Lessons from LEO: Part Two

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Assess the differences between nurses and allied health professionals, men and women undertaking leadership training.

More than 32,000 nurses and around 8,000 allied health professionals (AHPs) have experienced the Leading Empowered Organisations (LEO) programme during the three-year lifetime of the NHS national nursing leadership programme. An article in last month’s Nursing Management (Faugier and Woolnough 2003) outlined the main findings from its evaluation. This month’s highlights similarities and differences between nurses and AHPs undertaking the course and identifies gender differences.

Respondent profile

A random sample of just more than 12,000 participants returned self-completed evaluation questionnaires. This represents a response of about 38 per cent and, due to the sample size, information was collated and analysed independently for the NHS national nursing leadership programme. Most respondents, 78 per cent, were nurses from grades F and G and included ward sisters and charge nurses, with about 20 per cent being AHPs, usually front-line staff holding senior 1 level posts.

Nursing grades tended to have more experience than AHPs suggesting that AHPs reach more senior positions quicker. The vast majority of respondents, 90 per cent, were women reflecting the gendered nature of the profession and a similar proportion, 92 per cent, were white.

The LEO programme

Nurses and AHPs had heard about the programme from the same sources. The most frequently identified sources, for 78 per cent for both nurses and AHPs, were managers. Nurses were more likely to have their attendance decided for them by their managers, 50 per cent compared with 40 per cent of AHPs, with AHPs being more likely to attend as a result of joint or individual decisions, 37 per cent compared with 30 per cent of nurses.

Access to development was a key issue for front-line staff and respondents felt strongly about what was be perceived as the negative ‘filtering’ effect of management nominations. However, line manager sponsorship was frequently important in pursuing action plans upon return from the course.

The difference in decisions to attend may simply reflect the target audience of this roll out; the LEO programme was directed primarily at nurses. But it could raise issues around AHP access to leadership development, in that they may need to be more proactive. This could be particularly so in light of their being less likely to have received any preparatory leadership training, 15 per cent of AHPs had received no preparatory training compared with 11 per cent of nurses. Nevertheless, lack of previous leadership development is an issue of concern for both professional groups and highlights the express need for programmes such as LEO and for leadership development aimed exclusively at front-line staff.

There were apparent differences between nurses and AHPs in their motivation to attend the programme. Respondents were offered ten possible reasons for attending the course and were invited to rate each one on a scale of between one, ‘not at all important’, and ten, ‘very important’ (Table 1).

Nurses rated the improvement of patient care and their desire to be better clinicians significantly higher than AHPs did. This may reflect the differing roles employed by the different professions.

It is worth remembering however that participant motivation for attending the course may have an important impact on their understanding and use of the course content.

Depressingly, neither group held out much hope of increased development heralding the possibility of higher pay; an anathema to general managers, whose further development is quite appropriately linked to higher pay.

Table 2, outlining the assessment of LEO’s impact, suggests that the course is more relevant to nurses than to AHPs. Nurses awarded higher ratings to each possible consequence of attending the course.
Leadership

Respondents were asked to describe what the term ‘leadership’ meant to them in three words or less without prompting. The most frequent words used to describe leadership raised interesting differences both in terms of gender and role.

There were broad similarities, but results showed that men and women respondents appeared to define leadership differently. Men were more likely to define leadership in terms of ‘direction’, ‘setting an example’, and ‘vision’. Women were more likely to think in terms of ‘empowerment’, ‘supporting the team’, and ‘communication’ (Table 3).

Both men and women gave ‘supporting the team’ as the most commonly identified expression of leadership, but there were gender differences in the less popular definitions.

This may suggest that men define leadership in terms of action, believing that leaders seek direction and drive their visions forward, and that doing so effectively provides followers with role models. Women however may adopt a more ‘nurturing’ style and see leadership as a process of empowerment and communication, although they did also recognise their responsibilities as role models. While men and women clearly recognise the complexity of leadership, it appears that women highlight the need to develop and promote ‘great teams’ (Bennis 2000) through their work more readily than men.

Interestingly, few male respondents in this study equated communication with leadership, but many of them saw leadership as having a strong visionary and focus function. The prospect of having vision and direction but failing to adequately communicate it is perhaps a recipe for failing teams and organisations, and this finding deserves some attention from senior managers. There may be some value in investing in communication.

There were also differences between the way nurses and AHPs defined leadership. Both groups stated that ‘team support’ and ‘empowerment’ were critical aspects of leadership, but nurses placed more emphasis on leading by example while AHPs placed more emphasis on ‘direction’ and ‘vision’ (Table 4).

Interestingly, nurses were marginally more likely than AHPs to see leadership as an important aspect of their current role, 93 per cent compared with 89 per cent respectively. This may reflect a failure among some AHPs, and indeed nurses, to recognise leadership as an integral part of their role.
To encourage more clinical staff to pursue modern matron roles, it may be necessary to clarify the clinical components of this post and its relationship with the patient experience.

**Relationships with managers**

Twenty-five per cent of AHPs stated that their directors visited them within the previous week, compared with 14 per cent of nurses. They also appeared happier with their levels of contact with their directors or professional leads, 60 per cent compared with 51 per cent of nurses.

It is likely that the two findings are linked, but the greater number of nurses in organisations than AHPs needs to be taken into consideration. Nurse directors are likely to have more staff to oversee and, given the size of NHS trusts, it may be that they have difficulty seeing all nurses operating in their organisations regularly.

The findings may also reflect that AHPs often work more autonomously than nurses and are more likely to have clearer lines of responsibility. They are more likely to work similar hours to managers and therefore more able to access them.

Nurses may often have difficulty accessing senior managers due to the nature of their shift work. Furthermore, as many nurse directors have taken on responsibility for managing AHPs, it may be that they are putting more work into developing these relationships.

**Conclusion**

During its lifetime, the NHS national nursing leadership programme encouraged and supported leadership development and empowered thousands of front-line staff to make real improvements for patients.

To sustain this development and produce future clinical leaders there needs to be a heavy investment in clinical leadership at national, organisational and local level, and there is value in learning from our European neighbours.

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**References**


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It also appears that a proportion of nurse but particularly AHP front-line leaders are more likely to equate leadership with management functions.

The differences between nurses and AHPs may be partly attributable to gender variations; 12 per cent of AHPs were male compared with 9 per cent of nurses. Other explanations could include the nature of the differing roles, duties and demands.

Nurse respondents were asked whether they would consider applying for senior clinician, specifically modern matron, posts and all respondents were asked whether they would apply for nurse or therapy consultant posts.

Just under a fifth, 18 per cent, of all nurse respondents stated that they would consider applying for modern matron posts. A further 19 per cent stated they were unsure. Most, about 60 per cent, therefore would not. Nurses with minority ethnic backgrounds were more likely to consider applying for senior clinician posts. There was greater interest in nurse or therapy consultant posts, with more than a quarter, 27 per cent, of all respondents stating they would consider applying. A further 20 per cent were unsure and just under half claimed they would not apply. The remaining 5 per cent did not reply.

Allied health professionals appeared more interested in applying for consultant posts: 31 per cent compared with 26 per cent of nurses. Men were more likely to do so: 31 per cent compared with 27 per cent of women.

It is interesting that there was greater interest in nurse or therapy consultant than modern matron posts. This suggests that respondents are more interested in pursuing roles that retain a significant proportion of clinical focus rather than those that are attached to management.