefs about what we strive to understand as researchers, namely:

i) pragmatic aspects of contexts, relationships, what works and why this works through theorising from practice but building on what is known.
ii) how we want to be as researchers, that is; appreciative, transparent, authentic and collaborative; and,
iii) what counts as knowledge; recognising the interrelationship between contexts, complexity, actors and systems and that no knowledge is value free (Guba and Lincoln, 1994); and,
iv) developing knowledge with generative capacity (Gergen,1982) that challenges the status quo and creates a vision of what is possible.

The final distillation of the CMO relationships informing each of the 3 IPTs derived from interrogating the literature and workshop dialogue are shared as a supplemental table (Supplemental Table 2). The refinement of the CMO relationships from this integrative literature review, the workshops and social media exercise led to further development and co-creation of five "simple rules". (Plsek, 2001; Best *et al.,* 2012). This included refining the concept of simple rules to 'guiding lights' which acts as a set of principles to enable and strengthen leadership within a range of contexts. Work in progress was presented to the Advisory Board at key points in the project to ensure that there was sufficient external objective review and critique of the development of the framework and guiding lights and that the audit trail was clear.

<Insert Table VII: The Three IPTs and Guiding Lights>

The next section outlines each guiding light (Table VIII) and provides an overview of the context and mechanisms that enable each guiding light to happen and their outcomes in practice. The full Guiding Light framework is provided as Supplemental file 2. It is important to emphasise that all guiding lights are interrelated, and, in our discussion, we present each guiding light using the metaphor of light and aim to focus on a specific aspect of the principles that we suggest enable and strengthen leadership across a range of contexts in nursing, midwifery and allied health professional practice. Excerpts from the literature review and data gathered from Phase 2 and Phase 3 of the study are integrated to illustrate supporting evidence.

<Insert Table VIIII The Guiding Lights of NMAHP Leadership>

Findings

As a result of the retroductive processes used in Phases 1-3 of the study five Guiding Lights of NMAHP Leadership were distilled for the three IPTs. These are presented here supported by evidence from stakeholders and supportive literature.

The Five Guiding Lights of NMAHP Leadership

Guiding Light 1: "The Light Between Us as interactions in our relationships"

Guiding light 1 emphasises the importance of giving attention to what is happening between us when we are together. In response to a question about what makes a good leader, this excerpt from the twitter chat illustrates the light metaphor as a catalyst for others.

'They sparkle with passion and authenticity and encourage others to act' (Twitter chat, response 58)

Three contextual enablers identified were:

1) Being authentic, working towards ensuring a space of civility

'*Civility is claiming and caring for one's identity, needs, and beliefs without degrading someone else's in the process….[Civility] is about disagreeing without disrespect, seeking common ground as a starting point for dialogue about differences, listening past one's preconceptions, and teaching others to do the same.*' (Brown, 2017 citing Dahnke and Spath). Examples from the twitter chat that reinforce authenticity and civility include '*Leading humbly by example with respect and kindness'* (T1 L85), being *"inclusive and open to ideas* (T2, L852) and '*supporting me with tough decisions'* (T 1 L 162).

2.) Careful listening

Listening enables what is important to people to be heard and is the starting point for reflection, stretching our current thinking and innovating together. A ***"Willingness to listen"*** was a consistent theme generated in the workshops. Here one twitter chat participant explains the importance of "*Being present and facilitate a safe space to listen, hear, learning, understand and fuel action of the journey*" (T 1 L236).

3.) **Developing positive respectful relationships**

The realist evaluation identified a contextual focus on relational practices as a key principle to enabling and strengthening leadership (Cummings, 2010; Adamson *et al.,* 2011; Dewar and Cook, 2014; Manley, 2014; Hewison and Morrell, 2014; Hannah, 2016; Dewar *et al.,* 2017; Gotlieb, 2013). We have previously highlighted one of our underpinning substantive theories informing this study as being relationship centred care. The term relationship-centred care was first used by Tresolini and the Pew-Fetzer taskforce in 1994, who highlight the importance and centrality of relationships within healthcare. Tresolini and the Pew-Fetzer taskforce (1994) assert the foundation of high-quality care is on developing positive relationships not only between care provider and the person receiving care but with all those in the care process, that is, patient, staff members and relatives as well as communities. Whilst relationship centred practice has largely been discussed in the context of patient care (Nolan *et al.*, 2006,

Solkadaris *et al.,* 2016), the findings from this review also highlighted a focus on relationships as a key contextual enabler for strengthening leadership in health and social care. Workshop participants identified that as NMAHP leaders "*You succeed when you help others to succeed…..Working in a place where 'I've got your back' rather 'than watch your back'* as well as the importance of "*going the road less travelled – having the courage – what is the road? Focussing deeply on relationships – one step at a time".*

Three key mechanisms explain why a focus on building authentic caring relationships are linked to having caring and civil conversations. The first mechanism is including different methods, to focus moment by moment, on what matters to people (Dewar *et al.,* 2017).

"We need to nurture talent enabling others to take supported risks and learn from outcomes that are not always as desired" (T1 454)

The second explains how caring relationships focus on encouraging and sustaining genuine curiosity and kindness for self and others (Peus *et al.,* 2012; Dewar *et al.,* 2017). This linked to the importance of civility as well as caring in these conversations.
"They are approachable and happy to hear other people's thoughts and perspectives" (T1 L318)

The third mechanism that enabled caring relationships was having a deep understanding of self - our vulnerability, strengths, weaknesses, aspirations and what keeps us healthy in those relationships (Akerjordat and Severensson, 2008; Peus *et al.,* 2012). "*Quiet determination, self-belief and absolute faith and determination are important in nurturing young talent building capacity and capability takes time"* (T1 L 353)
This twitter chat participant identified the importance of a memorable leader that influenced their practice "*Took time with me and shared their vulnerabilities'* (T1 L95)
A focus on developing relationship with self, practicing self-compassion and building resilience all relate to emotional intelligence and the impact on the development of caring relationships. Building emotional intelligence as such is a key ingredient in strengthening leadership which leads to the final mechanism - working with and connecting with emotions (Akerjordet and Severinsson, 2008; Dewar et al., 2017; Sharp, 2018). *"They are wise, have great insight, can alter their approach depending on the situation of people involved" (T1 158)*

Literature widely supports the value of emotional intelligence in enabling and strengthening leadership, as a transformational leadership behaviour that enhances creativity and fosters the development of positive workplace cultures (Gifford *et al.,* 2018; Prezerakos, 2018).

Two outcomes result for all who are touched by this aspect of leadership

- it is experienced as compassionate and credible, authentic, caring and appreciative
- underpinned by positive working relationships.

As this twitter chat participant explains*" Leaders who connect with each individual, who are willing to be authentic, true to their values and at the same time value the values of others.* " (T2 L770)

Guiding lights two and three relate to the extensive literature on transformational leadership practices with a focus on collectively exploring multiple contributions and strengths to shape what people collectively want to happen. This is done through sharing stories and our hearts, motivating with passion, inviting inquiry and questions, admitting mistakes and celebrating successes. (Dewar *et al.* 2017a; Dewar *et al*. 2017b; Dewar and MacBride 2017; Gottlieb, 2013; Sharp, 2018; Soo Young, 2017).

Guiding Light 2:' Seeing People's Inner Light and keeping it glowing'

Seeing people's inner light is a metaphor for seeing each person's worth (including own), and cherishing the varied ways people connect, contribute and bring about change as illustrated by this comment in response to a question about when leadership is working well:

'They see something in you that you do not immediately see in yourself' (Twitter chat response, 136).

It is manifested through working with others, creating experiences of being safe to be authentic and share ideas and emotions. It is underpinned by three contextual enablers, with a focus on:

1) Creating the conditions of psychological safety (Edmonson and Lei, 2014) where people are clear about the positive consequences of voicing opinion, where people listen to understand and inquire together to explore shared meanings to help everyone to flourish and grow (Manley *et al.,* 2011).

2) Valuing, spotting and drawing on multiple perspectives - including our own - and nurturing talents for change (Dewar *et al.,* 2017a; Sharp, 2018); and,

"It's about helping you see the best you there is, helping you to stretch those boundaries and grow- not judging" .(T2 L 855)

3) Seeking out, inquiring into and valuing the experiences of those who give and receive services provides the basis for exploring and learning together so that practice can be celebrated, and places value on a culture of continuous development (Dewar *et al.,* 2017a; Sharp, 2018). This was described by one twitter chat participant as "*They walk the talk, role modelling an inclusive approach that takes people on a journey, consistently questioning to promote learning opportunities" (T2 545)*

Guiding Light 3: 'Kindling the Spark of light and keeping it glowing'

The metaphor for guiding light 3 builds on 'seeing the inner light'. 'Kindling the spark', and then, 'keeping it glowing' each demonstrate different subtleties. Kindling involves generating shared understanding of what lights people's fire and finding ways for people to get energy from each other's different light sources (priorities, values, beliefs, enabling them to come into their own – as described above). Keeping the light glowing when the light flickers involves

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helping ourselves and others to take risk and harness learning from disappointments alongside delights, as represented by the following comment from the Twitter Chat.

'Spreading a baton of encouragement, creating a pandemic of positivity and kindness' (Twitter chat response, 105)

Mechanisms that enable guiding light two and three to happen include building collective trust and respect (Gottlieb 2013; Soo Young, 2017; Sharp, 2018) enabling the development of relationships (Franks-Meeks, 2018); and creating a relational space where there is shared meaning about what matters to people (King's Fund, 2011; NHS Improvement, 2018; Sharp 2018).

"It is the ability to paint a compelling picture of the future and then chunk it up into bite sized chunks that people can see in relation to the whole picture" (T2 L593)

The second mechanism is actively seeking out multiple perspectives with a real desire to see the world through the eyes of others, recognising everyone is an expert of their own experience (National Improvement and Leadership Development Board, 2017; Soo Young, 2017; Sharp, 2018). This mechanism places value on cultures that place value on patient experience (Akhtar *et al.,* 2016) and commitment to hearing a range of perspectives - for example patient stories - and using this evidence to inform practice (Dewar and Cook, 2014; Sharp, 2018). This links to a third mechanism that enables the exploration of contributions and strengths – by focussing on engagement (Davies, 2013, West *et al.,* 2015, Akhtar *et al.,* 2016) in different and creative ways enabling a blending of different types of knowledge (people's experience, research, policy etc) (Sharp, 2018). This reduces the hierarchy of knowledge where intuitive knowledge - knowledge generated from hearing stories about people's experience - has equal value to research knowledge (Sharp, 2018). The fourth mechanism is around openness to shared learning and willingness to take collective action which fosters shared accountability, shared decision-making, shared priorities and shared learning across teams, organisations and systems (Manley and Jackson, 2020; Cardiff *et al.,* 2020, Kuluski and Guilcher, 2019). The fifth mechanism is around developing teams that can self-organise, moving from individual and heroic leadership models to that of shared, distributive and collective leadership (de Zelueta, 2016; Manley and Jackson, 2020; Cardiff *et al*., 2020, Sharp, 2018). As one participant identified, leaders are *"those willing to see beyond hierarchy, see beyond the conditioned and traditional systems and challenge"* (T2 L770)

The building of self- organising teams requires the fostering and sharing of knowledge, skills, and learning and creating the conditions where individuals feel safe to experiment and able to share mistakes so that new learning can be generated (Parker *et al*., 2015). Participants in the twitter chat talked about the importance of being '*Inclusive and open to ideas* (T2 L 852) '

"It's about helping you see the best you there is, helping you to stretch those boundaries and grow- not judging" (T2 L 855)

The outcomes of Guiding Lights 2 and 3 are that leadership is experienced as inclusive, collective, shared and distributive by all who are touched by it, thereby dispersing traditional views of leadership as something practiced only by hierarchical leaders. Additionally, there are also outcomes for staff and teams. Staff feel valued, supported, involved and heard, which leads to:

- improved morale, commitment, wellbeing, staff satisfaction and retention, with reduced burnout, stress and exhaustion
- Improved confidence to speak up, self-awareness, and empowerment, contributing to increased skills, improved relationships, and career development.

Teams are recognised as healthy, effective and empowered with cultures of active learning, engagement, reflection and adaptation. This results in a strong team commitment to better practice, creativity, innovation and improving performance.

Guiding Light 4: "Lighting up the known and the yet to be known"

Guiding Light 4 illustrated by the metaphor of a lighthouse with its rotating light beam, reveals features illuminated, before plunging them into darkness as the beams passes by.

The lighthouse metaphor was chosen as a way of acknowledging that there are stable structures in health and social care contexts, but also unlit unknown places, the light illuminates both. The light beam represents our aspiration to be a source of steadiness during change by sharing information on what is known and stable. This may include shared foundation values, purpose and ways of working as well as recognising that we work and live in contexts that are complex, often unpredictable or are yet to be known as the COVID-19 pandemic has shown.

Complex adaptive systems theory accounts for changes in different parts of a system often having unintended and unanticipated consequences for other parts and recognises that its continual creativity is a natural state, as is a constancy between tension and balance (Plsek, 2001).

Complexity covers a spectrum of factors from relationships e.g. service users with complex health and social care needs (Hurlock-Chorostecki and McCallum 2016); turbulent and human complexities linked to power emotions and relationships (Sharp, 2018); inter- professional and ethical issues; the complexity of medical and biological, psychological and social, multiple pathways with a choice of destination – navigating through difficult terrain; being able to make sense of confusion and conflict (Manley *et al.,* 2008); through to complexity generated by environments, the service, or the health and social system (NHS, 2017). Complex environments can lead to value conflicts with potential for moral distress (Morley *et al.*, 2018; Morley *et al.,* 2017).

Leadership in this guiding light involves showing a level of comfort when engaging with uncertainty – the unpredictability of the darkness; and valuing that which lights the way forward to be found in relationships that facilitate flexible and creative approaches. These approaches may differ from action plans, risk aversion strategies and hierarchical rules due to the relational aspect of NMAHP leadership.

The study identified two important contextual enablers:

1) Contexts that aspire to being a source of steadiness in the midst of change where information is shared on what is known and stable, and

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2) Contexts where there is a commitment to both pro-activity and adaptability that show a level of comfort when engaging with uncertainty; and valuing that which lights the way forward.

*'Leadership isn't easy, it's dangerous at times. It's stepping out of your comfort zone doing the right thing, whilst bringing others with you' (*Twitter chat response, 377)

These contexts support relationships which facilitate flexible and creative approaches that may differ from action plans, risk aversion strategies and hierarchical rules where instead minimum specifications yield more creativity than detailed plans (Cardiff *et al*., 2020; West *et al.,* 2015). A number of mechanisms when combined with these two contextual factors explain leadership outcomes. One, identified explicitly in the workshops, as sharing our knowledge for leadership and innovation in a way that everyone can make sense of, in order to learn, share, innovate and create. This approach, experienced as supportive by staff is also understood as motivating, stimulating and facilitating reflection, learning and action for improvement, including risk taking that is also safe.

'Be present and facilitate a safe space to listen, hear, learning, understand and fuel action of the journey' (Twitter chat response, 236)

The outcomes of guiding light 4 are for people and organisations.

- People experience better healthcare outcomes, quality and satisfaction.
- Organisations demonstrate improvement in services, performance, safety and quality with healthy teams.

These organisational outcomes further the positive outcomes for patients, clients and service users; and also, staff through improved retention, stability, and commitment aligned with the qualities of a learning organisation.

Guiding Light 5: 'Constellations of connected stars'

Guiding Light 5 is about fostering ways of connecting to maximise possibilities for collective action. This requires responding to the unique nature of local context and practicing adaptability in order to tap into the distinctive riches on offer. Such an approach benefits the system and society through building social capital (Stodd, 2016), identified as a resource for system change; increasing resources available to people, organisations and communities for change; and ultimately improving population health. The constellation of stars metaphor is used as stars are individually brilliant sources of energy. When connected invisibly through electromagnetic forces holding them in constellations, they are awesome. This metaphor accentuates the power of collective leadership and collective action through tuning into local resources, networks, communities, and recognising where there is potential for enhanced futures. The following comment from the Twitter Chat illustrates this point:

'Power to interconnect ideas into a brand-new vision or concept' (Twitter chat response, 148)

Contextual enablers that underpin this guiding light include:

1) a commitment to fostering ways of connecting together which maximise the possibilities for this collective action, and

2) responding to the unique nature of the local context and practicing adaptability in order to tap into the distinctive riches on offer.

Mechanisms that enable this to happen include the co-creation of systems/infrastructures and working together across these to share rich information about better practices. In order for this co-creation to flourish, there needs to be a good understanding of social network relationships among people within the organisation and those external to the organisation (Soo Young, 2017). In addition, the mechanism of building and using social capital through collaborative relationships and networks is key. Social capital exists in the active connections between people where trust, mutual understanding, shared values and behaviours link the members of human networks, making cooperative action possible. (Cardiff *et al.*, 2020; Manley and Jackson 2020; Manley *et al.,* 2019) . Developing these networks connects people to others from different backgrounds with a potentially different range of ideas and resources. This has the potential to open up new opportunities, span professional and social boundaries, and provide connections to useful resources such as knowledge, skills and new networks that may be beyond current networks.

Developing social capital emphasises adopting an open-systems mindset where emergence is valued and leveraging relational and interpersonal aspects of leadership development.

As one twitter chat participant identifies, it is "*Definitely about being interested, knowing people, forming relationships and trust, saying what you mean and meaning what you say. You need to position yourself where you can look forwards and backwards"* (T2 L 652)

Specific skills include the ability to identify tacit knowledge within individuals and networks, facilitating purposeful conversations, crafting insightful and curious questions to explore what is valued, working as coaches where sharing of learning builds collective energy which in turn leads to the creation and sharing of new understandings, engage others with compelling stories, building commitments and developing extended social networks (Soo Young, 2017). Statements that were made by twitter chat participants included the importance of influential NMAHP leaders having the "*Power to interconnect ideas into a brand new vision or concept*" (T1 L148) and "*Seeing the world differently, free thinkers understanding the importance of co creation*" (T1 157). *"They are wise, have great insight, can alter their approach depending on the situation of people involved*" (T1 158)

The potential impact of building social capital results in outcomes related to enhanced work motivation by increasing the sense of unity in an organisation, increased knowledge about resources available to people, organisations and communities for change, improving the organization's efficiency by promoting cooperation between individuals and groups and improved population health (Edmonstone, 2011; Soo Yong 2017).

Implications for Practice

The study has developed additional important resources to enable NMAHP leaders to demonstrate their leadership impact in a range of contexts through the Leadership Impact self -assessment framework (Figure III) which can be used for 360 feedback in the workplace using the appreciative assessment and reflection tool (Figure IV) . Impact is defined as '*making*

a positive difference' to individuals, including, colleagues, providers or recipients of health care or associated contexts, and the systems that support communities (NHS England, 2015).

The framework can be used for a number of different purposes, to:

- Self-assess for the purpose of guiding the practitioner in their professional and or career development.
- Demonstrate how the practitioner's leadership role contributes to or supports impact with others.
- Contribute to academic or professional accreditation and or professional revalidation.
- Facilitating continuing inquiry into the practitioner's own effectiveness of their leadership practice.
- Further development of leadership programmes that are based on sound theoretical principles.

The guiding lights are used to frame impact of leadership at three different levels- i) impact on self and others ;ii) impact on team(s)/ workplace(s); iii) impact on the system/communities, regionally, nationally or internationally.

<insert Leadership Impact Framework Figure IV and Figure V 360 Reflective Tool >

Implications for Research, Policy and Education

Firstly, it is important to acknowledge that this study has illuminated the a-theoretical nature of the relationships between contexts, mechanisms and outcomes in the existing leadership literature. There is more scope to develop the tentative programme theories developed in this study with NMAHP leaders in a variety of different contexts. The outcomes of leadership research mostly focused on staff outcomes and intermediate outcomes that are then linked to ultimate outcomes in both staff and patients (supplemental). More consideration needs to be given to the impact of leadership on patients, carers and their families.

Whilst policy makers note the increasing importance of leadership in facilitating the culture change needed to support health and care systems to adopt sustainable change at pace, there is still a prevailing focus on traditional approaches to individual leadership development as opposed to collective leadership across teams, services and systems. If we fail to understand how to transform leadership policy and education, then it will be impossible to support the workforce to adapt and flex to the increasingly complex contexts they are working in. This will serve to undermine system integration for health and social care if the capacity and capability for transformation is not attended to. Whilst there are ambitious global plans (WHO, 2015) to enable integrated services to be driven by citizen need, there is still a considerable void in understanding how to authentically engage with people to ensure transformation is driven by their needs as opposed to what we think they need. There is therefore a need for systems leaders with the full skillset required to enable integrated services across place-based systems, particularly clinicians who are able to break down barriers and silo working across boundaries through the credibility, leadership and facilitation expertise they provide.

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Areas for Development

Six key areas were identified in this study for development. The first is linked to the nature of the leadership literature which is predominantly atheoretical in its understanding of the links between contexts, mechanisms and outcomes. Hence the distillation of insights has been based at a level of abstraction that informs the scope of the research landscape but is much more tentative in generating theory. Recognising that theory is tentative, the level of abstraction applied has been very broad. There is therefore more scope to research this further and more specifically.

The second area, is that we have been heavily influenced by our philosophical predispositions captured in the substantive theories that have influenced the study and which have led us to focus on contexts and mechanism of leadership in health care contexts that are practical and common to any context. We have not been able to distil whether there are discriminating contexts and mechanisms that relate specifically to practice, education, research and strategic/policy contexts. The focus on leadership in military contexts is an area recognised as requiring further research, this arose from the Wales workshop.

The time limited nature of this inquiry into the strategies that work and why they work based on realist evaluation has enabled the development of theories that have been refined to a certain level. So whilst the key influential mechanisms have been distilled through working with leaders working in different contexts across nursing, midwifery and allied health professional practice through the workshops and social media, continued opportunities for engagement would have enabled further refinement.

Fourth, the methods used have focused on perspectives from the literature and the perceptions of nurses, midwives and allied health professions themselves across a wide range of contexts, many of whom who have been recognised by peers as leaders in their own rights. Other methods to refine the CMO relationships would therefore benefit further consideration, e.g. observational research and also longitudinal research.

Fifth, whilst developing philosophical understandings of leadership, other terms that focus on co-creation, social capital, self-organising communities etc. have been used in the literature and the search terms used may not have been inclusive enough to pick up innovations. This relates also to our focus in the search term - for pragmatic reasons- on nursing and consequentially, we may not have picked up on some of the innovative leadership happening within the allied health professionals and other healthcare contexts.

Lastly, the outcomes of leadership research mostly focused on staff outcomes and intermediate outcomes that are then linked to ultimate outcomes in both staff and patients (Supplemental). The relationship between staff outcomes and patient outcomes has previously been demonstrated (West et al; 2017), more consideration needs to be given to the impact of leadership on patients, carers and their families.

Limitations

The study provides a detailed snapshot of the context, mechanisms and outcomes of NMAHP leadership that warrants further detailed exploration in a follow up study. We have not been

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2
3 1011 able to distil whether there are discriminating contexts and mechanisms that relate specifically
4 1012 to practice, education, research and strategic policy/contexts from the work undertaken to
5 1013 date. Continued opportunities for engagement with practitioners would have enabled further
6 1014 refinement of the mechanisms distilled. Other methods to refine the programme theories
7 1015 would benefit further consideration such as observational and longitudinal research. Further,
8 1016 our work is heavily influenced by our philosophical predispositions that have influenced the
9 1017 approach taken in this study.
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12
13 1018 **Conclusion**
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15 1019 This realist evaluation has led to the development of a detailed landscape of factors distilled
16 1020 into relationships between context, mechanisms and outcomes that influence nursing,
17 1021 midwifery and applied health professional leadership in a range of different contexts. Three
18 1022 phases of collaborative work have included an interrogation of the literature, combined with
19 1023 appreciative framing and dialogue with workshop participants across the four countries of the
20 1024 UK, and an innovative social media strategy. Through a process of refinement and critique the
21 1025 initial programme theories 1) Authentic relationships and connections, 2) Transformational
22 1026 leadership linked to collective leadership and social capital and 3) Providing everyone a voice
23 1027 in complex and changing contexts. In the spirit of complex adaptive theory and the concept of
24 1028 'simple rules' these have been distilled into five guiding lights illuminated through a leadership
25 1029 as light metaphor. These capture the focus of effective leadership for contemporary nursing,
26 1030 midwifery and allied health practice in all contexts, and also guide a vision for strengthening
27 1031 what leadership needs to be in the future. They also provide an important practical resource
28 1032 for supporting the development of leadership talent and capability across the system to
29 1033 strengthen NMAHP career development and capacity building for the future. The work has
30 1034 highlighted the a-theoretical nature of leadership theory currently and will be the focus of a
31 1035 future paper by the authors in which we seek to challenge the leadership landscape and offer
32 1036 a contemporary critical review and argument for why theory is important for understanding and
33 1037 sustaining change at micro-meso and macro levels of the health and care system.
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Leadership in Health Services

No Reference Category Setting Context Mechanisms Outcomes Impact on whom Notes

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Appendix 1: Full list of papers included in the review using a CMO template

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact om whom	Notes
1	Henderson, A. (2013) Processes to Engage and Motivate Staff, Nursing Management Vol. 20(8), pp.18-24. Read 19.2.18	Peer review journal Research	• Specialist surgical unit • Australia	• 'poor working relationships'. • Manager adopted transformational leadership behaviours and facilitated activities with practice development nurses.	• Transformational leadership techniques/behaviours that focus on feedback, learning and improving quality rather than task focus, challenging the tradition of 'how things are done' to bring about the desired behaviours: ▪ Create a vision for staff to follow. ▪ Challenge existing behaviours, particularly negative interactions. ▪ Encourage staff to contribute to decisions. ▪ Support access to clinical knowledge and individual skills development. ▪ Sustain efforts through reward and recognition of desired behaviours • Activities involved coaching, interactive education, role play of clinical skills, study days, one to one guidance, small group teaching close to bedside, role modelling by nurse manager including providing positive feedback, explore and practice with staff how to challenge 'poor behaviours', practising conversations. • Practice development nurses involved in facilitation.	• Sinflo (Support instrument for nurses facilitating the learning of others) and CLOCS (Clinical Learning Organisation Survey) questionnaires at beginning of project and 12 months later. Results showed an improvement in most areas including support, culture and facilitating others learning. • Field notes of local successes and informal observations also documented a change in various areas including: Improved work relationships, Improved professional and clinical development, Being heard, Improved nursing practice, Inclusive of students and new staff, support them to develop specialist skills, improved staff performance, morale and motivation	• Nurses considered work was more acknowledged • Improved performance impact on patients and organisation.	• Reference to Magnet Recognition programme – recognises organisations for high quality care, nursing excellence and innovations on nursing practice (American Nurses Credentialing Center, 2013). • ? field notes of local successes indicating changes – how do we know these weren't happening before?
2	Pollard, C.L., and Wild, C. (2014) Nursing leadership competencies: Low-fidelity simulation as a teaching strategy, Nurse Education in Practice. Vol14, pp.620-626. Reviewed 19.2.18	Peer review Journal Research	• Nurses/healthcare professionals • Canada	• Communication strategies embedded in relational practices and authentic, civil communication and attentiveness to the moral climate. • Leadership requires 'ethical fitness' and learning strategies that provide opportunities to enact ethical fitness and moral courage in decision making • Canadian patient safety institute describe teamwork and communication as essential in creating a culture of safety providing a framework of communication including collaboration, transparency, leadership, open honest disclosure and commitment to continuous learning and process improvement. • Can teach leadership but to learn to be a leader involves personal embodiment of knowledge or transformation requiring time and situational awareness to 'be' a leader	• Development of leadership and followership competencies through simulation exercises with the aim of developing communication skills and situational awareness. • course over 15 weeks, groups of 5 students, exercises are examples of transformational leadership and followership – various activities and simulation – recreate a complex adaptive system. • Situational awareness and debriefing core to successful team communication programmes – most effective approach to team communication not known, focus is often on individual development • Reflective practice core in development of leadership (Grossman and Valiga, 2013) • Recursion seen as important concept for understanding of the transformation and embodiment of leadership (Hammond, 2013) – where student inquiry is facilitated during debriefing. Recursive learning: 'learning, in which the learner "constructs knowledge by linking new information and new experiences with previous knowledge and understanding" (Maran and Glavin, 2013). • Emphasis on communication (constructive feedback, succinct reporting and reciprocity); relational ethics, appreciative inquiry, emotional intelligence and civility	• Facilitate learning of theoretical constructs, in particular team communication skills and situational awareness •	• Impacts the students in terms of realistic scenarios they can apply to practice • Communication techniques improved as observed by faculty	• Concept of ethical fitness (trademark – Rushford Kidder, foundation of Institute for Global fitness) Discussion around impact is weak – how was it evaluated, seems very informal from student and faculty.
3	Lee, Y.K., Goh, H., Yeo, R., Kaur, K., and Chua, C.G. (2015) Evaluation of a Project: Clinical Leadership Programme that Prepared Senior Nurses and Nurse Managers at the National Kidney Foundation, Singapore for Renal Dialysis Nurse-Led Model of Care. Singapore Nursing Journal, Vol.42(2), pp.3-7. Read 20.2.18	Peer review journal. Research	44 participants – senior nurses and nurse managers. National Kidney Foundation (NKF), Singapore.	• Evaluation of clinical leadership programme delivered to renal dialysis senior nurses and nurse managers in National Kidney Foundation (NKF), Singapore. • NKF is a multidisciplinary service covering 25 centres. • The leadership programme is required due to the move towards nurse led services resulting in a changing role change for managers which can ultimately impact on patient care.	• Education programme to deliver knowledge and skills – 3 days of 'intensive' clinical leadership, followed by one month of applying skills and writing 8 reflective journals of their perception of their ability to apply theory to practice followed by a final day workshop. • Participants were supervised through an online platform – online discussion forum discussing issues arising from journals. • Theory covered included – Benner – novice to expert, Carper's ways of knowing, leadership styles, empowerment, team building, effective working relationships, communication, stewardship, engagement, project management. • 'Interactive' learning approach – seminar style simulations based on case scenarios relating to leadership e.g. supporting a new nurse, reflection.	• Participants were able to identify skills of an effective clinical leader and express confidence in using checklist for effective stakeholder engagement. Perceived improvement of leadership style and self-awareness	• Pre- and post- evaluation involved descriptive statistics and thematic analysis. Pre- and post questionnaires developed for the project and validated by external consultant. Increased knowledge for staff.	Impact on team and organisation not discussed.
4	Prentice, D. (2015) Enhancing Leadership skills for bedside RNS: Evaluation of a Leadership programme. Perspectives, Vol.38(1), pp.13-17. Read 20.2.18	Research Journal – peer review	Canada Continuing care and rehabilitation hospital RNs	• Study aimed to explore the impact of a leadership education programme on registered nurses in a continuing care and rehabilitation hospital in Canada. • Focus on 'bedside' RNs as there was a recognition their voice was often 'silent in the organisation	• In house leadership programme that focussed on: • Assisting RNs in articulating their role • Fostering and supporting RNs to use their voice • Empowering RNs to make decisions • Programme was based on RNs Association of Ontario's Health Work Environment Best Practice Guideline: Developing and Sustaining Leadership (2006) and involved didactic and interactive content over 3 half day workshops. Content included role articulation, leadership theory, team building, delegation, communication, managing conflict etc. with aim of improving personal, team and organisational effectiveness.	• Informally managers notices that nurses communicated issues more clearly and identified solutions rather than looking for answers. • A year later interviews were carried out with the participants to evaluate impact of the leadership course on the practice of RN. • Content of course was a good 'refresher', felt empowered to communicate decisions - this was felt to be not due to the content of the course but being valued as they were given the opportunity to discuss issues in their care setting.	• Able to clearly articulate their understanding of their role but confusion between RN and RPN (registered practical nurse – supervised by RN) role. • • More empowered to communicate decisions.	No pre- course information on level of understanding and practice of leadership.

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No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
5	Jukes, M., and Aspinall, S. (2015) Leadership And learning disability nursing. British Journal of Nursing, Vol.24(18), pp.912-916. Read 20.2.18	Peer review journal Discussion paper	Learning disability nursing and learning disability services.	• Leadership seen as important in transforming services particularly following publication of 'Transforming Care' (DoH), improving quality and effectiveness of services across health and social care. • Focus on importance of leadership in undergraduate learning disability nursing. • Reduced numbers of learning disability nurses, particularly at senior levels and therefore reduced engagement in service development and lack of direction on nursing leadership.	• Self-awareness • Collaborative working • Empowering others • Creating the vision • Developing the 'right' values and cultures • PARiHS (Promoting action on research implementation in health services) – framework that promotes and focusses on integrating knowledge transfer into service. Transformational leadership is one element of facilitating this. A change framework based on the idea that putting good quality research into practice will improve outcomes for service users and quality of care. Change is most likely when there is patient and professional agreement over evidence, context and how the change is facilitated. • Importance of valuing patient experience • Leaders should promote and role model good values and a positive culture within a learning organisation, good teamwork, enabling empowering relationships .	• Improved care/quality • Change is more likely to happen	• Service users (people with learning disabilities)	
6	DaCosta, J. (2012) Leadership models for healthcare improvement. British Journal of Healthcare Management, Vol.18(11), pp. 575-580. Read 1.3.18	Peer review journal Review	Medical staff/junior medical staff Healthcare UK	• Personal qualities – both innate and learned: extraversion, self-confidence, self-awareness and resilience. • Suggestion that introversion may be beneficial (Grant et al., 2011) • Formal position e.g. consultant brings authority although can be impacted by political context. • Leadership with authority = 'positional power' – i.e. through election or appointment • Darzi report (2008) recognises importance of clinical leadership for UK Health service • Less literature around leadership with doctors compared to nurses • Political constraints, budgets etc • Healthcare system in constant flux – dynamic • Organic structures with lateral communication, flat hierarchy, decentralisation of decision making – results in transformational leadership • Environment of 'psychological safety'. • Climate that encourages learning from failure and successes	• Higher the position = greater authority to exert influence • Transform organisations through influence • Relationship management • Emotional intelligence and coaching skills • Shared leadership – e.g. cancer collaborative • Individual combined with shared leadership • 'Leadership constellation':- leadership role passes through different people/groups with different expertise at different times. Evident in complex change systems such as restructuring. • 'Distributed leadership' Leading others to lead themselves • Change agents • Leadership without authority – 'informal leadership' • Direct leadership – engagement on frontline e.g. ward sister • Indirect leadership – through chain of command • Guo (2004) suggests 4 stages that reinforce a model of leadership in healthcare re-engineering; examination of environment; strategic plan; execution of plan and evaluation	• Distributed leadership by change agents results in increased empowerment • Transactional leadership more effective in hierarchical organisations • Transformational leadership more effective in dynamic environments • Organisation success in 8 areas; trust structure, prevailing culture, technological capability, operational capability, quality of staff, clinical reputation, strategic relationships and strategy • patient centred model • Organisational culture	• Multi-Factor Leadership Questionnaire (Avolio et al., 1990) • Greater focus on nurses • Increased transformational leadership in participative organisations • Organisation • Patients	Paper also discusses disadvantages of transformational leadership
7	Cattolico, D. (2012) Leadership Practices to Create a Caring Science Medical-Surgical Unit. International Journal for Human Caring. Vol.16(3), pp. 53-53. Read 2.3.18 ***(Duplicate of record 62)***	Conference abstract	USA Acute nursing 'Watson Caring Science Affiliate'	• Caring science innovations – Watson's theory of human caring; practitioners carry out caring reflection; daily huddles allowing time for reflection; 'Caritas' processes; caring moment stories; buddy programme	• Caritas processes – based on Jean Watson's theory of caring. Caritas - the practice of loving kindness, creating a caring-healing environment, self-care, and community caring. Caritas is Latin for cherish 10 caritas proesses in total including: – Being authentically present – Developing and sustaining loving trusting caring relationships. – Open to spirituality, mystery, allowing for miracles	• 0% vacancy rate • Informal comments that unit is 'changing'		***This CMO record is duplicated in record 62***
8	Giltinane, C.L. (2013) Leadership styles and theories, Nursing Standard. Vol.27(41), pp.35-39. Read 2.3.18	Peer review journal Review paper	UK Healthcare	• Leadership traits of ethical fitness, confidence, courage, purpose, ability to prioritise. • Emotional intelligence – self awareness; self-management; social awareness and social skills. • Trust	• Leadership framework (NHS Leadership Academy, 2011) – education programme • Develop successful relationships • Identify differences and develop strengths • Different types of transformational leadership; inspirational motivation – leaders influence followers through charismatic communication; individualised consideration – help followers meet desired needs; Idealised influence attributed – forming positive bonds; idealised influence behaviour – idealised behaviour becomes collective; intellectual stimulation – encourages others to think creatively. • Democratic leaders – believe workers are motivated to do well • Taking an interest in staff as people • Situational leadership – style adapted to situation	• Ability to influence others • Empower others to become leaders • Increased organisational loyalty, increased motivation and job satisfaction, decreased sickness • Positive work environment • Feel valued, improved self-esteem	• Improved patient outcomes • Greater empowerment and clarity over role for nurses	Comparison of transformational and transactional leadership as well as situational and democratic.
9	Norman, K. (2012) Leading service improvement in changing times. British Journal of Community Nursing, Vol.17(4), pp.162-167. Read 2.3.18	Peer review journal Discussion paper	UK Community nursing	• Leadership and change management interlinked • Leadership is 'everybody's business where all staff can make a difference • Front line care (DoH, 2010) states every organisation should create a culture that enables all nurses to be fully involved in leadership, design of services etc. • Active engagement is a core condition for developing leadership capacity in community nursing (RCN, 2010)	• Opportunity, support, encouragement to enhance confidence • NHS Leadership framework providing a consistent approach to all leadership programmes • In order to be politically and organisationally aware; DoH, CNO bulletins; local trust plan; know 'who's who.'; engaging with others, attending conferences • Being realistic about constraints such as finance • Building effective relationships • Collaborating with others 'find a man who can'	• Improved delivery of services for patients, service users and carers	• Patients, service users, carers	Discussion interlinks change management and leadership – focus on PDSA cycle.

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				• Good communicator, listener • Creating and sharing a vision • Motivated and motivational • Able to articulate views • Competent, proactive • Willing to persevere • Trustworthy, honesty • Values and beliefs aligned to cause • Confidence • Political and organisational awareness	• Transformational leadership style with participative methods			
10	Grogan, L. (2011) Leading the way. World of Irish Nursing & Midwifery, Vol. 19(9), pp.38-39. Read 2.3.18	Journal article Pictorial	Healthcare Nursing and Midwifery Ireland	• Less staff and less available finance • Increasingly complex organisations	• Leadership at all levels • Influencing and motivating others to achieve mutually agreed goals • Trust • Supporting and guiding colleagues through mentorship, supervision and inspiration • National leadership and innovation centre for Nursing and Midwifery – leadership programmes, resources, • networks and partnership strategies, evaluation tools	• High quality safe care • Develop leadership competencies in nurses and midwives	• Patients • Nurses and midwives • Organisation	
11	Goodare, P. (2017) Literature review: Why do we continue to lose our nurses? Australian Journal of Advanced Nursing, Vol. 34(4), pp. 50-56. Read 5.3.18	Peer review journal Research Systematic review – quantitative and qualitative	Australia Female dominated Average age 41.6 years Increased acuity, workload Ageing workforce	• Shortage of nurses	• Organisational factors impact on retention • Culture impacts on commitment • Social support from supervisors and co-workers • Support and guidance from senior leaders	• Retention of staff		
12	Zimring, C., Hyun-Bo, S. (2012) Making Acuity-Adaptable Units Work: Lessons From the Field. Health Environments Research & Design Journal Vol. 5(3), pp.115-128. Read 5.3.18	Peer review journal Qualitative research	Acuity adaptable units (AAUs) USA Nurses	• Some AAUs are successful in meeting operational objectives and some aren't but a lack of literature exploring this. • AAUs – appropriate level of care comes to patient rather than multiple transfers – preventing adverse events such as falls, infection etc. • Different culture – providing ICU care to discharge	• Helping staff adjust to a different culture of the AAU • Communication between leadership and staff for effective culture change • Team work meetings • Staff involved in reviewing building design etc. • Rewarding nurses for achieving training or achieving change. • Dealing with staff resistance • Robert Wood Johnson Report – 14 strategies for culture change (consolidated culture change of 10 hospitals) (Parker, 2008) o Find the urgency for change o Ensure support from top leadership o As people whose support is needed as part of original planning o Have a big vision o Communicate the vision over and over again o Look outside hospitals for lessons o Make expectations clear o Assign to a staff member the job of keeping the culture change o Give employees support to help them change o Give employees a forum where they have ability to make decisions about hospital policy o Demonstrate the impact of change through clinical and financial outcomes o Rewarding employees helps boost morale o Revisit plans and tweak them o Hold the course long enough to become habit • These 14 strategies (above) were compared to the findings of this study with most strategies evident when analysing interviews.	• Patient satisfaction – continuity with staff • Reduced adverse events	• Patients • Organisation	
13	McGilton, K.S., Boscart, V.M., Brown, M., and Bowers, B. (2014) Making tradeoffs between the reasons to leave and reasons to stay employed in long-term care homes: Perspectives of licensed nursing staff. International Journal of Nursing Studies, Vol.51(6), pp.917-926. Read 5.3.18	Peer review journal Mixed methods Quantitative and focus groups	Canada Long term care Nurses	• Difficulty in attracting and retaining staff in long term care settings resulting in high turnover impacting quality of care and attrition of nursing aides and organisational productivity, resident outcomes • Previous research focussed on carers rather than nurses • Leadership practices known to impact on retention of staff • Most retention research is focussed in acute care • Long term care (LTC) – longevity of stay of residents and resultant relationship between staff and residents, regulation on LTC	• Participants discuss a lack of supportive leadership impacting on their decisions to stay. They identify supportive leadership as involving recognition of excellent job performance and significant contributions, appreciation of staff. • Establishing relationships with residents and colleagues • Opportunities for personal growth, formal and informal learning opportunities	• Staff retention • Enhanced resident outcomes	• Residents • Staff • Organisation	
14	Shearer, D.A. (2012) Management styles and motivation. Radiology Management, Vol. 34(5), pp. 47-52.	Peer review journal Literature review	Healthcare	• Combinations of transformational and transactional leadership •	• Leaders must be flexible and able to change with organisation • Recognising individuals for accomplishments, knowledge and skills	• Staff motivation • Staff satisfaction – by combination of transactional contingent reward system and transformational leadership behaviours. • Followers finding own path to autonomy	• Staff • Service quality	

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	Read 5.3.18				• Implementation of motivation theories – Maslow and Herzberg (intrinsic and extrinsic motivators) • Encouraging staff to use critical thinking and problem solving creativity • Provide inspiration, feedback, advice,support and personal attention • Show empathy, relationship building, genuiness and respect • Management skills – conflict resolution, performance management effective communication, relationship building.			
15	Soo Young, J. (2017) Mediating Effect of Social Capital between Transformational Leadership Behavior and Organizational Citizenship Behavior in Hospital Nurses. Journal of Korean Academy of Nursing Administration, Vol.23(5), pp.558-566. Read 5.3.18	Peer review journal Cross-sectional descriptive study exploring relationship between transformational leadership behaviours, social capital and organisation citizenship behaviour	South Korea 2 hospitals Nurses	• Transformational leadership behaviours (TLB) • Organization citizenship behavior (OCB) - positive social behaviors that increase the efficiency of an organization as a whole; characterized as the behaviour of individuals in an organization and defined as extra role behaviours, rather than defined roles and responsibilities • increases tendencies towards helping and sharing information, promoting a feeling of conscience, tolerance, and praising the institution, positive social behaviours that increase the efficiency of the organisation. • Reciprocal communication • Social capital - the sum of the actual and potential resources derived from the network of relationships possessed by a social unit. The social complexities that are reciprocally connected within specific social structures marked by trust, networks, and norms. Promotes work motivation through a sense of unity	• Enhance OCB and determine OCB levels • Infrastructure that helps members actively interact • Organisational training programmes • Support nurses to have confidence in their practice • Shared vision	• Increase organisational citizenship behaviour – • Better patient outcomes • Successful healthcare organisations • Transformational leadership encourages voluntary OCBs • Social capital enhances ability to share knowledge and meet organisational goals • Social capital - Promotes work motivation by providing a sense of unity • Study shows social capital has a a partial mediating effect of TLB on OCB	• Patients • Organisations	Organisation citizenship behaviours Concept of civic virtue Social capital - the sum of the actual and potential resources derived from the network of relationships possessed by a social unit.... the social complexities that are reciprocally connected within specific social structures marked by trust, networks, and norms
16	Shear, K. (2017) Military Nursing. The Patient CaringTouch System: A Framework for Positive Practice Environments. MEDSURG Nursing, Vol.26(3), pp.215-218. Read 5.3.18	Peer review journal Discussion paper	Army Nurse Corps Introduction of Patient Caring Touch system (PCTS) – organisational and cultural change that enriched nursing care and reduced variation in healthcare delivery PCTS – patient centred care delivery system, a structured standards based framework for nursing practice comprising 5 pillars (enhanced communication, patient advocacy, capability building, healthy work environments, evidence based practice) and 10 components (leader development, talent management, skill building, standardised documentation, peer feedback, care teams, core values, shared accountability, optimised performance, centres for nursing science and clinical inquiry)	• gaining organizational acceptance • providing foundational knowledge • providing implementation strategies • Leaders must (a) understand and describe the impact of change on people; (b) build an emotional and rational case for change; (c) ensure the entire leadership team serves as a role model for the change; (d) mobilize people to own and accelerate the change; and (e) embed change in the fabric of the organization.	• Mechanisms relate to how the PCTS was implemented: o Communication between strategic leaders and senior leaders o PCTS training sessions for 'champions' o Incremental implementation of PCTS – pilot initially o Face to face sessions to discuss success and opportunities and build collaborative relationships o Teleconferencing and marketing e.g. pamphlets, online resources and info on notice boards to inform and engage staff	• Long term change • Reduced variation in healthcare delivery • Enhanced nursing care • Enhanced patient experience • Nurse empowerment • Nurse retention • Practice environment scale of the Nursing Work Index (PES-NWI) – validated tool measuring professional nursing practice environment. – Increased scores after implementation.	• Nurses • Patients • Organisations	Paper relates to implementation of a care delivery system in Army corps and impact of this, mechanisms describe how the change was facilitated
17	Edmonson, C. (2010) Moral courage and the nurse leader. Online Journal of Issues in Nursing, Vol.15(3), pp.1-1. Read 5.3.18	Peer review journal Discussion paper	Nurse leaders Complex environments leading to value conflicts and potential for moral distress	• Develop, role model and practice moral courage • Result of dispositional factors (i.e. characteristics) and situational factors • Healthful work environments that support moral courage • Create cultures that support courage in nursing	• Moral courage – leader who considers more than rules and policies, who demonstrates hardiness and determination, and who is self directed toward the good or what is right and moral routinely displays acts of moral courage • Moral courage – individual ability and capacity to overcome fear and openly support ones values. • Leaders who show moral courage are competent, credible, visible and expert • In situations of moral distress leaders must ask, affirm, assess and act. • Sacred spaces where nurses can pause to consider response to situation	• Prevent moral distress	• Nurses	Lack of discussion related to impact and outcome.
18	Barros, A.A., Oliveira, R.M., Pinheiro, C.A., Leitao, De Arruda, I.M.T., Pinheiro do Vale, A., Sales da Silva, L.M. (2014) Motivation Practices To Promote Safety Culture By Nursing Leaders According To Assisting Nurses. Journal of Nursing UFPE Vol.8(12), pp. 4330-4336. Read 5.3.18	Peer review journal Qualitative research	Brazil Nurses Hospital	• Identify factors that promote a safety of culture by nurse leaders - safety culture is defined as the sum of • the individual or group values, attitudes, • perceptions, competencies and patterns of • behavior that determine the commitment, • style and ability of health organization in • security management	• Effective communication about adverse events: capacity, training and feedback to the team • Establishment of participatory leadership – motivating • Build relationships between leaders and staff • Meetings with leaders and staff • Focus on analysing adverse events rather than punishing • Valuing the team	• Enhanced safety culture – reduced adverse events, hospital stay etc. • Motivation to practice a safety culture	• patients	Would be interesting if there was more detail about the what and how of participatory leadership

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				• Participatory leadership – encourage shared decision making • Authors identify in problems with safety culture in Brazil				
19	Carlin, A., and Duffy, K. (2013) Newly qualified staff's perceptions of senior charge nurse roles. Nursing Management. Vol.20(7), pp24-30. Read 5.3.18	Peer review journal Qualitative research	Acute hospitals Leadership roles of senior charge nurse (SCN) and perception of nurses of this role.	• STRONG, EFFECTIVE and visible clinical • leadership at senior charge nurse (SCN) level is • at the centre of the government's modernisation • programme for the NHS (Department of • Health (DH) 2010) • NHS Leadership programme for SCNs amongst others (e.g. RCN) – however doubt over effectiveness of strategies • Participants had difficulty in articulating the role of the SCN with overlap between management and leadership roles • Unattractiveness of leadership roles	• Visibility of SCN on ward, clinical presence • Support of leader to be able to make autonomous decisions • Emotional support in the form of praise • Leaders as nurturers • Role modelling – clinical and being with patients – beliefs and values • Approachability of leader – facilitating concept of belongingness	• Job satisfaction, retention	• Nurses	5 participants
20	Scott, J., Morales, D.R., McRitchie, A., Riviello, R., Smink, D., and Yule, S. (2016) Non-technical skills and health care provision in low- and middle-income countries: a systematic review. Medical Education, Vol.50(4), pp.441-455 Read 5.3.18	Peer review journal article Systematic literature review	Exploring non-technical skills (NTS) in low to middle income countries (LMIC), leadership is one element of NTS. Health workers	• Little is known about NTS in LMICs. • Study aims to explore contextual factors that affect their use – leadership being one of these. • Leadership literature focusses mostly on nursing leadership • Lack of leadership training in LMICs • Need for transformational leadership • Leadership styles used in LMICs include non-consultative, knee-jerk, abusive/hostile and depowered.	• Cross over with management • Organising, planning tasks • Developing teamwork/team skills • Developing a positive atmosphere	• Nurses more satisfied with transformational leadership • Improved nursing leadership = improved patient safety		What does 'improved' nursing leadership mean?
21	Boynton, B. (2012) Nurse Leaders' Critical Role in and Collaboration Strategies for Creating Safe, Positive Workplace Cultures. Journal of Legal Nurse Consulting, Vol.23(2), pp.31-34. Read 5.3.18	Peer review journal Discussion paper	Legal nurse consultants (LNC)	• Context of patient safety and promoting positive work environments. LNCs brought in when there is a problem but have a role to play in terms of leadership and prevention of adverse events • The Joint Comission (TJC) statistics on root cause sentinel events – leadership is a commonly cited root cause • Complexity science • Humans as adaptive systems	• Healthy communication skills – including assertiveness, respectful listening e.g. asking for, offering and accepting help; setting limits; respecting self and others. • Building trust and healthy relationships • Develop a plan with vision, commitment and consensus building • Incorporate training and practice – around respectful listening and speaking up, healthy communication, managing conflict • Coaching, role modelling • Discipline	• Safe positive workplace cultures	• Patients – safe care • Organisations	
22	Battle-Wherry, L. (2016) Bridging Gaps in Acute Wound Care: A Continuum of Care Using a Computerized Provider Order Entry System. Online Journal of Nursing Informatics, Vol.20(1), pp. 1-1. Read 8.3.18	Peer review journal article Quantitative research	Georgia, USA Evaluation of leadership project - Computerised physician order entry (CPOE) wound management project Acute care	• Gaps in wound care management • Varied approaches in wound management protocols • Pressure ulcers remain critical yet curable issue in acute care • Donabedian's model for quality – structure process and outcomes is the structure for US Healthcare • Transformational leadership •	• Identify and refine project goals as needed • Involve and motivate key stakeholders • Support to achieve goals • Resilience to support change • Supporting the development of knowledgeable clinicians • Creating a culture of safety • Communication • Collaborative working • Evaluate educational needs	• 20% decrease in pressure ulcer incidence in test site • Improved care delivery • Standardised documentation	• Healthcare staff • Patients • Organsation	
23	Sharkey, S., Lefebre, N. (2017) Bringing Nursing Back to the Future Through People-Powered Care. Nursing Leadership Vol.30(1), pp.11-22. Read 8.3.18	Peer review journal Discussion paper	Canada Homecare	• 'People powered care' – engaging and empowering nurses to engage and empower patients • HOPE model – focus on wellness and independence guiding clinical practice rather than number of visits. • Focus on human connections	• Co-design • Proactive in creating and sustaining the culture and responsive to needs goals and desires of people • Courageous • Experiment with new approaches on the go • Championing new models of healthcare • Expert communication • Transformative leaders explore the tensions between being bold and humble	• Increased patient satisfaction • Better alignment between those accessing the service and those delivering	• patients	I like how this paper is written.
24	Vasconcelos, R.M.A., Caldana, G., Lima, E.C., Marques da Silva, L.D., Bernardes, A., Gabriel, C.S. (2017) Communication In The Relationship Between Leaders And Lead In The Context Of Nursing. Journal of Nursing UFPE / Suppl.11, pp.4767-4777 Read 8.3.18	Peer review journal Integrative review	Brazil Nursing	• Literature review aims to explore importance of communication between leaders and the led in nursing. • Importance of the process communication identified as an area for exploration • Leadership competence directly related to ability to communicate • Good leadership will ensure professionals are committed to the vision of the organisation	• communication, commitment, responsibility, empathy, ability • to decision-making, and management • effectively • Open direct and transparent communication • Involving team members in the decision making process. • Theoretical and practical knowledge • Motivation and dedication • Ability to listen and speak and practicality in conflict resolution • Dialogic communication • Participatory leadership • Leadership training • Authentic dialogue with team with the purpose of sharing ideas and vision • Value less hierarchical communication	• Good team relationships • Promote desired changes in work environment • Quality safe care • Staff satisfaction	• Patients • Staff • Organisation	
25	Ulrich, B.T., Landero, R., Woods, D., and Early, S. (2014) Critical Care Nurse Work	Peer review journal Research - survey	Critical care registered nurses America	• AACN Standards for Establishing and Sustaining Healthy work environments of	• Authentic leadership involves nurse leaders embracing concept of health work environment and	• Staff satisfaction and retention • Enhanced patient safety and quality of care	• Patients • Staff	Note link between reduced access to

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	Environments 2013: A Status Report Critical Care Nurse. Vol.34(4), pp. 64-79. Read 14.3.18			• which authentic leadership is one essential standard – and absence on this impacts negatively on safety quality of care etc. • Environments RN work in impacts on job satisfaction, retention and patient outcomes • Overall health of critical care work environments has declined since 2008. • Nursing shortages in USA in 2006 and recession in 2007 resulting in reduced vacancy rates in 2008. 3rd survey carried out in 2013 when there signs of a general economic turnaround	• engaging others in achieving it, nurse leaders receiving support for educational programmes to develop as leaders • Authentic leadership 'the glue that holds together a healthy work environment' (McCauley, 2005). • Survey showed a decline in ratings for authentic leadership between 2008 and 2013. • Findings suggest nurses value authentic leadership in creating healthy work environments • Culture of respect • Communication and collaboration • Recognition from work	• Reduced medication errors, HAIs	• Organisation	leadership training and reduced display of authentic leadership as perceived by participants. Authentic leadership statement: - Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement.
26	Lima, E.C., Bernardes, A., Baldo, P.L., Maziero, V.G., Camelo, S.H.H., and Balsanelli, A.P. (2017) Critical incidents connected to nurses' leadership in Intensive Care Units. Revista Brasileira de Enfermagem, Vol.70(5), pp. 1018-1025. Read 14.3.18	Peer review journal Research – exploratory descriptive study using critical incident technique – positive and negative incidents that related to leadership	Brazil Nurses Intensive care unit	• High complexity care giving, busy stressful environment • Leadership and management training • For profit private hospital, public hospital and charity hospital	• Leaders as motivators and mediator of relationships • Value sharing information • Establishing targets for quality of care • People management – rotation schedule • Leadership style focussing on personal relations; contemporary leadership– transformational leadership, authentic leadership and situational leadership • Efficient communication • Collective thinking	• Enhanced quality of care	Organisation Patients	
27	Elwell, S.M., and Elikofer, A.N. (2015) Defining Leadership in a Changing Time Journal of Trauma Nursing, Vol. 22(6), pp.312-E4. Read 14.3.18	Peer review journal Discussion paper	Trauma nurses America	• Recognising difference between leadership and management • Clear understanding of where the organisation is, current climate of healthcare and mission and vision of organisation	• Empower staff • Goal setting – realistic and measurable • Awareness of emotional needs of team and social awareness of team • Encouraging active involvement of whole team • Modelling desired behaviour • Promote transparency • Willing to take risks • Creative and innovative • Coping with failure and understanding its value	• Positive patient outcomes • Recruitment and retention of staff • Job satisfaction scores • Improved work environments	• Patients • Nurses • Organisation	
28	Gifford, W.A., Davies, B.L., Graham, I.D., Tourangeau, A., Woodend, A.K., and Lefebre, N. (2013) Developing Leadership Capacity for Guideline Use: A Pilot Cluster Randomized Control Trial. Worldviews on Evidence-Based Nursing, Vol.10(1),pp.51-65. Read 14.3.18	Peer review journal article Feasability RCT and qualitative interviews	Home care nursing Canada	• Nurses use of guideline recommendations when caring for patients with diabetic foot ulcers • Complex and changing healthcare world • Managers incorporate elements of leadership and management • Increased delegation of clinical support responsibilities away from managers therefore emphasis on clinical leaders promoting research based practice • Leadership development is a priority for healthcare research funders in Canada • Guideline implementation strategy involving clinical education related to guidelines for diabetic foot ulcer • Leadership focussed intervention including workshop and teleconferences • Based on theories of planned change	• Behavioural leadership research and theory suggests effective leaders use behaviours from 3 categories: ○ Relationship orientated behaviours – supporting developing and recognising others increasing trust cooperation and commitment ○ Change-orientated behaviours – providing vision and direction ○ Task orientated behaviours – clarifying roles, monitoring performance and outcomes • Visibility of unit manager and understanding of clinical guidelines	• Influence nurses to use research evidence in clinical practice • Conscious act of setting goals affects actions and performance. • More relations and change orientated behaviours in experimental group (i.e. those who had undergone leadership intervention)	• Patients • Organisation	Interesting discussion about the gap between clinical leaders and managers – the need for presence seems important, but there tends to be a widening gap between frontline and management
29	Curtis, E.A., deVries, J., and Sheerin, F.K. (2011) Developing leadership in nursing: exploring core factors. British Journal of Nursing, Vol.20(5), pp.306-309. Read 14.3.18	Peer review journal Discussion paper	Leadership content in undergraduate programmes Theories underpinning leadership Factors that enhance leadership	• Leadership can be 'learned' through education, modelling and practising leadership • Importance of fostering leadership throughout education • Challenges facing leaders currently e.g. financial constraints, new roles, new technology	• Knowledgeable about leadership and able to apply leadership skills in all aspects of work • Transformational leadership is seen as effective in advancing nurse leadership which involves vision; ability to inspire; trust; sharing a bond and being able to empower others • Nursing knowledge • Relationship skills – effective communication, being approachable • Traits and characteristics of openness, extroversion and motivation to manage • Value over contact between leaders and care givers • Emotional intelligence • Empowering nurses	• Improved patient safety outcomes • Healthy work environments • Job satisfaction • Lower turnover rates • Positive outcomes for patients, organisations and healthcare providers • Positive work behaviours and attitudes	• Patients • Staff • Organisations	• Discussion related to difference between general leadership and nursing leadership due to responsibility for improving the practice environment • Few definitions offered for nursing leadership in the literature • Recommendation for leadership to be included at all levels of education.
30	Curtis, E.A., Sheerin, F.K., and deVries, J. (2011) Developing leadership in nursing: the impact of education and training. British Journal of Nursing, Vol.20(6), pp.344-352.	Peer review journal Discussion paper	Nursing education	• Nurse leadership education – MSc, Diploma and Certificate levels • Importance of aligning leadership with practice, not just management • Increased need for leadership in nursing • Age is positively correlated with leadership – older and more experienced nurses are more effective leaders. • Creating a warm, safe and supportive organisational culture and work climate	• Value in preparing nurses during primary degrees for leadership • Opportunities to reflect and apply new knowledge to practice • Empowerment 'plants the seeds of leadership' (Marquis and Huston, 2009) • Delegation – provides opportunities for learning, sharing ideas and working collectively • Mentoring	• Improved staff retention • Positive impact on patient care • Enhanced leadership skills	• Nurses • Patients • Students	

Leadership in Health Services

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
31	Power, J., and McManus, O. (2013) Development of a short-stay unit in an emergency department. Emergency Nurse, Vol.21(2), pp.18-22.	Peer review Case study	Ireland Emergency department Introduction of new short stay unit	• Adopting Lewin's (1951) 3 stage approach to management of change • Enhanced training for staff	• Motivation and ability to motivate others • Assertiveness • A vision of how the short stay unit would improve care • Willingness to engage with all staff • Emotional intelligence	• Improved services • Increase competence and professionalism of nursing • Strong multidisciplinary team ethos	• Patients • Staff • Organisation	Weak discussion of outcomes.
32	Lacey, S. (2017) Driving Organizational Change From the Bedside: The AACN Clinical Scene Investigator Academy. Critical Care Nurse, Vol. 37(4), pp.e12-e25.	Peer review journal Description of curriculum of leadership programme and mixed methods evaluation	America Critical Care Nurses	• American Association of Critical Care Nurses staff nurse leadership programme – 16 month programme • Hospitals chosen to participate were granted $10000 to backfill shifts etc to support project • Cohort approach	• Curriculum empowers and engages staff nurses in quality improvement and evidence translation, change strategies, leadership skills • John Kotter's 8 step change theory (has been successfully used to manage transformational change in healthcare): creates urgency, communication, vision and empowerment • Communicating and embedding a vision • Staff are mentored through a change project • Interactive and experiential • Workshops and web based communication • Internal coach to support participants	• Improved patient/family outcomes • Contributed to professional development of nurses • Financial impact • Pre and post measurements of empowerment, engagement and social entrepreneurship. 3 established instruments used: o Conditions of work effectiveness questionnaire-II o Oldenburg burnout inventory o Social Entrepreneurship scale • Statistically significant difference for empowerment – higher perception of empowerment at the end of the programme. • Qualitative data also highlighted a heightened sense of empowerment	• Nurses • Patients • Organisations	Highlight that patient and financial outcomes could not necessarily be wholly attributed to the leadership programme.
33	Roberts-Turner, R., Hinds, P.S., Nelson, J., Pryor, J., Robinson, N.C. and Wang, J. (2014) Effects of Leadership Characteristics on Pediatric Registered Nurses' Job Satisfaction Pediatric Nursing, Vol.40(5), pp.236-256. Read 14.3.18	Peer review journal Research – survey – qualitative and quantitative	America Paediatric nurses	• Job satisfaction among RNs in hospitals is lower than all workers in the USA • RN shortage • Lack of research focussing specifically on job satisfaction amongst paediatric nurses. Research available showed that lack of leadership support resulted in poor satisfaction with job. • This study aimed to explore leadership characteristics and job satisfaction in paediatric RNs. • Study guided by full range leadership theory which identifies transformational and transactional leadership as influencing followers in positive ways	• Transformational leadership – creating an environment allowing individuals to perform at their fullest potential – recognised by autonomy. • Transactional leadership involves an exchange process – achieving organisational goals in exchange for a reward – relates to distributive justice	• Healthcare environment survey Autonomy (authors describe as transformational leadership) and distributive justice (authors describe as transactional leadership - Degree to which rewards and punishments are related to individual's performance) impact positively on job satisfaction • Leadership/management although did not directly impact on job satisfaction, did significantly affect autonomy •	• Nurses	• Unsure how the authors represented transactional and transformational leadership with autonomy and distributive justice. • Could be more discussion around mechanisms.
34	Waite, R., and McKinney, N.S. (2014) Enhancing Conflict Competency ABNF Journal, Vol. 25(4), pp.123-128. Read 14.3.18	Peer review journal Research – non-experimental pre- and post-survey design	Undergraduate nursing students America	• Seeing conflict as potentially a positive – i.e. rather than negative injury, energising and an opportunity for growth • Undergraduate leadership programme specifically exploring changes in conflict style.	• Didactic and experiential activities to enhance leadership development • Reflective journaling, team building exercise • Thomas-Kilmann Conflict mode instrument was used to measure conflict resolution styles – the basis is 2 dimensions assertiveness and cooperativeness	• Increased self awareness of conflict style	• Student	• Vague findings and discussion related to impact of awareness of conflict style
35	Curtis, E., and Connell, O.A. (2011) Essential leadership skills for motivating and developing staff Nursing Management - UK, Vol.18(5), pp.32-35. Read 15.3.18	Peer review journal Discussion paper	Ireland Nurses	• Paper discusses link between transformational leadership and motivation • Context of a changing healthcare environment	• Skilled communication • Inspire trust • Develop relationships of mutual stimulation • Bass (1998) theory of transformational leadership identifies 4 main components o Idealised influence where leaders are admired and respected o Inspirational motivation o Intellectual stimulation o Individualised consideration • Articulate a vision that can motivate individuals to adapt to changing situations • Shared accountability, responsibility and power • Encourage creativity and innovation • Work enhancement – job enrichment (e.g. increased freedom), job enlargement (e.g. decreasing monotony), job rotation • Role models • Empowerment – top down: delegation and accountability; bottom up: encouraging employees to ask questions, make decisions.	• Motivation and empowerment among nurses • Higher level of performance • Nurse retention	• Staff • Organisation	
36	Tomlinson, J. (2012) Exploration of transformational and distributed leadership. Nursing Management - UK, Vol.19(4), pp.30-34. Read 15.3.18	Peer review journal Research - interpretivist	Scotland Nursing	• Need to restore public faith in healthcare • Introduction of 'modern matron' • Leading better care – introduction of senior charge nurse • Government policies highlighting transformational leadership enhanced motivation, morale and ultimately care	• Clinical leadership education early in career • Engaging whole team – shared vision • Good communication • Distributed leadership can have a positive effect on staff	• Enhanced motivation, morale and performance of team • Organisational goals met	• Staff • Patients • Organisation	
37	Schwendimann, R., Dhaini, S., Ausserhofer, D., Engberg, S., and Zúñiga, F. (2016) Factors associated with high job satisfaction among care workers in Swiss nursing homes -- a cross sectional survey study. BMC Nursing, Vol.15, pp. 1-10. Read 15.3.18	Peer review journal Quantitative research	Switzerland Nursing homes	• Research tends to focus on job satisfaction in acute care settings with a lack of research on factors that influence job satisfaction in nursing homes • Ongoing societal and demographic changes leading to increased demand for nursing care • High turnover rates in nursing homes	• Supportive leadership associated with high job satisfaction – strongest association. Leadership subscale (part of practice environment scale – nursing work index – PES-NWI) included: • Support by supervisors • Competency of supervisors • Back up in decision making • praise and recognition • use of mistakes as learning opportunities and not criticism	• High job satisfaction • Enhanced resident care	• Organisation/nursing home sector • Staff • Residents	Paper focusses on what helps those to feel a high sense of job satisfaction. Appreciative focus Refers to literature that suggests variety of leadership approaches are beneficial in nursing homes – sometimes more task focussed (Havig et al)

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					• Foster and maintain communication with front line care workers, monitor needs and support achievement of organisational goals • Reciprocal staff and management communication • Support from colleagues 'I would feel safe being a resident in this unit'			
38	Cummings, G., Olson, K., Raymond-Seniuk, C., Lo, E., Masaoud, E., Bakker, D., Fitch, M., Green, E., Butler, L., and Conlon, M. (2013) Factors influencing job satisfaction of oncology nurses over time. Canadian Oncology Nursing Journal, Vol.23(3), pp.62-171. Read 16.3.18	Peer review journal Research – prospective descriptive research design	Oncology nurses America	• International nursing shortages • Lack of literature exploring factors impacting on job satisfaction in specialist settings such as oncology • Increased demand for care in oncology due to rising cancer rates • Oncology nursing – specialist practice where additional knowledge and skills are required. Intense therapeutic relationships • Higher ratings related to nurse-physician relationships compared to non-oncology environments in terms of positive work environments • Patient centred care, autonomy and professional pride – specifically related to context of oncology nursing. • Study tests a theoretical model of relationship between work environment factors and nurses job satisfaction from data from previous studies (Bakker et al., 2004; 2006).	• Relational leadership characterised by administration that listens and responds to concerns leading to greater opportunities for development • Support for innovative ideas • Good physician – nurse relationships • Supervisor support in resolving conflict • Clear philosophy of nursing and identity • Strong, visible leaders who recognise specialism of oncology nursing • Of note is the changing relationships between variables and job satisfaction over time, for example, visible accessible leader was negatively associated with freedom to make patient decisions in 2004 study and no relationship in 2006 study but in 2006 visible leadership was related to support for innovation. These changes in relationships between variables and outcomes over time highlighted need to adopt different approaches to leadership depending on context.	• Quality care • Freedom to make patient care decisions • Job satisfaction • reduced mortality (in previous studies e.g. Cummings et al., 2010) •	• Patients • Nurses • Organisation	
39	Sherman, R., and Pross, E. (2010) Growing future nurse leaders to build and sustain healthy work environments at the unit level. Online Journal of Issues in Nursing, Vol.15(1), pp.4-4.	Peer review journal Literature review	America Nursing	• A need for strong nursing leadership, particularly at front line point of care • Nurse Manager Leadership Collaborative Learning Domain Framework • Literature supports positive relationship between healthy work environment, job satisfaction and positive patient outcomes. • Achievement of healthy work environment is challenging in changing healthcare • Some organisations in America are aiming to achieve Magnet status - Magnet practice environments include five major components: transformational leadership; structural empowerment; exemplary professional nursing practice; new knowledge, innovations and improvements; and empirical quality outcomes (ANCC, 2008). Identified as 'forces of magnetism' • Clinical Nurse Leadership (CNL) role developed in 2004 in America • However not all organisations investing in initiatives	• 9 elements that support development of healthful practice/work environments (Nursing Organizations Alliance, 2004): • A collaborative practice culture • A communication rich culture • A culture of accountability • The presence of adequate numbers of qualified nurses • The presence of expert, competent, credible, visible leadership • Shared decision making at all levels • The encouragement of professional practice & continued growth/development • Recognition of the value of nursing's contribution • Recognition by nurses for the their meaningful contributions to practice • Leaders who support the importance of positive organisational culture, authentically live it and engage others in its achievement • Transformational leadership • CNL working collaboratively with nurse manager to reduce tensions, communication difficulties and promote health work environment through coaching etc. • Nurse Manager Leadership Collaborative (NMLC) learning domain framework: • The leader within – creating the leader in yourself • The art of leadership: Leading people • The science of leadership – managing the business	• Healthy work environments – higher job satisfaction, recruitment, retention, improved patient outcomes	• Nurses • Organisation • Patients	
40	McGilton, K.S., Profetto-McGrath, J., and Robinson, A. (2013) Implementing the Supportive Supervision Intervention for Registered Nurses in a Long-Term Care Home: A Feasibility Study. Worldviews on Evidence-Based Nursing, Vol.10(4), pp.238-247. Read 19.3.18	Peer review journal Research – feasibility study Quantitative – surveys and focus groups	Canada Long term care RNs, LPNs (licensed practitioner nurses) and HCAs (healthcare aides)	• Study explores impact of a supportive supervision intervention for RNs in long term care home. • Evidence to support supportive supervision positively impacts HCAs job satisfaction, stress, retention and using research findings in practice. • Based on McGilton and Kadushin's work relating to effective supervision in long term care • Programme based on 3 essential elements of effective supervision; supportive, administrative and educational strategies:- building effective relationships with staff, empathy, conflict resolution etc.	• Supportive supervision workshop • Weekly reflection over 6 months – not seen feasible by all staff. • On-unit coaching over 6 weeks – this element did not happen due to staffing problems	• Nurse supervisor job satisfaction scale – no statistically significant changes in job satisfaction, although there was an increase in the mean supervision score throughout course of study • Castles' nursing home nursing aide job satisfaction questionnaire - no statistically significant changes in job satisfaction for supervised staff, job satisfaction scores stayed stable. • Supervisory support scale – mean supervision scores increased over time. • Conceptual and instrumental research use scales – statistically significant difference in use of evidence in practice, both instrumental and conceptual.	• Staff	Potential impact on residents due to enhanced use of research although this was not documented.
41	Coleman, C. (2013) Integrating Quality and Breast Cancer Care: Role of the Clinical Nurse Leader. Oncology Nursing Forum, Vol.40(4), pp.311-314. Read 19.3.18	Peer review journal Discussion paper	Oncology nursing USA	• Breast cancer global health problem, multifaceted and complex care • Development of clinical nurse leader (CNL) role in USA in 1999-2003, introduced by American Associations Colleges of Nursing (AACN) to address problems in quality of care in USA • CNLs are educated to masters level	• Clinical microsystems – listening to staff working on frontline with patients • SWOT analysis for organisational assessment • Advocate for overall organisational goals	• Organisational effectiveness • Optimise client outcomes • National accreditation Programme for breast centres	• Patients • Organisation	

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				• AACN leadership competencies (2007): CNL competencies include: advocate; clinician; educator; information manager; interdisciplinary collaborator; member of a profession; outcomes manager; systems analysist; team manager • CNLs required to undertake 400 hour internship				
42	deMoura, A., Bernardes, A., Balsanelli, A.P., Zanetti, A.C.B., and Gabriel, C.S. (2017) Leadership and nursing work satisfaction: an integrative review. Acta Paulista de Enfermagem, Vol.30(4), pp.442-450. Read 19.3.18	Peer review journal Integrative review	• Brazilian journal • Nursing leadership and relationship with job satisfaction • 9/15 articles focussed on hospital	• Leadership is an essential competency in nursing practice • Theoretical basis for leadership: transformational, authentic, resonant, task orientated, situational • Preparation for leadership role	• Shared objectives/vision • Most articles discuss transformational leadership with some identifying situational leadership as important • Communication • Nurture professional development • Authentic leadership identified in 2 papers – support for professional practice and empowerment, building trust and healthy work environments – honesty integrity and ethical standards in development of relationships • One article discussed resonant leadership – promoting relationships, empathy, listening	• Positive work environment • Job satisfaction • Motivation and commitment of employees • Better quality care • Increased retention • Use of multifactor leadership questionnaire, authentic leadership questionnaire; leadership practice inventory • A number of job satisfaction questionnaires identified	• Patients • Nurses • Organisation	Built on Cummings (2010) review. Identifies that literature tends to focus on acute setting One article highlighted that transformational leadership didn't enhance job satisfaction but did enhance organisational commitment.
43	Hewison, A., and Morrell, K. (2014) Leadership development in the English National Health Service: A counter narrative to inform policy. International Journal of Nursing Studies, Vol.51(4), pp.677-688. Read 19.3.18	Peer review journal Policy review paper	NHS England Leadership in healthcare including nurses, AHPs etc.	• Using Foucalt's concept of episteme - implicit logics that govern what constitutes legitimate knowledge, and that structure inference and action in social settings, - procedures to interpret and make sense of the social world. • this paper reviews current NHS leadership policy and provides a counter narrative to the competency base of leadership prorammes. • Darzi review placing emphasis on leadership in NHS at all levels • Development of leadership qualities framework – a set of standards for 'outstanding leadership' in the health service: 15 leadership behaviours • Leadership for quality certificate • NHS leadership academy	• Analysis highlights a need for an alternative approach to leadership in NHS – i.e. other than 'one size fits all' • Emphasis is currently competencies – the dominant narrative. • Different accounts of leadership in literature: ○ Traits (of leader) ○ Situational – diagnose and decide course of action ○ Contingency (trait and situational) ○ Constituitive – leader and context are interrelated: allows exploration of how leadership is socially constructed • Focus on team rather than individual leadership • Emotional intelligence • Empowerment	• Enhanced patient care	Organisation Patients	Interesting paper that provides counter narrative to idea of competency based leadership that underpins NHS.
44	Morrison, J. (2016) Nursing Leadership in ACO Payment Reform. Nursing Economic$. Vol.34(5), pp.230-235. Read 19.3.18	Peer review journal Discussion paper	Nursing leadership USA	• Accountable Care organisations in context of USA Healthcare reforms – values based payment model aimed at improving quality and coordination of care	• Understanding of political, cultural and financial facilitators and barriers to change • Understanding and application of Kotter model of change management: - Creating an urgency for change/emotional response - Building a guiding team - Getting the vision right - Communicate buy in - Enable action through continuous communication, connecting with others involved in similar change, educational opportunities - Create short term wins to maintain momentum - Not let up change • Making change stick e.g. check ins with staff	• Successful organisational change	• Organisation	

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45	Smith, N.M., and Satyshur, R.D. (2016) Pediatric Diabetes Telemedicine Program Improves Access to Care for Rural Families: Role of APRNs. Pediatric Nursing. Vol.42(6), pp.294-299. Date read 19.3.18	Peer review journal Quantitative research	Paediatric diabetes programme for rural communities in America Role of Advanced Practice Registered Nurses (APRNs)	• IOM (Institute of Medicine) report indicates ARPNs are well positioned to lead change • Paper provides an overview of leadership role ARPNs in context of diabetes telemedicine programme for a rural community.	• APRNs provided technology expertise and led interdisciplinary communication	• Care giver satisfaction (telemedicine diabetes caregiver satisfaction survey)	• Caregivers (parents/grandparents).	
46	Arabi, A., Rafii, F., Cheraghi, M.A., Ghiyasvandian, S. (2014) Nurses' policy influence: A concept analysis. Iranian Journal of Nursing and Midwifery Research. Vol.19(3), pp.315-322. Date read 22.3.18	Peer review journal Qualitative content analysis - 8 stage Walker and Avant approach	Nursing influence on policy making International context	• Rapidly changing health system • Nurse leaders need to be able to influence policy development not just implementation • Need for nurses to acquire policy making skills • Micro, meso and macro policy influence • Political ideology of a healthcare system will influence nursing leadership	• Identify issues and work with other decision makers to advance healthcare policies • Nurses need to be knowledgeable about all aspects of healthcare system, not just caring role • Nurses having a strong voice in the field of decision making • Policy involvement involves 3 levels: • Voter • Individual considers personal values, beliefs etc. • Reach a level of commitment that involves development of policies • Attributes to policy influence • Policy acumen – ability to analyse policy • Policy competence- ability to direct organisations in response to challenges and opportunities, and make policies with desirable effects on healthcare. • Policy influence – nurses give particular consultation to developing, implementing and evaluating policy • Power with others rather than power on others • Advocacy and recognising and managing conflict.	• Protect patient safety • Increase quality of care, promoting quality of care		• Interesting discussion over definition of policies: e.g. decisions made by people who have authority VS choices of society with consideration of purposes, health priorities and resources to meet purposes. • Policies can support (or not?) effective leadership • Margaret Newman's theory of health as 'expanding consciousness'. Consciousness – capacity of system to interact with environment through changing, relating, perceiving, knowing, choosing and moving. Expanding consciousness – a metaphor for the changing healthcare system.
47	Day, M., Shickle, D., Smith, K., Zakariasen, K., Moskol, J., Oliver, T. (2014) Training public health superheroes: five talents for public health leadership. Journal of Public Health. Vol. 36(4), pp.552-561 Read 22.3.18	Peer review Research – grounded theory	Public health UK Faculty of public health members were asked to identify their 'public health superhero' – this led to interviews to identify the leadership talents UK	• Literature suggesting concern over public health leaders ability to influence public health policies • International literature on leadership suggests that at the heart of the most successful organizations are individuals who have been described as 'Level 5 leaders' who are a 'paradoxical blend of personal humility and professional will' and make the right decisions happen •	• This study identified 5 leadership talents: • Mentoring-nurturing: articulation of strong sense of values, creating environment where individuals felt pride to be practising public health • Shaping-organising through effective meeting management, note taking and influencing internal agenda and external share holder; development of professional networks • Networking-connecting: developing relationships between individuals and organisations at all levels – 'cultivation' of long term relationships • Knowing-interpreting: specific information to further a cause. Used to exert authority and develop power and authority • Advocating-impacting: through writing etc. • Recommend an increased focus on identifying and developing leadership talents as opposed to competency based approaches to leadership development. Focussing on dominant talents amongst individuals, not necessarily one individual having all talents	• Strengthened public health leadership	• Individuals working in public health • Ultimately impacting on population as a whole?	Relates to 42T Hewison and Morrell (2014) discussion providing a counter narrative to competency based leadership programmes. Idea of 'level 5' leaders I like the approach of exploring with people who they value as good leaders and why Leadership practices inventory and Gallup organisations leadership talents – potentially worth reviewing these
48	Akerjordet, K., and Severinsson, E. (2008) Emotionally intelligent nurse leadership: a literature review study. Journal of Nursing Management. Vol.16, pp.565-577. Read 23.3.18	Peer review journal Literature review	• Nurse leaders	• Emotionally intelligent (EI) nurse leadership: EI represents a set of core competencies for: identifying, processing and managing emotions that enable nurse leaders to cope with daily demands in a knowledgeable, approachable and supportive manner	• Self-awareness • Supervisory skills • Ability to motivate self, be creative • Making use of emotions when mobilising teams, creating a vision • Correlations between EI and transformational leadership, specifically empathy • Transformational leadership behaviour exhibits positive characteristics such as intellectual stimulation, individualized consideration, inspirational motivation and positive influence that cause followers to identify with the leader • Coaching leadership style • EI leads to social self-confidence • Bring out the best of people in an organisation • Personal reflections, well-being, strong relationships, need for cooperation, pursuing shared goal • EI leaders facilitate healthy dialogue – being excellent listeners and maintaining emotional equanimity (calmness/composure)	• Positive empowerment processes • Positive organisational outcomes • Favourable work environment characterised by resilience, innovation and change • Job satisfaction, less emotional exhaustion • Improved work life balance • High quality nursing care	• Organisation • Nurses • Patients	Different theoretical perspectives on what EI is e.g. a personality theory, an intelligence or both. Leaders with high EI act out commitment rather than obligation – like this notion I like the discussion around relationships being the first condition of being human, leaders guiding with head and heart and EI being about inspiring to treat individuals as human beings by having

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					• Continuous self reflection – inner supervision			authentic empathy (P.570) Creativity being enhanced when people feel free and respected
49	Germain, P.B., and Cummings, G. G. (2010). The influence of nursing leadership on nurse performance: A systematic literature review. Journal of Nursing Management. Vol.18(4), pp.425–439. Read 23.2.18	Peer review journal Systematic literature review and content analysis	International literature review exploring impact of nurse leadership on nurse performance (from nurses perspective) and performance motivation Nurse performance defined as desire and ability to meet employers goal of providing excellent patient care	• Autonomy – expressing confidence in 'subordinates' ability to perform to a high level • Trusting and supportive working relationships – effective, strong, open communication • Appropriate management of resources • Individual characteristics such as hardiness	• Leaders being visible in clinical setting – opportunity for nurses to ask questions • Kouzes and Posner leadership practices e.g. modelling the way through earning respect and right to lead by involvement; inspire a shared vision through inspiring commitment • Searching for opportunities to create, develop and improve processes • Enabling others to act • Encouraging the heart	• Enhanced motivation of nurses and empowered to perform • Meeting organisational goals • Reduced burnout • Nurses seeing workplace as a challenge rather than overwhelming.	• Organisation • Nurses • Patients	Papers were in general theoretically based Appears a rigorous systematic review A number of instruments to measure performance Would be nice if there was more discussion around what effective communication is
50	Cummings, G., Lee, H., MacGregor, T., Davey, M.,Wong, C., Paul, L., and Stafford, E. (2008). Factors contributing to nursing leadership: A systematic review. Journal of Health Services Research and Policy. Vol.13, pp.240–248. Read 23.2.18	Peer review journal Systematic review	International review of factors relating to positive nursing leadership Authors based in Canada	• 4 groups of leadership factors identified: - Behaviours and practices of individual leaders - Traits and characteristics – openness, extroversion and motivation to manage - Influence of context and practice setting - Leader participation in educational activities • Transformational and emotionally intelligent leadership with a focus on relationship	• Leadership can be developed through educational activities and modelling and practising leadership competencies • Relationship based competencies more effective than financial • Staff value more contact with leader • Formal and informal leadership education related to transformational leadership behaviours • Leadership development programmes most significant factor in increased leadership practices	• Positive nursing leadership measured by a number of different tools e.g. • Leadership Practices Inventory (three studies), Multifactor Leadership Questionnaire (two studies), Leader Behaviour Descriptive Questionnaire (three studies) and the Leadership Effectiveness and Adaptability Description (two studies).	• Ultimately impacts on individuals, patients and organisation	Focus on competencies and leadership education seems in contrast to previous articles discussing critiquing competency based e.g. 42T Hewison and Morrell (2014) and 46T Day et al. (2014) Measurement of leadership only seems to be by quantitative scales some lack reporting of validity, reliability. Authors identify qualitative may add greater depth to findings. Leader author – Greta Cummings – written a number of reviews related to nursing leadership
51	Cummings G., Lee,H., MacGregor, T., Davey,M., Wong,C., Paul L.and Stafford E. (2008). Factors contributing to nursing leadership: A systematic review. Journal of Health Services Research and Policy. Vol.13, pp.240–248. Read 23.3.18	Peer review journal Systematic review	Multidisciplinary systematic review focussing on the how of leadership	• Policy advocating strong leadership for organisational change but less focus on how this is achieved	• Leadership styles focussing on people and relationships (transformational, resonant, supportive and consideration) • Leadership styles focussing on task had a negative effect on job satisfaction • Using emotional skills to understand what others are feeling developing trust through listening, empathy and responding to concerns	• Enhanced job satisfaction • Organisational commitment • Nurse empowerment • Intention to stay in post • Staff health • Nurse research utilisation • Enhanced teamwork between nurses and physicians	• Organisations • Patients • Healthcare providers •	Multidisciplinary review but focus on nursing? Review provides strong argument for relationally focussed leadership Would have liked to see more discussion on the how of relational leadership Lead author – Greta Cummings – written a number of reviews related to nursing leadership
52	Cowden, T., Cummings, G., and Profetto-McGrath, J. (2011) Leadership practices and staff nurses' intent to stay: a systematic review. Journal of. Nursing. Management. Vol.19(4), pp.461–477. Read 23.3.18	Peer review journal Systematic review	• Staff nurses and nurse managers • Various sites including hospital, home care, state nursing associations • International context	• A need to retain staff nurses led to need to explore relationship between leadership practices and nurses intent to stay • Relational leadership	• Positive relationship between relational leadership (transformational and intent to stay • Recommend incorporating relational leadership theory into management practices • Empowering others	• Increased intention to stay in role • A variety of different tools used to measure intent to stay and leadership	• Nurses • Organisation	Another paper by Greta Cummings that highlights value of transformational leadership – would again be interesting to hear more of the 'how'
53	Harvath, T.A., Swafford, K., Smith, K., Miller, L.L., Volpin, M., Sexson, K., White, D., and Young, H.A. (2008) Enhancing nursing leadership in long-term care. A review of the literature. Research in Gerontological Nursing. Vol.1(3), pp.187–96. Read 23.3.18	Peer review journal Review of literature	• Long term care • Nursing leadership	• Evidence that quality of care in nursing homes can be enhanced by nursing leadership • Need to develop leadership skills in nursing homes	• Motivate individuals and organisations to change • Visionary, creative and courageous • Business acumen • Different programmes explored in paper: • LEAP – Learn, Empower, Achieve, Power – programme developed by Mather Lifeways institute on ageing • Conflict management training • Clinical leadership skill training • Pacific northwest nursing leadership institute	• Note that evidence on outcomes is weak • Empowerment • Leadership effectiveness • Organisational climate • Job satisfaction • Work effectiveness • Intent to stay	• Not clear	Review identifies that evidence that leadership programmes enhance leadership in long term care is weak. Paper is 10 years old – developments such as MHL since!

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No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
								Recommendations for leadership programmes: - Interpersonal skills - Clinical skills - Organisational skills - Management skills
54	Krugman, M., Rudolph, M., Nenaber, A., and Dietrich, C. (2013) Clinical stars lead a successful professional practice programme, American Nurse Today. Vol.8(9), pp.46-50 Read 5.4.18	Discussion paper	America	• UEXCEL (University of Colorado's hospital's excellence in clinical practice, education, evidence based practice and leadership) practice programme developed – a significant force in developing nurse leadership, autonomy, empowerment and improving patient outcomes • UEXCEL programme based on Benner's novice to expert framework	• Programme involves different elements depending on practice level (levels 1-4): - Clinical narratives to reflect on complex issues - Written narrative articulating a philosophy of practice - Verbal reflection on practice that highlight excellence at their practice level Importance of: - Working with competent peers - Reflective practice - Mentorship FOCUS PDCA – a framework for improving processes: - Find a process to improve - Organise an effort to work on improvement - Clarify current knowledge of the process - Understand process variation and capability - Select a strategy for continued improvement - Plan, do, check, act	• Organisation – achievement of magnet status • Nurses • Staff		
55	Martin, J., McCormack, B., Fitzsimons, D., and Spirig, R. (2014) The importance of sharing an inspired vision, International practice development journal. Vol.4(2), pp.1-4. ***(Duplicate of record 58)***	Research Qualitative phase of a Mixed methods study	Switzerland	• Royal college of nursing clinical leadership programme adapted, implemented and evaluated in Switzerland • Explicit focus on the development of a unit based vision – in German speaking Switzerland the terms strategy and strategic direction were used instead of vision. • Gap in literature about experience of nurse leaders developing a vision.	• Transformational leadership – learned leaders behaviours of Kouzes and Posner (2007) with 5 fundamental practices of exemplary leadership: - Modelling the way - Inspiring a shared vision - Challenging the process - Enabling others to act - Encouraging the heart • Having a shared vision – 'display a picture of a better and more worthwhile future state' • Conceptual framework of practice development (Garbett and McCormack) • Empowerment and engagement of team members • Vision needs to be realistic and achievable	• High quality care • Effective workplace culture • Increased motivation, energy and commitment of staff • Move from traditional to evidence based practice	• Nurses • Patients • organisation	Was hoping to read more about the 'how' of creating a shared vision. Article focusses more on outcomes of adopting a shared vision. ***This CMO record is duplicated in record 58***
56	Karimi, B., Mills, J., Calvert, E., and Ryckman, M. (2017) Transformational leadership at point of care: approaches and outcomes in long term care Canadian Nursing Journal. Vol.28(1), pp. 2-7. ***(Duplicate of record 59)***	Research	Canada Long term care	Long term care setting Based on Thrive Group leaders as being results-driven individuals who are authentic, inspirational and effective in their communication abilities. Individual leaders worked courageously in showing vulnerabilities, self-reflecting and embracing change. Value best practice guidelines Value collaborative ethos. Commitment to work with challenges of limited resources and complex systems, Commitment to implement research based practice. Goal to improve service user experience and outcomes Relationships are a key part of the success Presence of quality improvement committees and support for champions.	Building relationships and trust. Empowering others. Contributing to an environment that supports knowledge integration. Leading, supporting, sustaining change Balancing complexities of the system and managing competing priorities. Working knowledge of Knowledge to action cycle. Involvement in decision making. Respectful interpersonal Relationships. A commitment to continuous Learning. A desire to meet legislated requirements, commitments to standards of practice, and strong followership behaviours. Sincerely engages its staff with mutual interest and intention to promote growth. Actively highlights the contributions and accomplishments of the staff in internal and external forums. Providing point of care staff with opportunities to participate in decision making and change Developing grass roots leaders Holding staff accountable for leading and sustaining change	Staff openly discuss feeling supported, empowered, engaged and valued based on the successes and improvements they are contributing to. High levels of engagement in quality groups. Great interest in staff becoming best practice champions Nurses more actively using the evidence base to inform decision making.	Staff – Unit was designated Great places to work following implementation of leadership programme.	Report on before and after evaluation of leadership programme -? peer reviewed ***This CMO record is duplicated in record 59***
57	Gehrs, M., Strudwick, G., Ling, S., Reisdorfer, E., & Cleverley, K. (2017). Addressing Gaps in Mental Health and Addictions Nursing Leadership: An Innovative Professional Development Initiative. Nursing Leadership. Vol.30(3), pp.23-42. Read 16.02.18	Describing initiative	Mental health and addictions services in Toronto, Canada	• Difficulty recruiting mental health & addictions nurse leaders with experience • Practice development • Implementing educational programme focusing on leadership • Initiative in 5th year of 10 year programme.	• long-term, 10-year investment in nursing leadership development in organisation • Invested in MSc scholarships followed by internships based on "Mutual Benefits Model" framework • Scholarship offered enhanced professional nursing leadership development • fostered confidence, critical thinking and leadership competency development	Initiative provided mentees with: • Improved understanding of the Clinical Nurse Specialist role. • Opportunity to observe and then mirror leadership styles. • Provided a safe space to receive feedback and improve leadership pra • Meeting their career goals, increasing their confidence level and helping them learn more about leadership styles. • Initiative increased visibility and credibility of nursing profession within organization.	• Nurse leaders • Nursing profession	Mutual Benefits Model" framework

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					• Individualized Role Development Plans align to organizational leadership competency needs, intern interests & mentor expertise. • Strategically selected leadership mentors invested time in supporting mentees. • Mentees invested effort in accepting guidance & coaching from mentors. • Mentees engaged in activities to further develop their informal leadership skills and participate in organization-wide initiatives.			
58	Martin, J., McCormack, B., Fitzsimons, D., and Spirig, R. (2014). The importance of inspiring a shared vision. International Practice Development Journal. Vol.4(2), pp.1-15. Read 16.02.18 ***(Duplicate of record 55)***	Research study	Study comprised 14 nurse leaders from the first two cohorts of the Clinical Leadership Programme in Switzerland	• mixed methods research study interviewing nurse leaders and focus group with respective teams • interviews with 14 nurse leaders from the first two cohorts of a Clinical Leadership Programme, • focus group interviews with their respective teams	Shared vision: • helped leaders and teams to become inspired and committed to a shared goal • strong driving force for practice development • strong tool for successful transformation of practice • importance of having shared values and defined goals • Leaders steered practice development more systematically and efficiently if they employed strategic goals through a shared vision. • Leaders and team members experienced that shared visions provided clear orientation and a strong purpose in practice. • positive impact of shared visions generated a great deal of enthusiasm, which had potential to overload the organisation through taking on more than could reasonably be accomplished • shared vision helps staff to focus their energies and engage in the transformation of practice • very important for leaders to monitor closely the energy level of teams and the organisation, in order to maintain the balance between innovation/transformation and relaxation/recovery • The empowerment of team members is key for to transform the culture of care into that of an effective workplace that adapts and responds to change • Team need to have a sense of vision and ownership • Leader can only create the vision in a top down approach with a small selection of staff members, so the integration of the entire team remained a huge challenge	Shared vision: • Vision was strong driving force for ongoing and systematic practice development and thus established a culture that favoured quality and safety improvement in patient care • Vision provided orientation and meaning for leaders and teams. • Focused energies and engaged in transformation of practice. • Helped leaders sort, focus, prioritise & evaluate practice development projects • Important for leaders to monitor energy level of teams to maintain balance between innovation/transformation and relaxation/recovery. • Care taken to ensure vision and core values are realistic & • achievable. • Provoked higher commitment to professional practice • Strategic direction with defined values & practical activities seen as promoting quality improvement in field • Having a vision helped leaders and their teams to become inspired and committed to a shared goal.	• Nurse leaders • Teams	Shared vision ***This CMO record is duplicated in record 55***
59	Karimi, B., Mills, J., Calvert, E., and Ryckman, M. (2017) Transformational leadership at point of care: approaches and outcomes in long term care Canadian Nursing Journal. Vol.28(1), pp. 2-7. Read 16.02.18 ***(Duplicate of record 56)***	Descriptive article	long-term care home Initiative in Canada	• staff in large long-term care home implemented a 'transformational leadership' approach to resident care based on best practice guidelines	• Initiative guided by 'Point-of-Care Leadership Tips and Tools for Nurses' based on the 'Healthy Work Environment Best Practice Guidelines: Developing and Sustaining Nursing Leadership'. • Implemented 5 Transformational Leadership practice recommendations for point-of-care leaders 1. Building relationships and trust. 2. Empowering others. 3. Contributing to an environment that supports knowledge integration. 4. Leading, supporting, sustaining change	Initiative: • provided guidance on infrastructures to put in place • facilitated involvement with decision-making and leading change. • Opportunities to participate in the creation of change initiatives • Participation in decision-making processes used to gain trust and commitment to strategic directions of organization. • Providing staff with support, resources, tools • Holding staff accountable for leading and sustaining change • increased engagement and commitment to culture of quality service provision	• Staff • Residents	Point-of-Care Leadership Tips and Tools for Nurses ***This CMO record is duplicated in record 56***
60	Yee Kew, L., Goh, H., Yeo, R., Kaur, K., and Chor Guek, C. (2015). Evaluation of a Project: Clinical Leadership Programme That Prepared Senior Nurses and Nurse Managers at the National Kidney Foundation, Singapore for Renal Dialysis Nurse-Led Model of Care. Singapore Nursing Journal. Vol.42(2), pp.3-7. Read 16.02.18	Evaluation report	education programme in Singapore	• education programme to deliver knowledge and skills in clinical leadership • education project spanned three days of intensive clinical leadership, one month opportunity to apply skills learned before final one-day workshop.	• Programme covered: Benners novice to expert model, Carper's four ways of knowing, Critical thinking, Leadership styles, Roles and responsibilities Leading to success, Empowerment, Change strategies, Team building skills, Effective working relationships with staff, patients and families, Communication, engagement, stewardship and stakeholder and finally Project management • interactive learning approach including reflective and critical analysis. • Use of action research in simulated case studies	• More able to identify skills of an effective clinical leader • Increased self-confidence and enhanced understanding of leadership knowledge and stakeholder engagement • Improved self-awareness and critical thinking through engaging in self-reflection activities.	• Nurse managers	
61	Hurlock-Chorostecki, C., and McCallum, J. (2016). Nurse Practitioner Role Value in Hospitals: New Strategies for Hospital Leaders. Nursing Leadership Vol.29(3), pp.82-92. Read 16.02.18	Descriptive article	Real life example of a Nurse practitioner role in Canada	• In Canada, Nurse practitioners (NP) employed within hospitals to aid in medical coverage, reduce care fragmentation, address the increasingly complex patient and family social issues and enhance patient-centred care • limited information available to leaders regarding the value of a NP. • (Reviewer's interpretation of NP being equivalent to advanced nurse practitioner in UK)	• The evidence-based Nurse Practitioner framework (HNPP) provides a renewed vision for understanding what is unique about the NP role and how to acquire full role value.(Hurlock-Chorostecki 2013; Hurlock-Chorostecki et al. 2014 • Author suggests hospital leaders and physicians play a major role in the success of reaching full NP role optimization. • An NP-led transitional care unit (TCU) provided a real-life example of an optimized NP role using the HNPP framework. • NP main person responsible for patient care decisions with part-time physician support.	Implementation of NP in one hospital led to • Broad systems cost savings being realized • Easy access to the NP on the TCU allowed for rapid and early intervention in situations of patient deterioration • Emergency room avoidance became more common	• Leaders Nurse practitioners (in Canadian Context) • Patient care and outcomes	
62	Cattolico, D. (2012) ' Leadership Practices to Create a Caring Science Medical-Surgical Unit', International Journal For Human Caring. Vol.16(3), p.53.	Conference proceedings from 33rd International Association for Human Caring Conference	Medical-Surgical Unit In USA	• Leadership Practices to Create a Caring Science Medical-Surgical Unit In USA • Integration of concepts from Watson's theory of human caring and caring science into leadership practices	• Employees do a "caring reflection" of practice based • Daily caring check-ins (huddles) • Staff learn to be still for 2 minutes, to center, pause and reflect. • Caritas bulletin board highlighting a caritas process	• Transformations have occurred. • Staff requesting not to miss the check-ins to de-stress • 0% vacancy rate for the first time in many years. • Leaders, employees and physicians commented on changes	• Leaders • Staff	Innovative and unique Watson's theory of human caring ***(Duplicate of record 7)***

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
	Read 23.02.18 ***(Duplicate of record 7)***				• Caring moment stories are part of the self-evaluation. • Buddy program—caring for colleagues. • Changing the language from daily goal to asking patient, "What is most important to you today?" • Leadership rounding book with patient comments and individual staff recognition. • Distribution of the Embody Caritas lanyards for • contemplation before entering a patient room. • Lanyards serve as a touchstone for employees to focus on caritas processes prior to entering a patient's room			
63	Tate, B. (2012) Caritas Consciousness as a Way of Healing'. International Journal For Human Caring. Vol.16(3), p.52. Read 23.02.18	Conference proceedings from 33rd International Association for Human Caring Conference	Caritas coach project focusing on experience of centering and reflecting prior to restraining patients	• Aim to transform the environment within a psychiatric unit • Recent loss of trust within the facility	• following caritas practices: • allow nursing staff to express positive and negative feelings. • Practicing with openness and loving kindness as staff expressed feelings of hurt and anger. • Staff share caring moments they experienced with patients or family members. • Recognizing caring practices of the staff instead of looking at the negative. • Providing reward and recognition cards to the staff, the experience was linked to a specific caritas process. • Practicing self-care to have the energy to be with staff who were hurt and angry. • Use Watson's theory of human caring. • Work with other caring science leaders to create a caring cart.	• provided an opportunity for staff to become familiar with the language of caring while providing tangible examples of how caring is expressed in practice	• staff	
64	Kingston, M.B. (2012) 'When Trust is Broken Let the Healing Begin' , International Journal For Human Caring. Vol.16(3), p.52. Read 23.02.18	Conference proceedings from 33rd International Association for Human Caring Conference	Behavioural health facility	• loss of trust between nursing staff and nursing administration • change in a long-standing scheduling practice. • staff thoughts their voice was not heard • staff became polarised	• initiated healing process grounded in a caring science framework • series of open forums on all shifts. • Sessions provided an arena for expression of positive and negative feelings. • HR worked with staff leadership to re-invigorate shared decision-making, reinforce authentic listening, honest communication, and authentic presence by nursing leadership.	• Education related to Watson's theory of human caring provided a renewed sense of hope and reminded nurses of the importance of practicing from the heart and not from anger	• Staff	
65	Linette, D. M. (2012) ' 10 Key Leadership Lessons Learned After Embracing Nursing as Caring: The Story of One Nursing Department's Journey to Grow in Caring Leadership '. International Journal For Human Caring. Vol.16(3), p.67. Read 23.02.18	Conference proceedings from 33rd International Association for Human Caring Conference	State Hospital in South Florida	• work to integrate nursing as caring - foundation for nursing practice	• Process of learning, reworking, reframing, growing, and evaluating • lessons learned • Listening, Collaborating, Recognition of caring in others, Use of daily reflection, Risk taking and courage, Acceptance, Commitment to direction/philosophy of the department, Individual growth, Finding the positive, Stepping up	• time to realize own personal growth through a caring lens • collectively, team believe they have moved forward. • positive relationships that translate to patient and staff care that is present, purposeful, and intentional. • Strides to being more cohesive, focused group of nursing leaders.	• Patients • Staff	
66	Malloy, M. (2012) ' Co-Creating Authentic Caring Science Leadership Practices within the Women's and Children's Service Line' , International Journal For Human Caring. Vol.16(3),p. 69 Read 23.02.18	Conference proceedings from 33rd International Association for Human Caring Conference	Women's and Children's Service Line	• adopted Watson's theory of human caring as the theoretical framework for nursing practice and the professional model of care delivery	Used caritas processes to guide leadership practice • Leadership meetings start with ritual of sharing a cup of hot tea and caring moment with a member of the nursing staff. • Caring practices on each units discussed and how they relate to caritas processes. • Manager committed to a 5-minute centering ritual to be used with nursing staff included doing hand massages, singing bowls, and caring huddles. • Visible expression of caring, i.e. heart on office door.	• Managers use 5-item Watson Caritas Assessment Score as a way for nursing staff to formally evaluate nurse manager caring behaviours.	• Staff	Watson's theory of human caring
67	Der Zijpp, T., Niessen, T., Eldh, A., Hawkes, C., McMullan, C., Mockford, C., Wallin, L., McCormack, B., Rycroft-Malone, J., and Seers, K. (2016) A Bridge Over Tur Turbulent Waters: Illustrating the Interaction Between Managerial Leaders and Facilitators When Implementing Research Evidence. Worldviews On Evidence-Based Nursing. Vol.13(1), pp. 25-31. Read 23.02.18	Journal Article research	Study based in long-term nursing care sites in England, Netherlands, Republic of Ireland and Sweden	• Qualitative research exploring interaction between managerial leaders and clinical leaders acting as facilitators	• realising commitment, negotiating conditions and encouragement to keep momentum going can support implementation of change • giving voice to the staff identified as enabling factor for keeping momentum going. • communication crucial between all involved. • supportive role modelling by managerial leader • change oriented behaviour by management such as "providing vision and direction	• continuous reciprocal relationship between managerial leaders and clinical leaders key to successful implementation	• staff	"building of a bridge"
68	Wildish, D., and Evers, S. (2010) A definition, description, and framework for advanced practice in dietetics. Canadian Journal of Dietetic Practice and Research. Vol.71(1), p.e4-e11. Read 23.02.18	Journal Article research	Delphi, involving 7 dietitians from different geographical locations and practice areas	• explored advanced practice across the diversity of dietetics to develop a definition, description, and framework for guiding future education, research agendas and policy development. • Research based in Canada • Delphi survey with advanced practitioners	• A key element of successful advanced practice is that of leadership capability and competency." • significant leadership experience is an enabler	• Advanced practitioner roles or positions would benefit dietitians	• dietitians	
69	Brousseau, S., Cara, C., and Biais, R. (2017) A Humanistic Caring Quality of Work Life Model in Nursing Administration Based on Watson's Philosophy', International Journal For Human Caring. Vol.21(1), pp. 2-8.Read 23.02.18	Discussion paper	Discussion paper	• paper discusses relevance of Watson's human caring philosophy to nurse managers understanding of the quality of work life experience.	• humanistic philosophy of caring facilitates in developing solutions aimed at personal and professional emancipation. • Humanistic nurse management based on a heuristic process that draws on various patterns of knowing (Carper, 1978), emancipatory(Chinn & Kramer, 2015), and socio-political (White,1995)	• Humanistic management of resources, expertise, professional skills, and innovation is proposed to allow nurse managers to offer quality care to clients • Work organization marked by caring brings essential benefits to personal empowerment of staff	• staff • patients	Philosophy of humanism

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No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
70	Pfaff, K., Baxter, P., Ploeg, J., and Jack, S. (2014) A mixed methods exploration of the team and organizational factors that may predict new graduate nurse engagement in collaborative practice. Journal Of Interprofessional Care. Vol. 8(2), pp. 142-148. Read 02.03.18	Journal Article research	Newly qualified nurses in Canada completed the Collaborative Practice Assessment Tool.	• study explored team and organizational factors that may predict newly qualified nurse engagement in collaborative practice.	• leadership which supports decision-making related to when and how to consult another healthcare professional • Supportive organizational leadership an important facilitator among newly qualified nurses. • promoting positive team relationships through regular team meetings, and supporting the learning needs of newly qualified nurses. • the integration of face-to-face team strategies within a supportive team and organizational environment.	• Study concludes priority given to strategies that promote accessible leadership, quality preceptorship and mentorship models for newly qualified nurses.	• newly qualified nurse	
71	Yupha, W., Warunee, F., Nitaya, P., and Hanneman, S. (2016) A Qualitative Study of Factors Affecting Sustainable Implementation of a Mechanical Ventilation Weaning Protocol. Pacific Rim International Journal Of Nursing Research. Vol.20(2), pp.132-147. Read 02.03.18	Journal Article research	ICU department in Thailand	• A Qualitative study focusing on sustainable Implementation mechanical ventilation weaning protocol (MVWP)	• Leadership encouragement including broad staff-assistive activities of educating, consulting, and coaching, role modelling, and monitoring implementation of practice. • leadership monitoring and audit helps to identify gaps in implementation for quality improvement.	• Study concludes continuing education important strategy to improve staff attitude and competence.	• Nursing staff	
72	Bøgh Andersen, L., Bjørnholt, B., Ladegaard Bro, L., and Holm-Petersen, C. (2018) Achieving High Quality Through Transformational Leadership: A Qualitative Multilevel Analysis of Transformational Leadership and Perceived Professional Quality. Public Personnel Management Vol.47(1), pp. 51-72. Read 02.03.18	Article - research,	public child care centers in Denmark	• Study focuses on analysing how transformational leadership can promote shared understandings of professional quality and how this relates to the perceived level of professional quality. • Study observes leadership and interviews leaders. • Two levels of analysis: the individual employee and the organization	• span of control influences leaders' ability to perform effective transformational leadership • leadership affects professionals' understandings and perceived level of professional quality. • leader using transformational leadership have a more shared understanding of professional quality and a higher level of performance • transformational leadership is highest when the span of control medium-sized – sufficient number of staff/ not too many staff to enable effective communication about the vision.	• transformational leadership can have positive performance effects in public organizations	• Leaders • Organisations	Span of control
73	Fynes, E., Martin, D., Hoy, L., and Cousley, A. (2014) Anaesthetic nurse specialist role: leading and facilitation in clinical practice, Journal Of Perioperative Practice. Vol.24(5) pp. 97-102. Read 02.03.18	Journal Article - review	Literature review	Article provided overview of leadership , followed by discussion on its applicability to Anaesthetic nurse specialist role	• Building trust, demonstrating integrity, inspiring, encouraging and coaching others led to positive working environment • sole use of transformational skills may not be enough to ensure effectiveness unless combined with some components of transactional leadership itself e.g. rewarding achievements and monitoring mistakes •	• Transformational leadership positively correlated with a more positive, conducive work environment, increases job satisfaction, commitment and motivation • transformational leadership embracing components of transactional leadership closely linked to reducing levels of emotional exhaustion and stress. • use of transformational leadership with shared accountability, equity and empowerment provides many benefits for staff, patients and the organisation.	• Staff • Patients • Organisations	
74	Bobbio, A., and Manganelli, A. (2015) Antecedents of hospital nurses' intention to leave the organization: A cross sectional survey, International Journal Of Nursing Studies, Vol.52 (7), pp.1180-1192. Read 02.03.18	journal article - research	Hospitals within Italy	• Servant Leadership Survey utilised • 711 Cross sectional surveys completed within two Italian public general hospitals	• Servant Leadership and perceived organizational support inspires trust in the leader and in the organization • creating leadership and organizational conditions that value nurses as individuals in an atmosphere of trust, support, participation and respect, may reduce job burnout and facilitate retention of staff	• Servant Leadership may reduce burnout in staff and facilitate retention of staff	• Staff • Organisation	Servant leaders • based on stewardship, ethical behaviour, collaboration and connection to people. • focus on serving people instead of using people. • genuine concern with serving others and putting followers first as individuals
75	Hansen, J. (2011) Be a change leader. Standard. Vol. 36(1), pp. 10-12. Read 02.03.18	Journal Article - pictorial	Rehabilitation Centre in Ontario, Canada	Implementing a change in practice	Suggestions for leaders leading change: • Being available for staff and increasing frequency of staff meetings • Be consistent when communicating what, how • and when change is coming. Mixed messages are not only confusing, they erode trust. • Talk about the "why." Don't just present the change; discuss the reason behind it. • Find champions. Identify nurses who understand what you're trying to do and are willing to walk the journey with you. • embrace the change. • Walk the talk. Don't just impose the change; become part of the change. • Applying the nursing process of assessment, planning, implementing and evaluating during the process of changing practice will help alleviate anxiety and resistance to change	• With understanding comes acceptance, which makes it easier to apply new knowledge or skills to make change successful	• Staff • Patients • Organisation	
76	Taylor Iii, D.L. (2014) Perioperative Leadership: Managing Change With Insights, Priorities, and Tools. AORN Journal. Vo.100(1), pp. 8-29. Read 09.03.18	Journal Article – Continuing education series	Discussion set within the context of Perioperative Care	Authors views on leaders' characteristics and the systems and processes leaders can employ to facilitate implementation of changes in practice	• establishing a mental framework amongst staff that is conducive to driving change • focus team members on the personal benefits of the change. • Depersonalizing situations. • emphasizing purpose of initiative is to achieve standards, either as best practices or requirements. • Emphasizing professional pride can make change more palatable by framing it in terms of achieving professional excellence. • present change initiatives in terms of personal benefits • Creating a Customer(Patient) - Centred Organization • focus less on single modifications and more on broad process improvements	Discussed the processes rather than evidencing the outcomes.	• Staff • Patients • Organisation	• Lean Six Sigma combination of Lean theory and Six Sigma • goal of Lean Six Sigma to identify and eliminate defects within a system • Specific tools include value stream maps and spaghetti diagrams that demonstrate waste and help users to

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					• Lean Six Sigma frequently used for process improvement in health care settings • critical to understand that culture change begins at the top • key to maintaining momentum in culture change is consistently engaging team members at intellectual, emotional, social, and personal levels. • Leaders have direct, substantive contact with the individuals who have a stake in the change and who will be responsible for implementing it. • Performing executive walkabouts which encourage flow of ideas and help leaders identify existing concerns as well as specific obstacles to implementing new operational models • identify key personnel who are interested in changing for the better. • Holding morning meetings/ huddles effective way to engage staff. • leader to discover what is going on in their department with employees and to know what is needed and how to collaborate with various stakeholder groups • ensure staff takes part in project planning & implementation. • team participation in decision making and problem solving • partner with team members to address specific problems to create a culture of professional empowerment and challenge. • Recognizing expertise of others & sharing information generates ideas & develops skills to enhance nursing care • bring together pockets of excellence that allow team members to take greater responsibility for organizational performance • Providing nursing education and educators in practice • Communication key component of successful change leadership • Sharing good practice and critical incidents/safety events • bulletin board for posting info about improvement initiatives • post key information in strategic locations (eg staff lounges). • Create series of one-page handouts with important info			create standardized workflow practices.
77	Agnew, C., and Flin, R. (2014) Senior charge nurses' leadership behaviours in relation to hospital ward safety: A mixed method study. International Journal Of Nursing Studies. Vol.51(5) pp.768-780. Read 09.03.18	journal article - research,	hospital ward context.	Aim of study: to determine the patterns of behaviours SCNs use in their daily leader role and to test the relevance of a standard leadership taxonomy in the hospital ward context.	Effective behaviours by leaders included: • acknowledging the good behaviour of staff nurses, • describing the reasons behind the desired outcomes • expressing the rationale for the targets to the team members. • importance of task oriented behaviours to improve productivity • SCNs require different leadership behaviours for particular situations they have to manage in their wards. • In order to cope with pressures, SCNs reported more task focused behaviours. More specifically, they engaged in more hands on clinical activities and displayed less consulting/empowering behaviours. • During a more stressful task, some SCNs reported supporting their staff by helping and advising them.	• For demanding situations, SCNs indicated a change in their leadership styles and reported task focused behaviours to be more effective. • In order to enable the staff to achieve desired organizational outcomes, SCNs reported displaying Recognition behaviours, such as ''acknowledging good behaviour'' and ''discussing desired changes with great enthusiasm''. • Study suggests several task, relations and change oriented behaviours appeared to be associated with lower infection rates, patient safety incidents, and better safety compliance by staff.	• Staff • Patients • Organisation	
78	Adelman-Mullally, T., Mulder, C., McCarter-Spalding, D., Hagler, D., Gaberson, K., Hanner, M., Oermann, M., Speakman, E., Yoder-Wise, P., and Young, P. (2013) The clinical nurse educator as leader, Nurse Education In Practice, Vol.13(1), pp. 29-34. Read 09.03.18	Literature review and yearlong discussions on leadership	• Nurse Education • Clinical nurse educator as leader	• carried out a review of leadership literature within and outside nursing and reflected on nursing education leadership during a year-long series of discussions with emerging nursing education leaders • Group progressed from wide exploration of leadership theories to identification of five overarching themes that demonstrate ways in which clinical nurse educators exemplify leadership	• clinical nurse educators exemplify leadership by: role modelling, providing vision, helping students to learn, challenging the system or status quo, and seeking relational integrity	• Suggest leadership potential of clinical nurse educators to help transform nursing education through meaningful interactions with students.	• Nursing students	
79	Reid, K., and Dennison, P. (2011) The Clinical Nurse Leader (CNL)Â®: Point-of-Care Safety Clinician. Online Journal Of Issues In Nursing. Vol.16(3), p. 1. Read 09.03.18	Journal article – discussion	• Clinical nurse leaders (CNL) working in hospital environments within America	• discussion and evaluation of the role of clinical nurse leaders within hospital environments	• CNLs receive advanced education about risk anticipation and risk reduction. • CNLs prepared to address change by the use of failure modes analysis techniques (anticipating potential negative effects of change prior to instituting change • conduct root cause analyses for care delivery near misses and errors	• serving as a point-of-care teacher and mentor stimulated stronger clinical reasoning skills among the staff and engaged everyone in the culture of safety • CNL educational focus on human diversity and cultural competence as a major support to the development of evidence-based healthcare practices and protocols in diverse settings	• Nursing teams	Appreciative based approach

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					• CNL brings evidence-based practice to the bedside and applies a "more robust knowledge of quality, safety, and statistical processes • appreciative-based approach focuses on what works well and building on existing strengths in a system# • to improve infection control practice - staff 'ticketed' or 'caught' washing their hands entered into a weekly raffle for a small prize • To meet the global health knowledge and competencies, CNLs have engaged in interdisciplinary clinical and leadership experiences in many settings around the world			
80	Jukkala, A., Greenwood, R., Ladner, K., and Hopkins, L. (2010) The clinical nurse leader and rural hospital safety and quality. Online Journal of Rural Nursing & Health Care. Vol.10(2), pp. 38-44. Read 09.03.18	Journal Article	Rural healthcare system in America	Discussion on the role of CNls in rural healthcare system in America	• As a master's prepared nurse, the CNL is educationally prepared as an advanced nurse generalist to improve patient care • CNL use evidence-based information to design and coordinate the care delivered to individuals and cohorts of patients • Comprehensive knowledge of patient and case management skills facilitates patient movement through healthcare system • CNLs lead quality improvement initiatives and design research-based interventions that reduce error, increase patient safety, and stream-line healthcare delivery processes. • CNL is able to use information systems and technology that put knowledge at the point of care to improve healthcare outcomes	Focused on processes and qualities rather than outcomes.	• Patients • Staff	
81	Stavrianopoulos, T. (2012) The clinical nurse leader. Health Science Journal. Vol.6(3), pp. 392-401. Read 09.03.18	Literature reviews on the role of the Clinical nurse leader	Literature review regarding the Clinical nurse leader role (CNL)	Clinical nurse leader role is prepared in a new master of nursing curriculum that educates nurses to understand how to provide care and improve quality in today's complex healthcare system.	• synthesize best practices from all disciplines and reach improved outcomes on patients' behalf while breaking down discipline-centric silos • CNL is educationally prepared as an advanced nurse generalist to improve patient care outcomes through use of the microsystem assessment process • Use evidence-based information to design and coordinate the care delivered to individuals and cohorts of patients within the rural hospital microsystem. • CNL can facilitate and coordinate multiple disciplines and services to ensure the most efficient and goal directed activities are performed at the right time and in partnership with other disciplines. • Through an understanding of human interactions, communication, problem-solving skills, conflict management, and coalition or team building18 the CNL is able to advance patient-care delivery through effective team work • Through analysis of differences in clinical outcomes for cohorts of patients in the microsystem,the CNL is able to address health disparities for the most vulnerable including the uninsured, the aged, the Utilizing tools such as the Failure Mode • Effect Analysis (FMEA) and Root Cause Analysis (RCA) allow the CNL to anticipate and respond appropriately to near misses and sentinel events less educated, and those with cultural barriers. • Identifying stakeholders with the influence and courage to initiate necessary changes to nursing practice is a key first step.	• Reduced fragmentation of care and gaps in communication result in cost-effective efficiency, improved clinical outcomes, and increased patient satisfaction. • Examples of CNL effectiveness in improving clinical outcomes include improved rates of home health referrals, discharge planning, improved core measure data, decreased nursing staff turnover, reduced length of stay increased patient satisfaction, a reduction in fall rates, and fewer cardiac arrests.	• Patients • Staff • Organisation	The Clinical Nurse Leader role developed in response to concerns about quality and safety of nursing care in the complex, technologically advanced, ever-changing healthcare system
82	Saleh, U., O'Connor, T., Al-Subhi, H., Alkattan, R., Al-Harbi, S., and Patton, D. (2018) The impact of nurse managers' leadership styles on ward staff. British Journal Of Nursing. Vol.27(4), pp. 197-20. Read 09.03.18	Journal article - research	Phenomenological study - 35 nurses working in different specialties of a medical city in Saudi Arabia.		• participants described four types of leadership styles: relational leadership, preferential leadership, communication chain leadership, and ineffectual leadership • relationship between ward nurses and their management team is a determinant of job satisfaction	• leadership style employed by nurse managers has a major impact on nurses' satisfaction, turnover, and the quality of patient care they deliver. • ward nurses' perceptions of their relationships with nurse leaders was very important to their job satisfaction • Ward nurses who describe their relationship with their nurse managers as 'supportive,' 'cooperative,' or 'understanding', reported a high level of job satisfaction • Remaining highly visible to clinical nurses and responsive to their needs and upholding an open line of communication are crucial in achieving organisational success and improved job satisfaction among nurses	• Staff	
83	Spence Laschinger, H.K., Wong, CA., and Grau, A.L. (2012) The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes: A cross-sectional study. International Journal Of Nursing Studies. Vol.49(10), pp. 1266-1276. Read 16.03.18	Journal article research	new graduate nurses working in acute care hospitals in Ontario, Canada.	cross-sectional survey design with 342 new graduate nurses (defined as less than two years of practice experience) study tested model linking new graduate nurses' perceptions of their immediate supervisor's authentic leadership behaviours to their experiences of workplace bullying and burnout in Canadian hospital work settings,	leadership practices that promote a supportive work climate by discouraging negative interpersonal interactions play an important role in retaining newly graduated nurses.	• authentic leadership practices promote healthy workplace conditions that positively influence factors that encourage new graduate nurse retention.	staff	

Leadership in Health Services

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
84	Andrews, D., Richard, D., Robinson, P., Celano, P., and Hallaron, J. (2012) The influence of staff nurse perception of leadership style on satisfaction with leadership: A cross-sectional survey of pediatric nurses, International Journal Of Nursing Studies. Vol.49(9), pp. 1103-1111. Read 16.03.18	Journal article research	Range of clinical areas. All authors from Florida – research possibly completed in Florida.	16 supervisors and 179 supervisees completed the Multifactor Leadership Questionnaire and a demographic survey	• staff show preference for leaders who clarify expectations and offer recognition for employee contributions. • satisfaction with leadership style was inversely related to a hands-off laissez faire style approach. • Strong relationship between satisfaction with leadership style and degree to which nurse leaders and raters agreed on leadership qualities. • Staff expect their leaders to be engaged, motivating and inspiring • Staff consider it important to know what is expected of them and rewards and consequences associated with those expectations. • Contingent Reward leadership skills are highly regarded;	• transformational leadership style promotes nursing excellence • satisfaction with leadership is associated with attributes consistent with a transformational approach. satisfaction is associated with leaders who motivate staff	• staff	
85	Gillet, N., Fouquereau, E., Bonnaud-Antignac, A., Mokounkolo, R., and Colombat, P. (2013) The mediating role of organizational justice in the relationship between transformational leadership and nurses' quality of work life: A cross-sectional questionnaire survey. International Journal Of Nursing Studies. Vol.50(10), pp. 1359-1367. Read 16.3.18	Journal article research	Study took place in 47 different haematology, oncology, and haematology/ oncology units in France. Participants were nurses and auxiliary nurses.	Study examined two possible psychological mechanisms that link transformational leadership behaviours to nurses' quality of work life. Second, to study relationship between nurses' quality of work life and their work engagement	• organizational justice an important psychological mechanism in the relationship between supervisors' leadership style and nurses' quality of work life.	• Distributive justice and interactional justice were found to fully mediate relationship between transformational leadership and nurses' quality of work life. • Transformational leaders may help ensure nurses' quality of work life which in turn increases their work engagement	• Organisation	
86	Schwartz, D., Spencer, T., Wilson, B., and Wood, K. (2011) Transformational leadership: implications for nursing leaders in facilities seeking magnet designation. AORN Journal. Vol.93(6) pp.737-748. Read 16.3.18	Journal article – research	Leaders, staff members, and educators in a two-hospital system in Virginia, USA	• Bass's four interrelated leadership components and associated behaviors were used by surgical services leaders to successfully achieve redesignation as a Magnet facility Survey completed to identify the leadership style of staff and ensure groups were consistent in their leadership style, and identify needs for education about transformational leadership.	• Leaders ensure a trusting environment • having an open door policy and providing employees with individual access. • leader actively listening to staff members and addressing their concerns. • In event of a near miss in practice, leaders encourage self-reporting of the event. • establish clear mission and philosophy statement that supports the mission and values of the organization. • Sharing common mission and value statement supports mutual understanding of shared responsibility for patient care. • Identified five critical success factors—people, service, quality, efficiency and finance—that drive strategic planning • Staff involved in annual all-day strategic planning process • Staff and leaders determine goals for the department, display them on department's bulletin board for everyone to view • leaders present reports on status of goal achievement to staff members at departmental meetings • Staff integral to establishing and monitoring goals; therefore, they have a sense of shared ownership in attaining unit goals • developed a strong model for shared governance which forms foundation for decision making related to patient care and nursing practice issues • Leaders recognize staff accomplishments during shift huddles and at staff meetings. • Recognise new staff members by posting a flyer on the unit that includes a photo and lists the new employee's credentials • When new employee arrives in department, they are greeted by this welcoming flyer. • to welcome new employees or celebrate staff accomplishments, department have a themed lunch to which they bring their favourite dishes to share • plan annual off-site retreat for staff members in surgical services. Leaders budget for this retreat and recruit professional speakers to present educational offerings. • Pay staff for their attendance and plan the retreat for a Saturday to allow for maximum participation. • Leaders encourage staff to further their professional development through the Clinical • Advancement Program (CAP). nurses participate in an online staff nurse satisfaction survey	• When leaders develop open, honest, and trusting relationships, staff members feel empowered to share and openly discuss concerns and proposed solutions without fear of penalty from the leader. • Self-reporting of incidents provides opportunity for discussion between staff member and leader. Analysis of the event and brainstorming prevention strategies provides an opportunity for improvement • Establishing these new positions encouraged individuals to take risks, be innovative, and meet their individual needs for growth and development. • Flyers allows current staff members and physicians to become familiar with new employee's name, background, and experience CAP programme fosters quality patient care by encouraging expertise at the bedside.	• Staff • Organisation • Patient	Bass's four interrelated leadership components—idealized influence, inspirational motivation, intellectual stimulation, and individual consideration Magnet and Magnet Recognition Program
87	Haycock-Stuart, E., Baggaley, S., Kean, S., and Carson, M. (2010) Understanding leadership in community nursing in Scotland. Community Practitioner. Vol.83 (7), pp. 24-28.	Journal article – research	Study in three health boards in Scotland with district nurses and health visitors	• paper reports findings of a research study that aimed to identify how leadership is perceived and experienced by community nurses	• leaders' visibility important • Community nursing needs a clear, shared vision from which people can lead and follow. leadership was viewed as positive when	• strong leadership can help address invisibility of community nursing work	• Staff • Organisation •	

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				• Mixed qualitative methods involving 31 individual interviews and three focus groups with community nurses and nurse leaders (n=39) in three health boards in Scotland	• leaders listened • consulted before implementing changes, • respected and valued the contributions staff were making to • community nursing, • explained why things were changing, • had an understanding of different policy agendas • motivated staff to develop the service with them.			
88	Kean, S., and Haycock-Stuart, E. (2011) Understanding the relationship between followers and leaders. Nursing Management - UK, Vol.18(8), pp. 31-35. Read 16.3.18	Journal article – research	Discussion based on the research study above in 32b	• Discussion based on the research study above in 32b	• Socially co-constructing leaders • engagement with staff and 'having a vision and direction' was crucial for successful leadership. • followers do not simply follow – 'following' is an active, context-bound decision. This insight suggests dependence and reciprocity between leaders and followers and assumes the heterogeneity of followers. • continuing belief that leaders are the only movers and shakers in organisations leads to a 'dependency to credit successful events to leaders, obscuring the significant contribution of followers • Leadership and followership are interdependent processes	• successful leadership is the result of a co-constructive process involving leaders and followers. •	• Staff • Organisation	
89	Last, R. (2012) Using patient stories to shape better services. Practice Nurse. Vol.42(13), pp. 33-37. Read 16.3.18	Journal article – discussion	Author appears to be within UK	article emphasizes how narrative leadership can be used by practice nurses to improve the services they offer	• most effective leaders score high in emotional intelligence • includes the characteristics of self-awareness, self-regulation, motivation and social skill • Narrative leadership involves harnessing the power of story and narrative to improve communication • willingness to hear and learn from patients stories, and to deliberately and co-operatively use such stories to change for the better	Narrative leadership skills can help create environments of trust and openness, inspiring and driving new and better directions for improvement	• Patients • Staff • Organisation	
90	Leeson, D, and Millar, M (2013) Using the 7 Habits programme to develop effective leadership. Nursing Management – UK. Vol.20(6), pp. 31-37. Read 16.3.18	Journal article – research	Evaluation of Leadership programme in England for community nursing and AHP managers.	• Leicestershire Partnership NHS Trust commissioned and delivered a leadership programme to strengthen the leadership and management skills of first-line community nursing and AHP managers. • Leadership programme based on (Covey 2004) 7 Habits of Highly Effective People which had been adapted for healthcare staff	• changing the way they present themselves to others to improve professional relationships and clinical environment • looking at problems from a different perspective	• Evaluations demonstrated tangible learning from the programme • Staff could articulate the benefits of using a framework to address challenges	• Patients • Staff • Organisation	Covey 2004) 7 Habits of Highly Effective People
91	McCue, C. (2011) Using the AACN Framework to Alleviate Moral Distress. Online Journal Of Issues In Nursing. Vol.16(1), p. 1. Read 16.3.18	Journal article – discussion	busy critical care unit within an inner-city, acute-care facility in America	• Discusses the context of moral distress in managing a chemically impaired staff member	Based on AACN Framework- 4 A's to Rise Above Moral Distress • 1. become aware of the moral distress one is experiencing • 2. recognize one's moral distress and one's professional responsibility to address this distress • 3. assessing and analyzing the risks of doing what one believes is the right thing to do • 4. namely, to act • Nurse leaders in unique position to focus attention on issue of moral distress and changes needed to resolve this distress	• AACN's 4A's framework enables nurse leaders and professionals to reduce moral distress in the work environment	• Staff • Organisation	AACN's 4A's framework- (American Association of Critical Care Nurses)
92	Davies, N. (2013) Visible leadership: going back to the front line. Nursing Management – UK. Vol.20(4), pp. 22-26. Read 16.3.18	Journal article – discussion	Discusses effectiveness of senior managers returning to work alongside staff providing hands-on care	article discusses need for visible leadership and different approaches to engaging with the front line. Lessons from other industries are considered and engagement activities • relevant to health care suggested	• improvements would result from stronger clinical leadership monitoring standards, supporting staff, resolving problems, acting as advocates and implementing change Jones and Griffiths (2011) - benefits of senior nurses going back to the floor included: • Empowerment. • Learning together. • Professional networking. • Communication. • Championing change. • 'Matron power' • purpose of going back to the floor to learn about patient experiences first hand and to discuss with staff their views about working in an organisation, including their problems and frustrations • Front line engagement • senior managers going back to the floor • ward or department visits related to specific issues or new • projects useful and quick exercises for managers to keep up with developments • staff meetings and patient forums provide opportunity for feedback and information exchange • shadowing colleagues in different locations or departments • structured walk-arounds • managers completing a shift as a staff nurse – taking part in standard working practices in the area	• staff having easy access to senior managers can respond quickly and effectively in fast changing environments • senior nurses and directors engaging with the front line benefits patients and staff. • going back to the floor allows first hand appreciation of gaps between the corporate rhetoric and real conditions on the front line. • Also better board-level understanding and focus on patient experience and patient safety.	• Patients • Staff • Organisation	

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					• 'rolling up your sleeves' will provide greater insight into working practices of the area. • Credibility for leaders comes from doing something • about the problems and frustrations that are raised and celebrating any successes and good practice observed.			
93	Dewar, B., Barrie, K., Sharp, C. and Meyer, J., (2017). Implementation of a Complex Intervention to Support Leadership Development in Nursing Homes: A Multimethod Participatory Study. Journal of Applied Gerontology. DOI: 10.1177/0733464817705957 Read 16.3.18	Journal article – Research	My Home Life Leadership Support program for nursing home managers being implemented in Scotland	• Analysis and evaluation of the transformational My Home Life Leadership Support program for nursing home managers being implemented in Scotland • Evidence-Based Practice, Relationship-Centered Care, Appreciative Inquiry, and Caring Conversations informed the intervention to develop transformational leadership • Study included baseline and post intervention questionnaires to describe culture change and in-depth qualitative data generated from group discussions • Data generated from 119 nursing home managers who had completed the MHL Leadership Support program • focus of the evaluation was on the "inner circle" of influence (nursing home managers and their practice).	• "theory of change" offers a credible mechanism for the enactment of positive changes in an area of practice Programme supported developing more relational way of thinking about leadership are closely intertwined and sit within the myriad of relational and conversational practices including: • knowing more about me • being curious about others • Valuing emotionality • new ways of initiating conversations, opening up • creating genuine ownership of new ideas, taking ideas forward in a collaborative and appreciative way • Security and belonging. Programme also supported • Developing more relational way of thinking begins with the managers' relationship with self, taking the time to critically reflect upon their own attitudes, behaviours, and assumptions before thinking about their impact on others • more aware of the way in which they led teams • greater awareness of their own hesitancy in trusting others to lead developments, questioning themselves and the concepts they had about their own practice • Acknowledged creating a positive culture starts with themselves • believe their role is to empower others to lead developments, rather than being seen as the "fixers" • managers feel more confident about taking things on, to be less frightened about "confrontation," to connect emotionally and explore issues beneath the surface and consider other perspectives. • developed a stronger "attitude of inquiry" • feeling more confident, less defensive, and better at taking time to explore things with people, rather than trying to solve problems instantly • Being more curious generated many surprises for managers to which they were able to respond without defensiveness • Through Caring Conversations framework (Dewar & Nolan, 2013) became accustomed to challenging in a curious and positive way from a place of support and in a way that helped them to consider other people's perspectives more. • Caring Conversations framework helped transform relationships with relatives by connecting emotionally and sharing how staff were feeling and asking for the relative's feelings in response and being more open and to use new knowledge they had about each other to move forward. • found new ways into different kinds of conversations that stopped previous unhelpful patterns of behaviour • using icebreakers and developing agreed ways of working during meetings • Principles of collaboration and appreciation were also evident in the way people gave and received feedback both within and outside the organization. • feedback more integrated, often informal and based on everyday encounters and relationships • theory of change seeks to understand contribution • Learning more about themselves helped them develop as leaders • Confidence to engage with a positive attitude in moments of conflict	After completing MHL Leadership Support programme managers: • actively listened compared with baseline measures • Actively providing space and time to listen to staff • identified positive change across many aspects of the workplace environment • had the management and leadership skills to undertake an effective role • understanding of how to improve the culture of care increased • development of effective influencing skills • confidence had increased over the past 12 months • broader positive changes within the home, notably staff prioritizing residents' quality of life over tasks, improved interaction with residents and relatives and improved staff morale. • reductions in their levels of stress, together with increased job satisfaction, enthusiasm for working in nursing homes, feeling valued and improvements in their own quality of life. • things had moved in a positive direction • program gave managers impetus, tools, confidence, and support to explore perspectives of others more fully to provide deeper insight • Sharing emotions was a significant shift in thinking for managers • Caring conversation approach produced a stronger sense of belonging and inclusivity, a "sense of justice in the room" and of greater value being given to the diversity of views • talking in a more open and honest way together led to "opening up and creating genuine ownership of new ideas" and "taking forward ideas together • sense of shared purpose helped to develop a culture of genuine "ownership"of ideas and of trust • element of "letting go" of assumed managerial control and a greater sense of mutuality • New insights led to substantive developments, enhanced individual and team morale, and produced positive forward momentum • evidence of staff being more connected to their work and to each other • managers explored residents' ideas and implemented changes based on resident's feedback • sense of security and belonging created among each cohort seemed critical to helping them to feel more confident in their role, better connected to each other, and part of something that had a collective vision and purpose • strong peer support was one of the surprises of the program • recognising importance of their own behaviours in influencing others and scope for greater involvement and collaboration with residents, relatives, and staff in deciding what should change within the home • developed a greater understanding of the perspective of others, which enabled them to share knowledge from a range of perspectives more deliberately and to support informal learning in the workplace. • Caring Conversations framework and principles of participation and appreciation helped managers to encourage and sustain genuine curiosity for themselves and others • Programme helped them to acknowledge achievements, encourage better listening, and so make room for more contributions	• Staff • Organisation	
94	Hutchinson, M., and Jackson, D. (2013) Transformational leadership in nursing: towards a more critical interpretation. Nursing inquiry. Vol.20(1), pp.11-22.	Literature view	Paper reviewing the literature and empirical evidence	Critical review of more than a decade of nursing scholarship on transformational model of leadership and its empirical evidence	Transformational leaders: • develop followers through creating a vision that provides meaning and motivation • inspire a shared vision and motivate people to do their best. • Communicate an attractive vision with enthusiasm and confidence • build strong sense of identification with the organisation and persuade individuals to transcend their own self-interest	• Bass (2003) linked transformational leadership to the capacity to enact moral behaviour through the constructs of intellectual stimulation and individual consideration. • transformational leadership has a positive effect on follower moral identity within organisations	• Staff • Organisation	multifactor leadership questionnaire (MLQ) - most widely used and authoritative instrument for establishing leadership style

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					• Seek to motivate followers to do more and perform beyond their own expectations • focus on structures, clarifying tasks and providing rewards for extra effort or meeting the needs of followers when they comply or meet expectations • Exemplary leaders engage in behaviours that challenge the process, inspire a shared vision, enable others to act, model the way and encourage the heart (Kouzes and Posner 1987). • engaging in visionary or exemplary behaviours which motivate, encourage or enable followers • enabling trust and human dignity are characteristics of exemplary leadership • transformational and exemplary leaders promote values such as honesty, loyalty and fairness, while emphasising justice, equality, human dignity and human rights • fostering co-operation and modelling actions that align with espoused values			
95	Künzle, B., Kolbe, M. and Grote, G. (2010). Ensuring patient safety through effective leadership behaviour: a literature review. Safety science. Vol.48(1), pp.1-17.	Literature review	• Review focused on leadership behaviour • Study tested model linking positive leadership approach and workplace empowerment to workplace incivility, burnout, and subsequently job satisfaction.	• number of years of leadership experience is a critical factor • more than 3 years leadership experience positively correlated with effective leadership behaviour • that only extensive experience makes a difference in performance • effective leadership is not dependent as much upon seniority as it is upon the training and experience of the individual assuming the role of team leader • personality to be an influencing factor for leadership behaviours • the higher the workload, the more directive and active influential leadership is required • leadership role can shift between team members depending upon the condition of the patient • effective leadership functions should be adaptive with respect to environmental conditions.	• Effective leadership is characterized by clear and unambiguous behaviour which is adaptable to situational demands and shared between team members • need for leadership training in order to learn human factor techniques and personnel management skills • developing self-awareness of one's own emotions has been described as important in helping manage the emotions of other team members better • team leader needs to be more directive and involved when a team is inexperienced, while in more experienced teams empowering leadership is more effective • leadership behaviour must be unambiguous and visible in order to succeed. • leaders can facilitate team effectiveness by providing feedback and debriefing	• Task-oriented leadership behaviours enables team members to coordinate and cooperate among themselves • Developing leadership behaviour enhances skills of team members • Leaders modelling positive behaviour helps improve individual performance by involving all team members from the outset	• Staff • Organisation	
96	Laschinger, H.K.S., Wong, C.A., Cummings, G.G. and Grau, A.L. (2014) Resonant leadership and workplace empowerment: The value of positive organizational cultures in reducing workplace incivility. Nursing Economics. Vol.32(1), p.5-15.	Paper is part of a larger national study of nurses' worklives	Canadian Study	• Paper supports the notion of resonant leadership	• Resonant leadership styles include visionary, coaching, affiliative, and democratic approaches	• Positive and supportive leadership styles can lower patient mortality and improve nurses' health, job satisfaction, organizational commitment, emotional exhaustion, and intent to stay in their position. • positive leadership practices create healthy work environments that promote retention of nurses in a time of severe nursing shortage. • leaders who employ positive leadership styles are less likely to create work environments that foster incivility and subsequent burnout and job dissatisfaction. • Relationally focused leadership styles are associated with positive work environments that promote employee engagement and result in greater work satisfaction and productivity resonant • leadership was significantly related to higher-quality leader nurse relationships, improved safety climates, and supportive professional practice environments, as well as lower-emotional	• Staff • Organisation	Resonant leadership, a relatively new theory of relationship-focused leadership approach
97	Manley, K., Sanders, K., Cardiff, S. and Webster, J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept. International Practice Development Journal. Vol. 1. (2) [Online] Available: https://www.fons.org/library/journal/volume1-issue2/article1 [Accessed 14th January 2019].	Literature review/ concept analysis	rigorous concept analysis presented within context of an international colloquium on theory in practice development Exploring effective workplace culture	• To understand workplace culture, to know what is an effective culture at the frontline, and also, how to develop one is an essential skill-set for all clinical leaders and facilitators of change in healthcare settings • importance of incorporating the essential facilitation skill-set into clinical leader roles, such as, those facilitating the development of practice, and others who work at the patient-provider interface	• Individual clinical leaders self assess themselves in terms of their own role clarity • clinical leaders self assess themselves in terms of own skill-set as transformational leaders and facilitators of others' effectiveness • Ongoing presence of skilled facilitation is needed to sustain the attributes of an effective workplace culture • Transformational leaders and skilled facilitators act with a moral intent, using sociological, psychological and learning theories, multiple intelligences and teaching/learning skills that enable individuals and teams to change themselves and their context for the better • cultures are enabled by transformational leaders, skilled facilitation and role clarity and are complemented by organisational readiness with a flattened and transparent management structure and supportive human resource depart. • organisations can support the development of effective workplace cultures by investing in the development of both transformational leadership and facilitation skills through skills development, and the provision of ongoing supervision, support and peer review for these key players	• cultural change is achieved through leadership, particularly transformational leadership • Leaders provide support and trust • Role-modelling of evidence-based practice by clinical staff is valued and is linked to leadership • Transformational leadership shares some similarities with skilled facilitation of others' effectiveness but few authors make a clear distinction between the processes used in leadership and those used in facilitating others' effectiveness	• Staff • Organisation	

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98	Mullen, J. and Kelloway, E. (2009) Safety leadership: a longitudinal study of the effects of transformational leadership on safety outcomes. Journal of Occupational and Organizational Psychology. Vol.82, pp.253–272.	Research	longitudinal study of effects of transformational leadership on safety outcomes Canadian Study	• Interventions assessed using a pre-test, post-test, and control group design. • Leaders (N:54) from 21 long-term health care organizations randomly assigned to general transformational leadership training, safety-specific transformational leadership training, or control group	• Ajzen's (1985, 1991) theory of planned behaviour used to assess likelihood that leaders will use what they learned through training to improve their transformational leadership behaviour. • Kelloway and Barling (2000) suggest that transformational leadership training should result in higher leader self-efficacy beliefs	• Leadership training resulted in significant effects on manager post-training ratings of safety attitudes, intent to promote safety, and self-efficacy. • leadership training resulted in significant effects on the safety-specific transformational leadership and safety climate outcomes. • transformational leadership (Bass, 1985) positively associated with employee perceptions of workplace safety climate when leadership behaviour focused specifically on safety. • growing body of safety literature provides empirical support for the positive impact of transformational leadership on workplace safety attitudes and behaviour (Zohar, 2004) and organizational performance (Geyer & Steyrer, 1998). • combining transformational leadership training and personal feedback, such that training branch managers in transformational leadership led to changes in employees' commitment to the organization and financial performance (Barling et al, 1996) • each of the four components of transformational leadership theory (Bass, 1985) are relevant to improving workplace safety • safety-specific transformational leadership behaviours will result in better safety outcomes than general transformational leadership. • leaders' safety attitudes were highest among managers who received the safety-specific transformational leadership training, as opposed to managers who participated in the general transformational leadership training or the control condition.	• Staff • Culture • Organisation • Patient safety	Ajzen's (1985, 1991) theory of planned behaviour
99	Peus, C., Wesche, J.S., Streicher, B., Braun, S., and Frey, D. (2012). Authentic leadership: an empirical test of its antecedents, consequences, and mediating mechanisms. Journal of Business Ethics. Vol.107, pp.331–348.	Literature review	Empirically investigation into concept of authentic leadership. Specifically, authentic leadership in business (Study 1; n = 306) as well as research organizations (Study 2; n = 105).	• Authentic leaders ''act in accordance with deep personal values and convictions, to build credibility and win the respect and trust of followers'' (Avolio et al. 2004, p. 806) and genuinely desire to serve others through their leadership (George 2003). • authentic leadership comprises four components (cf. Walumbwa et al. 2008): Balanced processing, internalized moral perspective, relational transparency, and self-awareness. • self-knowledge and self-consistency as key antecedents of authentic leadership. • authentic leaders are able to act in accordance with their values even if challenged by social or situational pressures (Erickson 1995). • authentic leaders' behaviours are motivated and controlled by integrated regulation (Gardner et al, 2005)	• Balanced processing - leader objectively analyzes all relevant data before making decisions. This includes processing information that contradicts his/her initial point of view. • Internalized moral perspective - leader is guided by internal moral standards and values and acts according to these, even against group, organizational, or societal pressures. • Relational transparency - presenting one's authentic self (as opposed to a fake or distorted self) to others. i.e. openly sharing information and expressing one's true thoughts and feelings in interpersonal interaction • self-awareness - process of reaching a deeper understanding of one's strengths and weaknesses (Gardner et al. 2005). • authentic leaders are guided by sound moral convictions and act in concordance with their deeply held values, even under pressure. • further elaborates • ''authentic leaders are effective in leading others because followers look for consistency between their leaders' true selves – as expressed in values, purpose, or voice – and their behaviors'' (Sparrowe, 2005) • trust identified as a crucial element for leader effectiveness by presenting their authentic self to team members and acting as role models authentic leaders are likely to increase commitment to team goals.	• leader self-knowledge and self-consistency antecedents of authentic leadership and followers' satisfaction with supervisor, organizational commitment, and extra effort as well as perceived team effectiveness as outcomes. • Walumbwa et al. (2008) found authentic leadership to be a significant positive predictor of followers' satisfaction with their supervisor, organizational commitment, and willingness to make extra efforts at work. • Clapp-Smith et al. (2009) found authentic leadership to be positively related to employee performance • (Walumbwa et al. 2010) reported authentic leadership to have significant positive relation with supervisor-rated organizational citizenship behaviour and work engagement. • Wong et al. (2010) reported authentic leadership to be significantly related to nurses' work engagement, voice behavior, and perceived unit care quality. • trust in leadership found to be related to a number of positive outcomes such as job satisfaction, commitment, and intention to stay • authentic leadership is likely to enhance team members' focus on quality and performance because this type of leadership assists in the building of shared mental models within the team (Yammarino et al. 2008). • authentic leadership facilitates a ''positive'' social exchange relationship where leaders and followers openly share information and provide constructive feedback, thus yielding effective decision-making and communication as well as support for innovation.	• Staff • Organisation	
100	Sandstrom, B., Borglin, G., Nilsson, R., and Willman, A. (2011). Promoting the implementation of evidence-based practice: A literature review focusing on the role of nursing leadership. Worldviews on Evidence-Based. Vol.8(4), pp.212-223.	Literature review	Authors from Sweden	• Pettigrew et al. 1992 suggested that successful change is more likely to take place in contexts with leaders who inspire and act within a supportive organisation. • might not be viable to study leadership in isolation from the work environment as there appears to be an intricate interplay between different factors (Rycroft-Malone&Bucknall 2010).	• leader has to have good communication skills and availability as well as providing staff with information about existing guidelines and the evidence underpinning them (Gifford et al. 2006). • Gifford et al. (2006) revealed that managers who acknowledged and appreciated the efforts of staff when implementing guidelines were a means of motivating sustained application of the guidelines. • need for leaders to create a positive milieu/culture to support best practice (Gifford et al. 2006)	• Emerging evidence also supports the assumption that leaders play an intrinsic role in the process of EBP implementation in practice although it is not specified in what ways (Kitson et al. 1998; McCormack et al. 2002; Rycroft-Malone 2004, 2008; Udod & Care 2004; Hutchinson & Johnston 2006). • McCormack et al. (2002) suggest that effective leadership leads to clear roles, enhanced teamwork and good organisational structures.	• Staff • Organisation	
101	Wang, G., Oh, I., Courtright, S.H., Colbert, A.E. (2011). Transformational leadership and performance across criteria and levels: a meta-analytic review of 25 years of research. Group & Organization Management. Vol.36(2), pp. 223–270.	Meta- analytic study of 113 primary studies	Authors from USA	• followers' responses to transformational leadership are more strongly reflected in their contextual performance than their task performance because transformational leaders affect their followers more by raising their levels of positive emotion and motivation than their levels of task-related skills and ability.	• transformational leaders link followers' work roles to a compelling vision of the future of the organization, causing followers of transformational leaders to view their work as more meaningful and significant and thus increasing its intrinsic motivating potential (Bono & Judge, 2003; Zhu, Avolio, & Walumbwa, 2009). • transformational leaders instill in their followers a belief that they can achieve the goals that are set for them (Shamir et al., 1993), and these increased levels of self-efficacy positively affect performance (Bandura, 1986). • transformational leaders serve as effective coaches and mentors to their followers, providing them with the support and tools that they need to accomplish their jobs (e.g., Howell & Hall-Merenda, 1999). • transformational leaders motivate followers to work for the good of the group by increasing social	• Bass (1985) proposed transformational leaders increase followers' confidence and the intrinsic value of performance, resulting in higher levels of motivation • transactional or exchange-based forms of leadership clarifies expectations and rewards followers for fulfilling them (Bass, 1985) • transformational leaders motivate their followers tomove beyond self-interest and work for the collective good (Avolio & Yammarino, 2002; Bass, 1985; Burns, 1978). • transformational leadership is associated with higher levels of performance from followers • Podsakoff, MacKenzie, and Bommer (1996) have proposed that transformational leadership motivates followers to go beyond the minimum requirements of their job descriptions, resulting in higher levels of contextual performance. • transformational leadership behaviors are expected to motivate followers to perform at higher levels.	• Staff • Patients • Organisation	

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No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					identification, thereby inspiring followers to engage in altruistic behaviors (e.g., helping coworkers in need of help) and to dedicate themselves to their jobs and organizations (e.g., working extra hours and promoting organizational public images; Bass & Avolio, 1993; Kouzes & Posner, 2002; Pillai, Schreisheim, & Williams, 1999; Sosik, 2005). • transformational leaders influence their followers to engage in contextual performance by serving as role models who are willing to sacrifice their own interests for the collective good and by bolstering a sense of group belongingness and cohesion (Podsakoff et al., 1990; van Knippenberg & van Knippenberg, 2005). • transformational leaders encourage and intellectually stimulate followers to challenge the status quo, question assumptions, take risks, suggest innovative ideas, and engage in divergent thinking (Bass, 1985). • Transformational leaders empower their followers to be problem solvers, such that employees grow in their creativity by learning from their failures and experimenting with various options without fear of failure (e.g., Jung, 2001; Jung, Chow, & Wu, 2003; Shin & Zhou, 2003). • transformational leaders communicate a vision for the group and motivate team members to work toward the collective vision (Bass, 1985). • Transformational leaders also express their confidence that teams will achieve their goals, leading to higher levels of team potency (Bass et al., 2003; Schaubroeck, Lam, & Cha, 2007). • transformational leaders encourage higher levels of team cohesion (Bass et al., 2003), which facilitates coordination and cooperation among group members. • transformational leaders positively influence performance through the communication of a vision that serves to • motivate employees and align their efforts (Bass, 1985). • transformational leadership augments transactional leadership and that transactional leadership augments transformational leadership primarily because these two types of leadership work through different motivational mechanisms. • Transactional leaders (especially those using contingent reward behaviours) clearly specify performance expectations and provide rewards for the achievement of these expectations (Bass, 1985). Thus, the task performance of followers is expected to be higher when they work with transactional leaders because of the motivational effects of performance goals (Locke & Latham, 1990) and because of the clear link between performance and rewards (Vroom, 1964). Transformational leadership may further enhance individual task performance through such mechanisms as increased effort-accomplishment expectancies and enhanced meaningfulness of goal accomplishment (Shamir et al., 1993).	• Research studies have consistently found positive relationships between transformational leadership and task performance (e.g., Liao & Chuang, 2007; MacKenzie, Podsakoff, & Rich, 2001) • transformational leadership is positively related to creative performance. • increasing team cohesion, motivation, and goal congruence within the top management team, transformational leaders facilitate higher levels of organizational performance (Colbert, Kristof-Brown, Bradley, & Barrick, 2008; Waldman & Yammarino, 1999). • transactional leaders may motivate higher levels of team performance by clarifying team goals and rewarding the team for the achievement of those goals. • transformational leadership is positively related to individual follower performance across job performance criterion types • transformational leadership has positive relationships with follower task • transformational leadership was also positively related to follower general job performance • transformational leadership is more strongly related to follower contextual performance than to follower task performance • Transformational leadership was found to be positively related to overall team performance and significantly associated with organizational performance. • transformational leadership generally shows the highest relationship with team performance • transformational leadership exhibits a positive relationship with performance across several individual performance criteria, including task, contextual, and creative performance; the influence of transformational leadership is stronger for contextual performance than for task performance across most study settings examined.		
102	Wong, C. and, Cummings, G. (2007) The relationship between nursing leadership and patient outcomes: a systematic review. Journal of Nursing Management. Vol.15(5), pp.508-21..	Systematic review	Authors from Canada	• Review examined the relationship between nursing leadership and patient outcomes in health care organizations	• When leaders communicate clear expectations for practice, patient care processes are facilitated which, in turn, lead to improved outcomes (McNeese-Smith 1999, Anderson et al. 2003, Boyle 2004, Doran et al. 2004). • It may be that effective leadership plays a key role in retaining and supporting experienced staff as experienced staff plays a role in reducing mortality rates (Tourangeau et al. 2002).	• Positive leadership behaviours (transformational, empowering, supportive, etc.) may be associated with outcomes through facilitation of more effective teamwork (McNeese-Smith 1999, Anderson et al. 2003, Pollack & Koch 2003, Doran et al. 2004). • Houser (2003) explained that empowering leadership may relate to patient outcomes by promoting greater nursing expertise through increased staff stability and reduced turnover. • may be that effective leadership is related to patient outcomes through increased nurse job satisfaction • Patient satisfaction was significantly associated with positive leadership behaviours. • Anderson et al. (2003) found a significant relationship between positive leadership practices (communication openness, formalization, participation in decision making, and relationship orientated leadership) and reduced prevalence of adverse events in nursing home residents, underscoring a strong association between leadership and safer patient care environments. • Houser (2003) found a significant indirect relationship between leadership and reduced patient falls and medication errors through increased staff expertise and stability. • Houser (2003) also found reduced incidence of pneumonia and urinary tract infections (UTIs) associated with positive leadership behaviours.	• Staff • Patients • Organisation	

Leadership in Health Services

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
						• These findings highlight an important relationship between leadership and the reduction of adverse events, perhaps, because leaders play a key role in managing the context, staffing and financial resources required to deliver effective care (Patrick & White 2005).		
103	Wong, C.A., Laschinger, H.K.S., and Cummings, G.G. (2010). Authentic leadership and nurses' voice behaviour and perceptions of care quality. Journal of Nursing Management. Vol.18(8), pp.889–900.	Research study	non-experimental, predictive survey design was used to test a theoretical model linking authentic leadership with staff nurses' trust in their manager, work engagement, voice behaviour and perceived unit care quality.	• Authentic leadership is conceptualized as a pattern of leader behaviour that is grounded in a leader's positive psychological capacities and sound ethical standards (Walumbwa et al. 2008a). • authentic leaders' influence on work attitudes and outcomes is mediated through the processes of personal identification with the leader, social identification with the work unit and organization, as well as the follower's trust in the leader and positive psychological capacities of hope, positive emotions and optimism. • Avolio et al. (2004) suggested that authentic leaders enhance follower's engagement in work and commitment to constantly improve their work and performance outcomes.	• relational transparency is a key component of authentic leadership and is a significant predictor of trust in the leader (Hughes 2005, Gardner et al. 2006, Norman 2006). • Gardner et al. (2006) found that authentic leaders who exhibit consistency between their expressed values and ethical conduct generate higher levels of trust and organizational advocacy among followers. • Authentic leaders facilitate personal identification by connecting with the self-concept of followers (Avolio et al. 2004). By setting a personal example of high standards of integrity, authentic leaders evoke a deeper sense of personal commitment among followers and greater clarity about personal identity and emotions (Walumbwa et al. 2008a). • Authentic leaders facilitate social identification by creating a deeper sense of high moral values and expressing high levels of honesty and integrity in their dealings with followers (Avolio et al. 2004).	• Authentic leadership significantly and positively influenced staff nurses' trust in their manager and work engagement which in turn predicted voice behaviour and perceived unit care quality. • Walumbwa et al. (2008a) reported that frequency of authentic leadership behaviour demonstrated by leaders in a variety of fields was positively related to job satisfaction, organizational commitment, satisfaction with the supervisor and supervisor-rated performance. • Wong and Cummings (2009) found that authentic leader behaviours, relational transparency, balanced processing and ethical behaviour had significant but differential effects on trust in management, voice, performance and burnout in the two groups of employees, clinical care providers and non-clinical staff. • In a meta-analysis of research findings on trust in leadership, Dirks and Ferrin (2002) reported significant relationships between trust and job satisfaction, organizational citizenship behaviour, job performance, intention to quit and organizational commitment. • This study provides the first test of the relationship between authentic leadership and work outcomes in a nursing sample. • Found a direct relationship between authentic leadership and trust which may mean that authentic leaders directly build trust in their followers by influencing nurses' perceptions of the credibility, benevolence and integrity of the leader (Mayer & Gavin 2005). • There was an indirect effect of authentic leadership on work attitudes (work engagement) and outcomes (voice and perceptions of quality) through personal and social identification. This is consistent with research that showed that leadership can have a positive influence on social identity with the work group which in turn can influence work outcomes (Hogg 2001, Kark et al. 2003, Cicero & Pierro 2007).		

Leadership in Health Services

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
F1	Peer review journal Research	America	Clinical nurse leader (CNL) integrated model introduced 10 years ago in USA to address quality and safety gaps. The CNL is a Registered Nurse with a Master's level education and advanced competencies in clinical leadership, care environment management and clinical outcomes management Rationale for study is that theoretical clarity is required to support effectiveness of this model. 4 Domains of CNL practice: • Preparing for CNL practice • Structuring the CNL workflow • CNL practice activities • CNL outcomes CNL practice integration is not merely placing an 'extra set of hands' into a dysfunctional care delivery system with hopes of solving entrenched care problems, but rather a systematic process that requires multilevel organizational input, significant resource allocation and commitment to care delivery redesign from leaders and practitioners across organizational levels to produce consistent care quality and safety outcomes Clinical leadership has been described in the literature as a complex process of managing relationships at the microsystem level to facilitate the restructuring of multirelational care delivery processes to improve care quality and has been conceived as a new model of behaviour that requires sustained effort and appropriate and supportive infrastructure to become embedded, or acculturated into everyday practice	Additional domain added – administrative/social integration at the macro to micro level CNL practice identified as a process of ongoing clinical leadership with the four fundamental practices: 1) facilitate effective ongoing communication, including the creation of multi- modal communication tools and rounding structures; (2) strengthen intra and inter-professional relationships by establishing a network of multi-professional microsystem partners who previously worked in isolation; (3) create and sustain teams by bringing people from all disciplines and departments affected by care processes to work together and improve them; and (4) support staff engagement via an ongoing, consistent supportive presence, the provision of resources based on in-the-moment needs and empowering staff to perform to their full scope of practice and identify and create solutions for patient care needs. It is important to note that data from this study confirmed that CNL practice is more complex than an independent role based on CNL competencies placed in a clinical microsystem. Rather, competencies are considered necessary structuring elements that enable the enactment of interdependent, relational continuous clinical leadership practices by CNLs at the microsystem level. The distinction is important because it highlights CNL clinical 'embeddedness' as a fundamental aspect of practice.	Improved care outcomes and improved care quality related to CNL practice (strong relationship) Effective communications across professions Perceptions of staff owning their own practice Perception that multiprofessional clinicians regularly work together to solve clinical problems Perception that CNL practice changes dynamics of clinical interactions between multiprofessional clinicians for the better Overall satisfaction with the clinical environment Improvement in nursing sensitive care quality indicators Better care coordination Fewer gaps or omissions in care Prevention of errors before reaching the patient Staff spending more time with patients Relationship between increased value of how care is delivered and outcomes but more research is required to explore the impact of other domains of CNL practice on value.	• Individual (patient, staff) • Team/Environment Organisational	? Another article has discussed this model. Strong evidence. • Didn't understand all the statistical measurements!	Peer review journal Research
F2	British Medical Association. (2012) Doctors' perspectives on clinical leadership. Health Policy and Economic Research Unit, BMA: London.	Report from Health policy and economic research unit of BMA Study aimed to explore concepts of and attitudes to leadership Focus groups – semi-structured	Medical staff, UK	Entering 'turbulent' period in healthcare were cost efficiency is required and implementation of reforms etc. Clinicians need to meet demands for a future NHS Medical Leadership Competency Framework translated into clinical leadership competency framework for all professions Concerns over leadership roles being away from patients Term clinical leadership not well defined Lack of leadership in early medical training Clinicians moving into more integral decision making roles, involvement in commissioning Lack of clarity around leadership roles and definitions	Clinical credibility and visibility Clinical knowledge Advocacy of patient interests Expert leadership versus shared leadership A need for leadership to be part of medical curriculum based on skills, values and interests around becoming expert leaders Leading by example at all levels including 'grass roots' Value being involved in decision making Ability to offer a vision to widest audience in the health service Recognised leadership roles more likely to gain authority of other senior professionals Identification of differences between leadership and management where a manager deals with routine tasks and a leader uses expertise and evidence to provide solutions to clinical problems Opportunities for leadership can arise through delegation of responsibilities Ability to provide innovative solutions and fresh ideas – innovation can transcend hierarchical relationships Doctors possessing innate professionalism that is useful for clinical leadership Influencing change, turning vision into reality People value transparency in seeing progression into leadership roles Passing on collective view to other groups (e.g. of GPs) A need for greater empowerment and confidence that leadership has potential to influence the health service Skills and attributes Clinical credibility seen as very important Personal qualities, interacting with others	More coherent and long term vision of healthcare provision	• organisation	Focus on medical staff therefore ? include Limited discussions of outcomes – more on perceptions.

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					Core values of integrity and respect Communication skills – ability to listen Political skills - Ability to build concensus among colleagues, influence and negotiating skills Ability to reach concise and comprehensible decisions that can be explained by peers Ability to perform in a team and take personal responsibility for actions Makes people feel inspired by exuding passion and charisma Resilient, determined and retain strong emotional and mental resolve under pressure Help colleagues feel empowered Empathy Integrity honesty and accountability Barriers to leadership Time, money, resources Lack of opportunity for leadership role in career pathway Diversity and autonomy of profession seen as both a barrier and an enabler Enablers of leadership Colleagues that value what you do and your strengths Experience and age Being a generalist (GP)			
F3	Franks-Meeks, S. (2018) Clinical staff nurse leadership: Identifying gaps in competency development. Nursing Forum. Vol.53, pp.35–39.	Literature review	Authors from Texas	Lack of research validating clinical staff nurse (CSN) leadership role, identifying competencies and involving staff nurses in this process Paper discusses validated competencies for Nurse executive (NE) and Nurse manager (NM) role but lack of research validating and involving CSN in CSN leadership competencies AONE – American organisation of nurse executives	Influence members of the healthcare team to work in tandem to accomplish shared goals Communication – able to convey ideas and vision to, and hear concerns and recommendations from the followers Relationship building – relationships are the result of trust building and experiences in collaboration (interestingly this is not a core competency of nurse manager role) Clinical expertise Patient safety (not included in NM role) Professionalism (not included in CSN role) Competencies assigned to CSN leader by management (but not explored with CSN) include relationship management, performance improvement, patient safety, foundational thinking skills and systems thinking	• Enhanced patient outcomes – fewer errors, higher satisfaction scores • Improved organisational and financial success	•	Interesting definition of leadership: one person persuading at least one other person to work in concert to achieve a common goal Article seems to separate competencies for CSN, NE, and NM arguing there is a lack of scientific evidence supporting the CSN competencies. Competencies, rather than mechanisms? Not much discussion of the how…
F4	Hahtela, N., B. McCormack; D. Doran, E. Paavilainen, P. Slater, M. Helminen and T. Suominen, (2017). Workplace culture and patient outcomes: What's the connection? Nursing Management. Vol.48(12), pp.37-44. DOI-10.1097/01.NUMA.0000526910.24168.ee	Research	Finland	Study aimed to explore connection between workplace culture and nursing sensitive patient outcomes Cross sectional design 14 healthcare units	Workplace culture – the unit level culture that patients and staff experience every day Managerial support associated with improved outcomes Constructs of workplace culture (Nursing Construct Index Questionnaire – Slater and McCormack)	Nursing sensitive patient outcomes: Patients pereceptions of self care and patient centred care Reduced complications e.g. pressure injury Adverse events (related to information, diagnosis, procedures etc.) RN job satisfaction	•	No mention of relatives? There are correlations between workplace culture and patient outcomes, however paper doesn't focus directly on mechanisms of leadership.
F5	Mianda, S., and Voce, A. (2017) Conceptualisations of clinical leadership: a review of the literature. Journal of Healthcare Leadership. Vol.7(9), pp. 79-87.	Systematic literature review	South Africa maternal health Literature review covered papers from Australia, UK, Ireland, New Zealand	Poor patient outcomes in South Africa maternal health associated with poor clinical leadership at point of care. Focus on frontline leadership as this has been neglected – a need to understand ways in which clinical leadership is conceptualised. Slow progress in promoting and developing clinical leadership among frontline health care providers in Africa (in comparison to US, UK, Canada, Australia) 'Frontline health providers' described as nurses, midwives, AHPs and doctors providing direct patient care. Lack of understanding amongst frontline health providers regarding what clinical leadership is and lack of clear career pathways to engage in clinical leadership roles.	Clinical leadership has a focus on patient care Clinical leadership has the purpose of delivering change in the quality of direct patient care and to motivate members of the team to provide effective health care that is safe and satisfying to patients; to promote staff retention and provide organisational support in the effort to improve patient outcomes Qualities and competencies of clinical leaders include; approachability, role modelling, visibility and availability to support, advise and guide, capacity to remain calm and confident in crisis, ability to gain support and influence others, ability to promote change, communicate effectively, and impact on standards of cares. Competencies include clinical expertise, being clinically focussed, remaining clinically engaged, understanding clinical leadership roles and clinical decision making A role to be fulfilled by every frontline health care provider; setting the direction, promoting the vision, promoting professionalism, teamwork, interprofessional collaborations, good practice and continued medical education. Representing nursing contribution to patient care Clinical leadership is distinct from health service management	Quality patient care/improved outcomes Staff retention Healthy and safe clinical work environment	Patient Teams Organisation	
F6	Murray, M., Sundin, D., Cope, V. (2018) The nexus of nursing leadership and a culture of safer	Discursive paper – integrative literature review	Authors from Australia	Paper explores connection between +6 leadership and enhanced patient safety	Visibility of leaders Credible support for patient safety initiatives Systems approach	Enhanced patient safety Patient outcomes Employee satisfaction	•	Comparison of transformational and transactional

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
	patient care. Journal of Clinical Nursing. Vol.27, pp.1287–1293.			Reflecting on high profile reports e.g. Francis where lack of safety culture impacts on patient outcomes. Factors required to foster organisational safety culture include supportive leadership, effective communication, orientation programme and ongoing training, appropriate staffing, open communication regarding errors, compliance to policy and procedure, environmental safety and security. Nurses are the nexus to influencing organisational culture towards safer practice due to high patient interaction and leadership at all levels of nursing A safe culture is one nurtured by effective leadership	Setting patient safety as an organisational priority, using failings to improve and enhance patient care and increase positive outcomes Positive safety culture requires alignment of quality and organisational priorities -Teamwork, Evidence based practice, Communication,Ongoing education, A just culture (blameless safety culture), Leadership and patient centred care. Shared values Zero tolerance for substandard care Empowerment of frontline staff Staff recognition Transformational/relational leadership associated with positive patient safety and patient outcomes – blameless safety culture (just culture) – non-punitive environment where inadvertent actions are used as a stepping stone to improve practice but where reckless behaviour will not be tolerated. Ability to engage, motivate, inspire and empower followers to aim above and beyond their own boundaries to achieve a shared vision or organisational goal Visible leaders, set clear expectations, promote open multidisciplinary communication, see errors as an opportunity for improvement. Transformational leaders invoke change, demonstrate emotional intelligence, consult with followers before making decisions and share the load. Develop trust and a just blame free environment. Value followers opinions, respect experience, affirm colleagues ideas and involve in decision making Transactional leadership uses rewards to motivate followers to achieve goals which can impact on follower's satisfaction levels. May negatively influence patient outcomes as it may reinforce task based behaviours Set clear guidelines, share vision and lead by example. Recognition of good practice to motivate and empower bedside nurses to improve quality of care. Empowering staff through leadership engagement Empowerment to contribute to policy development Open communication environment where there is no fear of repercussions of reporting errors, staff are encouraged to report errors, near misses, staff are enabled to seek help without threat of derision but knowing they can voice need for assistance to avoid possible harm. Develop trust in leaders Invest in leadership development – leadership education at undergraduate level, entry level to profession and ongoing leadership programmes to grow and nurture leaders at all levels Leadership WalkRounds (WR) – senior leaders and organisational executives engaging with bedside nurses to discuss patient safety concerns and raise these to the executive level. However also potential to expose disparity in perceptions between bedside nurses and organisational leaders opinions of most critical issues to be discussed – potential to miss what is happening at the bedside. Having CNOs in organisational leadership team – a nexus between bedside nurse and organisation executive Magnet recognition framework promoting exemplary nursing care through a positive workplace culture – 5 forces of magnetism: transformational leadership, structural empowerment, exemplary professional practice, new knowledge innovation and improvements, and empirical quality results. Followers of leaders should reflect on their influence on the support of their leader	Engagement –'positive fulfillIng, work related state of mind' Improved performance of bedside nurses Belief that concerns will be heard Job satisfaction Organisational commitment Intention to stay Staff build self awareness and become empowered which then empowers others to make autonomous decisions at the bed space Retaining staff, High staff satisfaction Decreased patient mortality rates Decreased adverse events such as falls, medication errors, complaints related to care, healthcare acquired infections		leadership as well as situational and democratic.

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					Responsibility for nurses to seek leadership education, and develop confidence and competence in leadership Bedside nurses have most influence on patient outcome and effective leadership can empower them to go above and beyond their self-imposed boundaries to meet a vision shared by their leader, without fear of recrimination			
F7	National Improvement and Leadership Development Board. (2017) Developing People - Improving Care: a national framework for action on improvement and leadership development in NHS-funded services. [Online] Available: https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf [Accessed 14th January 2019].	National framework to guide local regional and national action on developing NHS funded staff.	NHS England Framework for all health professions	Aim is to equip and encourage people in NHS funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work, to guide team leaders at every level to develop a critical set of improvement and leadership capabilities among their staff and themselves. A strategy for closing the 3 gaps identified in the NHS 5 year forward view. Background to framework – aim to work in partnership to dissolve barriers between primary care and hospitals, between physical and mental health and between health and social care. To build local health and care systems where people put shared aims of improving care for individuals, improving population health and improving value for money before organisational interests. Increased pressures and less time to reflect on leadership and how best to lead change. Currently a number of vacancies at senior levels. Led to framework for action on skill-building in improvement, leadership development and talent management at local, regional and national levels 5 Conditions common to high quality systems that interact to produce a culture of continuous learning and improvement: – Leaders equipped to develop high quality local health and care systems in partnership – requires joint ambition (clear aims for health and healthcare), positive relationships and trust at all levels – Compassionate, inclusive and effective leaders at all levels – collective leadership - – Knowledge of improvement methods and know how to use them at all levels – leadership for improvement in practice, partnering with staff patients and communities for improvement. – Support systems for learning at local regional and national levels – training, coaching and organisation development capacity Enabling supportive and aligned regulation and oversight	Framework focusses on helping NHS and social care staff to develop 4 critical capabilities: – Systems leadership skills leaders of organisations – help leaders to build trusting relationships, agree shared system goals and collaborate across organisational and professional boundaries – Improvement skills for staff at all levels – established quality improvement methods for improvement in operational performance, staff satisfaction and quality outcomes – Compassionate, inclusive leadership skills for leaders at all levels. Compassionate – playing close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. Inclusive – progressing equality, valuing diversity and challenging power imbalances. Creating just learning cultures where improvement methods engage colleagues, making health organisations great places to work. – Talent management to fill senior vacancies and future leadership pipelines with appropriately developed people Framework is in short cycles, reflecting feedback for as long as it takes to build cultures of continuous learning and improvement. -	Improve population health, patient care and value for money Continuous improvement in performance Cultures that engage and support all staff and teams Culture of continuous learning A number of **intended** outcomes are identified as a result of implementing the framework over 12 months and 1-3 years e.g. sustainable and diverse 'pipeline' of senior leaders who have the right skills.	Individuals, teams, organisation, communities	Future iterations of framework to involve social care staff as well as health staff A focus on compassionate and inclusive leadership A detailed framework whose 'ultimate potential rests on the extraordinary commitment of individuals working in health and care to caring for patients and service users……it's impact will come from equipping, empowering and trusting people fulfil that mission and celebrating their success' 3 pledges made by national organisations (e.g. CQC who will monitor)– to use the framework at a national level, model compassionate leadership and support local decision makers.
F8	National Institute for Health Research (2018) I am Research. NIHR CRN Allied Health Professionals Strategy 2018-2020. [Online] Available: https://www.nihr.ac.uk/our-faculty/clinical-research-staff/Allied%20Health%20Professionals/AHP%20strategy%20poster_explainer.pdf [Accessed 14th January 2019].	Strategy	UK AHPs	NIHR mission to provide a health research system in which the NHS supports outstanding individuals working in world class facilities, conducting leading edge research focussed on the needs of patients and the public. Core to this is to attract, develop and retain the best research professionals to conduct people based research by realising the potential of AHPS – the 3rd largest professional workforce in health and social care One strategic goal is to increase visibility of AHPs as leaders across all research settings. This strategy complements existing NIHR reports e.g. mapping research capacity activities in the CLAHRC – Collaboration and Leadership in Applied Health Research and Care - community	Building awareness, demonstrating innovation and promoting and sharing best practice Leaders who develop best clinical practice, are NIHR ambassadors, visible role models and building identity and momentum for the professions	Development of best clinical practice	Organisations Individuals	? relevance of this document – related to AHP leadership and research.
F9	National Health Service England (2017) Allied Health Professionals into Action. [Online] Available: https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf [Accessed 14th January 2019].	Framework to develop plan of delivery Review of national policy documents, engagement nd involvement of senior leaders	NHS England	A blueprint use to support local and regional decision making about AHPs, services they offer, how they can most efficiently and effectively utilised and to access areas requiring action to enable the change required to deliver future care across the system. One commitment is: AHPs can lead change Transformative potential of AHPs	Document is a tool to focus system leader attention on areas where they should consider the transformative role of AHPs and the support needed to achieve change. Document 'offers permission to AHPs to propose change and be engaged at all levels of decision making within the system'.	Improve health and well-being of individuals and populations Support and provide solutions to general practice and emergency services to address demand Support integration Deliver evidence based/informed practice		Document doesn't really drill down mechanisms of leadership, more an opportunity to systems leaders to support role of AHP in response to the 5 year forward view (NHS England) ? relevant for this review

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F10	Dewar, B., and Cook, F. (2014) Developing compassion through a relationship centred leadership programme. Nurse Education Today. Vol. 34(9), pp.1958-64.	Research Peer review journal	Scotland nursing	Appreciative relationship leadership programme with 86 nursing staff in on NHS Scotland board Aim of programme – to support staff to work together to develop a culture of inquiry that would enhance delivery of compassionate care Backdrop of mid staff inquiry and need for models of leadership in complex and unpredictable times Model of compassionate relationship centred care underpins programme – Knowing who I am and what matters to people (staff, patient, family) – Understanding how people feel about their experience – Working together to shape the way things are done Underpinned by interpersonal process of the caring conversations framework	Appreciative relationship centred leadership: – Explore relationship with self, patients and families; teams; wider organisations – Caring Conversations framework (courageous, connect emotionally, be curious, consider other perspectives, collaborate, compromise, celebrate) Nurture values attitudes behaviours and actions that are essential for relationship centred compassionate care Reflective and engaged participants rather than passive actors that can shape the cultural climate Senior manager support for programme, backfill organised to enable staff to attend sessions, recruiting those who are interested 'Way of being' rather than another quality programme Theoretical underpinnings: Inquiring appreciatively – what works well and why, how can we amplify this Relationship centred practice – leader creatives positive relationships within organisation Experience based design – seek out and value experience of those who give and receive service and use this to explore celebrate and develop practice. Reflective spaces facilitating learning together - Action learning sets and communities of practice Work based activities – participants supported to carry out activities that focussed on learning about experiences (short feedback forms, emotional touchpoints, photoelicitation, huddles, all about me)	Formative evaluation, ongoing reflections, culture questionnaire, case studies, staff interview were used to evaluate the programme. Enhanced self-awareness Enhanced relationships Greater ability to reflect on practice Different conversations that were more compassionate and respectful Ethos of continuing learning and improvement	• Individual, team, organisational	
F11	Strömgren, M., Eriksson, A., Ahlstrom, L., Bergman, D.K and Dellve, L. (2017) Leadership quality: a factor important for social capital in healthcare organisations. Journal of Health Organization and Management. Vol.31(2), pp.175-191.	Research – longitudinal quantitative study - questionnaires Peer review journal	Sweden 5 Hospitals	Paper aimed to investigate relationship between leadership and social capital and what qualities of leadership are important for social capital among employees in a hospital setting Context of challenges facing healthcare sector to maintain quality of care when effecting cost reductions Previous research highlights that social capital is an important resource when implementing organisational change Social capital – a resource fostered in relationships: Sum of reciprocity, trust regarding management, mutual trust between employees and recognition Leadership influence on employee outcomes: Relationships between leaders and followers to reach common goal Tasks to be accomplished Supporting employee development	3 types of leadership included – relation- orientated, task-orientated and development orientated. Elementary factors of relation-focussed leaders: – Inspiration and motivation – Intellectual stimulation – Idealized influence – Personal consideration Task orientated structure – role and goal clarity Development orientated leadership – employees are given opportunities to grow and become effective by developing knowledge and skills Authentic leaders foster relational social capital by creating empowering work environments Fostering cooperation Strengthening communication Stimulating growth of trust, solidarity and resilience Appreciate staff and show consideration for the individual Give high priority to job satisfaction Good at solving conflicts Good at communicating with staff High priority to further training Good at work planning and allocating work	Relation-orientated leadership has strongest association with social capital Study used validated questionnaires for quality of leadership and social capital (Copenhagan Psychosocial Questionnaire, and Modern worklife questionnaire) - Enhanced job satisfaction - Staff engagement in clinical improvements in patient safety and quality of care - Improved staff relationships with their health and well-being - Improved relationships with work - Enhanced productivity and effectiveness - Motivates people to put more effort into their performance - Enhanced organisational performance - Employee competence	• Individuals • Teams • Organisations	Study shows that leadership has an impact on social capital – previous research has shown that social capital has an impact on leadership
F12	The King's Fund (2012) Leadership and Engagement for Improvement in the NHS: Together We Can. London: King' Fund.	Review	UK	Commission set up to investigate the future of leadership and management in NHS in times of reforms No More Heroes report (2011) brought evidence to make case for excellent leadership and management – shared and distributed, less reliant and heroic individuals and more the property of teams and organisations. NHS Commissioning board and leadership Academy have key role to play in modelling and supporting development of leadership and engagement. Employee engagement – 'the business values the employee and the employee values the business	Effective leaders need to work through others Motivate and engage followers Leadership across organisations and systems of care, including engagement outwith NHS Need for leadership programmes across different professions and organisations, engaging clinicians notably in leadership roles Leadership from the board to the ward Cultivate a strong culture of engagement for patients and staff Range of leadership styles and behaviours Need for a more nuanced style of leadership giving priority to patient and staff engagement Valuing and recognising contribution of staff in early states of career to leadership and service improvement Give staff autonomy, enable to use a wide range of skills, ensure jobs are satisfying, e.g. by seeing something through from beginning to end, give support recognition and encouragement	• Improve population health • Improve patient care and patient outcomes • Enhance staff well-being • Better patient experience • Fewer errors • Lower infection and mortality rates • Stronger financial management • Higher staff morale and motivation • Less absenteeism • Less stress • Delivering more appropriate care • Enhanced staff performance • Motivating other staff resulting in a more engaged workforce • Staff feel energetic, enthusiastic and inspired	•	

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					Nurture personal qualities of optimism, resilience and self belief Psychological engagement (motivation), advocacy (employee would recommend their organisation as a place to work and be treated) and involvement (able to make suggestions, show initiative Creating trust and harmony 'coaching' Model of engaging leadership – 'leadership is not about being an extraordinary person but being open accessible and transparent' with an emphasis on 'teamwork collaboration and 'connectedness' and removing barriers to communication and original thinking. A desire to see the world through the eyes of others, to take on board their concerns and perspectives and work with their ideas' • An environment where the status quo is challenged, ideas are listend to and valued and innovation and entrepreneurialism are encouraged. • A culture that supports development • Leader is a role model for learning where mistakes are exploited for their learning opportunities • Leadership acts as a 'cognitive catalyst' • Commitment to building shared visions with a range of stake holders • Exploits diversity of perspectives and wealth of experiences, strengths and potential in organisation • Promote a diversity of leadership styles and centrality of patient and staff engagement in leading quality improvement • Service specific knowledge • improvement know-how – science of healthcare improvement • change management skills – handling relationships, building coalitions of support, countering resistance to change, communicating a vision • Commitment to learning from patient experiences • Willing to take risks such as challenging colleagues to change • Viewing the service through patients eye • Visible leaders who thrive on collaboration and network building Go out of their way to make new connections Have an open enquiring mind Embrace uncertainty and positive about change Draw on as many perspectives as possible Ensure leadership and decision making are distributed throughout the system Promote the importance of values – invest as much energy in relationships and behaviours as in delivery Developing and communicating a shared vision reflecting shared values Being emotionally intelligent and having effective negotiating, influencing and conflict resolution skills Understanding systems theory and how the system itself works			
F13	NHS Improvement (2018) Creating a Culture of Compassionate and Inclusive Leadership. [Online] Available: https://improvement.nhs.uk/resources/culture-leadership/ [Accessed 14th January 2019].	Website – NHS Improvement	NHS Improvement partnered with the King's Fund and the Centre for Creative Leadership to provide practical support and resources to help providers improve their culture. NHS England	This page focuses on creating a culture of compassionate and inclusive leadership	• Most powerful factor influencing culture is leadership • Compassionate, inclusive leadership key to enabling cultural change • Encouraging pride, positivity and identity in the team/organisation • Valuing diversity and fairness • Building partnerships between teams, departments and organisations • Facilitating shared agreement about direction, policies and objectives • Modelling support and compassion • Enabling learning and innovation • Building cohesive and effective team working • Helping people to grow and lead • Modelling organisational values and focusing on vision • Ensuring the team is aligned with its vision and modelling values • Ensuring they have clear objectives and receive helpful performance feedback Learning from each other and working together to develop and implement innovation	• Compassionate, inclusive leadership enables staff to show compassion, to speak up, to continuously improve and create an environment where there is no bullying , where there is learning, quality and the need for system leadership • Clinical effectiveness, positive experience, safe and financial efficiency • Healthy, flourishing and engaged staff • Leadership is crucial in creating an environment where real teamwork can flourish	• Patients • Staff • Team • Organisation	10 leadership behaviours
F14	Public Health England (2015) A strategy to develop the capacity, impact and profile of allied health professionals in public	Website	Strategy / policy paper NHS England	Aim of strategy is to help AHPs to further develop their leadership in public health, share practice with colleagues and partners and ultimately embed preventative health care across their work.	AHPs will work collaboratively with other early adopters, professions and organisations to apply a system leadership approach.	• Effective leadership at every level will support AHPs to be an integral part of the public healthforce.	• AHPs	

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	health 2015-2018. [Online] Available: http://www.ahpf.org.uk/files/AHP%20Public%20Health%20Strategy.pdf [Accessed 14th January 2019].							
F15	Royal College of Speech and Language Therapists (2008) Excellent AHP Leadership Connections. [Online] Available: https://www.rcslt.org/governments/docs/leadership_day_report [Accessed 14th January 2019].	Website	Report of Royal College of speech and language therapist.	• Report of RCSLT Leadership Conference May 2008 Edinburgh The purpose of paper to report the views of 50 plus AHP uni-professional leads (UPLs) and multi-professional leads (MPLs) on what makes for excellent leadership connections and which they believe deliver best outcomes for service users.	• Shared Values including honesty, mutual respect, trust, clarity of roles, open and transparent communication, open mindedness, professional debate, good listening and willingness to compromise. • Agreed, clear and flexible communication methods and frequency. • Direct face to face communication (in all its forms) rather than indirect or written communication. • "AMOLO" which stands for the rules of thumb on frequency of communication are summarized as • Agree meetings early • More meetings at the beginning of a important piece of work • Often meet (e.g. Weekly) "core" players; • Less often (e.g. 6 weekly) for non-core players • Ongoing between meetings via phone and e-mail contact • Project communication structures which accurately reflect a. the interest or potential impact of any particular piece of work on professional groups and their service users b. influence that professional person or person in a position of power can have on the success of the particular project. • Shared accountability for service quality and outcomes for service users • Networking • Personal initiative and trying new ways of doing things A positive approach to change	•	• Nurses • Teams	
F16	Scottish Government (2017) Nursing 2030 Vision. [Online] Available: http://www.gov.scot/Publications/2017/07/4277/1 [Accessed 14th January 2019].	Website	Nursing 2030 Vision paper NHS Scotland	• The Nursing 2030 Vision sets out where the nursing community in Scotland is currently and where we are going as we move towards 2030. Transforming Roles includes a focus on advanced nursing practice that aims not only to develop nursing leadership for the future, but also expand nursing practice and promote research, education and development.		• Nurses are already leading many national and local initiatives at strategic and operational levels. This will increase as we move towards 2030. More and more, nurses will be taking the lead on: • national initiatives, influencing and driving transformational change in the way services are designed and delivered • local-level service redesign, working with communities and partners to make things better for the population • Individual episodes and packages of care, working with others to assess people's needs, make plans, deliver or supervise care delivery, and evaluate outcomes.	• Nurse leaders • Services	
F17	Solent NHS Trust (2016) Allied Health Professionals (AHPs) Strategic Framework. [Online] Available: https://www.solent.nhs.uk/_store/documents/allied_health_professional(ahp)_strategicframework.pdf [Accessed 14th January 2019].	Website	Strategy / policy framework	• The framework is intended to provide clarity about the roles and contributions made by the diverse and highly skilled professionals collectively known as AHPs • Policy aims for AHPs to be recognised and valued for their potential in leading and shaping the future models of care in line with national drivers and professional standards and have a voice at the most senior levels of decision making within the organisation with access to the right professional leadership • Aim is an increase in AHPs leading new innovative models of care.	• Promoting training and leadership whilst celebrating and being inspired by examples of AHPs working in non-traditional roles across integrated care models.	•	• AHPs	
F18	Stanley, D.D., Blanchard, A., Hohol, M., Hutton and McDonald, A. (2017) Health professionals' perceptions of clinical leadership. A pilot study. Cogent Medicine. Vol.4, pp.1-12. [Online] Available: https://doi.org/10.1080/2331205X.2017.1321193 [Accessed 14th January 2019].	Website	Research article using mixed methods based in Australia	• To identify how clinical leadership was perceived by Health Professionals (HPs) (excluding nurses and doctors) and to understand how effective clinical leadership relates to initiating and establishing a culture of change and progression in the health services.	• The main attributes associated with clinical leadership were; effective communicator, clinical competence, approachability, role model and supportive. • formal leadership training or education are not considered prerequisites for success as a leader (or manager) • clinical leadership effectiveness is not dependent upon formal management or leadership training, although experience from all over the world has shown that specific, clinically focused leadership instruction can impact positively on the performance of clinical leaders and the application of clinical leadership • clinical focus was of value to be an effective clinical leader. The HPs built their approach to clinical leadership on a clinically focused foundation and clinical practice that was fundamental to their view of HP practice.	• Clinical leaders were perceived as having an impact on how clinical care is delivered, staff support and leading change and service improvement. •	• Staff • Team	
F19	Best, A., Greenhalgh, T., Lewis, S., Saul, J.E., Carroll, S., and Bitz, J. (2012) Large-System	Peer review journal Realist review		Need for evidence base that addresses issues of complexity and context for large system transformation.	5 simple rules:	• Large system change	• Organisaton	

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	Transformation in Healthcare: A Realist Review. The Milbank Quarterly. Vol.90(3), pp. 421-456. DOI: 10.1111/j.1468-0009.2012.00670.x			Review aimed to analyse examples of transformation initiatives (successful and unsuccessful) Background of the value of viewing health systems through a CAS lens	– Engage individuals at all levels in leading the change effort. Blend designated leadership with distributed leadership – which means focussing on practices and relationships involved in leadership as well as developing shared and evolving leadership through purposeful mentoring strategies. – Establish feedback loops – Attend to history – Engage physicians – Include patients and families Draw out and mobilise the natural creativity of health care professionals to adapt to circumstances and to evolve new and better ways of achieving quality. Create positive conditions for change by supporting a work environment conducive to harnessing relatinships and skills and capacities of individuals. Agent of change must give up notions of control and avoid language that emphasizes overcoming resistance Focus on changing systems behaviour rather than meeting targets Building principles and resources that support a learning environment (Senge) allows organisations to take full advantage of local knowledge in generating continuous improvements Distributed leadership invokes social capital theory – that different individuals have different types and levels of access to material and non material resources; Friedson's theory of professions (professions are closed shops with own internal logics and members seek to self organise); Social influence theory (people are influenced by others with whom they share their social and professional background) \mission, vision and strategies that set systems direction and priorities need to be clearly laid out and known by everyone at all levels Flexibility for informal norms and values – for people to behave differently Active management of change strategy perhaps through change agent – works by generating a sense of energy and reducing time and effort needed by those who don't need to make the change Assurance people won't be penalised for taking actions part of the change implementation			
F20	Manley, K., Sanders, K., Cardiff, S. and Webster, J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept. International Practice Development Journal. Vol. 1. (2) [Online] Available: https://www.fons.org/library/journal/volume1-issue2/article1 [Accessed 14th January 2019].	Research Peer review journal	Multiple case study framed around systems thinking South East England 5 hospitals, community health care trust and one ambulance trust Emergency and urgent care	Overcrowding in emergency departments impacting on delivery of safe care Study aims to identify workforce enablers for achieving whole systems urgent and emergency care delivery Emphasis on processes and structures overlooks patterns manifested in relationships, beliefs, traditions, power, values and assumptions which form workplace culture and are highly influential In adopting change in healthcare systems Difficulties in creating and maintaining an effective, efficient and motivated workforce. Unable to recruit to substantive posts and current stopgap solutions are unsustainable in longer term Existing whole systems workforce development models fail to draw on the workplace as the main resource for learning System defined as a complex entity at the core of which is the concept of a whole that can adapt and survive within limits in a changing environment. System strength is contingent on the functioning of contributing partners and ongoing dynamic feedback	Strong clinical systems leadership capable of enabling creative reshaping of emergency and urgent care services while coping with change: – Drives integration across boundaries – Specialised clinical credibility – Working with shared purposes to break down silos and deliver safe, person-centred effective care with continuity – Create a culture that values and retains staff – Consultancy fucntions that share expertise within wider system – Creating a learning culture that uses the workplace as the main resource for learning – Develop common values and shared purpose – Integrated career and competency framework: - Assess treat and SORT (support, discharge, organise admission, refer and/or transfer) – key competencies for interdependent partners - Work collaboratively across boundaries Facilitators of work based learning - Enable role clarity - Team approach to competencies needed for care demands across contexts - Workplace mentors and supervisors that facilitate learning development and improvement in a holistic way Rotation opportunities enabling staff to become familiar with the whole system and talents and contributions of interdependent partners	• Improve peoples' experience and health outcomes • Whole system working • Team work, staff wellbeing and satisfaction • Efficient use of resources		

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F21	Manley, K., Titchen, A. (2016) Facilitation Skills – The Catalyst For Increased Effectiveness In Consultant Practice And Clinical Systems Leadership. Educational Action Research, Vol.24(2), pp.1-24.	Peer review journal Research		Consultant nurse roles build on clinical credibility and expertise characteristic of advanced level practice but also possess expertise in clinical systems leadership and facilitation of culture change, learning and development, advanced consultancy approaches and research and evaluation to prioritise person centred, safe effective care Consultant practitioners were a response to a lack of clinical career pathway for senior nurses, midwives, health visitors and AHPs, aiming to keep expertise at the bedside. Consultant role comprises – expert practice, professional leadership and consultancy, education, training and development and practice and service development. Nurses and midwives practicing at higher levels also key to reforming health service This paper reports on a project that aimed to help new and emerging consultants become more effective in their role through a programme of support Need for clinical systems leadership – characterised by the skill set of consultant practitioners	Emancipatory action research supported by claims, concerns and issues Active learning – approach for in-depth learning that draws on, creatively synthesizes and integrates numerous learning methods, based in and from personal work experience of practitioners. Reflection in and on practice Creative approaches to make sense of reflections Action learning – continuous process of learning and reflection supported by colleagues with the intention of getting things done. Collaborative workshops – needs led Individual tools e.g. qualitative 360 degree feedback and reflective reviews Holistic enabling facilitation skills Inquiry into ones own practice Facilitate and inspire others to achieve a shared purpose Integrating learning and inquiry into everyday practice 10 principles of workplace learning: – Developing a learning and inquiry culture – Negotiating the learning objectives and action to be taken to achieve individual and collective goals – Optimising the use of appropriate resources – Helping participants to learn opportunistically in the group learning situation – Role modelling and articulating one's own professional knowledge about being an active learner, facilitator of active learning and practitioner researcher – Enabling the integration of knowledge and ways of knowing to develop professional artistry and praxis through using cognitive and creative approaches – Using a wide range of styles processes and skills that match participants level of knowledge and the context in which they are working – Enabling a working relationship/partnership built on mutual trust and high challenge and high support through paying attention to the whole person and processes as well as outcomes – Facilitating rigorous organisational cultural and practice changes at individual and collective levels through practitioner research Collaborating in project administration and management	• The programme helped participants research their own practice, theorise from practice and grow facilitation skills needed to develop and demonstrate their own effectiveness, foster effectiveness of others and transform practice culture • Transforming and sustaining cultures to ensure they support safe, integrated health services that are person centred, safe and effective • Empowered staff who maintain individual and team effectiveness and CPD. • Development of a learning culture that enables individual team and organisational learning	• Individuals • Teams • Organisations	
F22	Akhtar, M., Casha, J.N., Ronder, J., Sakel, M., Wight, C., and Manley, K., (2016) Leading the health service into the future: transforming the NHS through transforming ourselves International Journal of Practice Development Vol.6 (2) [Online] Available: https://doi.org/10.19043/ipdj.62.005	Peer review journal Research	UK Medical doctors One organisation: East Kent	Leadership development impacts on quality of care and on workplace cultures for staff. Clinical leadership embracing transformational and other collective leadership approaches is a key enabler for developing effective workplace cultures at micro-system level. No history of clinical leadership development across this organisation, whilst a programme had been developed, no uptake by medical colleagues. Literature identifies a need to increase medical engagement in leadership Practice development based clinical leadership programme – equipping medical doctors to become transformational and collective leaders, and facilitators with the skills to develop and sustain person-centred, safe and effective workplace cultures A rapidly changing sector where leadership needs to be more flexible and less top heavy Background of this NHS trust receiving an overall rating of inadequate – in the areas of safe and well led. There was reports of a culture of low morale, low staff engagement, bullying and harassment, little openness and transparency	Whole systems approach to healthcare, with core concepts of integration and interdependence of workforce partners Clinical systems leadership Interdisciplinary clinical leadership programme based on practice development principles: – Active learning and critical creativity – Self awareness, self empowerement – Critical companions – Skilled facilitation – Critical reflection – Collaborative, inclusive, participative approaches – Draw on workplace as main resource for learnig development, improvement and inquiry – Action learning Programme developed on principles of adult learning, self-assessment and co-creation 360 degree assessment to reflect on leadership development Claims, concerns and issues Values clarification Observations of practice Emotional touchpoints Individual support from cricital companions – 'sophisticated mentors who have the expertise to develop mutual learning relationships based on strategies that help empower people to learn and improve.' Practice development methods used to reflect on and inquire into own practice as leaders Co-facilitator model where 2 experienced leadership facilitators worked with 2 medical doctor co-facilitators, who were interested in developing their expertise in leadership facilitation.	Effective workplace culture at micro-system level Good places to work Retaining and developing staff Maintaining staff well being Quality of patient care Efficient high quality healthcare Building cultures that value patient and staff experiences, learning and safety, quality, effectiveness and knowledge translation Provide and justify a clear sense of purpose and contribution Motivate teams and individuals to work effectively Focus on improving system performance. Direction, alignment and commitment within teams and organisations Safer patient outcomes Well structured teams (who have clear objectives and meet regularly to review and improve performance) – strongly related to improved patient mortality Improved staff well-being and engagement strongly related to safe provision of healthcare Transformational leadership associated with enhanced staff satisfaction, unit or team performance, organisational climate and staff retention. Improved health outcomes and patient experience Staff: Improved job satisfaction, morale, and motivation, flourishing staff, improved worklife balance Team/service Objectives/goals achieved, action plan implemented, safety culture, increase in training, recruitment and retention of staff, responsive and proactive, innovation development, team happiness and cohesion Organisational: Improvements in cost effectiveness, positive local and national reputation	•	

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					Work towards a shared purpose, drawing on talents of staff, breaking down silos and enabling everyone to flourish Develop self-awareness and emotional intelligence Transformational leaders who can engage and inspire teams through collaboration, inclusion and participation Facilitators and enablers of others effectiveness through drawing on their own workplaces as the main resource for learning, development and improvement. Cultures characterised by shared values translated into agreed ways of working that embrace care, compassion and support and are developed through leadership recognised as a collective endeavour rather than command and control. Ability to recognise dynamism of healthcare systems and interconnectedness between all contributors. Enable people to innovate, be creative and flourish Can see what needs doing and can work with others to do it. Leadership development needs to focus on roles, relationships and practices in specific organisational context and requires conversations and learning with people who share that context. Leadership needs to be understood in terms of leadership practices and organisational interventions rather than just personal behavioural style or competencies Focus on organisational relations, connectedness and interventions to the system to change practices and processes. Creating positive climate to ensure staff feel involved and have the emotional capacity to care for others Entrepreneurial cultures where nitiative taking, group learning and innovate approaches to problem solving are enhanced valued over hierarchy rules and control which inhibits a positive safety climate. Leaders need to be equipped to establish effective teamworking and engaging workplace cultures that are supportive, caring and compassionate which enable and sustain staff wellbeing adaptability and creativity Transformational leadership that complements distributive and collective approaches – a set of behaviours that enable others to become empowered through facilitating them to take on challenges and develop ownership and realise their full potential. Role clarity Facilitation skills that enables other to flourish and developing others as leaders Leadership framework: Enabling factors: – Individual: caring, respect, flexibility, integrity,, accessible, tolerance, understand self and others – insight, clinical credibility – Resilience qualities: Presence, brave, persevere, decisive, accept failures as shared responsibility – Team: vision, common goal, effective team and team culture – Organisation: empowerment of leaders, time and money, organisational support, person centred qualities for leadership, personable, financial stability, clear transparent strategy Attributes (how would you recognise it?) – Leadership behaviours: developing a shared vision and direction, developing and working to an explicit team identity/purpose and priorities, leading by example, role modelling, true to word, being transparent – Working collaboratively as a team: enabling 2 way communication, listening, negotiating, responding, enabling everyone to be a team player, problem solving together, celebrating successes			

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					– Enabling others: empowering, inspiring and motivating; challenging/inquiring, supporting; being helpful; giving and receiving; tackling difficult situations – Humility comes from mutual and authentic opportunities for learning collectively Safe space and time to reflect and meet communally			
F23	Manley, K. (2014) Professional credibility: A Framework for executive nurse effectiveness. Final Report. ECPD ISBN 9781909067233.	Report commissioned by West Midlands Strategic Health Authority in partnership with RCN	West Midlands	Project commissioned to develop a framework around the concept of clinical credibility in relation to the role of nurse executives. Term changed to 'professional credibility' Report identifies characteristics, enabling factors and consequences of effective nurse executive nurse roles through concept analysis, systematic review and regional and national consultation Purpose of clinical credibility: – Setting and maintaining standards of care for patients – Being corporate and professional – Clinical leadership Personal impact and image to instil confidence	Framework identifies attributes of professionally credible executive nurses; individual and organisational enabling factors; consequence of outcomes of executive nurses who are professional credible **Leadership skills and qualities** Knows own values, beliefs, assumptions and world views and how to support others to do the same Clarity of purpose about role as a professional leader of nursing, non medical staff and healthcare development Reflects on, recognises and acts on own development needs, leadership thinking and knows when to seek support A strategic vision and leadership skills to deliver and sustain person-centred, safe and effective care within a changing organisational and political climate Keep patients at the heart of the role Application of clinical knowledge, theory and practice Exposure and visibility in the clinical environment to staff and patients on regular and ongoing basis. Examples of maintaining visibility: – Popping in out of hours in uniform in all areas – Walk-a-bouts – Always wearing uniform in clinical areas – Directly participate/engage in care/practice – Seeing standard of care delivered – writing up/feeding back to trust – Change purpose of visit so not predictable – Midwifery supervision Talking with stakeholders: – Talking to patients asking h=open questions – Listening to what patients say – Engaging with individuals and teams – Formal, informal and corporate levels – Meet with consultants, teams and managers – Lead on patient discussions, quality issues etc – Bed management and safe guarding Actively maintaining skills and knowledge: – Maintaining education and training Following patient pathway – Observation of practice – Reinforce patient perspective – Follow patient pathway from door-ward-discharge Promoting and acting on nursing values – Undertaking audit programmes **As a professional leader develops effective partnerships and organisational culture** Builds strong relationships & partnerships internally between services and the interdisciplinary team, and externally with local organisations, commissioners, voluntary agencies and patient forums Works in partnership with others, to develop, implement and evaluate direction, policies and strategies Develops a culture where staff dialogue and questioning is encouraged Supports learning and development of individuals (students and staff), teams and practice to meet complex healthcare needs Leads professional nursing/midwifery practice and non-medical clinical healthcare through the complexity of everyday practice and change to improve quality, patient experience, safety and effectiveness. Develops and maintains communication with people on complex matters, issues and situations Manages and resolves complex inter-professional and ethical issues ensuring practice is in line with research findings Manages and mitigates risks at different levels for quality, safety and safeguarding	Improved patient experience Improved patient safety Improved clinical outcomes Satisfaction that relate to the value addedness that professionally credible executive nurses bring to their organisations Interconnectedness of the patient and staff experience Systems wide change Quality of patient care – assurance provided to public and key stake holders **Excellence in care** Public confidence in clinical care Consistent excellence with demonstrable high standards of care experienced for patients Achievement of key outcomes, related to the patient experience, clinical safety, and clinical outcomes, continuous quality improvement and innovation Reductions in avoidable harm events System-wide change due to executive nurse input and application of knowledge and theory in practice Reputational excellence as a centre for learning and research Engaged workforce who are proactive in clinical risk management **Nursing/midwifery practice** Consistent high standards of nursing/midwifery practice are achieved and experienced by patients/service users Staff change their practice to meet the changing needs of patients/service users utilising existing resources to flex to the varying demands on their capacity Empowered staff, strong clinical leadership and nurse/midwife-led multi-disciplinary care An integrated workforce, learning and development strategy that meets healthcare needs with innovative and entrepreneurial roles **Professional and corporate credibility** Professional credibility and confidence as a nurse leader, perceived by nurses, midwives, peers and board members Other clinical professional groups represented by executive nurse at board level feel their professional needs and concerns are represented Valued as a board member by other board members, partners and stakeholders Maintains registration as a nurse/midwife linked to demonstrating professionally credibility Recognised by others as having a role in the training and developing of future leaders **Organisation and organisational culture** A culture of openness, raising concerns, and organisational learning Robust standards are preserved whilst achieving efficiencies Balance between good-quality risk assessed and mitigated care and financial prudence and efficiency Organisation keeps pace with changes in policy, practice and promotion of a healthy workforce to provide quality care to patients Services redesigned and modernised to meet the changing health and social care needs of local populations Good staff and student recruitment and retention **Executive Board** Discussions at every Board meeting about patient care Assurance of quality, safety and professional practice to Board and key stakeholders (SHA, CQC etc) Achieves regulatory compliance for quality and safety Board members and organisational strategy have been influenced by Executive Nurse Board and corporate objectives are achieved •	•	

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
F24	Manley, K., Webster, J., Hale, N., Hayes, N., Minardi, H. (2008) Leadership role of Consultant Nurses working with older people: a co-operative inquiry. Journal of Nursing Management. Vol.16, pp.147-158.	Peer review journal Research Cooperative enquiry		Leadership is one of the 4 key elements of the Consultant Nurse Role and is the key mechanism for achieving and embedding transformation in practice. This has not previously been explored within the role of the Consultant nurse A need for greater clarity and broader understanding of the impact of nursing leadership within the context of complex organisational cultures and clinical settings	A need to make visible the valuable contributions consultant nurses for older people make in enabling healthcare teams, organisations and work places. Clear role, credibility and responsibilities in the interdisciplinary team Being able to work across boundaries and use extensive networks. Consultant nurse integrates clinical and strategic leadership with transformational and political approaches. Patient experience of healthcare seen as a pathway and leadership involves ability to see, construct, enable, navigate alternative (creative) pathways for patients 9and organisations Seeing the whole pathway as a continuum Cross boundary working – across health and social care Managing complexity – including medical and biological, psychological and social, multiple pathways with a choice of destination – navigating through difficult terrain; being able to make sense of confusion and conflict Transformational leadership and skilled facilitation Patient-related leadership role: – Modelling and enabling expertise in Older – People_s nursing. – Active judgement taken to lead patient care – because of complexity. – Mediating between staff, patient and family. – Supporting all stakeholders. – Working across boundaries. Team-related leadership role: – Seizing opportunities to influence practice. – Planting seeds. – Facilitating support and participation towards a common vision with stakeholders. – Facilitating staff to reflect, think, learn and – act. – Working with non-conducive cultures to – develop practice. Organizational/strategic: – Building relationships at strategic level – developing networks for engagement. – Obtaining support from management. – Being an outsider – a lone wolf. – Addressing risk assessment. – Using governance frameworks.	Achieving and embedding transformation in practice Developing a culture of effectiveness in the workplace, specifically at microsystems level. Positive outcomes for patient relatives and staff: For patients & users: Achieving the right outcome for the patient and family. Continuity for the patient and users. For staff: Staff continue to learn and develop their practice. For organizations: Organizations are better at caring for older people through systems and processes that embed older people care and minimize risk.	•	
F25	Plsek, P.E., and Wilson, T. (2001) Complexity, leadership and management in healthcare organisations. British Medical Journal. Vol.323(7315), pp.746–749.	Peer reviewed paper		Complexity thinking suggests that relationships between parts are more important than the parts themselves, that minimum specifications yield more creativity than detailed plans	Minimum specifications to encourage creative new thinking – rather than detailed frameworks guidelines and action plans An understanding of attractors in complex systems Create systems that disseminate rich information about better practices, allowing others to adapt those practices in ways that are most meaningful to them Creation of simple rules Whole system targets Pooled budgets Development of generative relationships	Less resistance to change among teams Meaningful variation adopted by teams Self organising teams Higher level of innovation across organisation		
F26	MacNeill, F., and Vanzetta, J. (2014) Appreciative leadership: delivering sustainable difference through conversation and inquiry. Industrial and Commercial Training. Vol.46(1), pp.16-24. https://doi.org/10.1108/ICT-09-2013-0058	Peer review journal Research	Acute healthcare. Appreciative leadership programme developed and evaluated across one NHS Trust	Competitive public sector environment under significant financial pressures, corporate and clinical governance structures, complex delivery targets set by the government, and external monitoring around corporate accountability. Trust had six organisational values:integrity, respect, excellence, accountability, compassion and teamwork.	Appreciative inquiry and powerful questions, conversational-based change, transactional analysis, emotions of change, and appreciative coaching and mentoring. Emphasis on creating new futures together through storytelling rather than reshuffling the present into a different format. Leadership learning sets (LLS) create an opportunity to discuss the challenges and successes of implementing learning in operational environments; enable the development of conversation as a means of learning and improvement; allow a group of people from within the organisation to develop their skills as facilitators. Dialogical and relational processes	Enhanced engagement Reduced loss of talent Increase in individual potential and performance Enhanced ability to lead teams in times of change and functioning as communities of purpose. Seeking feedback about self • Positive outcomes assessed over time and were sustainable.	•	
F27	de Zulueta, P.C. (2016) Developing compassionate	A synthesis of perspectives from neuroscience,		Need for new leadership paradigm		Improved patient outcomes Reduction in malpractice complaints	•	

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
	leadership in health care: an integrative review, Journal of Healthcare Leadership, Vol.8, pp.1-10	psychology, and complexity science with modern leadership and organizational theories		Compassionate health care is universally valued as a social and moral good to be upheld and sustained. But concern that healthcare has lost its moral compass. Leadership is considered pivotal for enabling the development and preservation of compassionate health care organizations. Strategies for developing compassionate health care leadership in the complex, fast-moving world of today will require a paradigm shift from the prevalent dehumanizing model of the organization as machine to one of the organizations as a living complex adaptive system.	abandonment of individualistic, heroic models of leadership to one of shared, distributive, and adaptive leadership Collective holistic learning strategies combined with high levels of staff support and engagement. Appropriate training and well-being programs, sustaining high levels of trust and mutually supportive interpersonal connections, and fostering the sharing of knowledge, skills, and workload across silos. Enabling people to experiment without fear of reprisal. Development of a clan culture Extensive use of storytelling Coaching Minfullness training Appreciative inquiry Positive deviance Articulate the core values and vision of the health service and ensure that they resonate in all the self-organizing groups Tasks and relational care need to be integrated into a coherent unity. Creating space for real dialog between patients, clinicians, and managers, so that together they can cocreate ways to flourish in the context of illness and dying. Practicing self compassion Modeling and harnessing of positive adaptive responses to challenges Foster a culture of learning and openness Relational transparency Learning the art of humble inquiry Democratizing work Listening to all the relevant voices Focus on developing teams that can self organise	Compassionate safer care Higher patient satisfaction Increased staff engagement Enhanced staff well being Enhanced decision making by small self-organizing multidisciplinary teams. • Clinicians engage more with patients and work with them to bring about change and innovation, treating them as coproducers of health, not passive recipients of care		
F28	Adamson, E., Dewar, B., Donaldson, J. H., Gentleman, M., Gray, M., Horsburgh, D., and Waugh, A. (2011). Leadership in compassionate care programme: final report. Edinburgh, Scotland: NHS Lothian/ Edinburgh Napier University. [Online] Available: https://www.napier.ac.uk/~/media/worktribe/output-192596/compcarefinreptallapr13pdf.pdf	Final report		Development of leadership incompassionate care across education and practice	Key processes: Caring conversations, flexible person centred risk taking, knowing me knowing you, feedback, involving,valuing and transparaency, creating spaces that work. Relationship centred model Valuing emotiona support Recognsisng skilled facilitation required to foster cultures of inquiry. Action learning sets Share positive care practices and the processes that enable these to happen in a more systematic way across organisations	mproved confidence, assertiveness and the ability to delegate Empowered participants to initiate change, and in turn stimulate and lead others to think anew about 'the way things are done'. Enhanced ability to engage in 'courageous conversations' People able to optimize their leadership capability using autonomous motivation as a personal resource.	•	
F29	Gottlieb, K. (2013) The Nuka System of Care: improving health through ownership and relationships. International Journal of Circumpolar Health. Vol 72. DOI: 10.3402/ijch.v72i0.21118			Developing leadership in complex systems (Nuka Model)	Implementation of the Nuka model -Calculated risk-taking innovation and creativity on the part of employees Leadership drives quick change while being conscious of the potential for work fatigue in employees. SCF also strives to grow leadership from within by mentoring employees and supporting them in educational efforts. Tight alignment across all aspects of organisation All corporate, division, work unit, and individual goals and objectives flow out of the vision and mission's 3 "key points": shared responsibility, commitment to quality and family wellness. leadership works to maximize individual employee skill while encouraging personal relationships within all employee ranks without sacrificing accountability. Employees are encouraged to take ownership of the organization and are given power in decision-making. Leadership is also committed to building and maintaining the infrastructure needed to support the organization, as well as a data system to measure quality and improvements.	Enhanced patient outcomes Enhanced staff well being high-performing health care organizations reduced health disparity data at the local, state and national levels. • Broke down barriers of space, attitude, language and time – that previously stood in the way of better health and wellness.	•	

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No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					Relationships core aspect. This is done through sharing personal stories, inviting inquiry and questions, admitting mistakes and celebrating successes. **Core Concepts** **W**ork together in relationship to learn and grow **E**ncourage understanding **L**isten with an open mind **L**augh and enjoy humor throughout the day **N**otice the dignity and value of ourselves and others **E**ngage others with compassion **S**hare our stories and our hearts **S**trive to honor and respect ourselves and others			
F30	Hannah, M (2016) Humanising health care, Independent Nurse. [Online] Available: http://www.independentnurse.co.uk/professional-article/humanising-healthcare/141730 (Last accessed 14th January 2019).	Opinion piece		The combination of failing to adapt to current patterns of disease and having to make efficiencies year on year is having a devastating impact on staff. People are leaving to work elsewhere, retiring early or reducing their hours if they can afford it. Others are off sick due to stress. A new approach is needed which is rewarding to both patients and carers.	Nukka model - Healthcare in this system is based on seeing staff and patients as participants in a web of life that is strengthened by quality relationships. These relationships are built on open, trusting and dynamic conversations between patients, staff, politicians and the wider community. Focus on dialogue and relationships. Responsibility is shared throughout the organization and how leadership is flexible and responsive to concerns voiced by customer-owners. Safe places for learning Resources such as Prompt Cards, Kitbag and the Fear and Love loops from the International Futures Forum to encourage us to think and act differently.	Saves time because it gets to the heart of things quicker and facilitates discharge. Shifts from deficits to assets; problems to solutions; standard assessments to unique conversations; and from clinical to relational practice.	•	
F31	McKenzie, C., and Manley, K. (2011) Leadership and responsive care: Principle of Nursing Practice H. Nursing Standard. Vol.25(35), pp.35-37.	Peer review journal Discussion paper	England	Paper describes principles of nursing practice developed by RCN – Principle H – the need for leadership among staff and the provision of care that it is responsive to individual's needs: 'Nurses and nursing staff lead by example, develop themselves and other staff and influence the way care is given in a manner that is open and responds to individual needs'. Leadership importance in the context of national and local reforms A need for strong courageous leaders – everyone has leadership potential if they want it.	Good decision making, problem solving and critical thinking skills Challenge processes Inspire a shared vision Enable others to act Model the way forward Encourage the heart Role clarity Strengthening supervisory role of ward sister/team leader ensuring priority and time is given to managing and developing team performance Listening, interpreting and confirming understanding as well as evaluation and reflecting on effectiveness of interactions Remain visible and accessible in clinical area, being approachable Working with the team in different ways e.g. with junior colleagues Monitoring and evaluating standards of care provided by team Providing regular feedback to team Creating a culture for learning and development. Motivation to improve performance and therefore make a difference to health and quality of life of others Co-create and communicate the vision while ensuring relevant staff are engaged and working collaboratively to achieve change Commitment to making service performance improvements	Enhanced patient experience and improved patient outcomes Enhanced staff well being Assuring and sustaining quality care Effective workplace culture •	•	
F32	Sharp, C. (2018) Collective leadership. Exploring new Territories for Evaluation. [Online] Available: https://workforcescotland.files.wordpress.com/2018/11/collectiveleadershipreport1.pdf [Accessed 14th January 2019].		Scotland	Scotland experiences a range of systemic issues including poverty, climate change etc. Recent launch of national outcomes for Scotland developed with public, practitioners and experts on what kind of Scotland they would like to live in. Collective leadership for Scotland launched in 2018 with question of how can we build collective leadership for Scotland? Emphasis is on building whole system leadership	Working with real teams on real issues in real places, leads to system learning and development of facilitation skills. Highly skilled facilitation is critical to the work Building in learning and evaluation from start and sharing learning widely			

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
				Builds on previous work by workforce Scotland, looking at systemic issues of wider public transformation complexity is generated by the services, organisational systems and relationships amongst them and from both those who work in services and people who are intended to benefit. Greater acknowledgement of complexity in Scotland and UK policy	Create structured and regular opportunities for shared learning around theories, models etc. best suited to support collective leadership Work collaboratively and collectively to effect change Build trusting relationships that help us reflect, challenge current thinking and innovate together Work with real teams engaged in working with realities Learning through practice Action inquiry – a model of practising change together where nothing is clear and everything keeps changing Determine wise actions in real life situations – turbulent and human complexities of power emotions and relationships Facilitated action inquiry makes these elements part of conversations. Action inquiry is a model of co-creation at every stage Inquiry as intervention – importance of building inquiry into living systems Acknowledging someones social value to community and implies mutual moral obligation and participation Require multiple contributions to achieve results across hierarchies of position Valuing participants aspirations to design new social systems and acting in new ways to embed change. Need for a model of 5th generation evaluation - based on the idea that appreciative and challenging inquiry that is contextual, relational and open-minded will create better opportunities for change and development. Shifting focus from relationships as things to co-created dynamic relational processes in which we are embedded Individual and team coaching Opportunities to develop and share learning across sites Develop participants sense of inquiry into their own collective leadership Values diversity among people and organisations seeking to develop a collective vision or purpose Relationships need to be reciprocal for change to happen leadership is increasingly understood as no longer about a single, heroic, individual leader or expert that drives a predetermined change process, but as a participatory and improvisational practice that recognises the mutuality, reciprocity and interdependencies within any system. Enables people to understand what they can do the need to blend multidisciplinary and professional knowledge and experience with the expertise of people that use services; and, an attitude of mind that seeks out multiple perspectives and sees diversity of experience and perspective as an asset Learning is a relational achievement Leadership as practice does not focus on the relationship between 'leaders' and 'followers' but looks to the (relational) activity of all those who are engaged, to their social interactions, and to their reflections and adjustments to their ongoing work. Value of different ways of knowing – extended epistemology			

No	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on whom	Notes
					In complexity, change happens through emergence that begins as small, local actions and variations in practice. Emergence is thus co-created; small actions can have major effects by shifting the focus of attention and intention, triggering different choices by making visible options that did not previously appear to be available Change process must make sense to those on the ground – work imagined versus work done – 'work as done' perspective integrate first, second and third-person inquiry practices, blending the personal insights of each participant, with mutual learning and wider whole system change, awakening and supporting these inquiry practices in a wider community, so that participants can continue to learn in collaboration.			

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Supplemental Document: The CMO Relationships informing each of the three tentative programme theories derived from interrogating the literature and workshop dialogue

WHAT WORKS (CONTEXT)	WHY IT WORKS (MECHANISMS)	INTERMEDIATE OUTCOME FOR WHOM	ULTIMATE OUTCOME FOR WHOM
CMO relationships informing tentative Programme Theory 1: Authentic Relationships			
Contexts that focus on developing NMAHPs as leaders who can build & nurture authentic, caring & successful relationships with individuals, those important to them, staff and stakeholders [C1]	• Facilitate caring/compassionate civil conversations, caring reflections and practices using different opportunities and powerful inquiry questions for conversation based change [M1,M5] • Enables authentic presence and builds ethical trusting relationships where people feel safe to speak up [M2] • Enables self & situational awareness in self and others through self-assessment, inquiry, self-motivation, self-compassion, self-reflection for learning, role clarity [M6] • Emotions are valued and used to connect [M4] • Appreciative, mutual learning relationships are developed and nurtured in others [M3] • Saves time Time is saved because good relationships gets to the heart of things quicker [040]	*For staff:* • Staff feel valued and supported [O1] • Increased self-awareness & empowerment [O2] • Increased confidence including speaking up [O3] *For staff, patients, families service users*: • Improved relationships, experience and communication – more compassionate and respectful (04)	***FOR INDIVIDUAL STAFF:*** • Improved staff wellbeing, reduced stress & emotional exhaustion [O5] • Improved staff morale and satisfaction [06] ***FOR TEAMS:*** • Improved leadership – compassionate, inclusive, credible recognised & valued by others [07] • Healthy, safe workplace/culture with staff engagement [09] • Enhanced team effectiveness & learning culture [O8]

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CMO relationships informing tentative Programme Theory 2: Transformational leadership linked to collective leadership and social capital			
Contexts that: Develop transformational behaviours towards collective leadership & growing a network of relationships and human connections as resources with a shared vision [C2] Have a positive organisational culture, a flattened, transparent and supportive Infrastructure that helps members actively interact [C3] Invest in strategic mentors and skilled facilitators for organisation wide initiatives [C4]	• Build & use social capital and human connections through collaborative relationships & networks [M7] • Focus on what matters [M25] • Enable positive social behaviours around core values [M10] • Provides vision (a picture of a better more worthwhile state) with staff and a sense of unity which engenders a sense of belonging/identity/empowerment [M8] • Embeds shared vision in clear expectations, acting on shared priorities [M12] • Model the way/values and act with moral courage [M11] • Motivate and support people, enabling feedback and self-empowerment [M10.2] • Challenge, stimulate thinking and supports people with informed risk taking [M10.1] • Celebrate, praise and 'encourages the heart' [M10.3] • Focus on learning using different approaches to enable action [M14] • Use the workplace for learning, improving & reflection – including learning from the patients experience [M15] • Blend, draw on and implement different types of evidence (M16)	*For staff:* • Individuals feel involved & heard [O10] • Positive staff morale & Job Satisfaction [O12]. • Staff empowerment, commitment and wellbeing [O11] • Staff confidence, clinical, professional skills, attitudes, credibility, relationships and career goals [O13]. • Staff reduced burnout, stress and exhaustion [O14]. *For teams:* • Strong team identity [O13] • Enhanced work engagement, empowered team context team context performance, creativity, innovation [O16] • Evidence implementation, best practice, innovation [O17] *For organisation:* • Recruitment, retention and stability [O20]. • Successfully health care organisation & performance with staff commitment to organisation [O22] *For society:*	***PATIENTS & FAMILIES:*** • Improved patients & family outcomes [015] ***TEAMS:*** • Healthy teams [O14] • Culture and climate of safety and quality, improvement [O15] • Enhanced and strengthened leadership – shared, distributive and adaptive [O37] ***ORGANISATIONS:*** • Improved quality & safety, performance [019] • Improved services and health care delivery [O21]. • Positive organisational outcomes & learning culture [O18]

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		• Social capital for organisational/systems change [O41]	
CMO relationships informing tentative Programme Theory 3: Providing everyone a voice in complex and changing contexts.			
Contexts with: A commitment to everyone having a voice to support decision-making, learning and co-creation of services in partnership within increasing complexity across systems [C5] Engagement of all partners & development of interdisciplinary services for a shared vision [C6] Support by leaders to develop personal, team and organisational effectiveness [C7] Draw on new models and roles to support integration [C9] Leaders who are credible, competent, authentic and visible [M13] Leadership values, skills and attributes that embrace [C8]: • Purpose and shared values • Personal and professional skills • Personal attributes • Ethical/moral attributes: • Communication skills	• Engages all in the co-creation of a shared vision, ways of • working and adaption to changing contexts actively seeking out experiences of those using and providing services [M18] • Bring people together , creates and sustains teams [M24] • Creates a positive culture /milieu that enhances commitment through participation and draws on multiple perspectives and talents for change [M19] • Develops an appreciative learning culture that includes safe reflective spaces for collective learning [M20] • Creates and supports formal and informal learning and improvement opportunities using holistic facilitation [M21] • Enables curiosity, creativity, challenge, experiment, learning and feedback in the moment [M22] • Works with a social construction of leadership **-** therefore works with a social world and complexity and understanding how systems work [M23]	*Individuals (incl service users)* • Feel valued [O25] *For staff* • Clinicians engage/co-create with patients to bring about change & innovation as co-production [O39] • Enhanced critical thinking, creativity, improvement and inquiry skills [O27] • Role clarity, autonomy & shared accountability [O28] • Improved self-esteem, hope, empowerment; stress reduction [O26] *Organisation* • Decreased sickness & turnover [O33] • Enhanced visibility of community nursing/nursing *Society* • Enhanced citizen behaviours, social entrepreneurship and advocacy [O36]. • Enhances organisational citizen behaviour	*For staff;* • Increased motivation & job satisfaction [O29] • Flourishing staff and talent retention & management [O38] ***PATIENTS:*** • Improved patient outcomes [O30] ***TEAMS*** • Enhanced teamwork - self organising/high performing teams [O31] ***ORGANISATIONS*** • Enhanced safety culture **&** culture of openness [034] • Improved alignment & delivery of service [O32] • Organisational effectiveness excellence, innovation & increased organisational loyalty that is noticed [O35]

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• Collaboration • Transformational leadership behaviours • Related business and facilitation skills • Access to resources and networks		• Social entrepreneurship • Working for the collective good • Enhanced organisational advocacy • Improved social capital • Positive social exchange relationship	***SYSTEMS*** • Whole system working [O37] • Value for Money & cost effectiveness [039] ***SOCIETY:*** • Enhanced citizen behaviours, social entrepreneurship and advocacy (O36) • Improved population health [O38]

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Table I: Study Design

Key aspects informing understanding & interpretation of literature & data			Table 1 – Study design Three inter-related phases guided by the principals of realist evaluation	
ITERATIVE LITERATURE REVIEW	CMO TABLE	UNDERPINNING FOUR THEORIES	**PURPOSE** ***Insights arising from a realist review of literature, stakeholder dialogues and synthesis on leadership in nursing, midwifery and allied health professionals with a view to presenting key strategies and future vision for leadership in the complex world of health and social care.*** • Terms of reference and search strategy collaboratively discussed, developed and refined to ensure shared understanding. • Iterative approach to reviewing literature used throughout lifetime of study including: o Date parameters 2010 – 2018. o Databases: Cinahl, Medline, SocIndex, and Health Source: Nursing/Academic Edition databases o Search terms: nurse leadership combined with impact, culture, practice, education, organisation, policy and education. o Included grey literature, secondary sources and relevant literature provided by team. o 132 papers included after removal of duplicates and irrelevant papers.	
			PHASE 1: ***Interrogation of literature using a realist approach to generate insights between contexts, mechanisms and outcomes to generate tentative programme theories.*** • Papers reviewed in regards to what works well, why and in what contexts and described within CMO table leading to development of cross cutting themes. • Broad tentative hypothesis also distilled from the literature. • Stakeholders contributed in ongoing interrogation, analysis and synthesis of literature and development of cross cutting themes and simple rules.	
			PHASE 2: ***Use of innovative social media strategy to enable nomination of leaders in practice, education, research and strategy contexts as well as other insights about leadership.*** • Leaders from diverse range of health and social care contexts within the four countries of the UK were invited into social media events on Twitter (#Strengthening). • 2 twitter chats generated 998 tweets. • Tweets content analysed for key words and phrases that could be used to test out the language used in guiding light document. • Ensure language used in guiding lights is practical, grounded in the real world and readily understandable and used by practitioners at the front line.	**Questions for social media event & workshops:** • Which nurses, midwives and allied health professionals excite them/others to make a difference in practice, education, research, innovation or strategically? • What is it that these leaders do that excites you/others to make a difference? • What is the difference these leaders enable in you /others to make? • Are there any other observations you would like to make about these nurses, midwives and allied health professional leaders? **Both activities asked leaders to:** • Discuss the processes and indicators they use to achieve and demonstrate impact and embed innovative practices. • Consider cross-cutting themes and simple rules as a way of informing ways of thinking and being in leadership.
			PHASE 3: ***Workshops in each country in UK to develop narratives, critique of CMO relationships arising from the literature, based on their own stories, leadership insights and future orientated direction for leadership.*** • Leaders from diverse range of health and social care contexts within the four countries of the UK were invited to a workshop within their own country.	
			FINDINGS: • Knowledge generated from integrative literature review, workshops and social media exercise led to further development and co-creation of the five "simple rules". • Analysis of workshops provided valuable input into language development of the term 'simple rules, leading to this concept being understood as a 'guiding lights' which acts as a set of principles to enable and strengthen leadership within a range of contexts.	
			RECOMMENDATIONS FOR FUTURE PRACTICE: 5 Guiding lights for leadership in the complex world of health and social care. 1. **Guiding Light 1: The light between us as interactions in our relationships** 2. **Guiding Light 2: Seeing people's inner light** 3. **Guiding Light 3: Kindling the spark of light and keeping it glowing** 4. **Guiding Light 4: Lighting up the known and the yet to be known** 5. **Guiding Light 5: Constellations of connected stars**	

Table II: Example of Framework Constructed for first level analysis of the literature

Paper Number	Reference	Category	Setting	Context	Mechanisms	Outcomes	Impact on Whom	Notes
1	Henderson, A. (2013) Processes to Engage and Motivate Staff, Nursing Management Vol. 20(8), pp.18-24. Read 19.2.18	Peer review journal Research	• Specialist surgical unit • Australia	• 'poor working relationships'. • Manager adopted transformational leadership behaviours and facilitated activities with practice development nurses.	• Transformational leadership techniques/behaviours that focus on feedback, learning and improving quality rather than task focus, challenging the tradition of 'how things are done' to bring about the desired behaviours: ▪ Create a vision for staff to follow. ▪ Challenge existing behaviours, particularly negative interactions. ▪ Encourage staff to contribute to decisions. ▪ Support access to clinical knowledge and individual skills development. ▪ Sustain efforts through reward and recognition of desired behaviours • Activities involved coaching, interactive	• Sinflo (Support instrument for nurses facilitating the learning of others) and CLOCS (Clinical Learning Organisation Survey) questionnaires at beginning of project and 12 months later. Results showed an improvement in most areas including support, culture and facilitating others learning. • Field notes of local successes and informal observations also documented a change in various areas	• Nurses considered work was more acknowledged • Improved performance impact on patients and organisation.	• Reference to Magnet Recognition programme – recognises organisations for high quality care, nursing excellence and innovations on nursing practice (American Nurses Credentialing Center, 2013). • ? field notes of local successes indicating changes – how do we know these weren't happening before?

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					education, role play of clinical skills, study days, one to one guidance, small group teaching close to bedside, role modelling by nurse manager including providing positive feedback, explore and practice with staff how to challenge 'poor behaviours', practising conversations. Practice development nurses involved in facilitation.	including: Improved work relationships, Improved professional and clinical development, Being heard, Improved nursing practice, Inclusive of students and new staff, support them to develop specialist skills, improved staff performance, morale and motivation		

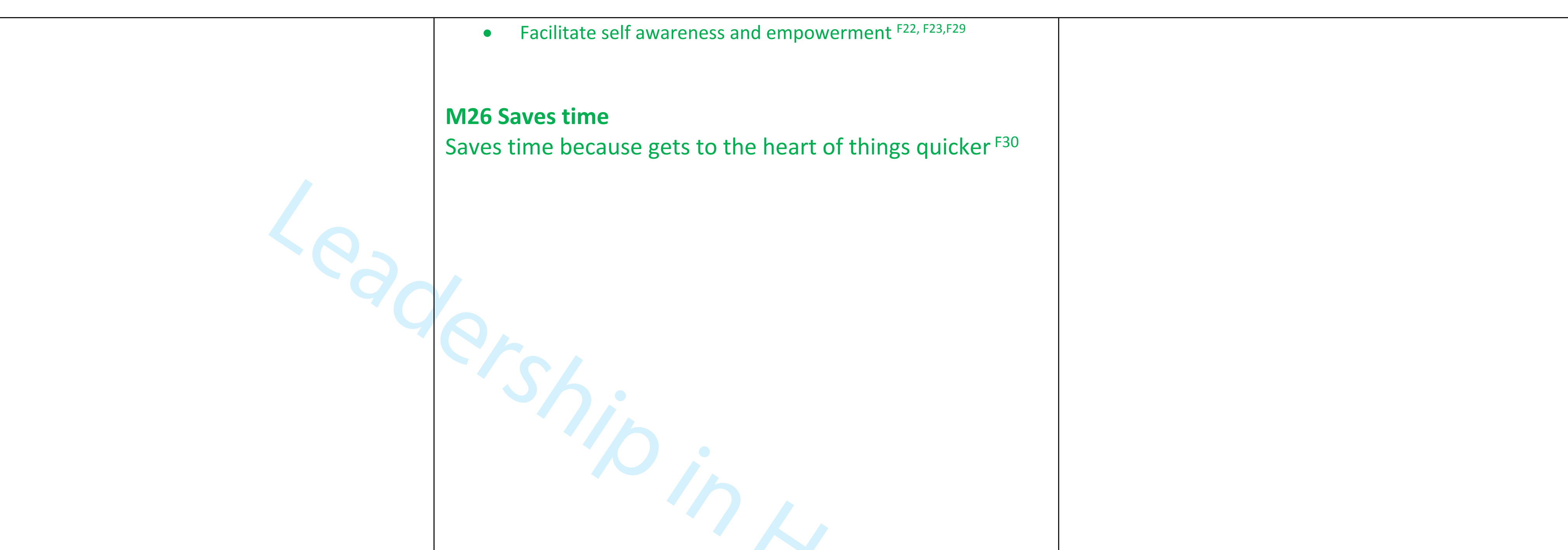
Table III Illustration of second level analysis CMO relationships in relation to NMAHP leadership derived from interrogating the literature for cross cutting theme Authentic Relationships and Connections

WHAT WORKS (CONTEXT)	WHY IT WORKS (MECHANISMS)	OUTCOME & FOR WHOM
C1.Contexts that focus on developing NMAHPs as leaders who can build relationships[43,48,56,78,82,88,89,90,92,93,96,99,102,60, F1,F3,F28,F10, F29,F30] **Descriptor of the context** Contexts that develop NMAHPs leaders who can build and nurture authentic, caring & successful relationships with individuals, those important to them, staff and stakeholders	**M1: Facilitate caring/compassionate civil conversations**[1,2,7,42,48,49,92,93,99, F28] **caring reflections and practices**[62,63,69,F10] • Integrating human caring into leadership practice[62,64,65,66] • Caring reflections[62,65] • Centre, pause and reflect, also before entering patient room[62,64,65,66] • Caring check-ins [62, 64,65,66] • What is most important thing for you today rather than goals[62] • Caring for colleagues[62,63] • Compassionate [F7,F10,F27,F29] **M2: Leaders are authentically present build ethical, trusting relationships where people feel safe to speak up by:** • Being authentically present[7,24,64] • Open and transparent [24,27,82,86,F12,] • Listening and responding as a catalyst for development[38] • Authentic empathy [40, 42,48,63,64,F15] • Emotional equanimity [48] • Relational ethics[2,42] • Integrity and ethical standards in development of relationships [42,78,103,F15,F29,F30] • Presenting ones authentic self – relational transparency [99,4,103] • Build trust[8,9,10,2,94,97,99,103,74] • Feels safe to speak up [F6] • Listen to all relevant voices [F27] **M3. Leaders develop appreciative, mutual learning relationships with all, and nurture these in others** [8,9,13,14,81, F1,F3,F11,F6] • Taking an interest in staff as people [8] • Valuing the team [18, 40] • Acknowledging and appreciating the efforts of staff [100] • Relationships with policy makers [46] • Understanding human reactions [81] • Nurture values, attitudes & behaviours for relationship centred compassionate care [F10],	***INDIVIDUALS*** **O1 feel valued & supported** • Feel valued[7,56,F6] • Staff feeling supported [56,F18] • 'It was the feeling valued and the discussion rather than the content that was influential'[3] **O2: Increased self awareness & empowerment** • Increased self awareness[60] • Enhanced empowerment [48,56,69,F2,F6,F10,F21,F28] **O3: Increased confidence including speaking up** • Enhanced staff confidence [93,60,F6,F28] • Confidence in stakeholder engagement[3,60] • Enhanced voice behaviour (speaking up) [99,103,F13] **O4: Improved relationships, experience and communication – more compassionate and respectful** • Develop a greater understanding of the perspective of others [93] • Sustaining caring relationships[7;63,F10] • Greater involvement in collaboration with residents and relatives and staff [93, 59] • Enhanced patient experience [92] • Improved communication[2,24] • Encouraged and sustained genuine curiosity for themselves and others [93] • Improved professional relationships [90,65] • Effective communication across professions [F1] • More compassionate and respectful [F10] • Increased patient satisfaction **05: Improved staff wellbeing, reduced stress & emotional exhaustion** • Improved nurses health and well being[96, F12,F22] • Improved work life balance [48]

Leadership in Health Services

	• Build mutual learning relationships [F22] • Build relationships with all [F23] • Focus shifts from deficits to assets [F30] **M4: Leaders connect emotions** • Emotional intelligence[2,27,29,31,43,48,51,89,95,8,43,50,51,F12] • Valuing emotionality[93,63,F28] • Build an emotional & rationale case for **change**[16,44,47,75] • Connect emotionally [F10] **M5: Leaders use different opportunities, use powerful inquiry questions for conversation- based change** • e.g Daily huddles[7,44]; Group discussions[3,20,22,23,24,29,36] • Debriefing[2] • Dialogic conversations [24,48,F26] • Value non-hierarchical communication [24] • Story telling [F27,F28,F29] • Have courageous conversations [F10,F28,f31] • Use powerful inquiry questions for conversation based change[F22,F26,F29] • Positive deviance [,F27] **M6: Leaders enable self & situational awareness in self and others through self-assessment, inquiry, self-motivation, self-compassion, self-reflection for learning, role clarity** [2,3,5,21,27,43,48,50,89,93,95,99] ***In Self*** • Developing and practising self care[7,63] • Self-regulation [89] • Knowing more about me [93,F26] • Deeper understanding of ones strengths and weaknesses [99] • Self-motivation [48, F12] • Continuous self-reflection and learning [48,54,56,60,65, F12] • Self-assessment of role clarity and skill set of transformational leaders [97] • Self-compassion [F23,F27] • An open inquiring mind [F12] ***In others*** • Facilitating embodied knowing [2, F12] • Openness to spirituality[7] • Facilitate personal identification by connecting with the self-concept of followers [103] • Wellness and independence [23,5]	• Reduced emotional exhaustion [48] • Reduction in stress [93] **06: Improved staff morale & satisfaction** • Intention to stay [99] • Increased job satisfaction [93,99,103,F6] • Increased staff satisfaction [23,24,38, 48,82,96,99,F5] • Improved staff morale [93] **07: Improved leadership – compassionate, inclusive, credible recognised & valued by others** • Improved knowledge of effective leadership[3,30,60] • Helped leaders to focus, prioritise and evaluate practice[58] • Freedom to make care decisions[38] • Improved leadership[3,30] • Ability to influence others[8] • Compassionate, inclusive leadership [F7,F13] • Credibility, recognised and valued by others [F23] ***TEAM (including service users and relatives)*** **08: Enhanced team effectiveness & learning culture** • Enhanced team effectiveness [99, F1,F21] • Building of shared mental models within team [99] • Perceptions unit is changing for the better[7] • Effective decision making [99] • Learning culture [F21] • Improvement skills [F7,F13] • Effective workplace culture at microsystems level[F21,F22,F24] • Ethos of continuous learning and improvement **[F10]** **09: Healthy, safe workplace/culture - staff engagement** • Safe positive workplace culture [21,24,89,96] • Enhanced work environment[48] characterised by resilience and innovation [48] • Healthy workplace/working environments [83,96] • Improved clinical environment [90] • Staff engagement [56,F7,F13,]

Leadership in Health Services



	• Facilitate self awareness and empowerment [F22, F23,F29] **M26 Saves time** Saves time because gets to the heart of things quicker [F30]	

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Table iV: Illustration of Cross Cutting Theme 1 Authentic Relationships and Connections further refined in preparation for presentation to workshop participants

WHAT WORKS (CONTEXT)	WHY IT WORKS (MECHANISMS)	INTERMEDIATE OUTCOME & FOR WHOM	ULTIMATE OUTCOME & FOR WHOM
Contexts that focus on developing NMAHPs as leaders who can build & nurture authentic, caring & successful relationships with individuals, those important to them, staff and stakeholders **[C1]**	Facilitate caring/compassionate civil conversations, caring reflections and practices using different opportunities and powerful inquiry questions for conversation based change [M1,M5] Enables authentic presence and builds ethical trusting relationships where people feel safe to speak up [M2] Enables self & situational awareness **in self and others** through self-assessment, inquiry, self-motivation, self-compassion, self-reflection for learning, role clarity [M6] Emotions are valued and used to connect [M4] **Appreciative, mutual learning relationships are developed and nurtured in others [M3]** **Saves time** Time is saved because gets to the heart of things quicker **[040]**	***FOR STAFF*** • Staff feel valued and supported [O1] • Increased self awareness & empowerment [O2] • Increased confidence including speaking up [O3] ***FOR STAFF, PATIENTS, FAMILIES SERVICE USERS***: • Improved relationships, experience and communication – more compassionate and respectful (04)	***FOR INDIVIDUAL STAFF MEMBERS*** • Improved staff wellbeing, reduced stress & emotional exhaustion [O5] • Improved staff morale and satisfaction [06] ***FOR TEAMS:*** • Improved leadership – compassionate, inclusive, credible recognised & valued by others [07] • Healthy, safe workplace/culture with staff engagement [09**]** • Enhanced team effectiveness & learning culture [O8]

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Table V: Sample of comments derived from Twitter Chat to help inform development of Guiding Light 1

GUIDING LIGHT	LEADERSHIP ATTRIBUTES identified as influential in twitterchat -useful for 360 (numbers in brackets indicate twitter statement)	IMPACT OF LEADERSHIP EXPERIENCED by participants in twitterchat on them selves	LEADERSHIP PROCESSES perceived as influential by participants (numbers in brackets indicate twitter statement)	IMPACT OF LEADERSHIP perceived by participants in twittechat more generally (numbers in brackets indicate twitter statement)
Guiding Light 1: 'The Light Between Us' **Working towards (OR BUILDING) authentic caring relationships.** Building caring relationships with all groups of people involved in giving and receiving health and social care that enable us to reflect, stretch our current thinking and innovate together was a core finding from the review and the data generated through the workshops and social media strand.	**APPROACHABLE,PERSONABLE, COMPASSIONATE,GENEROUS** Personal approach (147) Approachable (318) Approachability and friendly (383) Approachable, caring, (518) Compassionate (509) Generosity(147) Respect the respect they are given (536) Smile a lot (302) **SPARKLE, AUTHENTIC,RELAXED, PASSIONATE** Sparkle with passion and authenticity (58) Being relaxed allows me to make connections (383) Passionate without aggression (536) **OBSERVE, LISTEN,NON-JUDGEMENTAL** Observe and listen (577) Non-judgemental (509) Don't gossip or join cliques (509) Ability to observe and listen, (318)	**ENCOURAGED ME TO FOLLOW PASSION** Encourage me to follow passion(58) Passion is infectious (137) **SHOWING YOU ARE REAL PERSON** Showing you are a real person, having a friendly attribute (343) Took time with me, shared their vulnerabilities with me, co-created with me (95) Admitting they have failed – no-one is perfect (397) Share own experiences (152) Unselfish, share experiences, highs and lows – importantly including failure's (664)	**CONNECT IN A WAY THAT MAKES EVERYONE FEEL SPECIAL** Modest yet gifted in ability to make students feel extraordinary special (761) **CONNECTS AUTHENTICALLY,TRUE TO VALUES** Connect with each individual, willing to be authentic, true to their values and at same time values the values of others (770) Happy to hear other peoples thoughts and perspectives (318)	

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Table VI: Summary of Participants in the National Workshops

Participants from different contexts of nursing, midwifery and AHP contributing to national workshops								
Country	England		Northern Ireland/Eire		Scotland		Wales	
Nursing	Mental health x1 Researcher x2	3	Practice/services x6 Education x3 Research x2	6 3 2	Practice/services Strategy Education	3 1 1	Practice Strategy Research Education	4 1 1 3
Midwifery	Midwives x4 Student x1 Researcher x1	6	Practice x1 Research x1	2		0	Practice	1
AHP	Practice/service x5 Education x1 Strategic x2	8	Practice x3	3	Dietician Physiotherapist Education	1 1 1	Paramedic Pharmacist Other	4
Citizens through U3A		2		2		2		
Total		19		18		10		14

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Table VII Initial Programme Theories and Guiding Lights

Initial Programme Theories	Five 'Simple Rules'
1) Authentic relationships and connections,	Guiding Light 1
2) Transformational leadership linked to collective leadership and social capital	Guiding Light 2 Guiding Light 3
3) Providing everyone a voice in complex and changing contexts.	Guiding Light 4 Guiding Light 5

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Table VIIII The Guiding Lights of NMAHP Leadership

Guiding Light	Key Papers	Outcomes experienced by whom
Guiding Light 1: The light between us as interactions in our relationships Giving attention to what is happening between us when we are together. Working towards there being a space of civility and authentic care with a focus on careful listening. This listening enables what is important to people to be heard and is the starting point for reflection, stretching our current thinking and innovating together.	Hewison and Morrell, 2014; Cummings et al., 2010; Dewar et al., 2017, Dewar and Cook, 2014; Manley, 2011; Adamson et al., 2011; Gottlieb, 2013; Hannah, 2016; Sharp, 2018.	Leadership is experienced to be compassionate and credible **by all** who touch it Authentic, caring, appreciative and respectful relationships and communication is experienced **by all who provide and receive care**
Guiding Light 2: Seeing people's inner light Seeing each person's worth (including your own), and cherishing the varied ways in which people connect, contribute and bring about change. Working with others to create experiences of it being safe to be authentic and share one's ideas and emotions.	Pollard and Wild, 2014; Prentice, 2015; Sherman and Pross, 2010; Coleman, 2013; Karimi et al., 2017; Der Zipp et al., 2016; Taylor Lii, 2014; Schwartz et al., 2011; Dewar et al., 2017 F7, Dewar and Cook, 2014; The King's Fund, 2012, NHS Improvement, 2018; Royal College of Speech and Language Therapists, 2018; Manley et al., 2016, Manley and Titchen, 2016; Akhtar et al., 2016; Sharp, 2018.	Leadership is experienced by **people** to be: inclusive collective, shared, distributive by all who touch it by all who touch it **Staff** feel valued, supported, involved and heard, there is: • Reduced burn out, stress and exhaustion leading to: • improved morale,

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Guiding Light 3: Kindling the spark of light and keeping it glowing Generating a shared understanding of what it is that lights people's fire and finding ways for people to get energy from each other's different light sources (priorities, values, beliefs). Helping ourselves and others to take the risk and harness the learning from disappointments alongside delights.	Manley et al., 2011; Wong and Cummings, 2007; The King's Fund, 2012; Best et al., 2012; Manley and Titchen, 2016; Akhtar, 2016; Adamson et al., 2011; Sharp, 2018.	commitment, wellbeing, staff satisfaction & retention • Improved confidence to speak up , self-awareness, and empowerment leading to increased skills, improved relationships, and career development **Teams** are healthy, effective and empowered with cultures of active learning, engagement, reflection and adaptation. Have a strong team commitment to better practice, creativity, innovation and improving performance.
Guiding Light 4: Lighting up the known and the yet to be known Aspiring to be a source of steadiness in the midst of change by: Sharing information on what is known and stable Showing a level of comfort engaging with uncertainty; and valuing that what will light the way forward will be found in relationships which facilitate flexible and creative approaches that may differ from action plans, risk aversion strategies and hierarchical rules.	Soo Young, 2017; Edmonson, 2010; Hewison and Morrell, 2014; Cummings et al, 2008; Karimi et al., 2017; Hurlock- Chorostecki, C., & McCallum, 2016; Stavrianopoulos, 2012; Hutchison and Jackson, 2013; Bender et al., 2017; NHS England, 2017; Dewar and Cook, 2014; Best et al., 2012; Akhtar et al., 2016; Manley, 2011; Manley et al., 2008; Plsek and Wilson, 2001; deZulueta, 2016; Gottlieb, 2017; Sharp, 2018.	**People** experience better patient, family healthcare outcomes, quality and satisfaction **Organisations** demonstrate • Improved outcomes for patients/clients, staff and families with regards to quality, safety, performance, healthy teams, • Improved services and delivery, • Improved staff retention and stability, and staff commitment aligned with the qualities of a learning organisation

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Guiding Light 5: Constellations of connected stars Tuning into local resources, networks, communities and recognising where there is the potential for enhanced futures through collective action. Fostering ways of connecting together which maximise the possibilities for this collective action. Responding to the unique nature of the local context and practicing adaptability in order to tap into the distinctive riches	Soo Young, 2017; Hewison and Morrell, 2014; The King's Fund, 2012; Manley et al., 2008; Sharp, 2018.	**System & Society** benefit from • Social capital identified as a resource for system change • Resources available to people, organisations and communities for change' • Improved population health

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Figure !: Context, Mechanisms and Outcomes Relationships

Context, mechanisms and Outcomes Clarified	
Context (What works)	different care settings, clinical care, community care, hospital care, maternity care, residential and nursing home care, primary care, intermediary care social care, organisations, communities, multi-professional team environment, culture, systems and processes, interpersonal and social relationships, multi-professional, technological factors, economic conditions, enablers, education,
Mechanisms (Why)	how things work, what works, why does it work, triggers, what has to be in place to facilitate mechanism, does the context affect/impact how or why the process works, what enablers facilitate,
Outcome	What is the impact/outcome? What are the indicators of impact/outcome?
For whom does it work	Identify how the mechanism and outcome impacts on an individual, team and /or organisation

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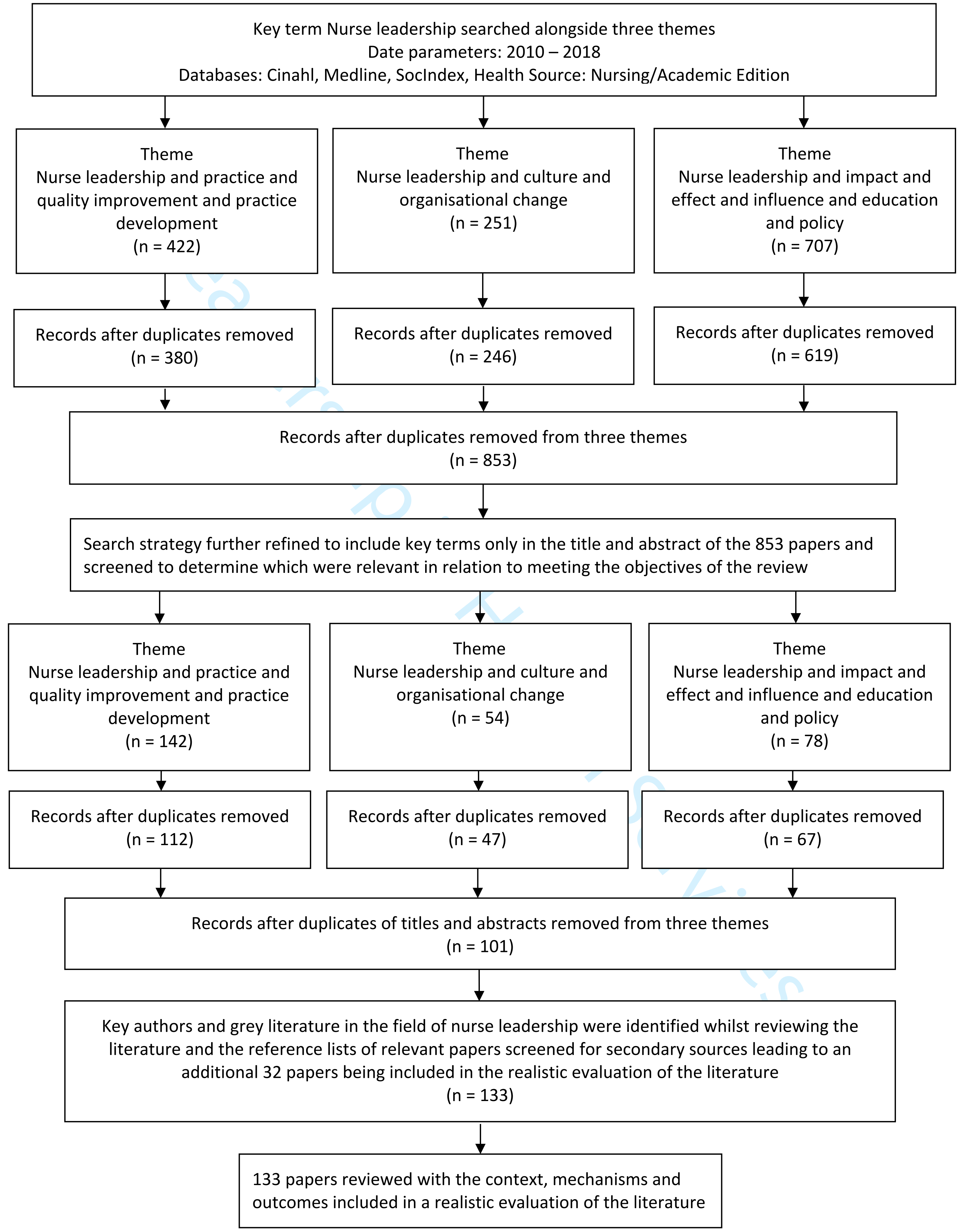
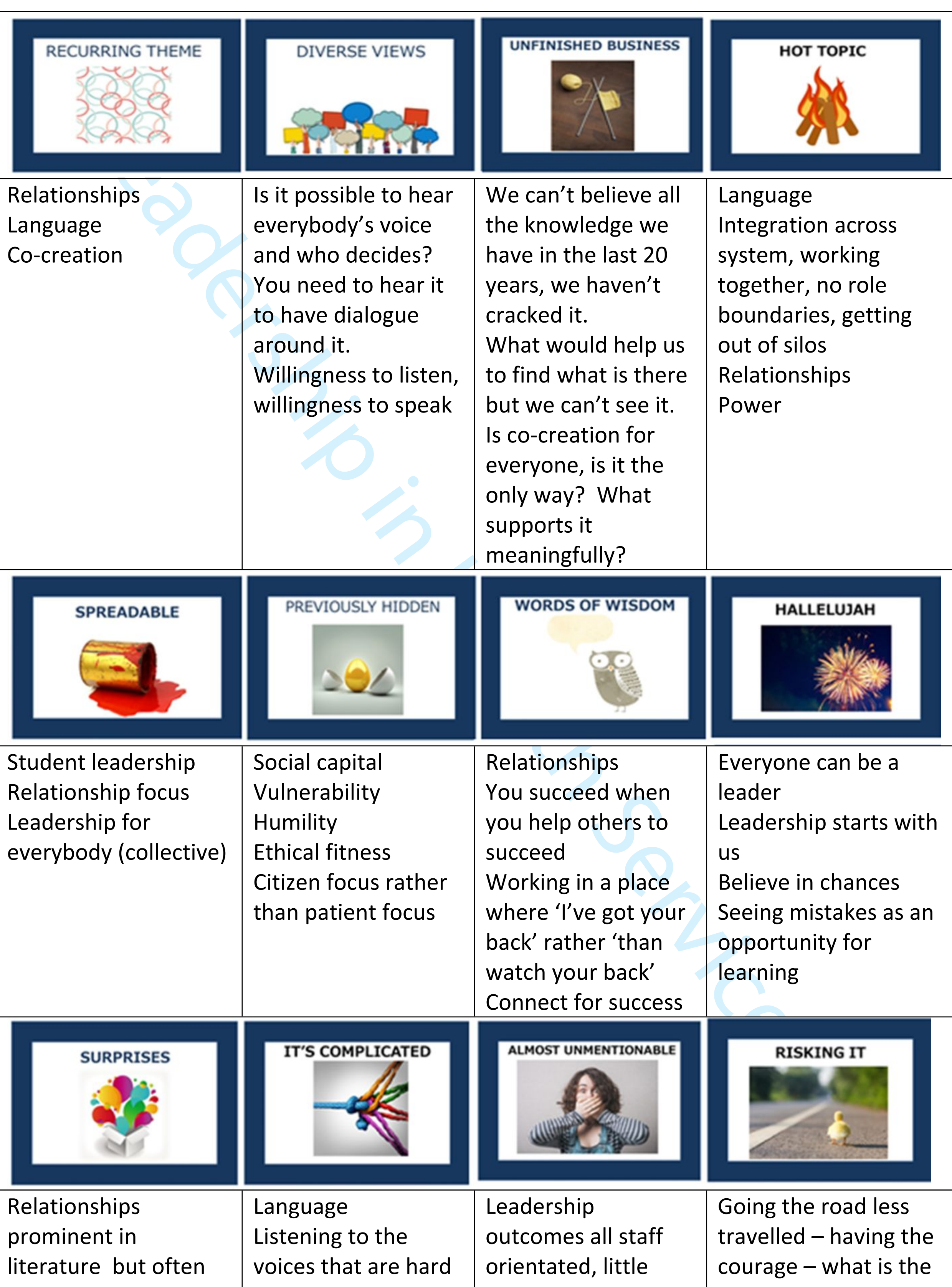

Key term Nurse leadership searched alongside three themes
Date parameters: 2010 – 2018
Databases: Cinahl, Medline, SocIndex, Health Source: Nursing/Academic Edition
Theme
Nurse leadership and practice and quality improvement and practice development
(n = 422)
Theme
Nurse leadership and culture and organisational change
(n = 251)
Theme
Nurse leadership and impact and effect and influence and education and policy
(n = 707)
Records after duplicates removed
(n = 380)
Records after duplicates removed
(n = 246)
Records after duplicates removed
(n = 619)
Records after duplicates removed from three themes
(n = 853)
Search strategy further refined to include key terms only in the title and abstract of the 853 papers and screened to determine which were relevant in relation to meeting the objectives of the review
Theme
Nurse leadership and practice and quality improvement and practice development
(n = 142)
Theme
Nurse leadership and culture and organisational change
(n = 54)
Theme
Nurse leadership and impact and effect and influence and education and policy
(n = 78)
Records after duplicates removed
(n = 112)
Records after duplicates removed
(n = 47)
Records after duplicates removed
(n = 67)
Records after duplicates of titles and abstracts removed from three themes
(n = 101)
Key authors and grey literature in the field of nurse leadership were identified whilst reviewing the literature and the reference lists of relevant papers screened for secondary sources leading to an additional 32 papers being included in the realistic evaluation of the literature
(n = 133)
133 papers reviewed with the context, mechanisms and outcomes included in a realistic evaluation of the literature

Figure III Composite of images chosen by participants and the conversations this sparked about leadership Phase 3 Workshops



RECURRING THEME	DIVERSE VIEWS	UNFINISHED BUSINESS	HOT TOPIC
Relationships Language Co-creation	Is it possible to hear everybody's voice and who decides? You need to hear it to have dialogue around it. Willingness to listen, willingness to speak	We can't believe all the knowledge we have in the last 20 years, we haven't cracked it. What would help us to find what is there but we can't see it. Is co-creation for everyone, is it the only way? What supports it meaningfully?	Language Integration across system, working together, no role boundaries, getting out of silos Relationships Power
SPREADABLE	**PREVIOUSLY HIDDEN**	**WORDS OF WISDOM**	**HALLELUJAH**
Student leadership Relationship focus Leadership for everybody (collective)	Social capital Vulnerability Humility Ethical fitness Citizen focus rather than patient focus	Relationships You succeed when you help others to succeed Working in a place where 'I've got your back' rather 'than watch your back' Connect for success	Everyone can be a leader Leadership starts with us Believe in chances Seeing mistakes as an opportunity for learning
SURPRISES	**IT'S COMPLICATED**	**ALMOST UNMENTIONABLE**	**RISKING IT**
Relationships prominent in literature but often missing in	Language Listening to the voices that are hard to hear.	Leadership outcomes all staff orientated, little about people,	Going the road less travelled – having the courage – what is the road?

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educational/caring context Leadership is ways of being	Everything is intertwined Relationships	family, citizens as leaders.	Focussing deeply on relationships – one step at a time

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Figure iV*: An appreciative 360 assessment and reflection tool.*

360 degree feedback form by Dewar (2011) is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/4.0/.

Appreciative Feedback for Me. Name:

I would be grateful if you could consider the following questions and make comments. (If there are questions you do not feel you can answer then leave blank). Do try to be as honest as you can to help me to learn and develop. If it is more helpful to discuss this with me rather than sending the form – please let me know. Try to think about specific examples in your feedback. Thank you in anticipation.

Area of exploration	Feedback
Guiding Light 1: The light between us as interactions in our relationships	
What feedback would you like to give me about the way that I communicate with you?	
What feedback would you like to give me about the way I communicate with and engage others?	
Have you seen me being courageous at work? If so what was this?	
Guiding Light 2: Seeing people's inner light	
What aspects about how I am at work do you think people value?	
What would you say about how I am with emotions, my own and others?	
How do I support people during stressful or emotional experiences?	
How do you think I respond to difficult or sensitive situations with others?	
In what ways do I give everyone a chance to participate or feel included?	
What do I do to help create a safe environment for everyone to flourish?	
What would you say about my ability to take on board other people's perspectives?	
Guiding Light 3: Kindling the spark of light and keeping it glowing	
What feedback can you give me about my ability to notice and build on people's strengths?	

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What would you say about my ability to work with and collaborate with others?	
What would you say about my ability to show support and appreciation to people?	
Can you give me an example when you have noticed that I have shared learning/new insights with others?	
Guiding Light 4: Lighting up the known and the yet to be known	
What feedback can you give me about my ability to remain calm and steady in complex and unpredictable situations?	
When I am communicating with you and others, what would you say about my ability to hold off in making assumptions and ask questions?	
What would you say about my ability to help people to come up with their own ideas?	
What would you say about my ability to constructively challenge or stretch people?	
What feedback can you give me about how I am and how I enable others to be flexible and creative with change and complexity?	
Guiding Light 5: Constellations of connected stars	
What do I do that helps to build networks?	
What feedback would describe how I connect internally and external with others to achieve collective action?	

General	
If you could choose one word to describe me what would it be?	
If there was one thing that you feel I could do more of what would this be?	

Please could you complete this form by and email/send this this back to me at ……

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Leadership in Health Services