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Leadership effectiveness within the function of nursing management

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Abstract

Nurses are often promoted into unit management posts as a result of extensive clinical experience and expertise in the field of nursing, but many lack the leadership skills necessary to be successful in this role. Once they are in a leadership position, there is no healthcare leadership competency model in place to identify and address areas of leadership weakness.

This quantitative cross-sectional study was carried out on 33 unit managers from four private healthcare organisations in KwaZulu Natal, using the National Health Service 360-degree leadership competency assessment tool to determine areas of leadership strengths and areas that required development. The unit managers were required to rate their leadership competencies according to the nine leadership dimensions identified in the tool, which were inspiring a shared purpose, leading with care, evaluating information, connecting the service, sharing the vision, engaging the team, holding to account, developing capability and influencing for results.

The findings revealed that only 66.7% of unit managers possessed a tertiary qualification in management. Although the unit managers rated their competencies positively across all nine dimensions, the areas that were rated poorly were the ability to share the organisation's vision, the ability to evaluate information, and the ability to maintain accountability. Three recommendations emerged from the findings, namely investment in leadership development, implementation of a leadership competency model, and a tertiary qualification in management as a prerequisite for a management post.

Key phrases

competencies; leadership; leadership dimensions; unit managers

1. INTRODUCTION

In the last decade, in response to the challenges inhibiting effective leadership, an emerging stream of academic studies has focussed on the competencies required for effective leadership (Gowan 2011:109; Murugan 2011:135). Savaneviciene, Ciutiene and Rutelione (2014:42) indicated that leadership competencies are made up of three components, namely the ability to manage the self, the ability to manage the business, and the ability to manage people. Self-management includes trustworthiness, agility, adaptability and self-control; business management competencies include strategic thinking and planning; and people management skills include collaboration, teamwork, empowering others and conflict management.

Bimray and Jooste (2014:202) brought to light the growing number of challenges faced by leaders, stressing the leadership competencies that must be assessed. Bulmer (2013:132) concurred with this, adding that leadership competencies influence organisational performance, while Fairhurst & Connaughton (2014:10) reiterated that intellectual, emotional and managerial competencies constitute critical predictors of such a framework.

In a view that echoes such interpretation, Ibarra (2015:33) also stressed the importance of bringing a vision together with strategic intent as the basis for effective leadership. Mabey and Morrell (2011:107), McCarthy (2014:57) and Probert and James (2011:140), meanwhile, shared their view that in these times of change and economic challenges, great leaders are a prerequisite for successful organisations.

Kelly (2011:21) emphasised that leadership forms a critical part of the healthcare management process and works synergistically with the other functions of planning, organising and controlling. Unit managers do not possess all the competencies required for effective leadership because they do not possess a tertiary qualification in management, are promoted to unit manager posts based on clinical experience and expertise, and because there is no leadership competency model in place which evaluates leadership strengths and weaknesses.

Baker, Marshburn, Crickmore, Rose, Dutton and Hudson (2012:26) stressed that the job of a healthcare manager is complex and demanding, and requires the incumbent to have a tertiary management qualification that equips them with sound theoretical knowledge. Fairhurst & Connaughton (2014:18) argued that nurses from direct patient care areas are often promoted to management posts based purely on clinical experience and expertise, yet they have limited formal training and minimal to no managerial experience, and are expected to fulfil the role immediately and with ease.

Although they may be able to communicate, plan, organise and prioritise, these managers lack the formal education and training that would have provided them with leadership and management skills (Ibarra 2015:35). Leadership competency models are extremely valuable in assessing leadership strengths and areas that require development. Effective leadership programmes can be developed from the implementation of competency models (Kvas, Seljak & Stare 2013:991).

2. LITERATURE REVIEW

2.1 Leadership and management

Leadership and management are firmly entwined, with some core differences in how they are implemented. Management is a process of coordinating actions and allocating resources to achieve organisational goals, while the ability to plan, organise, staff, lead and control are the other key management functions.

Leading is the most challenging of these processes, as it deals with changes in human behaviour. In order to achieve management functions, nurse managers utilise human resources, financial resources, physical resources and information resources (Kelly 2011:52). Management also involves decision making, planning, controlling, organising and directing, and includes delegating jobs to those who are capable of performing them. Further, managers have to motivate employees to perform well (Gonos & Gallo 2013:161).

Effective leadership is thus a prerequisite to successful management. Leadership provides inspiration to employees, secures cooperation, creates confidence, provides a conducive environment, implements change, maintains discipline among members, represents members and sets goals (Murugan 2011:75). A person can be a manager without being a leader and the converse is also true, where a person who is not a manager, with no formal

power, can be an effective leader. A managerial leader exhibits both managerial behaviour and leadership behaviour (Peterson & Peterson 2012:50).

2.2 Conceptual foundation of the contemporary notion of leadership

2.2.1 The Great Man Theory

The Great Man Theory, which was developed by Carlyle in 1840, suggests that leaders are born with certain characteristics that make them leaders. The strengths of the theory are that it focuses on the leader's personality and provides a benchmark against which to assess leadership competencies. The weakness is that it fails to consider the various situations that leaders find themselves in, and is not suitable for use in leadership training and development (Khan, Nawaz & Khan 2016: 23).

2.2.2 The Trait Theory of leadership

The Trait Theory moved away from the assumption that leaders are born with certain genetics that predispose them to being leaders. There is a difference between emergent traits–such as height, intelligence and attractiveness, and effective traits- such as charisma. Max Weber initiated much discussion about the term 'charisma', which he defined as almost magical, supernatural, superhuman qualities and powers. This theory moved away from inherent qualities and focussed on the leader's ability to attract followers (Khan, Nawaz & Khan2016: 25).

2.2.3 Contingency Leadership Theory

In 1967, Fiedler developed the Contingency Leadership Theory which suggests that the effectiveness of a leader depends on the leadership style that is utilised for a particular situation (Jooste 2015:43). Three situational variables were identified in this theory, namely leader-member relationship, task structure and position power. The strongest situations are those where the leader and the team members have a sound mutual understanding, the outputs are made clear to the team, and the leader possesses power as a result of position.

2.2.4 Transactional Leadership Theory

Transactional leaders encourage the attainment of goals through both rewarding staff for exceptional performance and punishing staff for non-compliance. Transactional leadership is also known as managerial leadership; the focus is on supervising employees, organising work activities, and ensuring that groups achieve their goals (Almansour 2012:36).

Transactional leadership differs from transformational leadership in that the focus is not on changing the future, but rather on maintaining the stability of the *status quo*; there are repercussions for deviations from performance.

Yet transactional leadership has its place - it is beneficial in situations that are considered critical, e.g. in emergencies where decisions need to be made quickly (Odumeru & Ogbonna 2013:57).

2.2.5 Transformational Leadership Theory

Weber (2015:87) defined transformational leadership as a type of leadership where there is a positive change created within employees; they look out for each other as well as the greater good of the organisation. Transformational leaders motivate employees toward the organisation's vision and goal achievement. They also ooze charisma and act confidently, thereby inspiring others to act confidently. Praise and recognition is high on the transformational leader's agenda (AANAC 2014:17).

Transformational leaders value relationships and focus on quality improvement; they welcome input and suggestions from subordinates and encourage communication, and workers are provided with responsibilities, accountability and feedback (AANAC 2014:17).

2.3 Role of the unit manager in private healthcare

Curtis, De Vries and Sheerin (2011:307) defined a nurse leader as someone who can provide assistance to others. They further stated that the role of the nurse leader is complex and challenging as they are responsible for ensuring safe clinical care, maintaining effective multidisciplinary relationships, managing resources within financial constraints, developing and building teams to provide efficient healthcare, and managing human resources with a view to recruiting and retaining skilled personnel.

Patton (2012:37) postulated that nurses are often promoted to leadership positions due to their experience and clinical expertise in the field, while Kerridge (2013:25) explained that new nurse managers are often put into management positions without the relevant management training and are expected to do well in these roles. For this reason, a management framework that addresses leadership skills and management development is an essential part of any healthcare organisation.

Spencer, Al-Sadoon, Hemmings, Jackson and Mulligan (2014:13) described the role of the unit manager as being essential in ensuring that safe, quality care is delivered to patients. Previously ward sisters were promoted to unit managers and performed the role through trial and error. Unit managers are expected to play a variety of roles; they are instrumental in developing junior staff, ensuring competence in care, communicating the organisation's vision and creating a culture of care.

Baker *et al.* (2012:27) argued that nurse managers have the complex and intricate job of ensuring safe patient clinical care, fostering team and interdisciplinary dynamics, maintaining healthy nurse-patient and nurse-physician relationships, managing the daily operational demands, and developing and maintaining an environment that promotes employee engagement and satisfaction.

Successfully balancing all of these demands requires a mix of knowledge, skills, talent, and leadership skills. Nurse managers budget, organise, staff, direct, plan, problem solve and control, while nurse leaders inspire followers, manage change and create a compelling vision for healthcare. Leaders are passionate, as demonstrated by their ability to inspire and align people to organisational goals and safe patient care (Kelly 2011:62).

The evidence is mounting that good management as well as leadership leads to safer patient outcomes, namely reduced adverse events and incidents, yet although the demand for clinical skills is increasing, there is inadequate focus on leadership skills (Gowan 2011:110). Kings Fund (2014:Internet) suggested that excellence is needed in both management and leadership, while McCarthy(2014:56) felt strongly that effective leadership is just as important as rendering patient care.

The healthcare landscape is dynamic and requires leadership that can foster a culture that is able to keep up with this change. Dyess, Prestia & Smith (2015:134) was of the opinion that nurse leaders play an integral role in ensuring that safe, clinical care is rendered to patients.

Although it is evident that healthcare leadership is largely transactional, recent leadership theories suggest that it is essential that the application of any leadership style is accompanied by a display of certain necessary leadership competencies.

2.4 Leadership competencies

The National Center for Healthcare Leadership (2015:Internet) defined leadership competencies as a combination of technical expertise and attributes of behaviour that leaders must possess in order to be effective. The National Health Service (NHS) Leadership Academy (2014:9) leadership framework stipulates that all levels of employees in an organisation, irrespective of their category, role or function, are responsible for service delivery and need to concentrate their efforts on reaching goals, therefore competency in these areas are essential. All employees need to be well developed and well versed in service delivery so that they deliver high standards of patient care consistently. In order to do this, they need to be deemed competent in these areas of care.

According to Kings Fund (2014:Internet), healthcare leaders must possess the following competencies:

- technical competence- knowledge of the organisation, structure, processes and healthcare itself to gain the respect of followers;
- conceptual skills - the ability to analyse, plan and make decisions in all situations, including those that are complex; and
- interpersonal skills – these are essential in fostering an environment of trust and respect. Leaders must also understand the needs and feelings of others and be aware of the impact of their own actions on others.

Nurse managers are expected to drive this process. Time after time the ability to set direction; formulate objectives; communicate; make decisions; exhibit customer focus; and display team leadership, conflict management and person related skills, as well as emotional intelligence and social responsibility, have been highlighted as essential leadership competencies (NHS 2014:Internet).

Martin, McCormack, Fitzsimons and Spirig (2012:76) found that if organisations are to provide a superior level of healthcare, leadership competencies must be regularly assessed and developed. Numerous countries have identified leadership gaps in nurse managers'

abilities, making the assessment of leadership competencies a priority for most healthcare organisations (Martin *et al*. 2012:75).

Curtis *et al.* (2011:307) remarked that the challenges facing nursing leadership are mounting. These include new roles, new technology, financial constraints, staff wellbeing, patient satisfaction, diversity management and ongoing education. Dyess, Prestia and Smith (2015:109) emphasised that nurse managers have a great scope of responsibility, which includes the staff, organisation, patients and relatives. Added to this is the ever-increasing demand for patient-centred successful leadership.

Shirey (2015:306) stressed that the challenges facing nurse managers are increasing, especially in the face of the rising costs associated with healthcare. Nurse managers are measured by clinical outcomes; adherence to budgets; utilisation of resources; providing excellent clinical care; and staff retention, productivity and satisfaction, therefore the development of leadership competencies is crucial to the success of healthcare.

2.5 Assessment of leadership competencies

As per Ulrich (2015:46), companies need a tool that is able to assess leadership. Areas that should be assessed are ability to inspire others, capacity to strategise, coping abilities, knowledge, building talent and nurturing a strong culture. Investors who are confident in these abilities are more likely to invest in such a company. It is essential to be aware that leadership establishes the intangible value of a company (Ulrich 2015:48). It is difficult for leaders to see themselves objectively, thus 360-degree feedback will go a long way toward assisting with leadership development (Patrick, Laschinger, Wong & Finegan 2011:453).

Developmental assignments and 360-degree feedback via questionnaires allow leaders to learn through experience; as opposed to formal training (McCauley & McCall 2014:56).Nine dimensions of leadership are highlighted in the NHS Healthcare Leadership Model:

- Inspiring a shared purpose is to role model the values and principles of the organisation and emphasise a service ethos.
- Leading with care is ensuring the creation of a safe working environment and displaying effective personal leadership attributes.
- Evaluating information is eliciting data from a range of sources and utilising this data to formulate improvement strategies.

- Connecting the service is fostering multi-disciplinary relationships so that the ultimate goals can be achieved together.
- Sharing the vision is making the vision known to all employees, ina realistic and achievable way.
- Engaging the team is allowing for employees to make valuable suggestions towards goal attainment.
- Holding to account is creating an environment where employees are accountable for their individual and collaborative actions.
- Developing capability is to embrace previous but valuable experience to develop employees and enhance learning within the organisation.
- Influencing for results is building relationships with others to recognise their passions and concerns.

Another important method of assessment is self-reflection. Leaders who engage in self-reflection are able to improve their own performance by developing the leadership competencies they view as being deficient (Shankman & Haber-Curran 2015:86).

Since leaders have to fulfil a variety of functions, which include living the values of the organisation, ensuring employee satisfaction, delivering on goals and leading change, it is essential to set out a framework that is capable of assessing leadership competencies. This would assist organisations in selecting appropriate leadership development programmes to build and sustain effective leadership. The leadership competencies associated with the various types of leadership styles and theories are required to provide a superior level of clinical care, therefore more and more institutions are pursuing leadership development as a priority (Martin *et al*. 2012:74).

3. RESEARCH PROBLEM

Although nurses are often promoted into unit management posts as a result of extensive clinical experience and expertise in the nursing field, their lack of leadership skills is often exacerbated by the lack of a healthcare leadership competency model, which affects their ability to perform more effectively in their leadership roles.

4. RESEARCH OBJECTIVES

The objectives of the study were to:

- determine the number of unit managers with a tertiary qualification in management;
- ascertain if seniority in a unit management position influences unit managers' perceptions of their leadership competencies;
- identify the leadership competencies that are positively rated and those that require development; and
- develop a cost-effective healthcare leadership model that can be used on an ongoing basis to evaluate the effectiveness of nurse leadership at the private healthcare institutions in KwaZulu Natal.

5. RESEARCH METHODOLOGY

5.1 Research paradigm

A quantitative, non-experimental study design was used for this research. A quantitative methodology is used when a researcher wants to compare relationships and correlations between different issues and to get a broad, comprehensive understanding of the subject being researched. The emphasis is on collecting scores that measure distinct attributes of individuals (Ram 2013:46).

5.2 Sampling

The sample was comprised of all the unit managers from four private healthcare organisations in KwaZulu Natal which was 33 unit managers. These four healthcare organisations fell under the umbrella of a single healthcare group. These unit managers were in charge of the complete outputs of a nursing unit.

5.3 Research instrument

The NHS 360-degree leadership competency assessment questionnaire was used as the research instrument since it encompassed the most important aspects of leadership competencies, as outlined in extensive literature reviews. It was adapted by the researcher to the South African healthcare context and emailed to unit managers for completion. They

were asked to complete certain demographic data and a Likert scale was used to rate their leadership competencies across the nine leadership competencies identified on the tool.

5.4 Data analysis

The electronic questionnaires were generated from the Survey Monkey website and completed questionnaires were received and collated on the Survey Monkey database. All 33 unit managers participated in the questionnaire with the assistance of each of the institutions' general manager and human resource department. The data gathered were organised into tables and graphs.

5.5 Validity and reliability

The data collection instrument for this study was adapted from the NHS Leadership Competency Model, which was based on an extensive literature review, therefore content validity was ensured. Reliability analysis was performed on the data, which concluded that the data were reliable.

6. FINDINGS

6.1 Reliability analysis

Cronbach's alpha coefficient statistical test was utilised to estimate the internal consistency of the questionnaire as illustrated in table 1.

A total of 33 nurse managers completed the self-administered questionnaire. It was found that the data were reliable as the overall Cronbach's alpha value was 0.996. For each of the dimensions, the Cronbach's alpha value was >0.80, indicating that the data were reliable (Ram 2013: 52).

6.2 Demographic data

Descriptive and inferential statistics were used to analyse the data. It was found that more than half of the unit managers (55%) had worked for five or more years in the current institution, while a third of unit managers did not have any tertiary qualification. Of those who had a tertiary qualification, none had a doctoral degree and only 4.5% had a Masters

qualification in nursing. While 40.9% had a management degree, just over half the managers (54.5%) had a diploma in management.

TABLE 1: Reliability analysis output

Dimensions	Reliability statistics	
	Cronbach's alpha	N of Items
1	0.888	8
2	0.936	9
3	0.895	7
4	0.934	7
5	0.910	11
6	0.955	12
7	0.946	13
8	0.944	10
9	0.932	11
Overall	0.998	88

Source: Calculated from survey results

Almost a quarter of the managers (23%) with either a diploma or degree in management did not feel that their qualification equipped them to be a better leader. This is consistent with Scott and Miles' (2013:80) findings that basic nursing education is inadequate for a nurse manager to succeed in such a position, that the incumbents of senior management positions in healthcare should embark on post-basic and university programmes that are designed to provide nurse leaders with appropriate leadership and management skills.

As per Naidoo *et al.*(2014:53), managers with formal qualifications in management are more skilled to handle a job in management than those who do not possess such a qualification; a formal management qualification equips managers with the necessary know-how to make sound and effective plans; and a tertiary qualification in management incorporates

knowledge of the various theories of leadership. For this reason, managers with a tertiary management qualification will possess a deeper understanding of the practice of leadership.

6.3 Ability to inspire a shared purpose

Unit managers were asked eight 5-point Likert type statements to determine if they had the ability to inspire a shared purpose. The responses are summarised in figure 1.

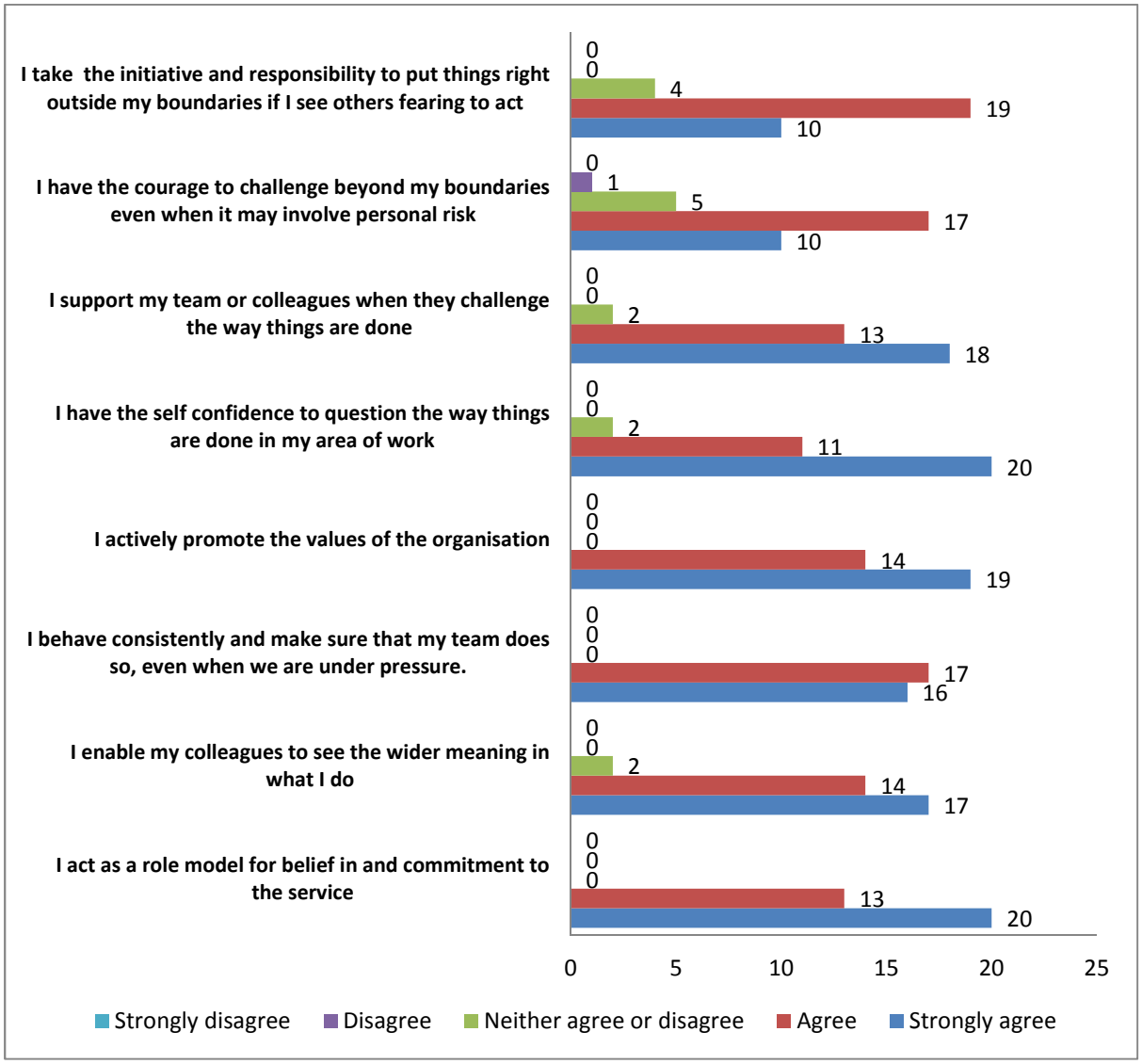

FIGURE 1: Ability to inspire a shared purpose

Source: Calculated from survey results

The results show that most of the line managers agreed or strongly agreed with all the statements, for example, all the managers positively indicated that they are directly involved in living the values and philosophy of the organisation. In addition, more than half of the managers strongly agreed that they have the self-confidence to challenge the *status quo* and provide assistance to the team when they question what is being done.

These findings are consistent with the results of research undertaken by Leeson and Millar (2013:34), who found that leaders have a desire to take risks; to change the way things are done when what is being done does not achieve the desired results; to speak out against things that prevent employees from achieving goals; and to confront issues with double meanings to bring about clarity.

The majority of the respondents in Dyess, Prestia and Smith's (2015:193) study believed that they were successful at their jobs because they had the courage to challenge the *status quo*. In order to advocate for their patients and promote patient centred care, courage is seen as a necessity (Dyess, Prestia and Smith 2015:101). Successful leaders encourage appropriate risk-taking and are open to diverse ideas and perspectives, i.e. they are not afraid to challenge the status quo (Dickson 2012:44).

6.4 Ability to lead with care

Figure 2 illustrates the nine Likert type statements that were posed to unit managers to determine their ability to lead with care.

When it came to investigating the line managers' ability to lead with care, the results showed that most of them agreed or strongly agreed with some of the statements. These were: sharing responsibility for their team members' emotional wellbeing; helping to create conditions that provide mutual care and support; acting with appropriate empathy; awareness of how their emotions impact others; and carrying out acts of kindness for their teams.

Research conducted on nurse leader resilience by Jackson and Daly (2011:22) found that nurse managers who are sensitive to changes in their working environment and who act to resolve negative situations build team spirit more effectively than those that do not. Effective leaders understand that negative emotions, if left unattended, can be detrimental to the attainment of organisational goals.

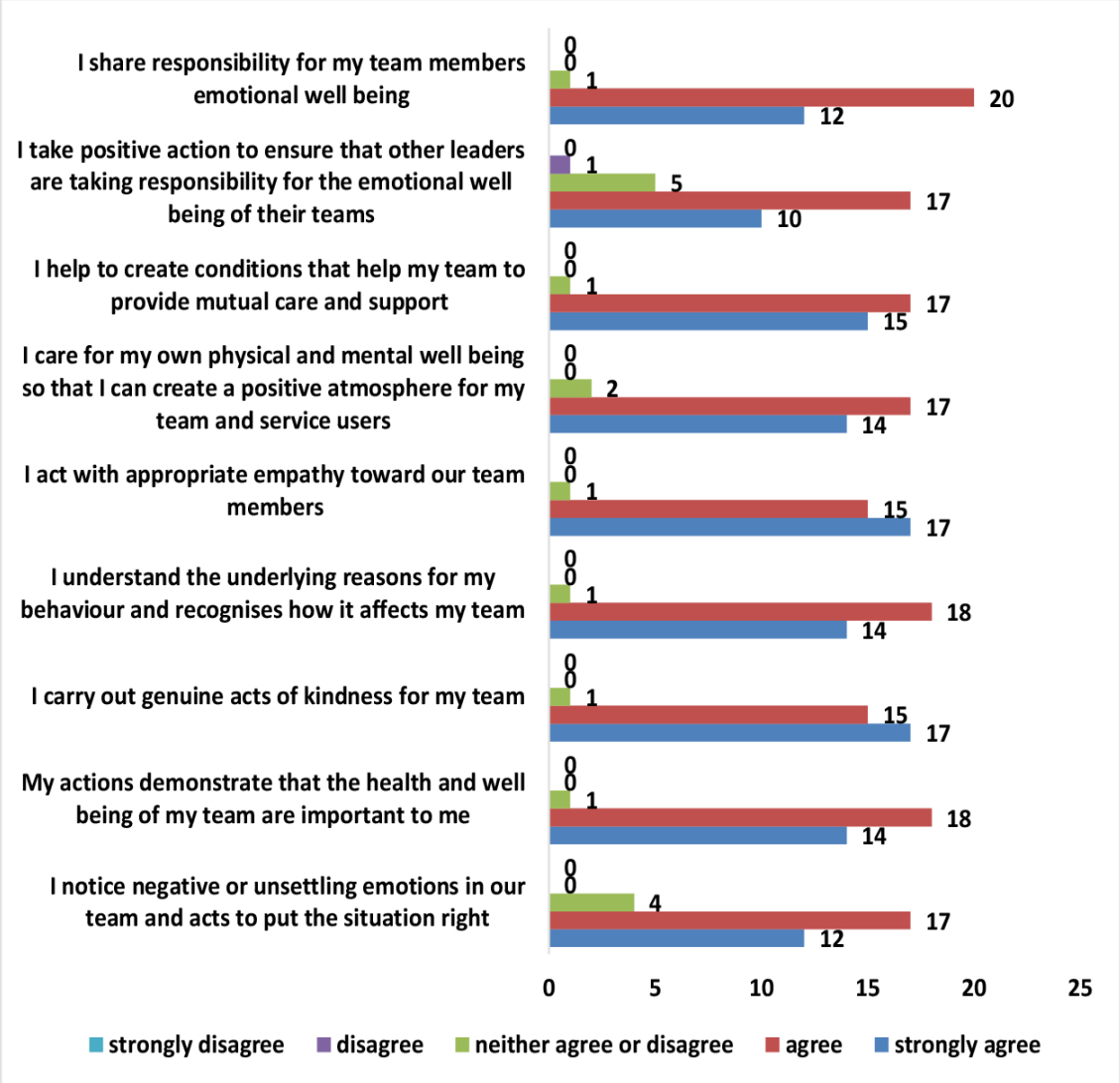

FIGURE 2: Ability to lead with care

Source: Calculated from survey results

6.5 Ability to evaluate information

Line managers were next asked to respond to seven statements that determined their ability to evaluate information. The responses are represented graphically in figure 3.

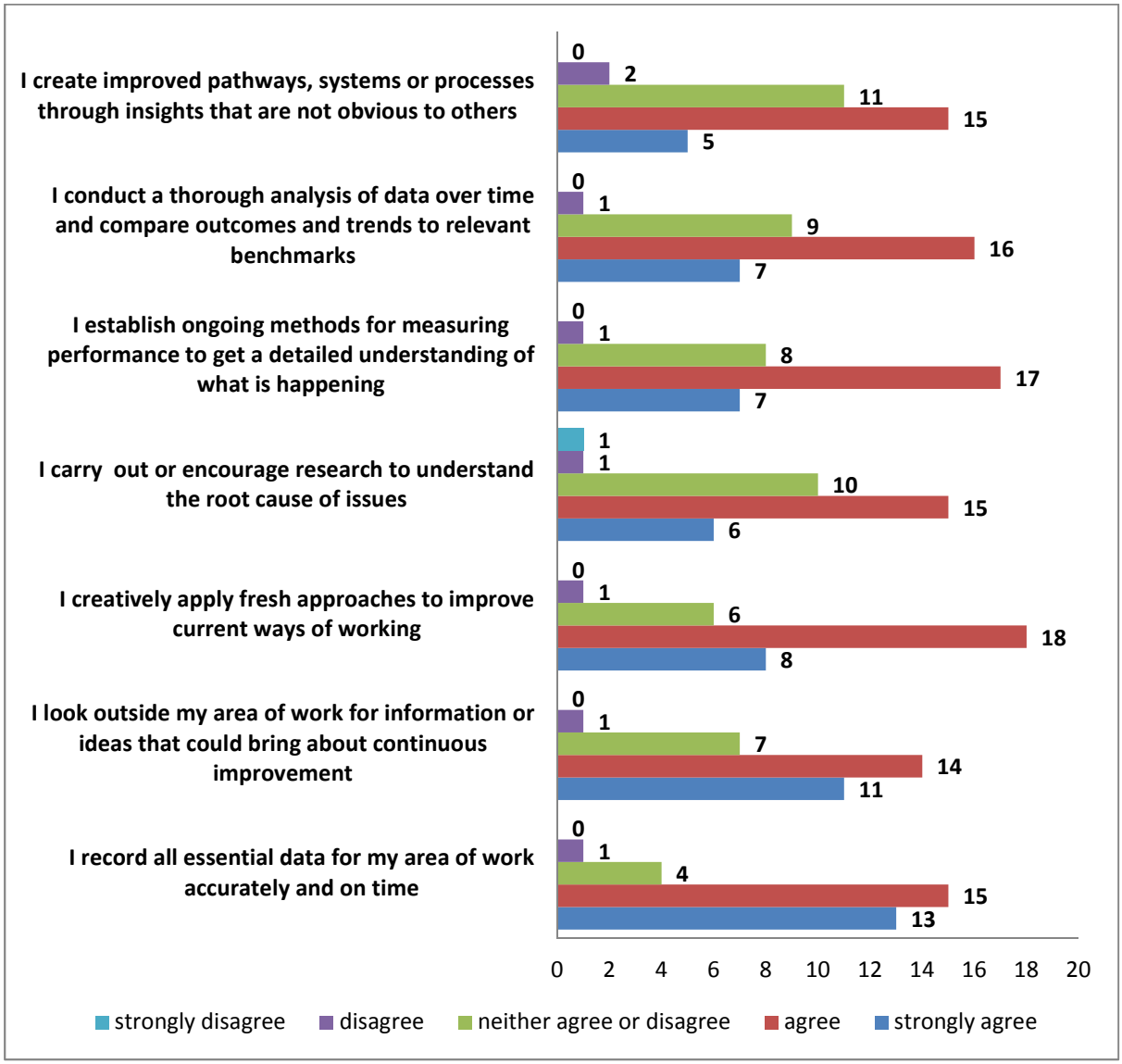

FIGURE 3: Ability to evaluate information

Source: Calculated from survey results

As per Figure 3, most line managers positively responded to all seven statements about their ability to evaluate information. For example, 55% of the managers strongly agreed that they produce innovative ideas to improve how work is done; and 85% positively mentioned that they record all relevant information timeously. When managers record essential data, they provide a communication tool for subordinates. This ensures that subordinates are aware of the progress towards goals, the clinical outcomes that need to be achieved, and the plan of

action to achieve them (NHS 2014:23).Nurse leaders do not underplay the importance of research; rather, they utilise opportunities to conduct research that will ultimately lead to an improved service. Strategic leaders believe that science must be incorporated into any plan that strives to improve the practice of nursing, including the formulation of policy. The profession of nursing has to be guided by research, whether in the practice of nursing or nursing education (Merrill 2015:321).

6.6 Ability to connect the service

Unit managers were asked seven statements that rated their ability to connect the service. The responses are graphically represented in figure 4.

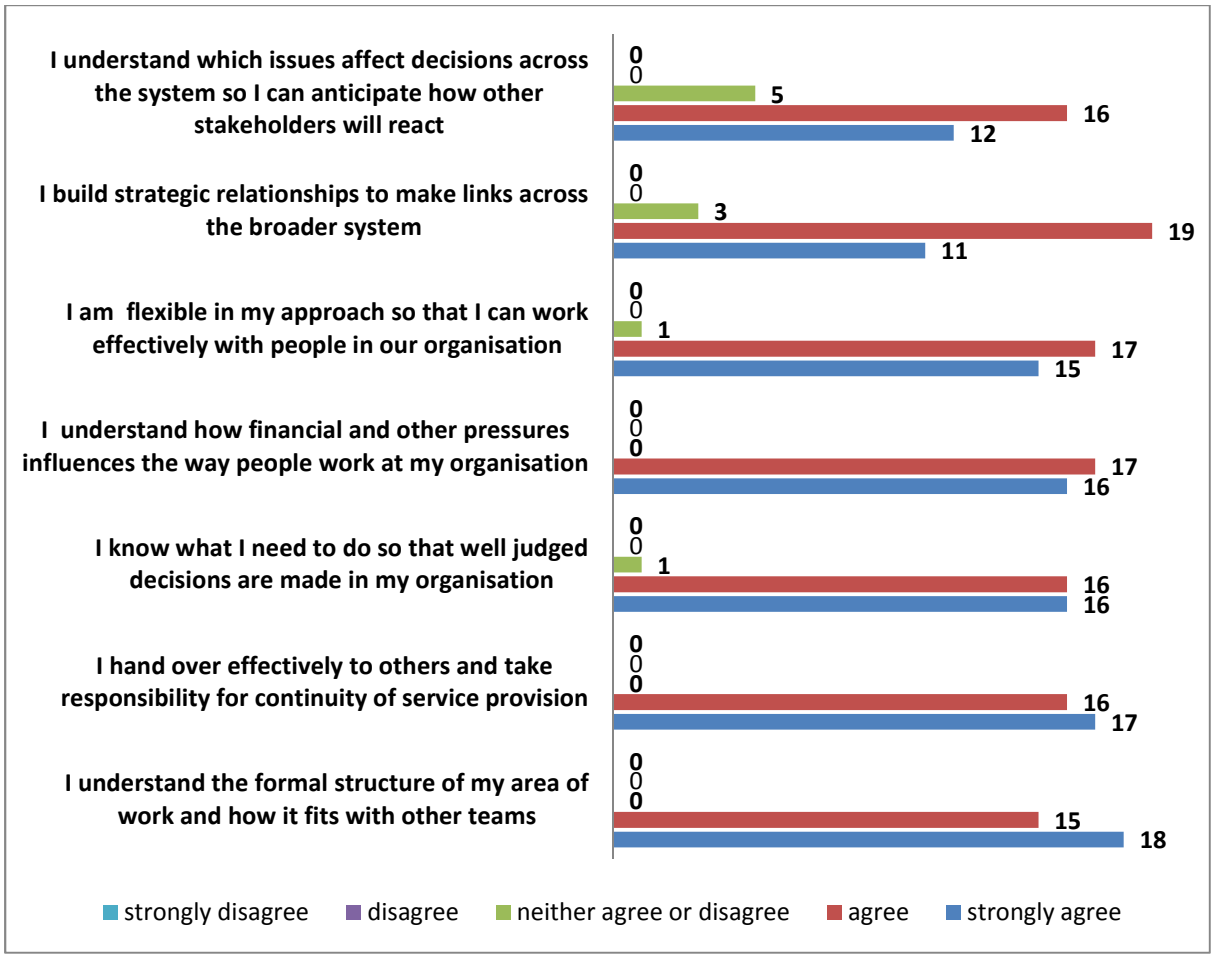

FIGURE 4: Ability to connect the service

Source: Calculated from survey results

It was found that most line managers agreed or strongly agreed with all the statements related to their ability to connect their service. The results highlight that all the managers positively indicated that they have a good understanding of how finances affect operations; that they hand over effectively to others and take responsibility for continuity of service provision; and that they are aware the nature of the operations that are performed and how different departments complement each other. The senior managers in a healthcare setting are responsible for formulating the vision and communicating the strategy to the rest of the organisation, while the leaders in the organisation take the vision forward and make it a reality by ensuring the continuity of service provision.

Although the strategy is developed at the executive level, the employees on the ground must be involved in how the strategy will be executed. This ensures that the vision is translated into a workable reality (NHS 2014:24).Employees who perceive that their organisation is flexible, humane, and inclusive obtain higher employment engagement scores than those who perceive otherwise (Bersin 2015:15).Effective leaders model flexibility and an openness to change, and tend to network outside of their work domains in an attempt to seek out new and innovative ideas (Dickenson, Snelling & Spugeon 2013:Internet).

6.7 Ability to share the organisation's vision

In order to determine their ability to share the organisation's vision, 11 statements were posed to unit managers.

Figure 5 illustrates the participants' responses to each of the statements.

The results show that most participants positively responded to all the statements. All the managers positively noted that they break things down and explain issues clearly, and that they are visible and available to all in their team. It was also found that the majority (91%) agreed that they inform their team about what needs to be done, the reasons for doing it, and the impact of the work on the future of the organisation.

In research undertaken by Probert and James (2011:142), the majority of respondents agreed that leaders who communicate with them according to their levels of understanding foster teamwork by doing so. Effective leaders understand that communication must be tailored to different needs and that there is no generic recipe for communication. The majority of the participants in a study conducted by Bersin (2015:13) did not know how the

vision would be achieved, while subordinates interviewed in Baker *et al.'s* (2012:511) research indicated that it was the nurse manager's responsibility to communicate the vision to them, with the majority agreeing that knowledge of the vision is important in achieving organisational goals.

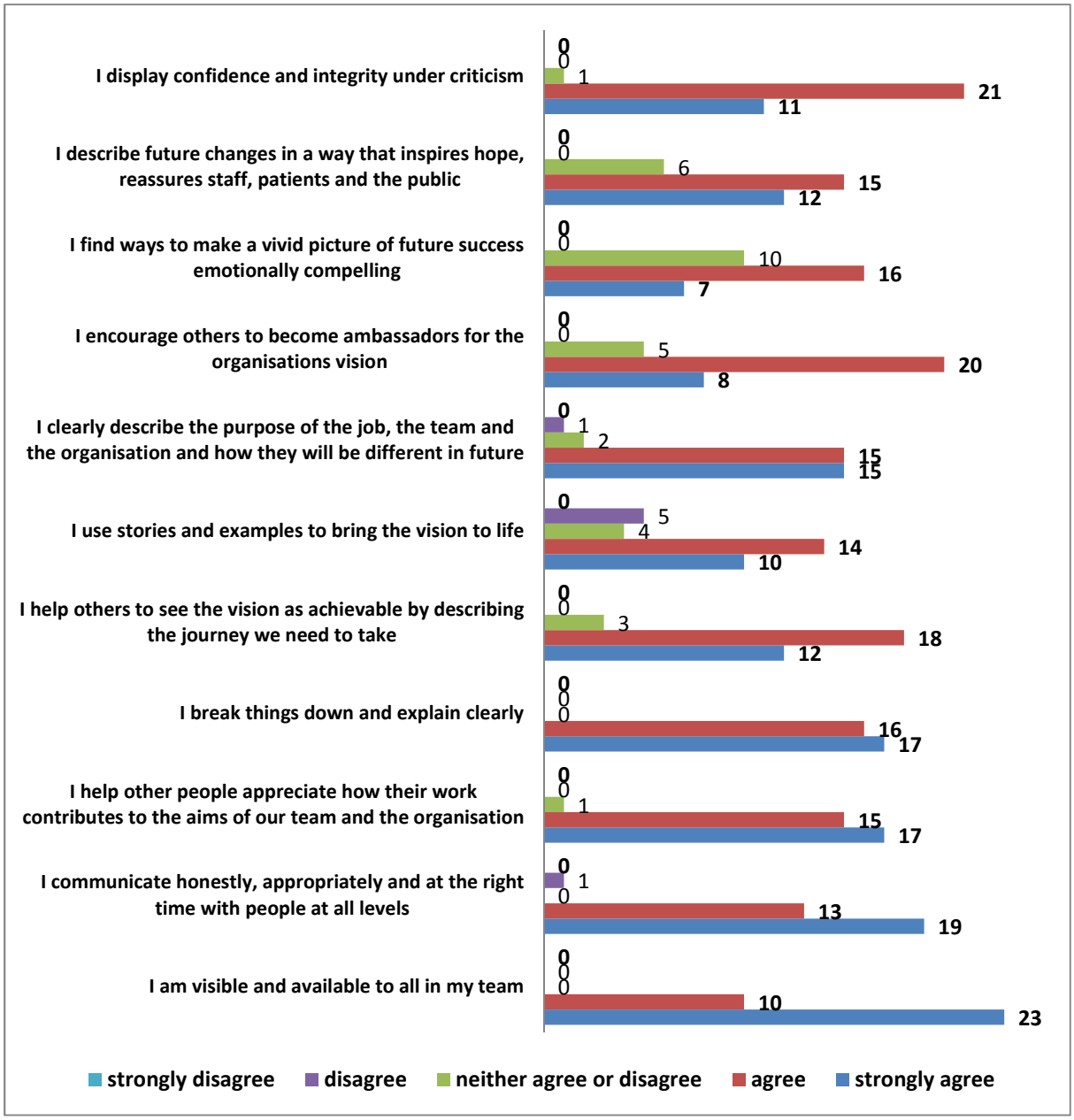

FIGURE 5: Ability to share the organisation's vision

Source: Calculated from survey results

6.8 Ability to engage the team

To determine the perception of the line managers towards their ability to engage the team, 12 statements were presented. The responses are represented graphically in figure 6.

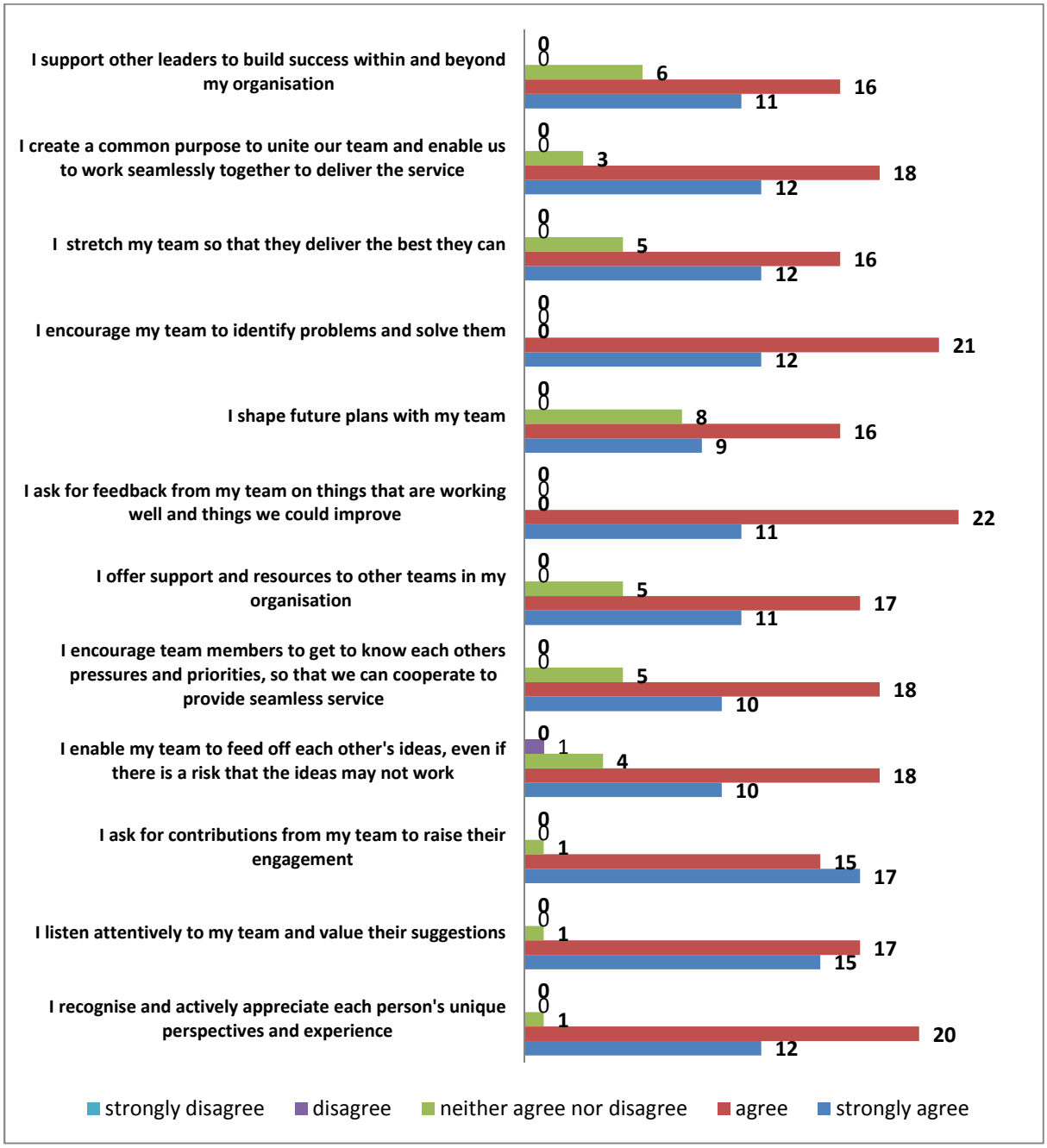

FIGURE 6: Ability to engage the team

Source: Calculated from survey results

The results show that most line managers agreed or strongly agreed with all the statements. All the participants reported that they gather opinions and suggestions from their teams regarding best practice and areas of work that require improvement, and they encourage their team to identify problems and solve them.

The majority of the respondents who participated in Blosky and Spegman's (2015:35) research agreed that they expect their leaders to discuss problems with them and include them in decision making. According to CCL (2014:27), trustworthiness and accountability displayed by leaders and team members lead directly to a healthy work environment; strong leaders use the leadership style of participation to ensure that employees are able to offer their contributions to influence decision making; and participative managers ensure that employees are included in decision making and inspire them to offer ideas, knowledge and information that can be used to improve the organisation.

6.9 Ability to maintain accountability

Figure 7 graphically represents the responses to the 13 statements posed to the unit managers to determine their ability to maintain accountability.

The results show that > 84% of the managers take personal responsibility for their own performance; they specify and prioritise what is expected of individuals and the team; they make tasks meaningful and link them to organisational goals; they ensure that individual and team goals are specific, measurable, time bound and realistic; they set clear standards for behaviour as well as for achieving tasks; they give balanced feedback and support to improve performance; and they act quickly to manage poor performance.

Efficient leaders also evaluate their own progress towards goals and maintain accountability for their performance, and hold others liable for their performance. Complex situations do not deter leaders from actively taking steps to improve outcomes, and they take personal responsibility for their actions and outcomes (NHS Leadership Academy 2014:14).

A study undertaken by Cavazotte, Moreno and Hickmann (2012:444) revealed that managers who are accountable for their actions perform better in their key performance indicators, as opposed to those managers who blame others for their failures.

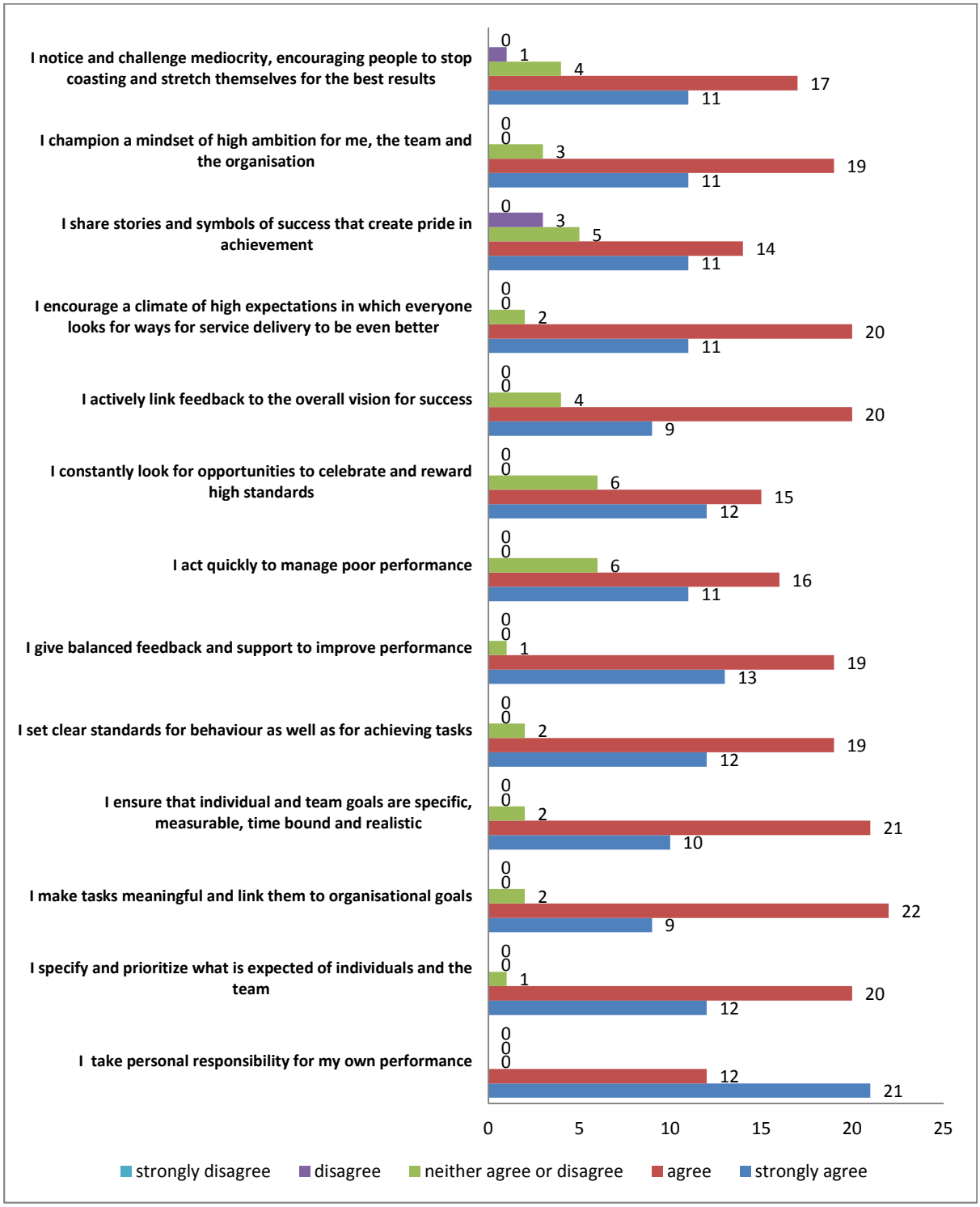

FIGURE: 7 Ability to maintain accountability

Source: Calculated from survey results

6.10 Ability to develop capability

To investigate the unit managers' perceptions of their ability to develop capabilities, ten statements were posed to them. The responses to each of these statements are represented in figure 8.

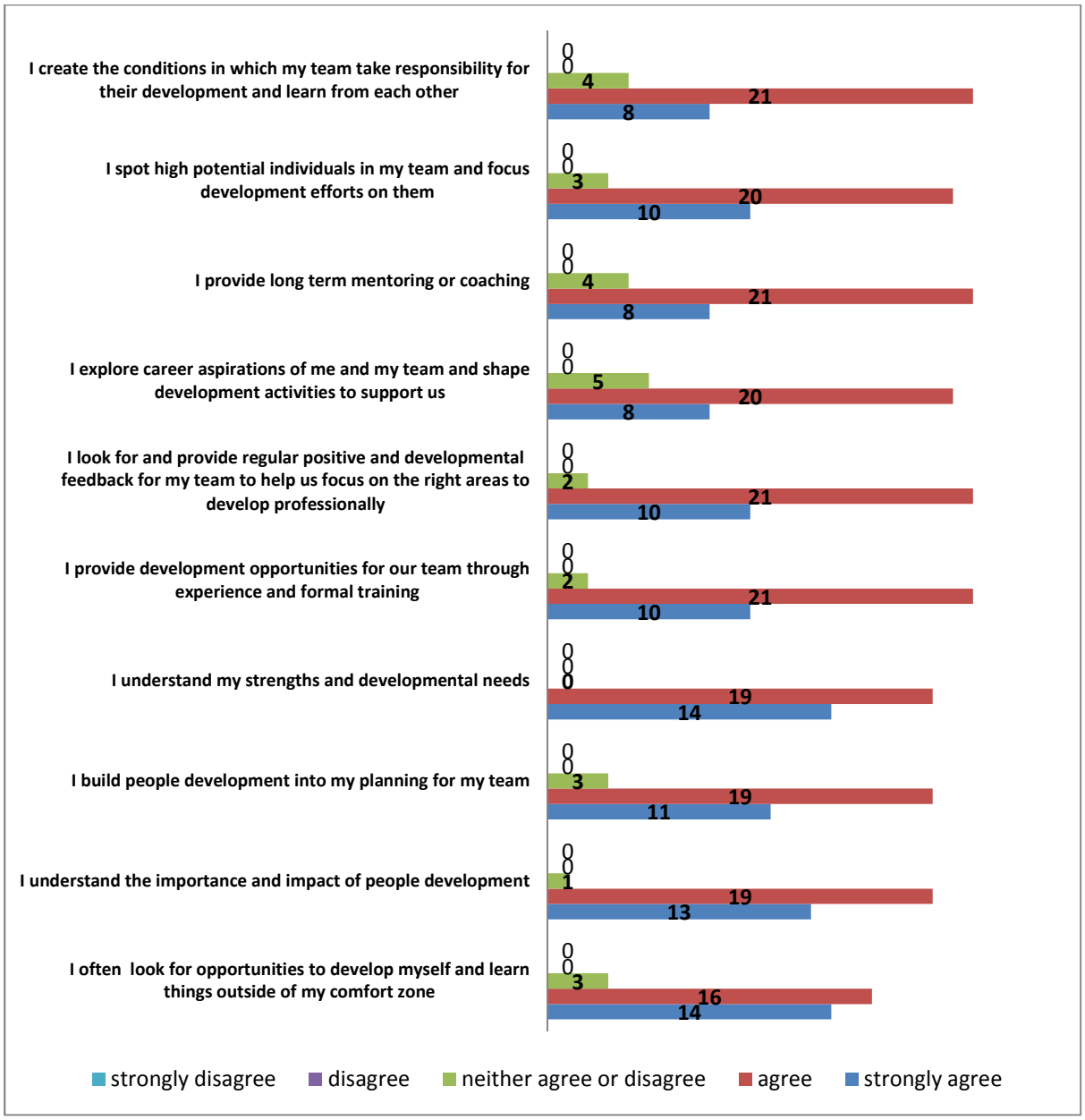

FIGURE 8: Ability to develop capability

Source: Calculated from survey results

The results found that most participants positively responded to all the statements, with > 90% of the managers agreeing that they often look for opportunities to develop themselves and learn things outside of their comfort zone. They also understand the importance and impact of people development, they build people development into their planning for their teams, they understand their strengths and developmental needs, they provide development opportunities for their teams through experience and formal training, and they look for and provide regular positive and developmental feedback to help their teams focus on the right areas to develop professionally.

Research conducted by Allen, Shankman and Miguel (2012:512) found that leaders who take the initiative to develop their leadership ability and learn outside of their boundaries feel more confident to lead others, while Sharma and Jain (2013:312) deduced that leaders who look for opportunities to improve themselves and their performance are self-aware, and that emotional intelligence is a prerequisite for successful leadership. Effective leaders create challenging roles, responsibilities, and developmental assignments that leverage and grow the talents of others (Voices of the Staff 2014:15). A significant amount of time must be spent on individual employees who are identified for succession planning. People development, performance development and succession planning are key competencies that an effective leader possesses (Ulrich 2015:109).

6.11 Ability to influence for results

In order to determine the line managers' perceptions with regards to their ability to influence for results, 11 statements were presented. Figure 9 represents the degree to which participants agreed and disagreed with these statements.

The results show that >84% of the managers take personal responsibility for their own performance; they specify and prioritise what is expected of individuals and the team; they make tasks meaningful and link them to organisational goals; they ensure that individual and team goals are specific, measurable, time bound and realistic; they set clear standards for behaviour as well as for achieving tasks; they give balanced feedback and support to improve performance; and they act quickly to manage poor performance.

Efficient leaders also evaluate their own progress towards goals and maintain accountability for their performance, and hold others liable for their performance.

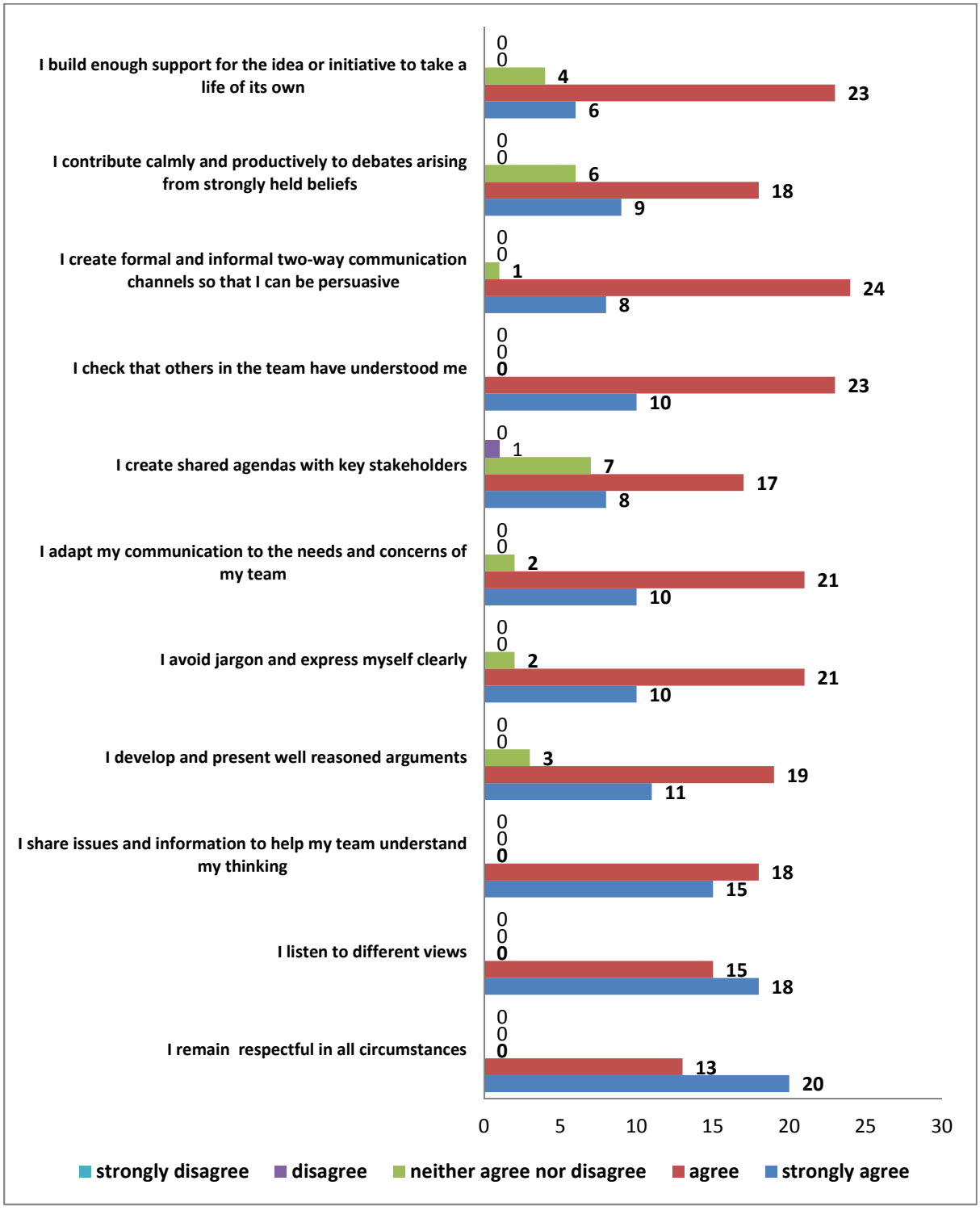

FIGURE 9: Ability to influence for results

Source: Calculated from survey results

Complex situations do not deter leaders from actively taking steps to improve outcomes, and they take personal responsibility for their actions and outcomes (NHS Leadership Academy 2014:14).

A study undertaken by Cavazotte, Moreno and Hickmann (2012:444) revealed that managers who are accountable for their actions perform better in their key performance indicators, as opposed to those managers who blame others for their failures.

It was found that all the managers agreed that they maintain respect in various situations, that they are open to contributions from the team, and that they communicate the happenings in the workplace to employees so that everyone has a shared understanding. In research undertaken by Shirey (2015:306) on leadership behaviours, it was found that leaders who respect employees also listen to their points of view and opinions. This leads to employees feeling safer and more satisfied with their jobs.

Leaders create relationships with employees, and once they develop a sense of mutual trust, respect and caring, they will work toward organisational goals (Shirey 2015:307). Excellent leaders display authenticity in that they are natural, honest and open; they are able to reflect on their deepest thoughts, feelings and intuition, and they are trustworthy in that they gain the trust of followers even when they are facing an uphill battle. Employees feel safe when they are able to trust their leader, as they feel that their hard work will pay dividends (Ham 2013:16).

6.12 Normality test output

To conduct further analysis, the scores for all the statements for each of the dimensions were added to get the final score, as illustrated in table 2.

TABLE 2: Normality test output

	Kolmogorov-Smirnov[a]		
	Statistic	**df**	**Sig**
Ability to inspire a shared purpose	0.157	33	0.058
Ability to lead with care	0.222	33	0.060

	Kolmogorov-Smirnov[a]		
	Statistic	**df**	**Sig**
Ability to evaluate information	0.093	33	0.200*
Ability to connect your service	0.258	33	0.070
Ability to share the organisation's vision	0.118	33	0.200*
Ability to engage with the team	0.144	33	0.080
Ability to maintain accountability	0.211	33	0.071
Ability to develop capability	0.206	33	0.065
Ability to influence for results	0.125	33	0.200*

a. Lilliefors Significance Correct

* This is a lower bound of the true significance

Source: Calculated from survey results 1

The overall scores for each dimension were tested for normality, which showed that the overall scores for all the dimensions were not normally distributed (p>0.05) (see Table 2). For this reason, inferential tests were conducted using a non-parametric test.

6.13 Years employed in a management position

The number of years employed in a management position was compared with the ratings on all nine leadership dimensions. The results of the comparisons are displayed in table 3 below.

The years of employment of the managers did not impact on any dimension, as they had a similar mean rank for all the dimensions (p>0.05).Research by Curtis *et al*. (2011:307) concluded that age and experience facilitates leadership, while gender is unimportant. The line managers employed in their respective healthcare organisations for less than one year held themselves in higher regard in terms of their leadership competencies as opposed to those who were line managers for more than ten years.

TABLE 3: Comparison of mean rank for all dimensions among managers with regard to their years of employment in a management position

	Years employed as a unit manager	N	Mean rank	Chi-square	P value
Ability to inspire a shared purpose	<1 year	4	17.88	0.297	0.961
	1-<5 years	11	17.86		
	5 - <10 years	9	16.89		
	>= 10 years	9	15.67		
Ability to lead with care	<1 year	4	23.63	4.235	0.237
	1-<5 years	11	16.82		
	5 - <10 years	9	18.78		
	>= 10 years	9	12.50		
Ability to evaluate information	<1 year	4	22.63	1.632	0.652
	1-<5 years	11	16.68		
	5 - <10 years	9	16.39		
	>= 10 years	9	15.50		
Ability to connect your service	<1 year	4	21.25	1.708	0.635
	1-<5 years	11	17.73		
	5 - <10 years	9	14.17		
	>= 10 years	9	17.06		
Ability to share the organisation's vision	<1 year	4	19.38	1.333	0.721
	1-<5 years	11	18.86		
	5 - <10 years	9	16.17		
	>= 10 years	9	14.50		

	Years employed as a unit manager	N	Mean rank	Chi-square	P value
Ability to engage with team	<1 year	4	23.63	2.731	0.435
	1-<5 years	11	17.64		
	5 - <10 years	9	15.94		
	>= 10 years	9	14.33		
Ability to maintain accountability	<1 year	4	21.25	2.581	0.461
	1-<5 years	11	19.05		
	5 - <10 years	9	16.17		
	>= 10 years	9	13.44		
Ability to develop capability	<1 year	4	18.38	0.220	0.974
	1-<5 years	11	17.50		
	5 - <10 years	9	16.78		
	>= 10 years	9	16.00		
Ability to influence for results	<1 year	4	24.50	2.958	0.398
	1-<5 years	11	16.95		
	5 - <10 years	9	15.56		
	>= 10 years	9	15.17		

Source: Calculated from survey results

It is possible that the line managers employed for under a year at a particular facility were previously employed in the same capacity at another healthcare organisation, and thus had more years' experience as a unit manager overall.

6.14 Impact of a tertiary qualification in management on perception of leadership competencies

A Mann Whitney U test was conducted to determine the relationship between a tertiary qualification in management and the unit managers' perceptions of their leadership competencies. This relationship is represented in table 4.

TABLE 4: Comparison of mean rank for all dimensions among managers with a tertiary qualification and those without

	Do you have a tertiary qualification in management?	N	Mean rank	Mann-Whitney U	p-value
Ability to inspire a shared purpose	No	11	18.95	99.500	0.408
	Yes	22	16.02		
Ability to lead with care	No	11	16.09	111.000	0.699
	Yes	22	17.45		
Ability to evaluate information	No	11	14.95	98.500	0.388
	Yes	22	18.02		
Ability to connect your service	No	11	15.18	101.000	0.431
	Yes	22	17.91		
Ability to share the organisation's vision	No	11	18.59	103.500	0.502
	Yes	22	16.20		
Ability to engage with team	No	11	16.91	120.000	0.969
	Yes	22	17.05		
Ability to maintain accountability	No	11	16.91	120.000	0.969
	Yes	22	17.05		
Ability to develop capability	No	11	16.82	119.000	0.938
	Yes	22	17.09		

	Do you have a tertiary qualification in management?	N	Mean rank	Mann-Whitney U	p-value
Ability to influence for results	No	11	16.86	119.500	0.954
	Yes	22	17.07		

Source: Calculated from survey results

A Mann-Whitney U test showed that having a tertiary qualification does not have any significant impact on any dimensions ($p>0.05$).The unit managers who do not have a tertiary qualification in management have a better perception of their leadership competencies when it comes to the ability to inspire a shared purpose and share the organisation's vision, while the unit managers with a tertiary qualification rated themselves better in certain leadership dimensions. These were the ability to lead with care, evaluate information, connect the service, engage the team, maintain accountability, develop capability, and influence for results. The latter dimensions are covered adequately in the theory of nursing management; therefore these managers may perceive that they are successful at these competencies.

7. DISCUSSION

There are leadership competencies among all nine leadership dimensions that unit managers feel they display adequately, however there are competencies that have been identified that require development. The NHS Leadership Competency Model stipulates that all competencies on each of the dimensions must be fulfilled in order for effective leadership to be achieved. The dimension that scored the lowest overall was the ability to evaluate information.

The components of this dimension are not covered in the existing theories on leadership competencies, but rather in the theories of managerial competencies at the degree or higher level. The majority of unit managers are not exposed to this level of knowledge since they have either a diploma in management or no tertiary management qualification at all. (Refer table 4.) The percentage of unit managers with a tertiary qualification in management is illustrated in figure 10.

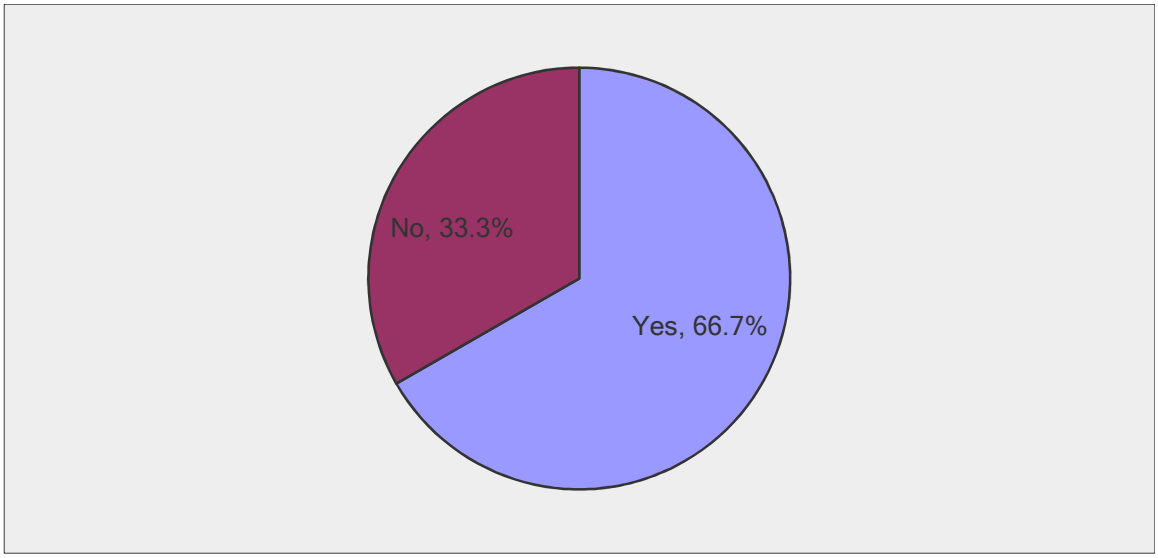

FIGURE 10: Percentage of unit managers with a tertiary qualification in management

Source: Calculated from survey results

The key competency of finding ways to make a vivid picture of future success emotionally compelling is featured largely in existing theories on leadership competencies. It is regarded as one of the most crucial competencies for effective leadership, yet it rated lowest on the dimension of sharing the organisation's vision. The other area that scored poorly was the use of stories and symbols to bring the vision to life. Although this aspect is covered in the various theories of leadership, the way to achieve this is not clearly defined, which could result in unit managers not being aware of how to achieve this competency.

Although there are no existing leadership theories that promote the need for a tertiary qualification in management, extensive literature supports the need for nurse managers to possess such a qualification. A substantial part of this qualification is based on leadership theories and the criteria for effective leadership. Nurse leaders who are of the opinion that this qualification does not benefit them in their leadership role have not utilised this qualification effectively.

8. MANAGERIAL IMPLICATIONS

The fundamental hypothesis of this research is that since nurses are appointed into leadership positions without the necessary managerial and leadership qualifications, they are often not able to effectively accomplish the required healthcare leadership tasks. This is further exacerbated by lack of a suitable healthcare leadership competency model for evaluating and improving the importance of nurse leaders.

Against these paradoxes, it is argued that this study is important because it seeks to develop a healthcare leadership competency model that can be replicated using the nine leadership competency dimensions in the 360-degree leadership assessment tool.

The requirements of leadership at the NHS are in tandem with what is required of leadership in South African healthcare. The 360-degree leadership assessment tool can therefore be applied to South African healthcare institutions to ascertain the current state of leadership effectiveness.

It can be used in a host of ways:

- with new unit managers to ascertain their coping skills and performance in their new role
- with existing unit managers biannually to evaluate leadership effectiveness and formulate performance plans
- to understand overall leadership strengths and weaknesses in the organisation
- to utilise best operating practice by sharing ideas from managers who are strong in certain competencies
- to plan leadership development activities from a point of reference as opposed to a general perspective.

A newly employed unit manager can rate their leadership competencies after six months of employment, and subordinates can rate their manager's competencies using the same tool. A discussion and comparison of results can take place between the unit manager and the senior manager, where they evaluate results and discuss areas of leadership strengths and weaknesses.

The Leadership Competency Model that was developed from this study can then be applied to formulate and implement actions that will improve leadership competencies across the affected dimensions. This process can also be carried out biannually on all unit managers

and even extended to senior management, resulting in an overall improvement in nursing leadership.

9. LIMITATIONS OF THE RESEARCH

Nursing services managers were not included in the study as only one is employed at each healthcare organisation. This would have made it easy to identify the participants as the names of the healthcare institutions were revealed in the study. For this reason, no deductions could be reached in terms of whether the nursing services managers' leadership competencies influence their subordinates' competencies in any way.

10. RECOMMENDATIONS

The healthcare institutions under study will benefit from the Leadership Competency Model that has been developed from the findings of the study. The model, which is inclusive of a 360-degree feedback tool and self-assessment tool, will provide valuable insight to line managers in the areas they feel they are strong versus the areas that subordinates feel they are lacking. The Leadership Competency Model will thus go a long way in addressing the leadership gaps that have been identified.

The second recommendation is that a formal leadership orientation programme is provided for new nurse managers, including those employed from outside the organisation. Currently, the organisations under study have a formal corporate orientation for nursing services managers only, i.e. the unit managers at ward level are excluded from this orientation programme.

Thirdly, a tertiary qualification in management should be a requirement for a unit manager role.

11. CONCLUSION

The study concluded that a tertiary management qualification is not a prerequisite for an incumbent embarking on a nursing leadership position at the four private healthcare organisations under study. The newer unit managers have a far more positive outlook on their leadership ability as opposed to those who are considered senior unit managers.

The highest reported leadership competency ratings included actively promoting the values of the organisation; behaving consistently even when under pressure; acting as a role model for belief in and commitment to the service; understanding how financial and other pressures influence the way people work; handing over effectively to others; understanding the formal structure of the area of work; being visible and available to all in the team; encouraging the team to identify problems and solve them; taking personal responsibility for own performance; and understanding own strengths, weaknesses and developmental needs. As outlined by the NHS assessment tool, these are essential competencies that influence and develop leadership.

The lowest reported competency ratings included:

- having the courage to challenge beyond their boundaries even when it involves personal risk
- taking positive action to ensure that other leaders are taking responsibility for the wellbeing of their teams
- recording all essential data for their area of work accurately and on time
- seeing patterns that help them to do things better, more efficiently or with less waste
- looking outside their area of work for information and ideas that could bring about continuous improvement
- establishing ongoing methods for measuring performance to gain a detailed understanding of what is happening
- conducting a thorough analysis of data over time and comparing outcomes and trends to relevant benchmarks
- carrying out or encouraging research to understand the root cause of issues
- creatively applying fresh approaches to improve current ways of working
- using stories and examples to bring the vision to life; shaping future plans with their team
- sharing stories and symbols of success that create pride in achievement.

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