

**Exploring the transition from
staff nurse to
ward sister/manager –
An exploratory case study**

Judith Enterkin

orcid.org/0000-0002-4381-7024

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Abstract

Background

The ward sister/manager figure has traditionally been considered the ward based clinical leader. This role has evolved over time in response to professional and political demands; despite or because of this, reports of role ambiguity exist and the ward sister/manager position has become increasingly difficult to recruit to, with nurses arguably looking to roles perceived to have greater influence and status, but less onerous managerial responsibility. Understanding the nature of this role and the factors that may impact upon the transition from staff nurse to ward sister/manager is of great significance. The gaps in understanding related to development in preparation for and in the early stages of this role, led to this research, with the aim of understanding the experience of the transition and the impact of organisation factors, and whether they facilitate or hinder the process of transition for this group of nurses.

Study design

A case study approach consisting of interviews and documentary analysis was undertaken in one metropolitan National Health Service hospital, underpinned by a critical realist approach. The case study comprised interviews with six nurses, repeated over time with three of those nurses, who had recently participated in a leadership development programme and key informants who were senior practitioners within the organisation or who were recommended by participants, in combination with strategy and policy scrutiny and website analysis. Ritchie and

Spencer's Framework approach was used to support the management and subsequent analysis of the data.

Findings

The ward sister/manager role was identified as a vital role, but the managerial components of the role served as a significant disincentive to participants.

Participants required support from significant role models during the transition process, although the degree of support, both required and available, varied.

Motivating factors and the sense of job satisfaction were essential for developing a sense of self-fulfilment. A range of support mechanisms were present and utilised across the organisation but these appeared disparate and the lack of a unifying vision for nursing services was apparent.

Contribution to knowledge

Developing into the ward sister/manager role involves a significant transition that has not previously been acknowledged. Job satisfaction in the ward sister/manager role is significantly affected by organisational factors, as well as individual factors. The organisation itself contributes to the role legitimacy of this role.

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My final thanks go to my parents. Without all their early years of encouragement I would never have dared to dream that I could achieve so much. Sadly they are no longer alive to witness the culmination of this doctoral journey. I take great comfort however from the fact that my father knew that I hoped to embark upon this journey, and my mother did know, at one point that I had started the doctoral journey, and they were immensely proud of me.

Abbreviations

Name in full	Abbreviation	Page number
Department of Health	DH	3
Leading Empowered Organisations	LEO	58
National Health Service	NHS	1
Registered Nurse	RN	8
Royal College of Nursing	RCN	4
Senior Charge Nurse	SCN	17
United Kingdom	UK	5
United States of America	USA	9

Chapter 1 Introduction

Leadership in health care services in England has never been more under the spotlight. In her forward to the document entitled *Leading Change: Adding Value*, Jane Cummings, Chief Nursing Officer for England has commented that “the key leadership contribution of nursing, midwifery and care staff is crucial to maintaining high standards and delivering change” (NHS England, 2016, p4).

Failings in leadership amongst managers, executives and health care professionals have contributed to the poor standards of care in a number of National Health Service (NHS) hospital trusts (Francis, 2013; Kirkup, 2015). Francis (2013), Berwick (2013) and Keogh (2013) all highlight the need for strong clinical leadership in today’s health service, and indeed Francis and Keogh identify the serious threats to patient safety when it is lacking. The new ambitious framework, *Developing People –Improving Care*, champions compassionate and inclusive leadership for health care staff, acknowledging that such leadership “is embedded in high quality, high performing systems ... and is also the right way to unleash people’s full potential to improve care working with patients and service users” (NHS Improvement, 2016, p7). The essential role of leadership in clinical practice has been widely accepted (Brown and Dewing, 2016); clinical leadership at the point of service delivery has been recognised as the precursor for the provision of safe, high quality care which is also compassionate (McSherry and Pearce, 2016). Indeed Brown and Dewing (2016) have argued that, for the sake and benefit of patients, service users and professionals, the nursing workforce requires better preparation for the clinical leadership role and thus the development of such leaders should be a professional priority.

Boyal and Hewison (2016) have contended that the ward sister, has been a key determinant for the quality of patient care delivered. More recently however the ward sister role has, for a number of reasons, become unattractive (Drennan et al, 2016; Wise et al, 2007). It is thus timely to consider the preparation of future or aspiring ward sisters; those novice clinical leaders upon whom our expectations rest for the delivery of high quality care in the future. An in-depth exploration of the transition from the role of staff nurse to that of ward sister/charge nurse was therefore undertaken.

For the purposes of this study, the focus is on the senior individual holding twenty-four hour responsibility for a ward, the staff and the patients therein, regardless of their title (ward sister, senior sister, ward sister/manager, charge nurse, senior charge nurse being used variously in the literature). Henceforth the term ward sister/manager is used. Presented here is a study investigating the development, preparation and support for aspiring ward sister/managers in one NHS large metropolitan hospital between 2011 and 2014.

This introductory chapter sets the scene to this investigation, establishing both the local and political background to the study. In presenting the origin of interest in this area, this first chapter establishes the initial questions for exploration and states my particular concern and focus in this area. The research question and research objectives are listed; the chosen research methodology and method introduced. An indication of the intended contribution to knowledge is proposed.

This chapter concludes with a brief overview of the content of chapters in this thesis. This account is presented in the first person throughout, the research journey being a personal one; inevitably however there are sections and chapters in which my voice is more explicit and chapters where it is more implicit. This is signposted at the introduction to each chapter.

1.1 Background

Leadership is no longer regarded as the preserve of the powerful few but a function of people's roles throughout the NHS (Bolton, 2005), and leadership needs to be developed and enhanced to create environments which allow the delivery of high quality care (Department of Health (DH), 2008b; NHS Improvement, 2016). Edmonstone (2014) proposed that clinical leadership may be interpreted as clinicians leading clinicians, and argued that the term 'clinician' implied by clinical leadership, has become an inclusive one concerning doctors, nurses and allied health professionals.

Clinical nurse leaders work at the forefront of health care; the need to develop and support clinical leaders is apparent; the ability of nurse leaders to lead, support and direct their team in inpatient areas directly impacts on patient care (Locke et al, 2011). Whilst clinical leadership in the wider political context refers almost exclusively to medical leadership (West et al, 2015), nursing leadership as a constituent part of clinical leadership, was highlighted as substandard in the failings at Mid Staffordshire Hospital and since, in other failing NHS trusts. Francis

(2013) reported a widespread lack of caring and compassion, and this failing was significantly laid at the door of nurses (Hewison, 2013).

Fealy et al (2015) have proposed that clinical leadership, as opposed to more generic leadership, is the development of leadership in the clinical arena, and that, as such, leadership development can enhance clinical practice and the local service. Although Stanley (2006a, 2006b) reported from his grounded theory study that a clinical nurse leader does not necessarily need to have the ward leader role, and that the clinical leaders identified by ward nurses were commonly not the ward sister/charge nurse, Bradshaw (2010) argues that clinical nursing leadership at ward level has traditionally been under the control of the ward sister/manager. Whether clinical nurse leadership and clinical nurse leaders are in fact, synonymous concepts, is open to debate.

The ward sister/manager figure has conventionally been considered the ward based clinical leader and front-line manager for nurses who constitute the largest single group of staff working in the NHS (Hewison, 2013; Royal College of Nursing (RCN), 2009). Throughout recent history the ward sister/manager role has been identified as having three key components; that of team leader/manager, nursing expert and educator (RCN, 2009), although the emphasis and interpretation of these components has varied significantly and there has been little large-scale research on the role (Doherty, 2003). The power associated with the role of ward sister/manager was a finding from early ward sister studies, although this power

has not generally been recognised by ward sister/managers themselves (Cunningham and Kitson, 2000a).

The time-honoured view of the ward sister/manager role has been of one individual with total responsibility for a clinical area, leading a team of nurses to deliver round the clock care to the patients in that area (Bradshaw, 2010). Over the last thirty years the role has developed and changed, and political and policy changes have impacted on the demands and requirements placed upon the ward sister/manager (Enterkin et al, 2013). Whilst these changes have been made in response to changing service and workforce needs, the impact upon current and aspiring ward sister/managers has been considerable and arguably was unforeseen.

The ward sister/manager role has undergone significant change since the 1990s. Ward sister/managers have been compelled to take on devolved responsibilities of management and administration (Locke et al, 2011). Similar reports of increasing management components to the ward sister/manager role have been reported outside of the United Kingdom (UK) (Ericsson and Augustinsson, 2015; Koivula and Paunonen-Ilmonen, 2001; McCallin and Frankson, 2010; Townsend et al, 2015). Ward sister/managers have increasingly been tasked with compiling progress reports in relation to targets from local and national policy initiatives, managing recruitment singlehandedly, dealing with complaints, resourcing and with budgetary responsibility for their clinical areas. Broad human resource management, a core constituent part of a managerial role, has become an

established part of the ward sister/manager role (Townsend et al, 2015). Time for direct clinical care for most has been eradicated completely, for others the best that can be achieved is providing a clinical presence intermittently and often whilst managing the entire ward (RCN, 2009). Bonner and McLaughlin (2014, p26) have commented on the impact of this reduction in clinical care, suggesting that “fewer opportunities to provide the role modelling and senior clinical leadership required to support a recovery-focussed environment”. Whether this intimates a devaluing of the ward sister/managers’ role in providing skilful care, or whether it merely reflects additional work area pressure is unclear. The lack of role modelling opportunities by ward sister/managers impacts on the entire ward team, thus interfering with their delivery of clinical leadership.

Recruiting to the ward sister/manager role is reported as increasingly difficult. In a study of executive nurses and human resource managers from seven NHS organisations, Drennan et al (2016, p4) reported “the ward sister/manager role was singled out as a critical role which was becoming difficult to recruit to”. With the lack of clear definitions and lack of consensus as to the dimensions of the role of the ward sister/manager, post holders may experience incongruence between the role title, the demands of the position. Sofarelli and Brown’s (1998) review of the literature on leadership within nursing, referred to the multiple views that leadership and management are substantially different roles. They concluded however, that it was important for managers to also become leaders. This ward sister/manager nurse role has evolved over time in response to professional and political demands; despite or because of this, reports of role ambiguity exist and

strategies to support the developing set of skills that ward sister/managers need have yet to be evaluated (Pegram et al, 2014).

Ward sister/managers reported that clinical nurse specialist positions were increasingly attractive in comparison with the ward sister/manager role due to “similar or better salaries ... with a lot less responsibility” (RCN, 2009, p6). Clinical nurse specialist roles have been developing for twenty years or more, nurse consultant roles and advanced nurse practitioner roles have been developing since the early 2000s; these roles have high status amongst the profession, have high levels of direct patient contact, are generally given senior gradings and are without the administrative burden that accompanies the ward sister/manager position. Junior nurse participants in Wise’s study (2007) expressed a reluctance to consider the ward sister/manager role and discussed the more specialist roles as a more desirable career progression route.

Changes to the ward sister/manager title have failed to ameliorate the problems stemming from the increasing range of enticing career options for nurses. The traditional ward sister/manager post, common across the United Kingdom in the 80s and 90s, was one of ward leader, manager of the ward team and clinical role model. Today this post is, in many cases, referred to as a ward manager, thus giving an explicit unequivocal message that the role is now firmly concerned with management (Bolton, 2003; Doherty, 2003; Locke et al, 2011; Wise, 2007). In more recent years, other titles have been referred to in the literature: clinical ward leader, clinical nurse manager, charge nurse manager. Figure 1.1 provides

an illustration of these changing staff nurse and ward sister and ward sister/manager titles over time, and this exemplifies the challenges of exploring both the staff nurse and ward sister/manager role.

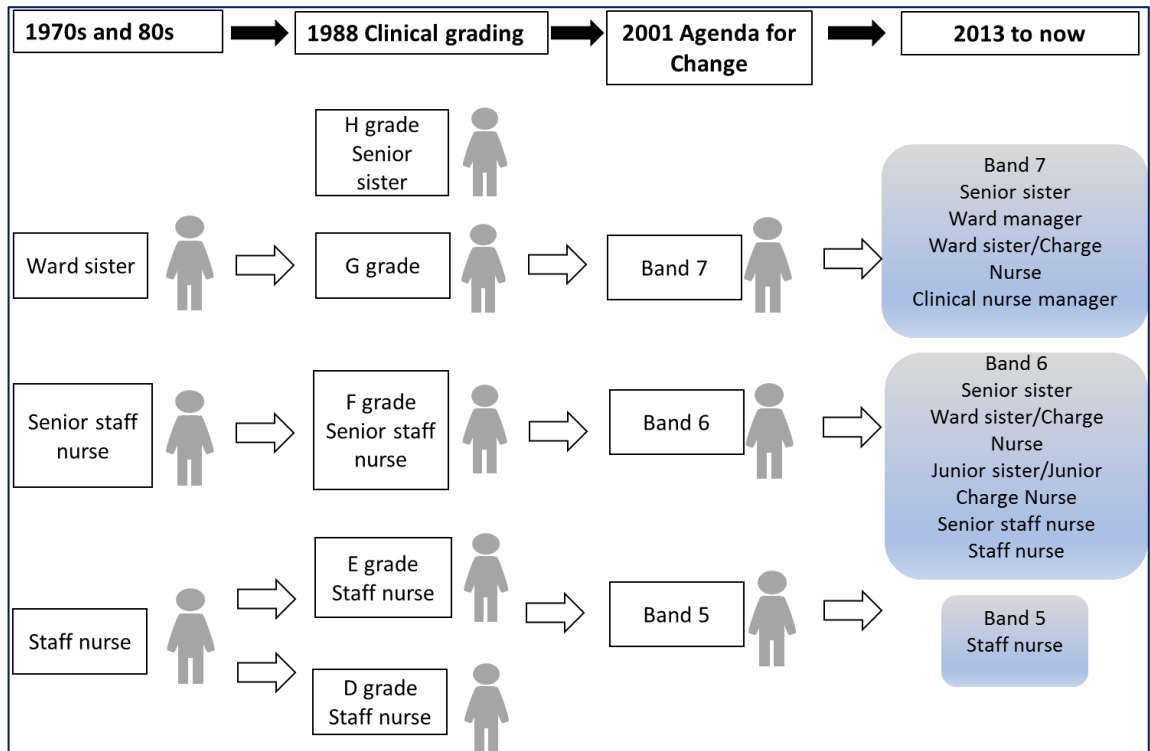


Figure 1.1 Evolving ward level qualified nurse titles

It is not only ward sister/manager titles that have evolved over the past three decades; registered nurse (RN) titles have undergone parallel changes (Figure 1.1). Prior to 1998, in the UK RNs were called staff nurses at the point of registration. The title of senior staff nurse conveyed seniority but without any specific increase in pay levels. In 1988, a change was made to the nursing career structure establishing two additional pay levels for RNs. At the point of registration, nurses would be positioned as a 'D grade' staff nurse, subsequent levels of seniority were 'E grade' staff nurse and 'F grade staff nurse'. F grade staff nurses in some areas were also referred to as senior staff nurses. The Agenda for

Change NHS pay modernisation programme, initiated in 1999 but implemented in 2001 sought to simplify this structure and condense the three pay grades to two pay bands (DH, 1999b). Nurses at the point of registration were appointed as band five staff nurses with the subsequent pay banding, band six being termed variously staff nurse, senior staff nurse, junior sister, and ward sister.

Bolton (2003, 2005) reported that nurses did not wish to be associated with the label of 'manager' and that ward sister/managers were uncomfortable with their management role. Wise's (2007) exploration of ward management in an NHS Scotland Trust identified that only 10% of junior nurses questioned had career aspirations for their line-managers' position. In addition, of those with any clear career aspirations, many were looking at clinical nurse specialist /advanced practice routes rather than that of the ward sister/manager. Similar findings have been reported by others both in the UK and elsewhere (Sherman 2005) highlighting serious concerns for the future recruitment situation for this role. Recruiting to these ward sister/manager roles has become more difficult in recent years in the UK; this pattern has in addition been identified more broadly across Europe, the United States of America (USA), Canada and Australia. Changing workforce patterns in combination with an ageing nursing population compound this difficulty (DH, 1999a; DH, 2008a; RCN, 2009).

It is possible that for some nurses the perception of 'cultural dissonance' (Ericsson and Augustinsson, 2015; Schriener 2007; Stanley, 2008,) between caring and managing, affects their interpretation of the ward sister/manager role and

their enthusiasm for undertaking it. Sofarelli and Brown (1998) identified transformational leadership as a valid leadership approach that offers congruence between the nurse as carer and the nurse as leader. The need for management skills alongside transformational leadership to challenge and lead organisations into the future is recognised (Sofarelli and Brown 1998).

With these difficulties firmly in mind, there is a pressing need to understand the career aspirations of aspiring ward sister/managers and to understand and support them in making a timely and successful transition to this role. That this transition process should be supported should come as no surprise, however, whilst the development needs of the ward sister/manager have been debated and explored since the early 1980s (Dodwell and Lathlean 1987; Pembrey 1980; Thomas and Bond 1990), there has been little if any focus on developing the next generation of ward sister/managers until very recently (Enterkin et al, 2013). Indeed developing nursing leadership featured in three specific recommendations from the Francis report (Francis, 2013).

Empirical evidence to date has suggested that role change can be a stressful and challenging time; student to staff nurse transitions, staff nurse to clinical nurse specialist (CNS) and from staff nurse to clinical nurse educator (CNE) have been explored in the literature (Bamford and Gibson, 2000; Edwards et al, 2015; Johnstone et al, 2008; Manning and Neville, 2009). In contrast, the transition process to ward sister/manager role has received almost no specific attention from researchers, despite the fact that irrespective of changes to nursing

structures within the NHS, this remains an important clinical and managerial position.

The concept of succession planning for the ward sister/manager, has not widely been considered in the nursing literature until 2010, since when a slow but steady stream of interest has been noted. The initial focus of interest prompting the research presented here is an exploration of the experience of undergoing the transition from staff nurse to ward sister/manager.

1.1.1 Initial question of interest

What are the factors that impact on the transition from staff nurse to ward sister/manager?

The ward sister/manager role has been acknowledged as pivotal; the clinical expert responsible for all aspects of patient care (Hewison, 2012; Locke et al, 2011). The ward sister/manager role is arguably the lynch pin of the success of the UK government's health modernisation agenda, being at the forefront of patient care, with the potential to utilise strong leadership to provide a high quality service (Doherty 2003), through influencing attitudes and behaviours of nursing staff (Koivula and Paunonen-Ilmonen, 2001). Jasper (2005) reported that leadership was a relatively new concept for the British NHS however, and the development of leadership within health care has consequently been a core component of the modernisation agenda since the late 1990s (Boomer and

McCormack, 2010; Carr, 2009; Jasper, 2005). Indeed the UK government has equated poor leadership with poor standards of care (DH, 1999).

1.1.2 Workforce demographics

The recent global financial crisis (Wray, 2013) has resulted in a reduction in nursing student training places, and the loss of senior nurses who had previously overseen quality and safety. This reduction in both new and experienced practitioners, in conjunction with an ageing nursing workforce (Snow, 2012; Wray et al, 2009, 2013), has implications for health care and nursing which are complex and arguably poorly understood. Indeed, the ageing nursing workforce, in Europe, the Australias and the USA and Canada has been referred to as a ticking time-bomb (Wray, 2013). In addition, leadership roles, such as the ward sister/manager role, do not appear to be the career of choice for a large number of nurses (Abraham, 2011; Wise, 2007). The challenge facing health care organisations is to ensure a continuing supply of appropriately skilled nurses and clinical nurse leaders to lead the service for the next ten to twenty years (Sherman et al, 2013).

A breakdown of the workforce demographics amongst UK nurses, midwives and health visitors from 2001 to 2013 is shown in Figure 1.2. Of note, is the increase in the mode age banding during the past 12 years. In 2001, the mode age banding band for nursing, midwifery and health visitors was aged 35-39. By 2005, the mode age banding had increased to 40-44. In 2010 and 2013 the mode age banding is 45-49. These figures clearly demonstrate that overall, the nursing,

midwifery and health visiting workforce is ageing. This trend will inevitably continue, and this sizeable group of health care staff, aged between 50 and 54 in 2013, will be reaching retirement by 2023-28. Unless recruitment into the professions increases commensurately, year on year, staffing shortages in the future will be inevitable.

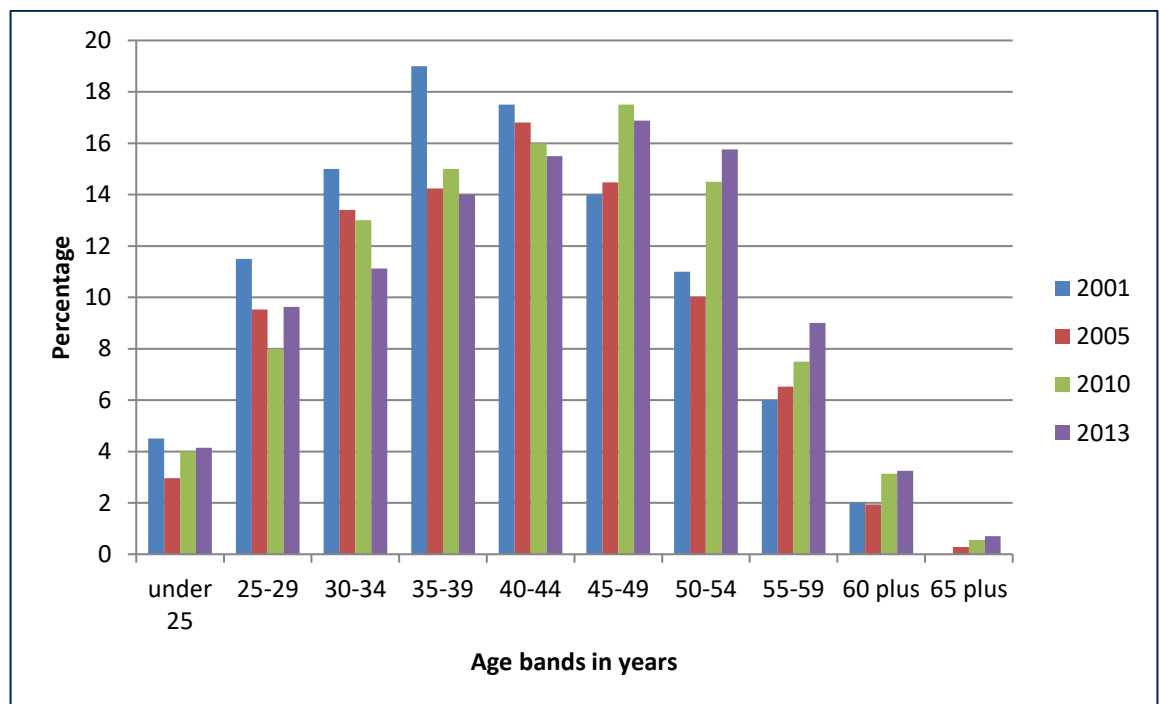


Figure 1.2 Workforce demographic, percentages across qualified workforce of nurses, midwives and health visitors, at age bands staff (Health and Social Care Information Centre, 2013).

Figure 1.3 illustrates staff level by banding in 2013. The classifications utilised in this data refer to level 1 nurses, managers, modern matrons and nurse consultants, with no specific definition of each term, thus rendering it challenging to specifically locate the ward sister/manager. The overall ageing of each group

however supports the contentions that the entire workforce is ageing overall and that ward sister/managers within the workforce are likely to be ageing similarly. The implications of this ageing workforce, and more especially the ageing band of managers, is that unless management and leadership positions are made more attractive and meaningful to today’s nursing workforce, a severe shortage of managers will occur within the foreseeable future.

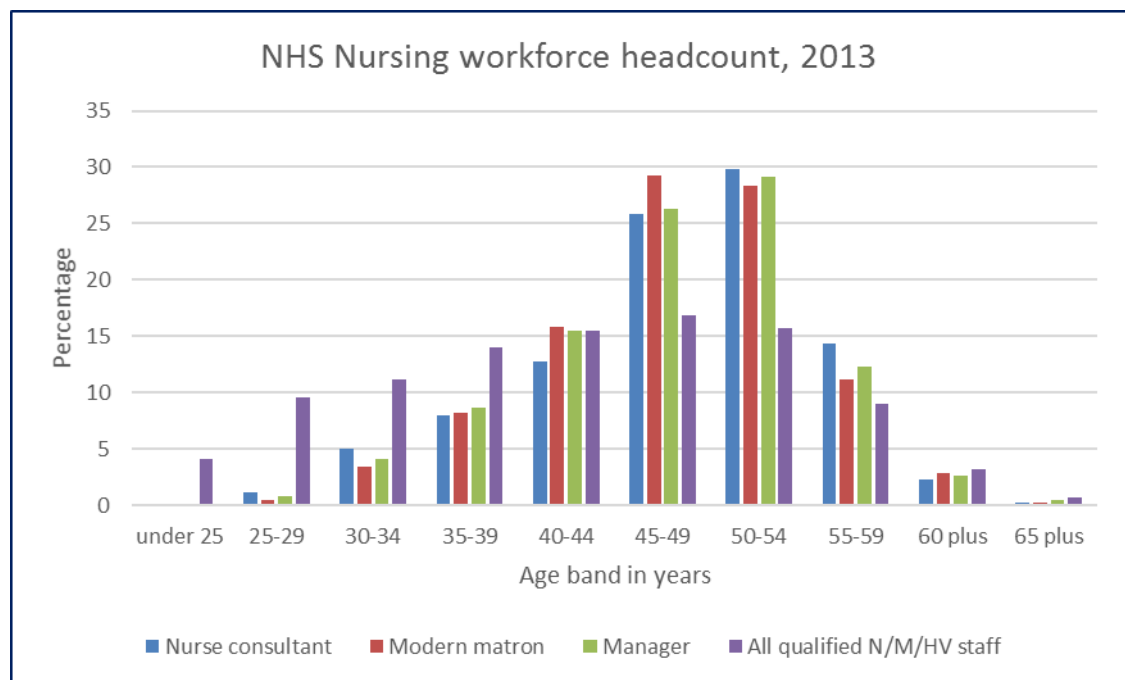


Figure 1.3 Staff level by age band in 2013 (Health and Social Care Information Centre, 2013).

1.1.3 Leadership and the organisational context


Checkland has suggested that contemporary UK policy documents communicate the message that “the NHS in England is now in the hands of clinical leaders” and that the “problem of the NHS can be understood as driven by a lack of clinical leadership” (Checkland, 2014, p254). Hewison and Morrell (2014) have used the

concept of the 'episteme', a collectively internalised code of culture to consider the policy effects on nursing leadership development in the NHS. They have argued that this episteme results in a "narrative about leadership that is theoretically thin and simplistic" considering a competency based view of leadership which ignores the context within which leadership is situated (Hewison and Morrell, 2014, p678). The individual organisation, an NHS hospital, sits within this NHS context. Doherty (2009, p1135) reported that "simultaneous centralisation and decentralisation has occurred, as management of NHS Trusts has been devolved locally with government remaining in control of strategy, resource allocation and performance targets". This has resulted in increasing external performance measurement of targets with resulting incentives or sanctions for reaching or failing to achieve performance targets. In this context, formal organisation leaders are required to conform to targets and central control thus potentially inhibiting the "empowerment of informal leadership", thereby preventing distributed leadership (Ogilvie, 2012, unpublished thesis, p57). This highlights the resultant tensions between the requirement to meet targets and key performance indicators and the desire to develop and empower the nursing workforce to deliver the highest quality, person-centred care. It would appear that the quantitative nature of targets is given precedence over qualitative measures. Nursing work, which has been considered as difficult to measure, is thus challenging to link with performance targets (Doherty, 2009).

It is imperative to situate this discussion in the context of an evolving political and professional context in the United Kingdom. Since the 1960s, central health policy

initiatives have affected the nursing workforce, both directly and indirectly (Table 1.1, Central Policy timeline).

Table 1.1 Central Policy timeline


Timeframes	Policy Initiative	Source of Origin
1966  2010	1966 Salmon Report	Ministry of Health
	1972 Briggs Report	Report of the Committee on Nursing
	1983 Griffiths Report	Department of Health and Social Security
	1990 NHS and Community Care Act	National Health Service
	1999a Making a Difference, strengthening the nursing midwifery and health visiting contribution to health and healthcare	Department of Health
	1999b Agenda for Change, modernising the NHS pay system	Department of Health
	2000 NHS Plan	Department of Health
	2006 Modernising Nursing Careers	Department of Health
	2008b High Quality Care for All NHS Next Stage Review	Department of Health
	2008c A High Quality Workforce: NHS Next Stage review	Department of Health
	2010 Prime Minister's Commission on the Future of Nursing and Midwifery	Prime Minister's Commission

Salmon in 1966 set out to improve the career structure above that of ward sister/manager (Pegram, 2014). The Griffiths Report in 1983 introduced general management into the NHS. In 1999, the White Paper, Making a Difference (Department of Health, 1999) sought to strengthen the contribution of nursing and midwifery by establishing a clearly defined career structure, offering the

potential for expert practitioners to become advanced or consultant nurse practitioners. Designated academic levels of achievement were set alongside this framework. Subsequently, nurses seeking increased professional autonomy and recognition, have started to explore and take up the widening range of nurse specialist and advanced nursing posts, rather than the ward sister/manager post (Currie et al, 2010).

Of note is that through devolved government, the Scottish government initiated the Leading Better Care policy in 2008. The purpose of this policy was to provide clarity for the “senior charge nurse (SCN)” (replacing the less well-defined role of ward sister), recognising the need to “enable SCNs to provide high quality clinical leadership, visibility and accessibility to patients, their families and their teams, including other healthcare professionals” (Russell and McGuire, 2014, p37). A succession of position statements, research reports and models for best practice concerning nurses and nursing have been forthcoming in recent years (Table 1.2). Ward level nursing leadership, delivered by the ward sister/manager has been a consistent theme throughout these and despite the many changes to the ward sister/manager position, the role remains vital to the delivery of high quality care.

Table 1.2 Professional policy/strategy for developing nursing practice and leadership

Timeframes	Policy/strategy title	Source of Origin
2006  2013	2006 NHS Leadership Qualities Framework	National Health Service Institute for Innovation and Improvement
	2008 Releasing time to care: the Productive Ward Series	National Health Service Institute for Innovation and Improvement
	2009 Breaking down barriers, driving up standards	Royal College of Nursing
	2010a Position Statement on Advanced Nursing Roles	Department of Health
	2010b Nursing Roadmap for quality	Department of Health
	2011 Energise for Excellence	Chief Nursing Officer, Department of Health
	2012 Establishment of the NHS Leadership Academy	National Health Service
	2013 How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability	National Quality Board
	2013 Safe staffing levels – a national imperative. The UK nursing labour market review 2013	Royal College of Nursing

The NHS Leadership Qualities Framework established in 2006 (NHS Institute for Innovation and Improvement), was intended to provide a framework for clinical and managerial leadership in England. Edmonstone (2011) has suggested that this was much criticised as being focussed on the roles of senior leaders and reinforcing the concept that leadership exists only within individual leaders.

Subsequent leadership development in healthcare was fragmented with the establishment of the Medical Leadership Competency Framework from the Academy of Medical Royal Colleges and the Clinical Leadership competency Framework extending a framework to other healthcare professionals (Edmonstone, 2014). A change in focus and an attempt to provide a more uniform approach to leadership in healthcare led to the establishment of the NHS Leadership Framework in 2011; this framework, like others before it, was developed as a primarily competency based framework (Edmonstone, 2014). The NHS Leadership Academy, established in 2012 as a stand-alone body, has developed and is providing varying levels of leadership development for health care workers across England, based upon the NHS Leadership Framework which was published in 2013. Four levels of pathways have been established for different levels of practitioners within this framework of programmes for leadership development (NHS Leadership Academy, 2013). The NHS Leadership Academy (2016) states that 26,000 people had registered to participate in the development programmes, however to date there is no published evidence of evaluation from these programmes other than opinion pieces and comments on social media platforms. NHS England's Five Year Forward View states that "we will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality" (NHS England, 2014, p8). In 2015 the NHS Leadership Academy was subsumed within Health Education England following concerns expressed in the Rose Report that the Leadership training and education was not sufficient for the needs of the workforce and that the NHS Leadership Academy did not have the status required and education and

training provided lacked diversity (Rose, 2015). Edmonstone (2014) has contended that the multiplicity of leadership competency frameworks and bodies involved in their development (Medical Royal Colleges, NHS Institute for Innovation and Improvement and National Leadership College for the NHS) served to confuse the workforce, seeming in addition to highlight tension between the needs for conformity on the one hand and for diversity and flexibility on the other. Rose (2015) stipulated the need for leadership training to be flexible and responsive and has noted some concerns about the value of the various leadership competency frameworks which lack evidence of their utility and effectiveness in practice. NHS Improvement (2016, p6) have more recently established their “evidence-based national framework to guide action on improvement skill-building, leadership development and talent management in NHS-funded services”, although their espoused vision is that systems based, competency driven leadership is the only way forward, and the evidence base for leadership development is limited.

Thus the national health and professional policy agendas serve to confuse rather than provide a clear evidence based pathway for the development and establishment of clinical leadership, delivered by ward sister/managers, for nurses and other health care professionals. West et al (2015) suggest that the Royal College of Nursing Clinical Leadership project has had more successful implementation and has been used as a toolkit across a number of other countries. They comment though that evidence of impact on clinical care is lacking (West et al, 2015).

1.1.4 My focus of interest in this area

The starting point in this study was a challenge in the practice setting that warranted investigation. The start of the process of enquiry was an interest in the progression of staff nurses to ward sister/managers in a large outer London NHS Hospital. The hospital was struggling to recruit to ward sister/manager positions and as a result sought to develop and prepare staff nurses, variously termed staff nurse, senior staff nurse, junior sister, in preparation for the role. A leadership development programme was established; I was one of the two facilitators responsible for building and delivering the resulting programme. The focus of this research reported here, was not to evaluate the leadership development programme or to attempt to measure outcomes; it served purely as a vehicle for accessing participants in aspiring ward sister/manager positions.

I am a nurse of thirty years' experience, ten years of which were in the clinical leadership role of ward sister/manager, and thirteen of which have been in education. My focus of teaching and interest is in developing clinical leaders and leadership to enhance service delivery. I was inspired to explore the experience of role transition for nurses in this hospital, to understand what influenced staff nurses to apply for ward sister/manager positions and to understand what might be influencing those who chose not to pursue this career direction.

Ashforth (2001, p3) has defined role transition as the "psychological and physical movement between roles, including disengagement from one role and

engagement in another". Meleis and colleagues (2000) identified a vulnerability associated with transition experiences and identified that transitions may be identified as a result of and a result in change in lives, health, relationships and environments (Meleis et al 2000). Whilst nurses may be the primary care-givers of clients and families undergoing transition, and are significant in preparing clients for impending transitions (Meleis et al 2000), little, if any emphasis has been placed upon understanding the role transitions that nurses themselves experience at different times in their careers.

The focus of the study reported here is the transition process from the role of staff nurse (various local titles as described above) to that of ward sister/manager. The term 'ward sister' is one that remains consistently used by the RCN, but in the context of the organisation which was the focus for study, this needed to be explained to participants as 'the transition from staff nurse (or junior sister at Band 6) to ward sister/manager (at Band 7)'.

The research site selected is a large metropolitan NHS Hospital in the London area taking surgical and medical patients, adults and children and with a large midwifery department and a busy emergency department. At the time of the inception of the study, the hospital in question was experiencing difficulties in recruiting to the ward sister/manager post and had commissioned a tailor-made leadership development programme for ward nurses aspiring to the ward sister/manager position.

1.2 Proposed contribution to knowledge

I will be arguing that in order to understand the experience during the transition from staff nurse to ward sister/manager, it is necessary to understand what gives self-fulfilment to the practitioner, how they work in the context of their own ward or department and how that forms part of the organisation as a whole.

I offer a contribution to knowledge with two elements:

- Role transition, which has been reported amongst other groups, appears to be a process that staff nurses progress through to become ward sister/managers.
- Job satisfaction is essential for practitioners to enable them to achieve self-fulfilment. The organisation has a responsibility to support individuals in achieving job satisfaction and to establish the role that has legitimacy thus contributing to role fulfilment and thus self-fulfilment.

In addition to the theoretical contribution, I also offer recommendations for practice and for further research in the concluding chapter.

1.3 Overview of the structure of this thesis

The direction and structure of this thesis is set out as follows. In chapter two, I set out the evolution and detail of the search strategy and ensuing literature review which has established the foundations and backbone for this research. I expound on the scoping literature review that was carried out in 2010 and then revised

and refreshed over the ensuing period. This critical literature review is then presented in two constituent parts in chapters three and four.

In chapter three the nature of the ward sister/manager role is presented. The ensuing discussion explores the nature of leadership demonstrated by ward sister/managers, the multiple roles that ward sister/managers hold and tensions created by these multiple roles. The concept of ward sister/manager as clinical expert is considered. A summary of what is known and what knowledge gaps exist is the conclusion of this chapter.

Chapter four explores the development of nurses for the ward sister/manager role. This chapter commences with an exploration of knowledge and skills deficits identified by ward sister/managers themselves. Development initiatives for aspiring or established ward sister/managers are explored with a view to uncovering further learning and development needs and establishing how these initiatives impact upon individual experience. Barriers to the development of leadership are considered next. Systematic, organisation-wide strategies for preparing future ward sister/managers are explored in the latter part of this chapter. A summary of what is known and what knowledge gaps exist is the culmination of this chapter. The evolution of my thinking, through critical reflection and dialogue, led to this design for the study, and the research question will be introduced at the conclusion of this chapter.

The research methodology and method is detailed in chapter five. This methodology was established to answer the questions:

- What is the experience of transition from the role of staff nurse to ward sister/manager in an organisation?
- What is the culture of this organisation as evidenced by structures, policies, work roles, power structures, and from the perspectives of staff nurses and senior trust team?
- What influence do these factors (structures and policies) have: do they contribute to, facilitate or hinder this process of transition?

In this chapter I have explored the underpinning methodology for this research and established the context. The research method is detailed setting out the necessary steps and stages involved with developing the proposal, gaining ethical approvals, sampling and the research process itself. The analysis section sets out the use of Framework analysis (Ritchie and Spencer, 1994) to support the data management and subsequent iterative process of analysis. An illustration of the development of the thematic map for the study is included.

In chapter six, the findings from the study are set out to enable to reader to understand the richness of the data and to be submerged in the development of themes that provide the ultimate conceptual map.

Chapter seven presents a discussion of the research findings in the context of the literature explored.

The concluding chapter, chapter eight, sets out a fuller description of my contribution to new knowledge. Included here is a synopsis of my reflections through this journey of inquiry. The impact of these findings on practice will be considered. The limitations that have arisen from this study and the potential for future research will be explored. The dissemination of my findings will be incorporated here.

1.4 Chapter summary

In this introductory chapter I have established the context for this research exploring the nature and context of transition from staff nurse to ward sister/manager in a large NHS hospital in London. The content and context of the study presented in this thesis has been introduced. The research reported here is narrated in the first person, although my voice is necessarily less evident in some sections and more in others. The introduction to each chapter establishes the tone and nature of that chapter, thus enabling the reader to appreciate the narrative decisions arrived at, at the outset.

Chapter 2 Searching, retrieval and quality assessment of the literature

2.1 Introduction

This review chapter presents the developing literature search that informed the conception of the research question, the research design and the subsequent implementation of the research strategy. For the purposes of supporting and guiding this research, a detailed and systematically applied scoping review was undertaken (Peters et al, 2015). The scoping review, a form of survey in effect, (Peters et al, 2015) has been identified as appropriate for broad research questions where the focus is to map the relevant literature (Norman and Griffiths, 2014).

A preliminary scoping literature review was commenced in 2010 and this was updated through the ensuing years of this study. Figure 2.1 illustrates this evolving literature review. Pegram et al (2014) indicated that little empirical evidence existed whilst there is an extensive amount of opinion based literature relating to ward sister/managers, this did indeed prove to be the case. A number of published systematic, integrative (Whitmore and Knafl, 2005) and scoping reviews have been included in this literature review; their findings are explored in the following chapters three and four.

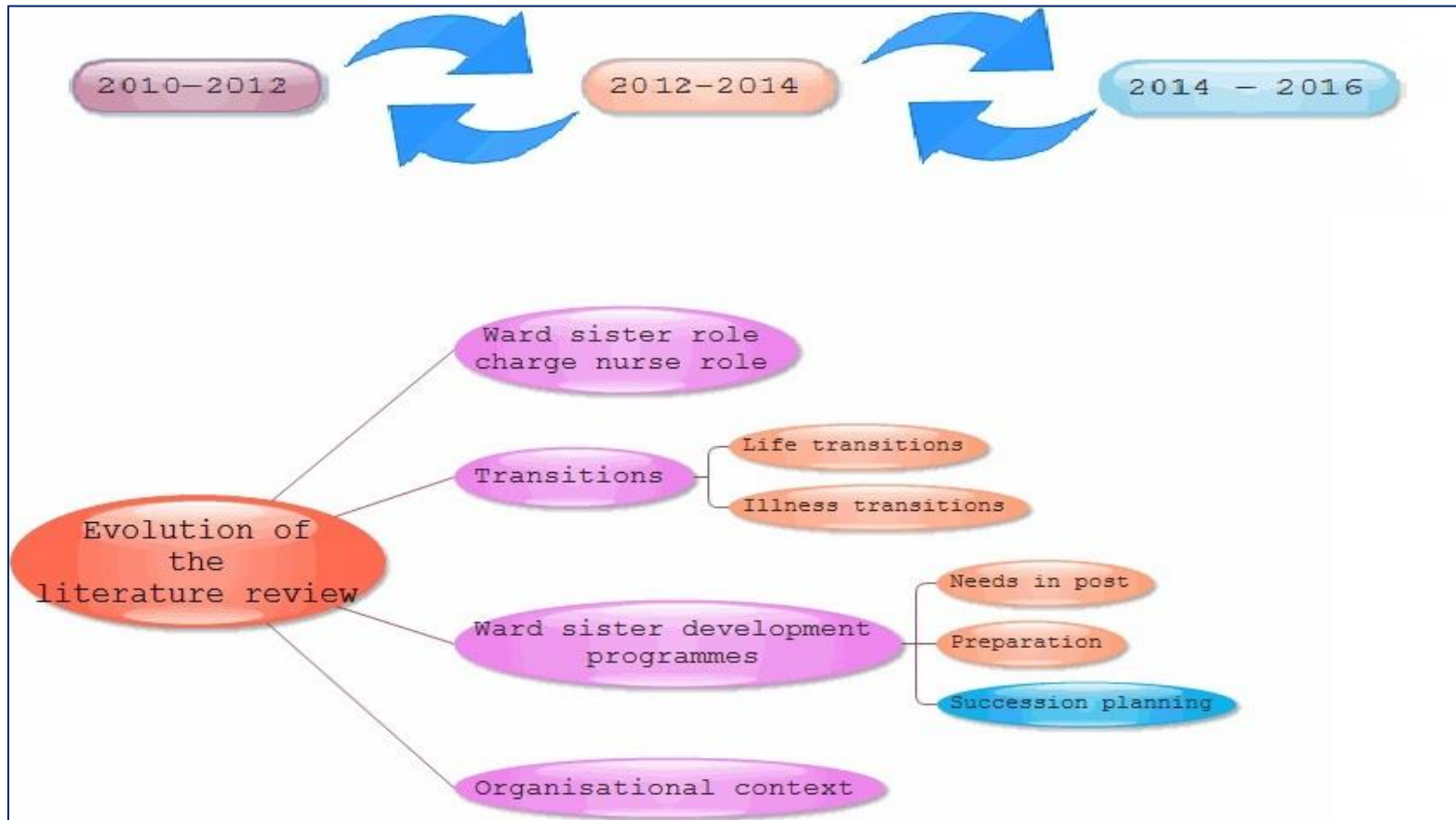


Figure 2.1 Evolving literature review

2.2 Search terms

The search terms to be utilised required consideration and reflection; it was not a static process although compiling a list of search terms necessarily implies that the searching process is a straightforward and linear process. The role confusion and title confusion of the ward sister/manager role, referred to in Chapter 1, necessitated a flexible and evolving approach to defining the search terms. The use of 'ward sister', 'charge nurse' and 'senior charge nurse' in the literature generally refers to the clinical ward leadership figure. The term 'ward sister/manager' is also used to convey the clinical ward leader, thus the variation of all these terms was used in the literature search. Role transition and related terms were utilised but early indications suggested that this strand to the search would produce few results. The decision was made, therefore, to include terms relating to leadership development initiatives for nurses, aspiring ward sister/managers and established ward sister/managers to identify learning, development and support needs, and to explore the impact of participating in such initiatives on experience.

Five databases were searched using the same search terms and combinations of these using Boolean operators [See Appendix 1]: the Cumulative Index to Nursing and Allied Health Literature, Medline, Business Source Complete [initially Business Source Premier), Scopus and Emerald. The consistent quality of database indexing has been called into question and thus reference list searching was used in addition to aid in highlighting material appropriate to the review,

which had not been located via the database searches (Mays et al, 2005). The initial search was carried out in 2010, updated searches were performed in 2014, 2015 and the final search was comprehensively updated in 2016 and the results from this final search have been presented in this and the following two chapters.

Because of the extent and range of the search terms utilised, one broad set of inclusion and exclusion criteria was established that applied (Table 2.1). Individual strands of the search determined a search-specific inclusion exclusion criteria. For example the search relating to succession planning included only material specifically referring to succession planning in addition to the main inclusion criteria. The rationale for including empirical evidence from Western Europe, Australia and New Zealand in addition to the UK is due to the relative similarities in health care systems and nursing role structures.

Table 2.1 Inclusion and exclusion criteria operationalised for the literature searches

Inclusion criteria	Exclusion criteria
Empirical studies, and systematic, scoping or integrative literature reviews,	Other than empirical studies and systematic reviews (e.g. case reports, opinion based publications and policy documents)
Publications in English	Publications other than in English
Material published from 1990	Material published before 1990
Country of origin – UK, Western Europe Australia and New Zealand	Country of origin USA, Canada, Africa, India and Asia
RNs	Non registered nurses and health care assistants/support workers
Relating to the ward sister/ward sister/manager/charge nurse role (and related titles)	Roles other than the ward sister (and related titles) role I.e. material relevant to matrons, directors of nursing excluded

A total of nine hundred and ninety three titles were identified through the database searches; the search results and paper selection process is illustrated in Figure 2.2.

The two most extensive components of the literature search concerned the ward sister/manager role and the development of ward sister/managers. Further details of the search results and paper selection process for these two arms of the search are included in Appendix 2.

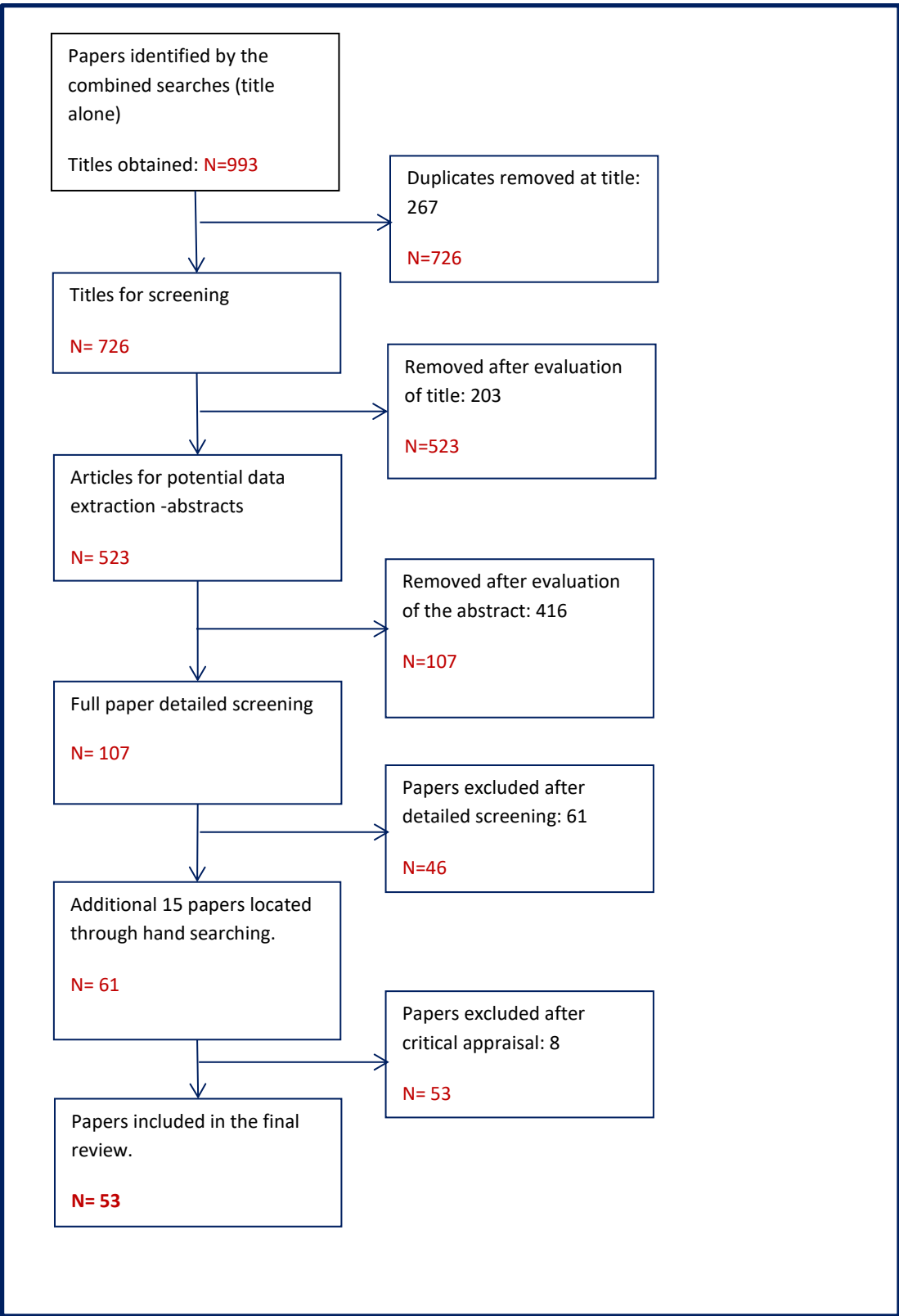


Figure 2.2 Combined search results and paper selection processes

As illustrated in Figure 2.2, a combined total of nine hundred and ninety three titles were obtained through searching the previously mentioned databases. Databases did not automatically recognise duplicates, thus duplicated titles were manually removed: seven hundred and twenty six remained once duplicates were removed. Two hundred and three papers were then excluded following review of the title. Four hundred and sixteen papers were lost following the review of abstracts because they were not in English (5), not research papers (75), not relevant to the topic (252), from a country outside the inclusion criteria (84). One hundred and seven papers were obtained in full text format for critique, fifteen additional papers were located through hand searching and subsequently sixty one of these were excluded for failure to meet the inclusion criteria (Table 2.1). Of the sixty one papers remaining, eight were removed through the critical appraisal process (See Appendix 4), resulting in fifty three papers: these have been included in the final review (See Appendix 3).

2.3 Critical appraisal

The following data were extracted from the retrieved articles: study authors, research question, methodology, sampling, theoretical framework, data collection methods, analysis and findings. A log entry number was assigned to each article to facilitate easier tracking. The lack of consensus regarding assessment of the quality and credibility of both qualitative and quantitative material has been noted (Mays et al, 2005) and thus an adapted tool was developed to review methodological quality and evaluate the rigour of each study and credibility of findings (Joanna Briggs Institute, 2014). This consisted of a ten

point critical appraisal tool (Table 2.2) in combination with a credibility of findings assessment.

Table 2.2 Ten point critical appraisal tool (Joanna Briggs Institute, 2014)

1. Congruity between stated philosophical perspective and the research methodology
2. Congruity between the research methodology and research question or objectives
3. Congruity between the research methodology and methods to collect data
4. Congruity between the research methodology and representation and analysis of data
5. Congruity between the research methodology and interpretation of results
6. Statement locating the researcher culturally or theoretically
7. Influence of the researcher on the research or vice versa is addressed
8. Participants and their voices are adequately represented
9. Research is ethical according to current criteria/evidence of ethical approval
10. Conclusions drawn in the research report appear to flow from the analysis or interpretation of the data

Table 2.3 details an extract of the rigour and credibility assessment for studies obtained from the search. The credibility of findings was graded according to the following criteria: findings were unequivocal; findings were credible, partially credible (between credible and unsupported) and unsupported (adapted from Joanna Briggs Institute, 2014). The unequivocal rating refers to findings supported by illustrations that appear to be beyond doubt; the credible rating refers to findings supported by illustrations that are not clearly associated with them and are open to question; partially supported refers to findings which may be illustrated in part and are open to question in terms of their lack of association to the findings; the unsupported rating refers to findings that are not supported

by the data or that no data are included. The adequacy of representation of the participants' voices was included in this table to provide an assessment of the link between the authors' conclusions and the analysis of data from the studies themselves.

Eight studies with poor methodological quality and a lack of credibility of findings, which were classed as having unsupported findings (See Appendix 4), have not been included in the detail of this review.

Table 2.3 Extract from the credibility/rigour appraisal of included material –

Credibility of findings	Conclusions linked to analysis of data	Participant voice represented	Study authors
Unequivocal	Yes	Yes	Fealy et al 2015 Ireland
"	"	"	Paterson et al 2015
"	"	"	McNamara et al 2014 Ireland
"	"	"	Miskelly and Duncan 2014 New Zealand
"	"	"	Enterkin et al 2013 England
"	"	"	Patton et al 2013 Ireland
"	"	"	Hewison 2012 England
"	"	"	Spehar et al 2012 Norway
"	"	"	Martin et al 2012 Switzerland
"	"	"	Locke et al 2011 England
"	"	"	Duygulu and Kublay 2011 Turkey
"	"	"	Doherty 2009 England
"	"	"	Brunero et al 2009
"	"	"	Dierckx de Casterlé et al 2008 Belgium
"	"	"	Woolnough and Faugier 2002 UK
"	"	"	Cunningham and Kitson 2000b England
"	"	"	Persson and Thylefors 1999 Sweden
"	"	"	Willmot 1998 Scotland
Credible	Yes	Yes	Pegram et al 2015 England
"	"	"	Townsend et al 2015 Australia
"	"	"	Manning et al 2015
"	"	"	Stoddart et al 2014 Scotland
"	"	"	Duffy and Carlin 2014 Scotland
"	"	"	Agnew and Flin 2014 Scotland
"	"	"	Carlin and Duffy 2013 Scotland
"	"	"	Fealy et al 2011 Ireland
"	"	"	Bolton 2005 England
"	"	"	Greenwood and Parsons 2002b
"	"	"	Greenwood and Parsons 2002a Australia
"	"	"	Lewis 1990 England

Credibility of findings	Conclusions linked to analysis of data	Participant voice represented	Study authors
Credible	Yes	Unclear	Ericsson and Augustinsson 2015 Sweden
"	"	"	Russell and McGuire 2014 Scotland
"	"	"	Boomer and McCormack 2010 Northern Ireland
"	"	"	McCallin and Frankson 2010 New Zealand
"	"	"	Porter et al 2006 Scotland
"	"	"	Stanley 2006 a England
"	"	"	Thomas and Bond 1990 England
"	"	"	Faugier and Woolnough 2003 UK
Partially credible	Yes	Unclear	McEwen et al 2005 England
"	"	"	Bolton 2003 England
Partially credible	Unclear	Unclear	Firth 2002 England
"	"	"	Dodwell and Lathlean 1987 England
"	Unclear	No	Bonner and McLaughlin 2014 England
"	"	"	Clarke and Marks-Maran 2014 England
Partially credible	Unclear	No	Jasper et al 2010 Wales
"	"	"	Duffield 2005 Australia
"	"	"	Hancock et al 2005 England
"	"	"	Pitkänen et al 2004 Finland
"	"	"	Koivula and Paunonen-Ilmonen 2001 Finland
"	"	"	Williams et al 2001 England
Partially credible	Unclear	N/A	Titzer et al 2013
"	"	"	Griffith 2012
"	"	"	Bradshaw 2010 UK

2.4 Findings

The empirical evidence reviewed included both quantitative and qualitative studies and two systematic reviews of the literature, both pertaining to succession planning. Combining findings from qualitative and quantitative evidence in literature reviews has been referred to as complex and attempts to

synthesise findings from studies with diverse methodological approaches has been noted as problematic (Mays et al, 2005). A narrative approach to the presentation of findings from qualitative and quantitative studies has been suggested as a feasible way to summarise and interpret evidence, thus in this review the data extracted from the resultant studies has been presented as a narrative review in the following two chapters.

Combining findings and extrapolating from the extracted study data proved challenging. As noted in Appendix 3, ontology and epistemology, if introduced at all was very brief, and detail of the methodology was often superficial. Authors did not generally direct the reader to the inclusion of detailed methodology reported elsewhere. In some instances the methods of data collection appeared incongruous with the methodology espoused (for example Firth, 2002). The location of the researcher, either culturally or methodologically, was absent in all but two of the studies reviewed (Greenwood and Parsons, 2002a; 2002b), additionally, with only a few exceptions (Ericsson and Augustinsson, 2015; Persson and Thylefors, 1999), researchers failed to consider any potential impact of their role on participants or the data collection process. Data collection methods were described superficially at times and details from the interview guides for semi-structured interviews were lacking (for example: Bolton, 2003; McCallin and Frankson, 2010; Willmot, 1998). Questionnaires referred to in the paper were not included (for example: Willmot, 1998), or select excerpts only were presented (McEwen et al, 2005). Frequently titles and roles were not clearly

defined, the exact nature of participants was, at times, unclear (Bolton, 2003), and observation tools or schedules were not detailed.

From the evidence reviewed, findings clearly sat in two areas, related to the nature of the role of the ward sister/manager and the process of developing nurses for this role for current and future service need, with a view to comprehending how these development initiatives impact upon the experience of participants. Within these two broad areas, eight subtopics were identified:

- The ward sister/manager as clinical expert
- Ward sister/manager: What kind of leader?
- Multifaceted nature of the ward sister/manager role
- Tensions between managerial and clinical roles
- Knowledge and skills deficits identified by ward sister/managers
- Development initiatives for aspiring and established ward sister/managers
- Barriers to leadership development
- Systematic organisation-wide approaches to preparing for future ward sister/managers

For the purpose of ease of reading, the term 'ward sister/manager' is used here to reflect roles referred to in the evidence as ward sisters, ward sister/managers, charge nurses, senior charge nurses and/or ward leaders. This literature review has been structured in those two main sections:

- The role of the ward sister/manager
- Developing nurses for the ward sister/manager role

Of the empirical studies that explored the ward sister/manager role, in depth interviews with ward sister/managers themselves was a commonly used approach (for example: Doherty, 2009; Hewison, 2012; Lewis, 1990; McCallin and Frankson, 2010; McWhirter, 2011; Spehar et al, 2012; Townsend et al , 2015). Interviews in conjunction with survey questionnaires or observational episodes were common. A survey as the sole method was used in three studies (McEwen et al, 2005; Pegram et al, 2015; Thomas and Bond, 1990). Williams et al (2001) used combined methods of focus groups and postal questionnaires. Bonner and McLaughlin (2014) utilised a survey tool, leadership self-assessment score and findings from participants' activity logs. An observational element was utilised in five papers (Bolton, 2003; Bolton, 2005; Ericsson and Augustinsson, 2015; Firth, 2002; Russell and McGuire, 2014). Whilst the majority of papers reported on the views of ward sister/managers themselves, the outsider view from junior RNs regarding their ward sister/managers was reported by Carlin and Duffy (2013).

It was remarkable to note that few authors refer to either the findings or approach of others, suggesting that the choice of methodology to explore the ward sister/manager role was often locally driven and idiosyncratic. Thus, the moderate number of studies reviewed arose from a plethora of approaches and a range of often interrelated topics.

The most commonly used approach in papers exploring the development of ward sister/managers was that of surveys, eleven papers used either locally designed

tools, validated tools or a combination. Interviews or focus groups were utilised in five papers (Fealy et al, 2015; Greenwood and Parsons, 2002a; Greenwood and Parsons, 2002b; Hancock et al, 2005; Woolnough and Faugier, 2002). Multiple methods of data collection were reported in eight studies (Boomer and McCormack, 2010 ; Cunningham and Kitson, 2000b; Dierckx de Casterlé et al, 2008; Dodwell and Lathlean, 1987; Fealy et al, 2011; McNamara et al, 2014; Miskelly and Duncan, 2014; Patton et al, 2013). Boomer and McCormack (2010) were the only authors to report an observational element to their study.

2.5 Chapter summary

This chapter has set out the literature search that has supported this research. The scoping literature review has been detailed, with inclusion and exclusion criteria clearly detailed. The process from search to retrieval and subsequent critique is elucidated. It seemed pertinent to present the empirical evidence reviewed two chapters which are titled; the role of the ward sister/manager and developing nurses for the ward sister/manager role. These two chapters now follow on from this searching retrieval and quality assessment chapter.

Chapter 3 Role of the ward sister/manager

3.1 Introduction

This chapter establishes the empirical evidence related to the evolving role of ward sister/managers. Whilst there has been no shortage of published literature that focuses on nurse leadership (Stanley, 2006a) little has been research based and a relatively modest quantity of research has specifically investigated the ward sister/manager role (Pegram et al, 2014).

The four themes that arose from the literature review concerning the ward sister/manager role have been presented in the following sections. The ward sister/manager as a clinical expert is included first, in section 3.2, and this is followed by an exploration of the nature of leadership shown by ward sister/managers in section 3.3. The multifaceted nature of the role of ward sister/manager is explored in section 3.4, and the tensions between managerial and clinical roles constitute section 3.5. This chapter, which concludes with a summary of what is known about the ward sister/manager role and an introduction to chapter four in which the literature review presents the development of nurses for the ward sister/manager role.

3.2 The ward sister/manager as clinical expert

Whilst the clinical component of the ward sister/manager role was mostly unquestioned, the very nature of that clinical component was often unspecified, and where specified, was variable. The ward sister/manager as clinical expert was primarily identified through self-report methods: interview or survey methods.

Role components such as demonstrating tasks, leading by example and acting as a role model were identified by ward sister/managers themselves in a number of studies (Firth, 2002; Lewis, 1990; Pegram et al, 2015). Episodes of direct patient care were reported by ward sister/manager participants (Lewis, 1990; McEwen, 2005) and identified as one of the most important roles of the ward sister/manager (McEwen et al, 2005). This participation in hands-on care was identified as key to the setting of standards in the ward area (Lewis, 1990; Pegram et al, 2015). Lewis proposed that the ward sister/manager operates through both positional power and expert power but this conclusion was unsupported. The credibility associated with direct practice was identified as significant for improving team working and patient care (Stoddart et al, 2014). This last finding was supported by findings from Russell and McGuire (2014) who reported that improvements in a number of care quality indicators were noted during a project to release time for the ward sister/managers to undertake direct practice.

While most studies used results from self-reported data to support their findings, one paper reported the views of junior RNs regarding the (ward sister/manager) role (Carlin and Duffy, 2013). These RNs identified and admired the direct and skilful care of patients that they witnessed by ward sister/managers on occasions. Direct objective observation of expert practice was noted in the conclusion of one study but this finding was unsubstantiated by the results presented however (Firth, 2002).

3.3 Ward sister/manager: What kind of leader?

Whilst studies did not apparently set out to establish the nature of leadership required or enacted by ward sister/managers, facets of leadership were evident in the reported findings. The nature of relationships developed by ward sister/managers, in terms of their approach and communication style, and their behaviours, marked out the kind of leadership that they embodied. Human kindness, communication and the willingness to listen were identified as important skills by ward sister/managers in Persson and Thylefors (1999) study. Noticing and rewarding good behaviours of staff and explaining rationale behind targets and the intended outcomes, had noticeable outcomes in one study, such as increased motivation and compliance in the team (Agnew and Flin, 2014). Indeed, improving relationships and changes in work patterns were identified by ward sister/managers themselves in Russell and McGuire's study (2014). Coaching and developing staff, more time to spend with patients and thus increasing visibility in the ward areas were also identified as beneficial for ward sister/managers and their staff and patients (Russell and McGuire, 2014).

The issue of visibility was noted by Carlin and Duffy's (2013) participants who were newly qualified RNs. These neophyte nurses commented that ward sister/managers were not always visible in their clinical areas, and some were uncertain as to how their leaders could see the quality of care on their wards when they were preoccupied with managerial tasks. The visible leadership role that these nurses wanted was seen as essential for setting the example and gaining respect. Approval and support from the ward sister/manager were also

key requirements described by participants for their own well-being. The visibility of leadership was similarly explored in Stanley's (2006a) research, which did not restrict itself to exploring leadership amongst ward sister/managers, but rather sought RNs and ward sister/managers' views on where and by whom leadership was demonstrated. Stanley reported that clinical leaders, most commonly identified as F or G grade nurses (senior staff nurses and ward sister/managers, respectively, Figure 1.1) could in addition be found amongst matrons and more junior staff nurses. Leading by example was similarly identified by ward sister/managers themselves, and their colleagues as the most important of described leadership behaviours in Agnew and Flin's study (2014). Using Yukl's Hierarchical leadership taxonomy (Yukl et al , 2002), reported leadership behaviours were grouped according to the three categories of leadership behaviours: relations orientated, task orientated and change orientated (Agnew and Flin, 2014). Overall, relations related behaviours were most frequently noted during interviews with ward sister/managers suggesting their awareness of the need for strong and positive interpersonal actions.

Whilst the visibility of the ward sister/manager was not an explicit finding in one study, Clarke and Marks Maran (2014) reported that the strong-minded motivating leadership demonstrated in ward areas was crucial to the success of the productive ward programme in one hospital, however their findings to support this assertion were limited.

3.4 Multifaceted nature of the role of the ward sister/manager

A move to a more managerial role was highlighted by 1990 (Lewis, 1990) and the change in role and title from ward sister to ward manager appeared to be accepted uncritically, although there was no support for this assertion from the data presented. This change from a clinically focussed ward sister role to that of ward sister/manager was not universally welcomed by participants in Willmot's (1998) study although some saw some benefits from this and some welcomed this change, however (Willmot, 1998). Participants in Locke et al's (2011) study referred to burdensome administrative tasks as part of the role of the ward sister/manager. This burden associated with administrative work was implied in Williams et al's (2001) study of ward sister/managers and specialist nurses in one NHS hospital, where support for clerical tasks was considered to be lacking. Clinical nurse leaders, identified as such by colleagues, commented on the need to balance and even out both clinical and managerial responsibilities. For one participant however, a preoccupation with administrative matters was reported (Stanley, 2006a).

Multiple facets of the role were noted by ward sister/managers in Bolton's (2003) longitudinal study. For some participants this was unwelcome whilst for some the challenge was valued; being able to sit in two camps was seen as a positive development (Bolton, 2003). This multitude of roles was also highlighted by Persson and Thylefors' (1999) participants; one third of participants recognised that they had difficulties with clear role boundaries and struggled with work-life balance. The absence of explicit boundaries was similarly noted by ward

sister/managers elsewhere (Firth, 2002; McCallin and Frankson, 2010). Role ambiguity appeared to be the direct result of lack of role clarity for McCallin and Frankson's (2010) ward sister/manager participants in New Zealand. These multiple and varied roles resulted in ward sister/managers in one mental health setting feeling uncertain about their role priorities and in some instances, unsure whether they should actually be the clinical lead figure (Bonner and McLaughlin, 2014). Variations in the views of senior managers compounded this confusion over whether priorities should be primarily clinical or managerial (Bonner and McLaughlin, 2014). Similar confusion created tension and conflict between some senior figures in Greenwood and Parsons' (2002b) Australian study.

Whilst role confusion and ambiguity have been reported above, in contrast, ward sister/managers (specifically termed SCNs in Scotland) noted a more clearly defined role than that of the previous role (Stoddart et al, 2014). It was considered that under the old Scottish nursing system, nursing roles had become blurred and explicit leadership was missing (Stoddart et al, 2014). Ward sister/managers in Pegram et al's study (2015), were noted as valuing the multifaceted focus. This variety of roles even provided job satisfaction, however, overall levels of job satisfaction reported, were scored as low to moderate. Participants were not asked to comment on the job satisfaction associated with the clinical components of the ward sister/managers' work however (Pegram et al, 2014). Additionally, it was reported that time pressures and workload caused extreme or considerable pressure for participants, and 82% of ward sister/manager respondents agreed that multiple responsibilities made it hard to

keep on top of everything (Pegram et al, 2015). The seeming disparity and misalignment between these results was left unexplained by the authors.

Of note is that ward sister/managers in Persson and Thyefors' (1999) study, reported that they had taken on the role initially for personal advancement, suggesting that the multifaceted nature of the role had appeal. The authors point out however, that the factors that motivate a person to take up a position are not necessarily the same as those facts that will keep them in post.

3.5 Tensions between managerial and clinical roles

Participants in Persson and Thylefors' (1999) study acknowledged a divide between their managerial roles and their professional role. Across a number of studies, clinical and managerial roles have been identified as diametrically opposed to each other (Bolton, 2005; Willmot, 1998), with tensions between meeting managerial goals and being a clinical nurse (Hewison, 2012). Ward sister/managers reported that the balancing of clinical and managerial roles gave the greatest dissatisfaction (Williams et al, 2001). Similarly, only 11% of ward sister/managers had sufficient time to complete their managerial commitments each shift, suggesting tension between the clinical and managerial requirement of the role (McEwen et al, 2005). McEwen et al (2005) reported that ward sister/manager participants in their study spent an average of two and a half shifts each week caring for allocated patients themselves, but this finding was not specifically supported in the presentation of results. The majority of the same respondents did not feel they had sufficient time to advise and support others on

patient care issues, and fewer than half reported that they had sufficient time to evaluate current clinical practice in their areas (McEwen et al, 2005). Similarly, ward sister/managers elsewhere reported that time for clinical work was unprotected (Pegram et al, 2015) and Doherty's participants reported that they were "losing nursing" (Doherty, 2009, p1138).

Stanley suggested that appointing senior clinical staff into ward sister/manager positions results in challenges to clinical beliefs and values which might result in ineffective leadership and management (Stanley, 2006a), supporting Firth's (2002) assertion that that ward sister/managers experienced conflict in having to carry out incompatible roles. Methodological detail in Stanley 2006a was lacking however, the data analysis process was absent and the primary findings presented were limited, and this assertion of role conflict from Firth was not clearly supported by the data reported.

The increasing administrative burden was reported in two studies (Bonner and McLaughlin, 2014; Locke et al, 2011). Locke et al (2011) reported on an evaluation of a pilot project introducing administrative assistants for ward sister/managers in the South of England. Ward sister/managers reported increased morale and having more time for clinical contact as administrative assistants were able to relieve them of administrative tasks. Ward sister/manager support for the project was overwhelming; Locke et al (2011) emphasised the need for long term follow up however. Bonner and McLaughlin (2014) highlighted the concerns expressed by ward sister/managers that the increase of administrative role requirements

was impacting on their ability to lead and manage their staff. Participants in this study were required to keep an activity log and this highlighted the reality of wide variations in the amount of time each ward sister/manager spent in clinical and managerial activities, with those spending more time clinically expressing concerns about meeting their managerial role components. These concerns were echoed by participants in Agnew and Flin's (2014) study of ward sister/managers (SCNs) in Scotland: one ward sister/manager commented on the impossibility of being in the clinical area for the majority of time due to the increasing administrative burden, although they were clear that clinical need always took precedence over administration.

3.7 Summary of what we know now

The role of ward sister/manager is still considered to be a valuable position despite changes to the role and context of healthcare. Multiple facets to the role have been identified since the 1980s, but ward sister/managers' satisfaction with these multiple roles appears to be declining. The multiplicity of the role has in the main created dissatisfaction and frustration; Pegram et al (2015) appear to be alone in reporting that ward sister/managers value the multiple aspects of their role, although their findings appear inconsistent in places. Changes to the title of this role have been noted across Europe, Australia and New Zealand; whether these changes in titles have exacerbated the challenges experienced by the ward sister/manager is open to debate. Authors of studies across the United Kingdom, Australia, New Zealand have noted the increase in administrative and managerial components to the role with the concurrent reduction in clinical contact time,

and at times a significant reduction in clinical presence. Authors have reported national and local projects to attempt to define the role more clearly and provide clearer definition to the role; in these instances, ward sister/managers in these areas appear to convey increased satisfaction and improving ability to supervise and influence clinical care. A number of research initiatives have explored facets of the ward sister/manager (SCN) role in Scotland, following the national Leading Better Care initiative (Scottish Government, 2008); early indications suggest that ward sister/managers are valuing the more consistent and defined role and that this is associated with improvements in quality care indicators.

Research studies have tended to investigate the views of ward sister/managers themselves via various methods, thus self-report data has produced the majority of findings and extrapolated themes. What has not been explored is the relationship between the organisation and the ward sister/manager role, whether this role is still a necessary and valued role, and whether the configuration of the role is impacted on by the organisation itself.

What is notable is that authors have not referred to pertinent earlier work except on a few occasions. The majority of authors have set out their research methodology and method but few have justified this, and fewer still cite a methodology and method that has been informed by earlier relevant work. It is striking that study authors have tended to refer to other authors uncritically, making no distinction in their references to opinion and anecdotal pieces or empirical evidence. Thus all in all, the research has tended to be small scale and

has not evidently built upon the findings of others in either a minor or major manner. Researchers should not of course be criticised for their choice of research topic and the limits or extent of their focus; the lack of linkage with other work necessarily limits any learning that could follow from the work however. It may be salient that there is a lack of any evidence that employers endeavour to change practice or processes in account of the published empirical evidence.

3.8 Chapter summary

In this chapter, the complex, multifaceted nature of the ward sister/manager role has been established. Despite a constant flow of policy initiatives in the United Kingdom to strengthen clinical nursing leadership in the form of the ward sister/manager role, this position appears to be an increasingly unattractive post with a lack of role clarity and which prioritises managerial tasks above clinical tasks. Empirical evidence suggests that whilst some ward sister/managers value the complexities of the role, others feel tension in balancing the clinical and managerial aspects of the role.

The following chapter presents empirical evidence relating to the development of the ward sister/managers is examined, with a view to understanding the impact of this development support on experience of those undertaking it.

Chapter 4 Developing nurses for the ward sister/manager role

4.1 Introduction

In the previous chapter, empirical evidence that explored the role of the ward sister/manager was presented and debated. This current chapter explores the development needs of ward sister/managers and of those in aspiring ward sister/manager roles. The absence of empirical investigation of the transition experience from staff nurse to ward sister/manager dictated that the needs of this group needed to be sought via other related evidence. Knowledge and skills deficits identified from those already in the ward sister/manager role are explored, the rationale being that these established deficits impact upon the transition experience of those aspiring to the roles.

Development initiatives aimed at both aspiring ward sister/managers and ward sister/managers themselves give additional insight into the needs of these individuals and how the experience of undertaking a development initiative can be helpful in meeting those needs, thus impacting upon their experience. This is then followed by discussion of the empirical evidence to illustrate the barriers to leadership development and encompasses discussion pertaining to the transition to the role.

The final section of this chapter then considers systematic, organisation-wide strategies for succession planning for the ward sister/manager role. The chapter ends with a summary of what is known about the development needs of ward

sister/managers and those aspiring to the role, and what gaps might exist in this knowledge.

4.2 Knowledge and skills deficits experienced or identified by ward sister/managers

Participants across a number of studies exploring the ward sister/manager role identified knowledge and skills deficits for the roles that they occupied, suggesting that their transition to the role was not complete. A lack of training for new responsibilities concerned Willmot's (1998) participants. Participants in McCallin and Frankson's (2010) study reported that clinical expertise was not a preparation for management roles and commented that they lacked management knowledge and skills (McCallin and Frankson, 2010). Participants in Spehar et al's study noted that they were thrown into the management role (2012). Two thirds of respondents in McEwen et al's (2005) study considered that they did not have the necessary skills, knowledge or experience to manage their team effectively, despite the fact that respondents had been in their ward sister/manager post for an average of five years. Budgetary responsibilities especially caused concern (McEwen et al, 2005).

In contrast to other studies, where participants appeared to recognise their own deficits but without plans to address them, Williams et al (2001) reported that ward sister/managers in their study could determine their own self development needs, however a lack of staff available to cover for their absence prevented them attending training days. Ward sister/managers were reported as needing

support from their managers and colleagues, but the nature or extent of this support was not reported. Difficulties in dealing with conflict with colleagues were stated by ward sister/managers in a number of studies (Bonner and McLaughlin, 2014; Persson and Thylefors, 1999), and this was acknowledged by Townsend et al (2015) that the devolving of managerial powers in hospitals had not been matched with increased managerial training and support for those concerned.

Townsend et al (2015) suggested that skilled practitioners, when promoted to a managerial role, such as the ward sister/manager role, move from a position of expertise at the bedside to one of managerial novice. This focus on a skills deficit carries with it the implication that there should be an agreed list of skills and attributes, a package of knowledge that is universally agreed; there has been no evidence to suggest that this is the case however.

Knowledge and skills gaps were also identified through those initiatives developed to support ward sister/managers in post. The learning and support provided through these initiatives did not greatly vary from those learning and support provided to those in aspiring ward sister/manager roles.

4.3 Development initiatives for aspiring and established ward sister/managers

There is a lack of empirical evidence that directly explores the experience of transition from staff nurse to ward sister/manager. Evidence of the development

needs of this group of aspiring ward sister/managers therefore give an indication of the challenges they may experience during this period of their career. These development needs may be inferred from the published development initiatives to support aspiring ward sister/managers.

A small number of programmes have been developed specifically for aspiring ward sister/managers (Table 4.1) (Boomer and McCormack, 2010; Duffy and Carlin, 2014; Enterkin et al, 2013; Miskelly and Duncan, 2014; Pitkänen et al, 2004; Porter et al, 2006).

Paterson et al (2015) discussed a leadership development initiative for junior RNs with a longer term view of their needs in preparation for the ward sister/manager role, and two programmes were noted for all grades of nursing and midwifery staff; Faugier and Woolnough (2003) and Woolnough and Faugier (2002) reporting one, Fealy et al (2015), McNamara et al (2014) and Patton et al (2013) reporting on the other. These initiatives aimed at wider groups of nurses have been summarised in Table 4.2. This focus upon providing leadership development for wider groups of nurses suggests that their needs are not being met, and thus progress to more senior roles may be problematic.

Faugier and Woolnough (2003) reported on the Leading Empowered Organisations (LEO) national initiative to develop leadership across professional groups and Hancock et al (2005) evaluated the impact of this LEO programme on ward based nurse managers in one particular organisation. Cunningham and

Kitson (2000b) reported on a leadership initiative provided by the RCN for individual nurses from across the United Kingdom. Fealy et al (2015), McNamara et al (2014) and Patton et al (2013) all related one leadership development initiative following the implementation of a national approach to supporting nurse leadership across all grades in Ireland, whilst Duffy and Carlin (2014) detailed one Scottish initiative following a change in national policy and Jasper et al (2010) reported on a Welsh nurse leadership initiative.

Development initiatives for established ward sister/managers have been summarised in Table 4.3.

The frameworks or underpinnings for the development initiatives were often unremarked, with a small number of exceptions. Enterkin et al (2013) based their development programme on the United Kingdom's National Health Service (NHS) Leadership Qualities Framework (NHS Institute for Innovation and Improvement, 2006) and the Knowledge and Skills Framework (Department of Health, 2004). Jasper et al (2010) reported that job descriptions and Welsh national framework competencies were utilised to underpin the leadership development work. Martin et al (2012) and Dierckx de Casterlé et al (2008) utilised an adapted form of the RCN Clinical leadership programme. The Irish development programme reported on by Fealy et al (2015) and Patton et al (2013) was similarly developed, based upon the RCN Clinical Leadership programme, following the creation of a national leadership framework. The use of pre-existing frameworks to underpin some development initiatives conveyed that learning needs were viewed in a

boundaried manner. Whether this use of underpinning frameworks in this manner led to a restrictive vehicle for support is uncertain.

Table 4.1 An outline of development initiatives for aspiring ward sister/managers included in this review

STUDY AUTHORS	TARGET GROUP FOR THE DEVELOPMENT PROGRAMME	DATA COLLECTION METHODS	FINDINGS	CREDIBILITY OF FINDINGS
Miskelly and Duncan 2014 New Zealand	60 RNs/RMs nominated by their charge nurses	Questionnaire for quantitative data, semi structured interviews and focus groups	Participants self-confidence improved -leading to 'growing up', study participants appeared to have developed professionally and psychologically.	Unequivocal
Enterkin et al 2013 England	Band 6 RNs (Aspiring ward sisters)	Semi structured questionnaires	Reported increased political, organisational awareness. Increased self-awareness. Increases in confidence noted and increased feelings of empowerment and ability to empower others.	Unequivocal
Duffy and Carlin 2014 Scotland	Band 6 nurses, midwives and AHPs	Short evaluation questionnaire, follow up contact	Participants valued the programme, for most it had impacted on their personal and professional development, 2 nurse managers identified improvements in practice	Credible
Boomer and McCormack 2010 Northern Ireland	48 RNs (F grade/band 6 or above) from 16 units in 2 hospital	Workshops, action learning set data, evaluation from observations of practice (ward work method assessment questionnaire, patient handover audit, short quality of interaction schedule), interviews with participants, facilitators, managers, patients and nurses	The course appeared to be successful in providing leaders with strategic skills. Increased understanding of trying to implement change	Credible
Porter et al 2006 Scotland	21 RNs (E and F grades)	Not specified	Mentoring was not successful for all due to lack of mentor skills, lack of trust was highlighted. Tensions between clinical leadership and management noted. Time needed to learn new concepts	Credible
Pitkanen et al 2004 Finland	16 deputy ward sister/managers in 1 hospital	Survey at outset of programme to 16 deputy ward sisters, 16 ward sisters and 4 senior executives (75% response rate)	Master class programme was positively evaluated. Participants valued choosing what they wanted to learn and networking and support from others.	

Table 4.2 An outline of development initiatives - various grades of staff

STUDY AUTHORS	TARGET GROUP FOR THE DEVELOPMENT PROGRAMME	DATA COLLECTION METHODS	FINDINGS	CREDIBILITY OF FINDINGS
Fealy et al 2015 Ireland	RNs and midwives undertaking the clinical leadership development pathway	Focus groups, group and individual interviews	Accounts of service development activities were evident. Subtle benefits such as improved working relationships, better ward atmospheres	Unequivocal
Paterson et al 2015	Newly qualified or new in post RNs	Survey - Leadership Capability Instrument at 3 time points and participant descriptive accounts	Mean scores for each area of leadership capability increased significantly over the programme	Unequivocal
McNamara et al 2014 Ireland	RNs and midwives undertaking the clinical leadership development pathway	Focus groups, observation of action learning sets, 3 individual interviews	Mentoring, coaching and action learning sets were experienced positively by participants. Not all coaches were experienced and coaching took a while to establish for some.	Unequivocal
Patton et al 2013 Ireland	RNs and midwives undertaking the clinical leadership development pathway	Questionnaires (LPI-self, LPI-others, bespoke clinical leader behaviours questionnaire), participant experience questionnaire, focus groups, interviews - individual and group (36 participants),	Evidence of development of leadership competencies, improved capabilities noted and improvements in participants professional and personal development.	Unequivocal
Woolnough and Faugier 2002 UK	Nurses, midwives, therapists and doctors	Interviews with 109 participants, 6/12 after the completion of the programme	Leadership development an ongoing iterative process of leader and co-workers. The head nurse became more effective in self-awareness, communication skills, performance and vision. Benefits to the team through more effective leadership.	Unequivocal
Faugier and Woolnough 2003 UK	Purposive sample of 40,000 nurses and 8000 AHPs who had completed LEO	Evaluation questionnaire from 12000 participants (? Nurses)	A cultural shift was noted with a strong sense of becoming, development of self-awareness. Evidence of increasing the effectiveness of patient centeredness in participating units	Credible

Table 4.3 An outline of development initiatives for ward sister/managers

STUDY AUTHORS	TARGET GROUP FOR THE DEVELOPMENT PROGRAMME	DATA COLLECTION METHODS	FINDINGS	CREDIBILITY OF FINDINGS
Martin et al 2012 Switzerland	16 ward sister/managers from 1 hospital	LPI at 3 intervals -start, end and 6/12 after the programme (from participants and observers)	Nurse leaders demonstrated significant improvement in 'inspiring shared vision' and 'challenge the process' subscales of the LPI	Unequivocal
Duygulu and Kublay 2011 Turkey	30 unit charge nurses from 2 hospitals	LPI (modified) self and observer ratings at 4 points -pre, at the end, 3/12 and 9/12 after the programme	3 phases in clinician's journey to management: development of leadership awareness, taking on manager role and experience of entering management. Participants have different journeys into management. Being thrown into management was common, learning 'on the fly'	Unequivocal
Dierckx de Casterlé et al 2008 Belgium	12 head nurses	Individual interviews, focus groups and observation	Leadership practices improved significant according to self and observer ratings. Self ratings were significantly higher than observer ratings	Unequivocal
Cunningham and Kitson 2000b England	24 ward sisters from 4 hospitals	Pre-test using MLQ (given to participants and to 6 ward staff members), Organisation of care tool, Newcastle satisfaction with nursing scale and team roles effectiveness tool. Post-test re-administered all the tools after the intervention.	Mostly participants rated the course highly, although thought it too basic. Clearer understanding of leadership styles was reported. 67% felt leadership capabilities had improved. The 24% who did not have improving leadership skills also rated the programme as poor. Participants identified areas in which their practice had changed	Unequivocal
Greenwood and Parsons 2002a Australia	10 clinical unit leaders from 2 area health services	2 Focus group interviews	Participants valued the programme, for most it had impacted on their personal and professional development, 2 nurse managers identified improvements in practice	Credible
Greenwood and Parsons 2002b Australia	10 clinical unit leaders from 2 area health services	2 Focus group interviews	Barriers to clinical leadership development perceived as lowered in relation to quality care as opposed to interdisciplinary relationships and influence and recognition	Credible

STUDY AUTHORS	TARGET GROUP FOR THE DEVELOPMENT PROGRAMME	DATA COLLECTION METHODS	FINDINGS	CREDIBILITY OF FINDINGS
Dodwell and Lathlean 1987 England	194 ward sisters in a group of hospitals	Interviews at 3 intervals (before during and after the course) and questionnaire at the end of 6th month of the course completed by the participant and facilitator and manager.	Generally objectives were not met for the pilot. Human resources content was most useful in the pilot programme. 84% stated knowledge was enhanced. On programme 1, objectives were met, 100% felt knowledge was enhanced. Human resources content was useful, clinical governance was not.	Partially credible
Jasper et al 2010 Wales	936 ward sister/managers/charge nurses across Wales	programme review from 33 participants in pilot area	Taught programme well received, examples of transformational change reported, participants appeared empowered	Partially credible
Duffield 2005 Australia	18 nurse unit managers	University evaluation tool 6/12 after the programme	Positive outcomes were noted in terms of improvements in individuals and noticeable effects for the hospital. Managers noted participants as more enthusiastic and motivated. Some participants still needed further help however	Partially credible

4.3.1 Learning and development needs addressed by development initiatives

With few exceptions, development initiatives originated from a local organisational need to support those already in the ward leadership position. Duffy and Carlin (2014), Enterkin et al (2013) and Miskelly and Duncan (2014) presented initiatives to identify and develop those aspiring to be the next generation of ward sister/managers. Aspiring ward sister/managers, in this study termed E and F grade staff nurses (See Figure 1.1 for the situating the terminology), were also the focus of an initiative presented by Porter et al (2006). Pitkänen et al (2004) similarly focussed on aspiring ward sister/managers, but established their development initiative to improve nurses' ability to deputise for ward sister/managers in Finland. This appeared to take a pragmatic approach to enable nurses to work in the absence of their ward sister/manager rather than to specifically develop the next generation of ward sister/managers. In contrast, newly registered nurses were the focus of the locally driven initiative relayed by Paterson et al (2015). The aim of this programme was to develop leadership capability at the earliest stage amongst new registrants to prepare them well for the future.

Programme content and approach varied greatly. Authors tended to give no clear rationale for the length of the face to face components of the programme or the overall duration of the programme, and made little if any reference to other published development initiatives. Development initiatives for ward sister/managers (Table 4.3), those aspiring to the roles (Table 4.1), and all grades of nursing staff (Table 4.2) did not differ appreciatively in this regard.

Opportunities for observation in practice combined with theoretical study was provided in one development programme for ward sister/managers (Dodwell and Lathlean, 1987). Group discussion for group support was provided in six initiatives for aspiring and established ward sister/managers, suggesting that the collegiate peer support approach is helpful (Duffy and Carlin, 2014; Enterkin et al, 2013; Martin et al, 2012; Miskelly and Duncan, 2014; Paterson et al, 2015). The Irish initiative referred to by Fealy et al (2015) and others (McNamara et al, 2014; Patton et al, 2013) encompassed individualised interventions agreed upon between participant and manager.

Mentoring and/or coaching initiatives as a constituent part of development programmes were reported in a number of initiatives, for aspiring and established ward sister/managers and for all staff groups, established with some justification for their inclusion (Boomer and McCormack, 2010; Duffield, 2005; Jasper et al, 2010; McNamara et al, 2015). Action learning sets were referred to by other authors additionally: Boomer and McCormack (2010), Cunningham and Kitson (2000b), Dierckx de Casterlé et al (2008) and Jasper et al (2010).

Participants were encouraged to embrace feedback from others, to increase their self-awareness through the use of 360 degree feedback was used in conjunction with the development initiative (Dierckx de Casterlé et al, 2008; Enterkin et al, 2013; Martin et al, 2012).

Participants were required to undertake reflective activities upon their learning. Portfolios and competency assessments were used by some (Jasper et al, 2010). Self-assessment of learning was carried out by others. Reflective accounts of self-directed activities were submitted as part of the learning programme (Paterson et al, 2015). Several programmes refer to participants undertaking assignments; Miskelly and Duncan (2014) refer to participants undertaking assignments between workshops, Jasper et al (2010), Enterkin et al (2013) and Pitkänen et al (2004) refer to academic accreditation for work undertaken.

The inconsistency noted in programme content suggests that there has been little agreement as to the needs of this group of staff. Variation in content, programme length, mode of delivery and approaches to evaluation suggests that robust empirical evidence is lacking.

4.3.2 Individual experiences from development initiatives

Participants reported developing a sense of empowerment, across a number of studies. Feeling more empowered and being able to empower others was reported (Enterkin et al, 2013). Hancock et al (2005) present contradictory but valuable findings concerning empowerment. Ward sister/managers appeared to demonstrate versatility and flexibility, argued to be fundamental to empowered individuals (Hancock et al, 2005) but local and organisational restrictions to their roles resonated rather with disempowerment. In a similar manner, whilst many participants of the LEO programme reported feeling empowered, some reported

feeling disempowered when unable to bring about change in their place of work (Woolnough and Faugier, 2002).

Duffield et al (2005, p72) reported that their participants were able to share their views and develop their understanding, commenting that the programme “allowed them to express their own opinions and stretched their minds”. Being able to see beyond the immediate clinical area was identified similarly by Enterkin et al (2013) and Miskelly and Duncan (2014). An increase in self-awareness was noted by participants in several studies (Dierckx de Casterlé et al, 2008; Enterkin et al, 2013; McNamara et al, 2014) and increased confidence and motivation was reported from Miskelly and Duncan’s (2014) study. The self-report data presented (Enterkin et al, 2013; Miskelly and Duncan, 2014) is of interest; however the lack of confirmation from other parties leaves these findings unsubstantiated. In contrast, findings from an in-depth case study arose from one ward sister/manager and their ward colleagues, thus providing the confirmatory element (Dierckx de Casterlé et al, 2008). Similarly, the findings presented from McNamara et al (2014) represented a broader perspective, having arisen from focus groups with participants and mentors and coaches. A more aesthetic element was noted in the evaluation presented by Boomer and McCormack (2010, p638); participants’ “sense of becoming” was highlighted.

Hancock et al (2005) reported that ward sister/managers cited their experience impacting on their approach to leadership and management, with the least experienced managers noting the greatest change in their practices following the

development programme. Martin et al (2012) noted a significant increase in self-report scores for 'inspiring shared vision' and 'challenging the process' in the Leadership Practices Inventory (LPI) utilised before during and after the development initiative. Similar significance differences were noted from the observer data. Duygulu and Kublay (2011) reported similar changes to Martin et al (2012), with significantly different self-report scores in the LPI for inspiring shared vision and challenging the process. Additionally, significant differences were reported across the 'enabling others to act' sub-scale. Observer data similarly demonstrated significant differences across these sub-scales and the additional two sub-scales: 'model the way' and 'encourage the heart'. The authors have noted that despite the noted statistically significant differences in ratings across time by both participants and observers, the observer ratings were statistically significantly lower across three sub-scales. Whilst authors referred to other studies with similar results, no hypothesis was provided for why observers might rate participants lower than they rate themselves.

Programme participation and completion statistics were given by some but not all authors. In many cases, authors failed to be explicit when referring to participants, thus rendering it difficult to distinguish between evaluations from all development programme participants or participants in the evaluation process. Methodological inexactitudes were noted across studies, with details of sampling, data collection tools and methods given, often incomplete (for example: Boomer and McCormack, 2010; Duffy and Carlin, 2014; Dodwell and Lathlean, 1987; Hancock et al, 2005; Porter et al, 2006).

4.3.3 Organisational/service level outcomes

In the papers reviewed, individual level outcomes have been sought through various means; authors have unsurprisingly struggled to provide detailed measurable organisational outcomes. Indeed, Duffy and Carlin (2014) commented on the challenge of identifying service impact data. Evidence of an unequivocal link between development initiatives identifiable service outcomes would demonstrate the value of investing in staff development.

Fealy et al (2015) noted that participants and their managers identified service improvements resulting from the project; participants in the development initiative were required to establish practice development projects and a number of these were cited as providing evidence of service change. Fealy et al (2015) in addition refer to more implicit, less tangible service benefits; changing behaviours in teams and an increased willingness to embrace change. Boomer and McCormack (2010) reported developments in the effectiveness of patient-centred care in units that had staff participating in their long term practice development initiative. Managers commented on the active management of sickness and performance issues and that poor practice was being challenged (Boomer and McCormack, 2010).

4.4 Barriers to leadership development

Having explored development initiatives for existing or aspiring ward sister/managers, this next section considers barriers that exist in relation to leadership development which may be of significance to aspiring ward

sister/managers. The challenges with sustainability of the LEO programme itself and the learning and enthusiasm generated by it was a prominent theme from participants; lack of time, dwindling enthusiasm, lack of managerial support were all cited as contributory factors to this lack of sustainability (Woolnough and Faugier, 2002). The lack of time was similarly highlighted as a barrier to completing proposed action plans or more generally for development work (Carlin and Duffy, 2014; Koivula and Paunonen-Ilmonen, 2011). A lack of readiness and lack of commitment on the part of the organisation was reported by Carlin and Duffy (2014) and variations in the organisational culture to support development initiatives were noted (Jasper et al, 2010).

Mentors and coaches were, in some cases, lacking in appropriate mentoring/coaching skills and this inevitably impacted upon the success of mentoring and coaching as support mechanisms for those undertaking development initiatives. Jasper et al (2010) and Greenwood and Parsons (2002b) similarly reported challenges with the mentoring relationships that caused concern to participants. McNamara et al (2014) additionally noted that not all coaches were experienced and that the relationships took time to develop. A lack of trust in the mentoring relationships was highlighted as a major concern for some participants in one study (Greenwood and Parsons, 2002b) but this was not reported elsewhere.

Lack of staff and lack of time served as a major barrier to development leadership and practice for Hancock et al's ward sister/managers following completion of the

LEO programme (2005). In addition, role changes in the wider organisation impacted on their own roles and responsibilities, sometimes negatively.

Delegation appeared problematic for two reasons, with staff shortages making delegation difficult and a reluctance to let go of roles and responsibilities (Hancock et al, 2005).

Lack of research knowledge was cited as a barrier to developing practice by Greenwood et al (2002b). This lack of knowledge took several forms; lack of knowledge and understanding amongst unit managers, their staff, and lack of receptiveness to research (Greenwood et al, 2002b). The written ability of participants was found to be variable, and participants required substantial support to develop their reflective ability in writing (Jasper et al, 2010). Lack of knowledge was also identified by Koivula and Paunonen-Ilmonen (2001), and they noted that occasionally the enthusiasm for development was lacking amongst Finnish ward sister/managers.

Self-reported barriers to leadership development amongst nurses and midwives fell into three groups: influencing, interdisciplinary working, recognition and quality of care factors (Fealy et al, 2011). Barriers related to the ability to influence were rated by respondents overall as having the highest significance. Staff nurses and midwives rated interdisciplinary relationships more highly as a barrier to leadership development than did clinical managers. Fealy et al summarised their findings: “nurses and midwives perceived greatest barriers to leadership development are related to their spheres of influence in the areas of

interdisciplinary working and in the wider departmental and organisational sphere” (Fealy et al, 2011, p2030).

Needing to feel valued and lack of trust was also noted amongst participants serving as a barrier to development (Greenwood et al, 2002b). Age related staff attitudes were also reported on as a major cause for staff conflict impacting on the development of practice (Koivula and Paunonen-Ilmonen, 2001).

4.5 Systematic organisation-wide approaches to preparing for future ward sister/managers

Sustained and systematic development initiatives with a view to planning for future staffing requirements have been noted and this section has explored the empirical evidence related to these initiatives. The establishment of an organisation-wide approach to developing the ward/sister manager in conjunction with junior and senior nursing roles, suggests an understanding of the needs of nurses up to and beyond the ward sister/manager position. This might be expected to have a beneficial effect on those staff navigating this career progression route.

Succession planning has been defined as “a strategic process involving identification, development and evaluation of intellectual capacity ensuring leadership continuity within organisations” (Titzer et al, 2013, p972). Primary research investigating succession planning strategies and/or outcomes for nurse leaders and, particularly, for ward sister/managers, has been very limited to date;

much of the published material on succession planning in nursing has been case based or opinion based.

Four literature reviews have been conducted over the past seven years reviewing the evidence for succession planning initiatives from a range of sources, some more rigorous than others; all have called for more research in this area (Carriere et al, 2009; Griffith, 2012; Hampel et al, 2010; Titzer et al, 2013). Of the four literature reviews examined, only Titzer et al (2013) stipulated that they had conducted a systematic review. Griffith (2012) conducted a scoping review of the literature, intending to critique research and non-research based material.

Searches were conducted for these two reviews between 1987 and 2010 (Griffith, 2012), from 2007 to 2012 (Titzer et al, 2013), some variation of search terms was noted with Titzer et al (2013) utilising a broader and thus, more encompassing, search strategy.

From an initial fourteen hundred papers, Titzer et al (2013) reviewed thirteen papers that met their stated inclusion criteria; Griffith reviewed twenty four papers (2012) from one hundred and forty two relevant titles. Whilst Titzer et al set out their systematic review process for the reader, Griffith (2012) presented little detail of the review process and the term succession planning was not defined. Griffith (2012) reported three major themes emerging from this review; the varied and unspecified nature of leadership competencies, the nature of succession planning programmes and the process of implementing these

programmes, although primary data was lacking to provide unequivocal support for these findings.

Titzer et al (2013) identified the challenge of multiple titles for nurse managers resulting in their search of material using terms nurse manager, nurse leader, front line nursing leadership; all terms that may be utilised with equivalence to the ward sister/manager position. Of the thirteen papers extracted in their review however, only five were research studies (Abraham, 2011; Benjamin et al, 2001; Brunero et al, 2009; Coughlin and Hogan, 2008; Picker Rotem et al, 2008); one was a review of case studies and the remaining seven were anecdotal accounts. All five research papers detailed the participant sample but only two of these referred to the research design. Outcome measures were presented from three of these research papers (Abraham, 2011; Benjamin et al, 2011; Coughlin and Hogan, 2008). Titzer et al's (2013) review identified common elements discussed in succession planning initiatives: the need to define short, medium and long term goals, to develop core competencies needed and to integrate succession planning strategies within the organisation's vision and strategic plan. Barriers to succession planning included ignoring the need for succession planning, making assumptions about staff willingness to take on new and more senior roles, lack of role clarity and constantly changing environments with limited resources.

Of the five research papers included in Titzer et al's review, only one of those met the inclusion criteria for this literature review set out in Table 2.1 (Brunero et al,

2008), the others were excluded due to the country of origin of the research. One additional paper was located through hand searching, that explored succession planning for nurse leaders at the ward or department level (Manning et al, 2015). For the purposes of this review, succession planning has been considered to be an organisational programme which identifies, nurtures and develops staff to enable them to progress to more senior leadership positions within the organisation.

In a strategy to develop future ward sister/managers and specialist practitioners, Brunero et al (2009) reported on an initiative whereby short term relief opportunities were established for aspiring ward sister/managers and nurse specialists. Brunero et al (2009) identified the need to take a whole organisation approach to identifying future leaders and providing opportunities for shadowing and short-term secondments to try out new roles. Arising from her review of the literature, Griffith (2012) proposed a plan to develop nurses from nursing student to chief nursing officer with a smooth interface between practice and education. Programmes were designed to encourage those aspiring to ward sister/managers positions (Enterkin et al, 2013; Manning et al, 2015) and in a range of senior positions, of which the ward sister/manager was one (Brunero et al, 2009).

4.5.1 Development opportunities and programmes specifically for succession planning

Similarly to the isolated development initiatives that focus upon one particular staff grade, development programmes with succession planning in mind, varied in

length and the format of support and attendance varied across all programmes. Brunero et al (2008) reported on a programme encompassing relief positions, participants were given a locally designed competency booklet to support them in their six month relief position, and were encouraged to take up mentoring, coaching and supervision opportunities already established (Brunero et al, 2008). Manning et al (2015) reported on an initiative which combined placements and shadowing with a self-directed managerial skills workbook. The underpinnings of programme design were not always reported, other than local steering committees were established to inform the direction of the initiative; Manning et al (2015) commented only that their initiative was based upon basic principles of succession planning. It is unsurprising, due to the very limited empirical evidence related to succession planning in nursing, that there was no commonality in terms of approach.

4.5.2 Evaluations and individual outcomes

Brunero et al (2008) surveyed their programme participants; the results reported were summarised with little empirical data presented. Participants noted gaining additional skills and experience in other roles and that this gave insight into career choices. Manning et al (2015) utilised three self-report survey tools, of which the LPI was one, both before and after the succession planning programme. The authors commented that significant differences were noted in participants' ability to undertake managerial tasks after the programme and significant differences were noted in two subsets of the LPI: 'encourage the heart' and 'challenge the process'. The results were noted as encouraging but having

arisen from a sample of eight participants, the significance of the statistical findings must be taken with some caution.

Outcome data was not presented by Brunero et al (2008). Manning et al (2015) reported evaluation data in some detail and presented outcome data under the banner of cost benefit data; noting that of eight participants, one was appointed to ward sister/manager position, one was in a long term relief position and two had left the organisation to take ward sister/manager positions elsewhere. The intentions of the remaining candidates were not reported. These findings suggest that providing development opportunities as part of succession planning initiatives leads to beneficial outcomes for individuals and the organisation.

4.6 Summary of what we know

Having presented a critical appraisal of the literature concerning the development of current and future ward sister/managers, this section provides a summary of what is known. Development initiatives for ward sister/managers and aspiring ward sister/managers have been reported, but research evidence has been limited. Studies have tended to be small scale local studies and the focus of these development initiatives has been predominantly individualistic in nature. Whilst no criticism can be made over establishing development initiatives to meet local need, the lack of reference to other published initiatives is remarkable. Authors and programme developers appeared not to have scrutinised previous work for methodology, method or evaluation. Each development programme then has a tendency to sit as an isolated episode which

may be of benefit to the local participants and organisation but which has not obviously, contributed widely to a much-needed body of knowledge.

Development programmes have taken many forms with variability in attendance mode and patterns, programme content and formulations of the evidence of learning. Participants in these initiatives tended to evaluate them positively through self-report evaluations and or interviews. There is little evidence that the learning experienced by individuals is distributed across wider staff populations in organisations. Service and/or practice based outcomes are challenging to unravel, however a number of studies are now attempting to report service-level outcomes of leadership development initiatives (Fealy et al, 2015).

Succession planning is increasingly widely discussed amongst nurses, but systematic planning and implementation of succession planning strategies, including to the position of ward sister/manager, has been lacking. Research detailing and evaluating succession planning activities for the ward sister level of practitioner is minimal, with only two studies identified that met the inclusion criteria of this literature review. Good practice suggestions have mostly been derived from anecdotal reports and opinion based papers stemming from local need. Some limited evidence has been reported of the success of succession planning strategies in preparing practitioners to develop and progress. A note of caution is warranted however, Manning et al (2015) noted that two of the cohort from their succession planning initiative had left to take promotions elsewhere. It would appear that having prepared practitioners for the next role, a lack of

suitable opportunities will inevitably cause them to look at other opportunities outside their organisations.

4.7 Gaps in knowledge

In chapter three, empirical evidence was presented illustrating the multifaceted nature of the ward sister/manager role and findings suggest that ward sister/managers experience tensions between their clinical and managerial roles. Whilst it has been argued that ward sister/managers may derive job satisfaction from these multiple roles, there is empirical evidence to contend that job satisfaction is not universal and that the role is not one that junior staff necessarily aspire to. Whilst research which has explored the ward sister/manager role has been detailed from 1990 onwards, it appears that researchers have presented their work in isolation. The wisdom acquired from investigations into the role, and the experiences of the ward sister/managers themselves, does not appear to have been built upon. Compounding this lack of progression in the body of knowledge is the absence of the organisational perspective. What appears to be lacking is the wider perspective that examines the ward sister/manager role within the context of an organisation. Investigation of a role without consideration of the context in which the role is situated omits or overlooks the realities of the role. Practitioners' experience in any role takes place within that context of the department, alongside colleagues, within the organisation and not in a vacuum. An organisation's structures, policies and practices contextualise the ward sister/manager role and thus may impact

directly and indirectly on the role and therefore on the experience of the post holder.

Whilst the transition from student to staff nurse has received considerable attention in the literature, and a growing number of authors have explored the transition from RN to academic and nurse practitioner, this review identified only two papers that specially focussed upon the transition from staff nurse to ward sister/manager. Whilst this lack of material related to the transition from staff nurse to ward sister/manager is surprising, it is perhaps a reflection of the interpretation of role transition. Arguably researchers and academics view the transition process as one that involves moving from one boundaried role to a different boundaried role. From this it could be inferred that the move, the progression from staff nurse to ward sister/manager, is a smooth and straightforward one. Research exploring the role of the ward sister/manager and development initiatives required for ward sister/managers, suggests that the move into this role is not a straightforward one however.

Despite the interest in nursing leadership, especially the ward sister/manager role, and a plethora of opinion pieces, systematic planning and support initiatives for the next generation of ward sister/managers remain absent from the literature. Local initiatives may be reported as case reports but evaluation of these strategies is often missing. Research which investigates the links between individual needs and motivation with development and succession planning initiatives is lacking.

There is a lack of systematic succession planning for ward leadership in the shape of the ward sister/manager, and immediately above in the UK. With the exception of Wales in the UK (Jasper et al, 2010), national strategies for developing ward sister/managers are lacking.

The principal objectives for this study have thus arisen from the exploration of the literature and the identified gaps in knowledge concerning the ward sister/manager role and preparation for and transition to this role in one particular NHS organisation. This process of transition to the ward sister/manager role is situated within an organisation which may impact directly or indirectly upon the transition, leading to the two objectives identified in 4.7.1.

4.7.1 Principal objectives

1. To explore the experience of transition from staff nurse to ward sister/manager
2. To understand the impact of organisational factors on that transition

To answer these two objectives, there are three discrete questions listed in Section 4.7.2.

4.7.2 Final research questions

1. What is the experience of transition from the role of staff nurse to ward sister/manager in an organisation?
2. What is the culture of this organisation as evidenced by structures, policies, work roles, power structures, and, from the perspectives of staff nurses and senior trust team?
3. What influence do these factors (structures and policies) have: do they contribute to, facilitate or hinder this process of transition?

4.8 Chapter summary

This chapter has explored the knowledge and skills deficits identified by ward sister/managers themselves and the needs of aspiring and established ward sister/managers as evidenced through the various development initiatives established to support them. The impact of these development initiatives on the individual participants has been established. Barriers to leadership development which could impact on those aspiring to the ward sister/manager role have been set out.

This chapter has culminated in a section which details the gaps in knowledge that have become apparent following the review of literature presented in chapters three and four. The principal objectives and final research questions that stem from this extensive literature review presented in chapters three and four have been detailed. In the next chapter, the research methodology will be established and the research method employed will be explored.

Chapter 5 Methodology and Method

5.1 Introduction

This chapter opens with an exploration of the underpinning philosophical stance that has guided the study. The justification for a case study approach is then made and this is followed by detail of the research methods established. A leadership development programme was used as the vehicle to identify and recruit participants for the study from across the organisation. Further detail of this programme is provided in section 5.8.1 and the evaluation of this development initiative has been reported elsewhere (Enterkin et al, 2013).

Additional participants (key informants) were identified through the organisation's training and development department and through recommendation from the first group of respondents. Policy and strategy documents were reviewed, the organisation's intranet and external web sites were scrutinised to add context to the research findings and the data collection processes have been detailed. The data analysis process is then presented in detail, with illustrations of thematic analysis presented to illustrate the utilisation of coding matrices. Ethical considerations are explored. The research participants are introduced in this chapter. The chapter ends with a summary of the discussions and debates included within.

5.2 Philosophical approach

The nature of reality, of truth, inspires and divides philosophers and researchers. Debate has provided clear illuminations to some and deep reflection and consternation to others. Philosophers may spend a lifetime endeavouring to

answer this very question. Whilst researchers may not necessarily be setting out to answer the question –‘what is the nature of truth’, the researcher’s selection of method and methodology may however, reflect the researcher’s own personal belief as to the nature of truth and knowledge and thus the best means to understand and illustrate this for others to see.

Research paradigms vary according to the assumptions held within them about the nature of social reality that is investigated, and the related assumptions, as to the way that knowledge of this reality can be uncovered (Blaikie, 2007). Oakley (2000) suggests that the differences between the two major methodological paradigms concern how people know things. Positivist/empiricist researchers believe they are studying the real world; naturalists, in contrast, argue that there is not one sole reality to be known (Oakley, 2000). Snape and Spencer (2003) refer to key questions in social research concerning ontological beliefs: whether social reality exists independently of human beliefs and interpretations, and whether there is a common shared reality or there are multiple contextually specific realities. Whether social behaviour is governed by “laws that can be seen as immutable or generalizable”, is open to debate (Snape and Spencer, 2003 p11).

For Blaikie (2007), the nature of social reality held by ontologies is frequently narrowed down to two opposing categories – that of an idealist or realist. The idealist theory assumes that the external world has no existence that is independent of our thoughts; reality is only “knowable through the human mind

and through socially constructed meaning” (Ormston et al, 2014, p5). Realist theories consider that natural and social phenomena can exist independently of the activity of the human observer (Ormston et al, 2014). Many variations of idealist and realist theories exist; the commonality is arguably that they all hold that there is an existence of some form of reality (Maxwell, 2012). Questions arising from these held beliefs are about the nature of that reality and how researchers would investigate and identify it, and thus, methodological problems for researchers stem from uncovering “what kinds of connections are possible between ideas, social experience and social reality?” (Blaikie, 2007, p13).

Maxwell has commented that one of the most prominent forms of realism is that of critical realism following the work of Bhaskar (Maxwell, 2012). Bhaskar’s critical realism attempted to take the middle ground between the positivist ‘universal order’ and the unknowable chaos proposed by those advocating that there is no independent real world in existence. It has been argued that the critical realist position is a contradictory one, having arisen from the conflation of a relativist epistemology with a realist ontology which results in the collapse of the epistemology and ontology into reflections of themselves. This has been termed the epistemic fallacy (Maxwell, 2012): the view that “statements about being can be reduced to or analysed as statements about knowledge” (Bhaskar, 1998, p27). Critical realists dispute the existence of this epistemic fallacy, however justifying the case for the separate existence of ontology and epistemology; scientific knowledge must be separate from the knowledge of what must be, for science to be feasible (Bhaskar, 1989).

For critical realists then, a real world exists, although Easton (2010) acknowledges that this can never be entirely proved or disproved. Realists refute that there can be objective knowledge about the world, accepting that there will always be the possibility of alternate views (Maxwell, 2012), however critical realists believe that people live and act as though the world is real (Easton, 2010). Knowledge of the world is thus theory-laden, fallible and ever evolving. Whilst people cannot know what else there is to know in the world beyond their own knowledge, they must accept that knowledge of the world changes and adapts day by day; therefore what is not known of the world must change accordingly. Within critical realism, social entities have an independent existence regardless of whether they are known or understood, as suggested by Clark et al (2008, pE69) “social structures and phenomena exist as a product of the existence of human beings, these entities are seen to be independent of individual human beings as physical entities”. These existing structures may also exert power whether or not people know or recognise this. Clark et al (2008), in support of Easton, caution however, that human social processes and perceptions may be fallible and should not be regarded as indisputable truth without some form of verification.

Lipscomb (2008) refers to critical realist distinctions between what is known (the social production of knowledge) and what can be known (the things that might exist). Bhaskar’s extensive writings expand on this distinction, proposing that three levels of ontology are in existence: the empirical, the actual and the real (1998). The empirical comprises human perceptions and experiences, that which

can be observed, although it may be fallible (Clarke et al, 2008). The actual comprises what is real but cannot always be seen, and the real, akin to the roots of a tree, comprises the hidden structures, causations and mechanisms which allow the actual and empirical to exist (Walsh and Evans, 2014). It is the contention of critical realists that these unobservable facts are real in as much as their effects can be identified. Within critical realist thinking, structure and agency are both significant concepts: agency referring to individual characteristics such as beliefs and attitudes, where structure refers to social norms, culture, geography and environment (Clarke et al, 2008).

Angus and Clark (2011) acknowledge that although frameworks for research based upon critical realism have been discussed, most researchers must develop their own methodological strategy for their particular question of interest adhering to the foundational beliefs of critical realism. Critical realism has been described as having multiple applications in healthcare research and has been utilised in an increasing number of health care and nursing related research accounts (Clarke et al, 2008; O'Brien and Ackroyd, 2012). The existence of undiscovered or unknown social processes and connections can be explored through the lens of critical realism to produce description of causal links and thus inform policy (O'Brien and Ackroyd, 2012). The appeal of this approach to nursing is unsurprising. Whilst critical realism has not been obviously utilised to explore either the role of the ward sister or the development of ward sisters, it has been shown to be of use in a number of studies exploring work roles and processes. For example, Maxwell et al (2013) utilised a critical realist lens to explore how

those in new nursing roles develop work place jurisdiction, whilst O'Brien and Ackroyd (2012) explored the recruitment and retention of overseas recruited nurses.

The research study reported here has been informed by critical realism in a number of ways: firstly, through the approach to considering the behaviour of the groups of 'actors', secondly, in the research design consequently adopted which is expounded in section 5.4, and thirdly through the iterative process of data analysis and forming descriptive and explanatory accounts which is established in section 5.9.

5.3 Case study as a method

Easton (2000) has noted that the term case study research has often been used indiscriminately, even by experienced researchers. Yin (2009) and Stake (1995) may be considered the most notable authors on the subject of case study research. Case studies produce a rich picture of a particular situation (Easton, 2010). Yin (2009, p18) proposes that a case study is an empirical investigation which is able to explore "a contemporary phenomenon in depth within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". Schwandt (2002) in support of the case study, proposes that to be able to comprehend the meanings of a phrase or expression, the whole context must be understood; where the whole might comprise values, beliefs and wider situations and contexts.

Laukner is one of a number of authors who has suggested that Yin's (2009) approach to case study research appears heavily influenced by quantitative methods and values and is positivist in nature (Laukner et al, 2012). Holloway and Wheeler (2010) contest that Yin gives primacy to the quantitative approach, although he does consider that the qualitative approach may have validity in addition. Yin himself clearly situates his approach within social science research, without obviously claiming to be either a confirmed positivist or interpretivist; he acknowledges the value of both qualitative and quantitative methods in pursuit of the exploration and description of the case (2009). Stake (1995) in contrast to Yin's more pragmatic approach, proposes a case study situated decidedly in the interpretivist paradigm. Stake has suggested that his work on the case study has been influenced by "naturalistic, holistic, ethnographic, phenomenological and biographical research methods" (1995, pxi), but makes no attempt to situate it firmly and exclusively in any one of those positions. It could thus be proposed that Yin and Stake hold views that position them at the opposite ends of a spectrum of case study research.

The case study design is one suited to exploration of an unbounded problem that involves complexities. 'What' and 'how' questions can be effectively answered through this approach (Johnstone et al, 2008; Yin, 2009). In order to achieve this exploration of unbounded problems, multiple sources of data may be utilised to consider and align different perspectives and views about any phenomena (Clark et al, 2008). Indeed, case study research has been likened to removing the layers of an onion, one by one, although Easton cautions that this layer by layer

approach may not in itself be sufficient to comprehend all forces and mechanisms at work within a case.

Criticisms have been levelled against case study research; the most contentious of which is that generalisation is not possible from a single case (Flyvbjerg, 2006).

Yin argues however that this view is mistaken and situated in a world view that gives primacy to statistical generalisation (Yin, 2009). He argues that the role of the case study is to enable analytic or theoretical generalisation rather than any statistical generalisation. Eisenhardt and Graebner refer to the use of the case as the foundation for inductive theory development, with theory emerging that is “situated in and developed by recognising patterns of relationships among constructs within and across cases and their underlying logical arguments” (Eisenhardt and Graebner 2007, p25). Easton agrees with Flyvberg that, at least for positivist researchers, one case study would never be sufficient, however he has argued that one case study can be sufficient where a “causal explanation has been developed from one case, the constituents of that causal explanation provide the basis for generating theory beyond that case” (Easton, 2010, p12).

The ability to utilise a range of data sources that may generate rich data from more than one perspective in order to explore a potentially complex and multifaceted problem, directed that the case study method, suited to the exploration of complex, unbounded problems (Clark et al, 2008; Johnstone et al, 2008; Yin, 2009) was the most appropriate method to answer the research questions established in section 4.7.2. These research questions were established

to uncover the experience of practitioners undergoing the transition from staff nurse to ward sister/manager. Additionally, this study seeks to uncover the nature of the culture of the organisation and the impact of this upon the transition process, in terms, both of experience and process. Perspectives of other members of the nursing team, staff nurses and senior trust team members which might comprise views of this transition process in terms of their own experience and their observations of the transition process in the organisation add to the exploration.

Easton (2010) amongst a growing body of researchers (for example: McEvoy and Richards, 2006; Maxwell et al, 2013; O'Brien and Ackroyd, 2012), sets out a persuasive argument for locating case study research under the umbrella of critical realism. Easton argues that critical realism assumes that events are caused by processes and structures which are real, but mostly invisible. The causes of events can only be explained with reference to the interplay between these forces and case studies are well suited to explore and uncover these interplays (Easton, 2010). Proponents of the critical realist case study argue that the case study can and indeed must sit explicitly within a particular paradigm and be judged against the very criteria of that paradigm. Without a firm epistemological position, a researcher struggles to show how theory can be generated, justified and judged (Easton, 2010).

Lipscomb (2008) proposes that the role of the critical realist researcher is to identify mechanisms and their interplay in actualising events. The case study

methodology presents the ideal framework for investigating these mechanisms and their interplay with the aim of generating theory as to the nature of the relationships and the nature of truth. The critical realist case study must therefore be “inquisitive” to uncover the origins of things, to uncover and unpick complexity, to “seek for the underlying reality through the thick veil which hides it” (Easton, 2000, p212). Indeed Maxwell (2012, p103) asserts that realists must have awareness that data should be seen “not merely as texts to be interpreted or as the constructions of participants, but as evidence for real phenomena and processes ...that are not available for direct observation”. Thus a critical realist approach to the case study design appeared best suited to enable exploration of a contemporary phenomenon within a real life context in a complex situation.

5.4 Research design

Having established the merit of a critical realist case study to address the research objectives and answer the research questions, a description of the case in this research is reported here. This is illustrated in Figure 5.1. The case in this study is an organisation, one NHS metropolitan hospital, with multiple medical specialities, an accident and emergency department and a maternity department, serving a broad and diverse local community. The organisation consisted of two hospital sites, separated by a little distance that required staff or patients to navigate with hospital or local public transport. These two hospital sites were unequal in size, number of specialities and levels of patient acuity. The organisation was selected as the focus for the case to facilitate exploration of potential mechanisms and processes, both apparent and hidden, which might

have impact on those individuals undergoing the transition from staff nurse to ward sister/manager. The case therefore is the organisation in which this transition is taking place: investigation of this case explores the experiences of those undergoing the transition during the period of this study, aspiring ward sister/managers. In addition, peer or senior practitioners add a more distant perception of this transition process, nurses looking inwards and potentially at themselves. Local policy and strategy documents relating to the time period in question bring the organisational context into the research and intranet and external website searching support this investigation. The constituent parts of this case support the investigation to answer the research questions established in section 4.7.2 and reaffirmed here.

- What is the experience of transition from the role of staff nurse to ward sister in an organisation?
- What is the culture of the organisation as evidenced by structures, policies, work roles, power structures, and from the perspectives of staff nurses and senior trust team?
- What influences do these factors have: do they contribute to, facilitate or hinder this process of transition?

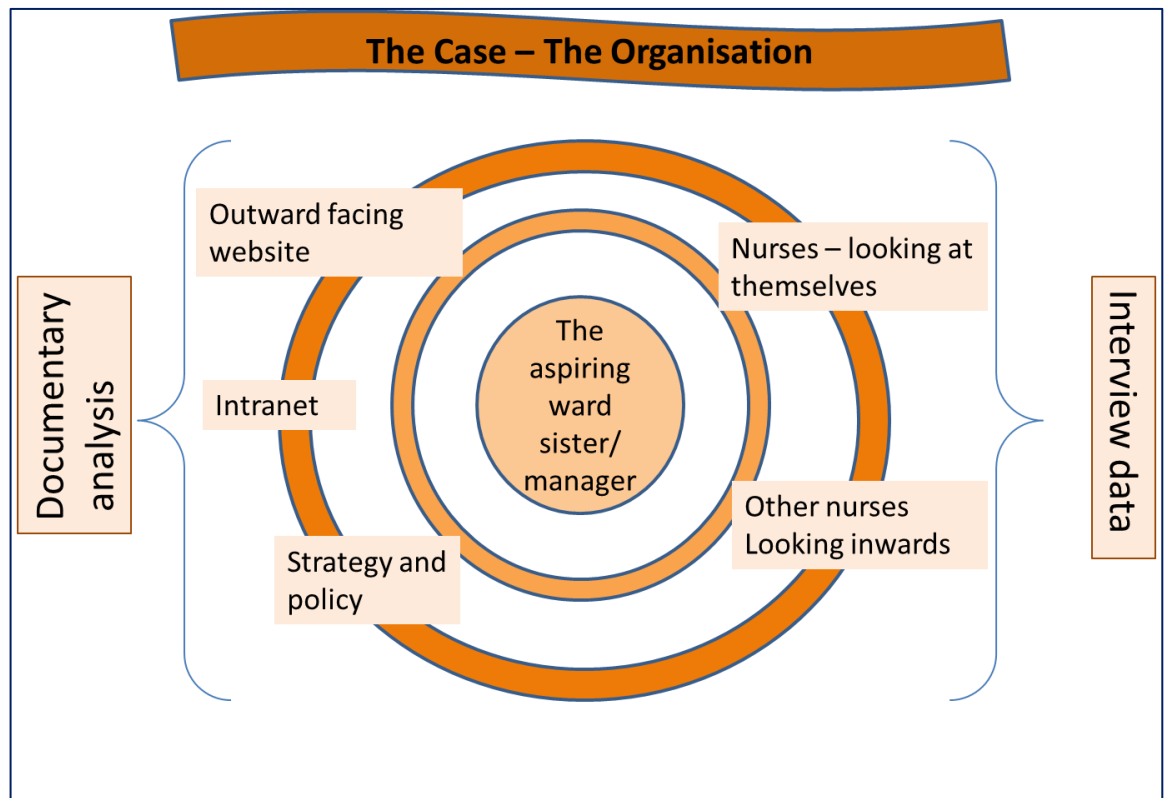


Figure 5.1 Illustration of the case in question

5.4.1 Ethical issues

In broader terms, ethical discussions in the process of research have changed very little. Webster et al (2014) illustrate this broad consensus that research should have utility and should not place excessive requirements upon the participants in this research, stating that “participation in research should be voluntary, free from coercion and pressure and based on informed consent.

Adverse consequences of participation should be avoided and risks known and confidentiality and anonymity should be respected” (Webster et al, 2014, p78).

This primary aim of the researcher must be to follow these broad principles which govern the formal ethical scrutiny process carried out by organisations such as the National Health Service Health Research Authority (NHS HRA). This next section sets out to explore coercion to participate through power relationships,

insider outsider status and confidentiality and anonymity, and the application of these ethics principles in the pursuance of this research has been explored in section 5.7.

Invitations to participate in research must necessarily be free from coercion. The boundaries between encouragement and coercion may however seem blurred and the researcher should be mindful of the effect of their request on potential participants. The relative positions of researcher and participant may confer an unintended relationship vested in the power of the researcher over participants. Webster et al (2014) propose that the researcher should endeavour to stand in the participants' shoes and consider the research from their perspective. What may appear to be a reasonable request and series of reminders to reply on the part of the researcher may appear to the participant to be more than that. This then begs the question, how should researchers make contact with potential participants, who should provide study information, who should be the point of contact, who should take the consent to participate. The issues do not end there of course; once participation is agreed, how can the researcher maintain contact to arrange the next step without running the risk of stepping into that zone of coercion?

Debate concerning the insider or outsider position of the researcher is not new (Cousin, 2010), arguably views concerning this positioning are guided by the philosophical stance of the research and researcher. Venegas and Huerta (2010, p157) argue that researchers must be "cognizant of their insider/outsider status"

where the “insider is a native of that particular geographic area, culture or acutely aware of social norms, whereas an outsider does not possess any of the previous listed characteristics”. Yin (2009), whilst not specifically addressing this insider-outsider dimension, guides the researcher to be observant, asking meaningful questions which are “unbiased by preconceived notions” (p69). He does however acknowledge that the case study researcher must possess a sufficient knowledge about theoretical and political issues relevant to the case. There appears to be no definitive critical realist position in relation to the insider outsider debate; the researcher’s mission to explore connections such that mechanisms and processes can be uncovered must surely require objectivity and reflexivity at the least. Pelias (2011) asks if the researcher considers themselves as a contaminant of the research. Indeed, Cousin (2010, p10) posits that “the self is not some kind of virus which contaminates the research. On the contrary, the self is the research tool, and thus intimately connected to the methods we deploy”. Arguably, whether the researcher is considered as an outsider or insider is immaterial; what is significant is the degree of reflexivity and transparency that the researcher utilises and conveys such that the reader can understand both the methods selected and the process and nuances of analysis (Cousins, 2010). In relation to this, where I as a researcher position myself is fundamental; I am and have been the research instrument. I cannot consider myself wholly as an outsider; I am known to participants and to the organisation as the leader of an educational development initiative. I am not, however, an insider, in the sense that I belong either to the organisation or to the group that the participants come from, that of aspiring leaders within this organisation. I might therefore consider

myself to have hybrid status, closer to outsider than insider, but with a degree of inside acceptance in terms of introduction to the participants.

In the writing of findings and results both before and at publication an issue of anonymity and confidentiality arises. The complexity of anonymisation has been acknowledged and Saunders comments that “changing people’s names or disguising locations are only first steps in a more nuanced process around managing identifying details” (Saunders et al, 2014, p 2). This is of great significance in a small study aiming for rich descriptions from a small group of participants (Webster et al, 2014). The researcher must take great care to protect the identity of individuals. A point perhaps not often considered by researchers however, is whether participants wish to be unrecognised or whether they wish to be known and seen openly through the research (Saunders et al, 2014, Grinyer, 2002).

The danger of accidental disclosure may occur in a number of ways: disclosure to others during the interview of subsequent participants, discussing the research with those outside the research team or through the means of reporting the data from the study. The use of verbatim quotations to illustrate points is established practice in qualitative research, and yet this poses a risk. The content of excerpts may inadvertently reveal the identity of a participant, the patterns of phrasing, syntax use and idiomatic language may reveal identity. Qualitative researchers aim to show the depth of their work, trying to make the participants appear the real, thinking, complex individuals they are, but this brings a risk, amongst a small

group of participants, who may or may not be known to each other, the use of pen portraits, a matter of growing interest in the qualitative research world, is potentially difficult. Tod et al (2012) utilised pen portraits in their study of older people keeping warm in winter to capture the diversity of their participants' experience. They utilised six portraits to represent the experience from over thirty participants, to enable them to demonstrate the richness of their participant group, but without revealing individuals who might subsequently be recognised. Webster et al (2014) reflect concerns at the potential for distortion that is inherent in attempting to protect identity. In the research reported in this thesis, pen portraits were considered to be overly revealing about the individuals and thus were not utilised.

5.4.2 Researcher integrity

Key to any research is the role of the researcher; in qualitative research however, the researcher is arguably the research instrument (Maxwell, 2012). The relationship that the researcher develops with the participants is significant. The desire exists to create trust and intimacy; whether this is entirely ethical is debatable. The researcher aims to collect data, but what the participant seeks from participation is perhaps less clear. It is possible that the participant aims for partnership, for some degree of reciprocity, for gaining some form of credibility or status through participation. Perhaps it is misplaced for the researcher to anguish over the possible motivation of the participant to participate; it does however require moral and ethical consideration. The concept of reciprocity is a complex and potentially problematic one. The researcher is advised to encourage

and engage with but not guide, direct or indeed influence the participant. As a researcher who was known to participants as a teacher, a facilitator, this was a difficult tightrope to walk. Maxwell (2012, p100) suggests that the researcher participant relationships should be understood as realist complex phenomena that may have a “profound, and often unanticipated consequences for the research”, thus the reflective practices and subsequent reflexivity of the researcher are essential to enable the researcher to appraise any and all potential impacts upon the data gathered and subsequent analytical process.

Legard et al (2003) have commented upon the need for the qualitative interviewer to utilise personal professional qualities to develop rapport quickly with the participant. In addition, the need to demonstrate credibility is paramount. This however means that the researcher must navigate a precarious balance between demonstrating credibility through asking pertinent and sound questions whilst not using the interview as the forum in which to show off their own knowledge (Legard et al, 2003). Interviewer participant relationships, both in terms of their nature and the balance between them have been discussed extensively; Yeo et al (2014) propose that the researcher must be flexible in their approach depending upon the nature of their research. The distinction of roles between researcher and researched has become less marked in feminist and emancipatory approaches to research (Yeo, 2014). Sword (1999) discusses the need to maintain a form of neutrality whilst working on a principle of ‘fair exchange’ with the research participants.

5.5 Data collection methods

5.5.1 Interviews

The in-depth interview is used as a means of gaining understanding and clarity, a window into the thinking and understanding of participants (Legard et al, 2003).

There are a number of potential mediums for interviews; face to face and telephone interviews are perhaps the most typical (Cassell, 2009). The interview has a specific benefit within critical realism as expounded by Edwards and Holland (2013): “from a critical realist approach, even if reality and structures are not fully available to people, researchers can still grasp them by working from interviewees’ accounts of their understandings and experiences in dialogue with theories about what social reality is like and how it works” (Edwards and Holland, 2013, p22).

A single, one-off episode of data collection may, or may not be sufficient (Lewis and McNaughton-Nicholls, 2014). Repeating some or all elements of data collection over time may be of value in capturing a process that may evolve over time and this may include repeat research with the same group of individuals.

Miller comments that “lives unfold in all sorts of unplanned ways and as researchers we go back into unknowable situations” (Miller, 2015, p297).

5.5.2 Documents, policies and web based material

The collection and exploration of documentation as part of the case study is well established (Yin 2009). Prior (2008, p822) reports that “documents should not merely be regarded as containers for words, images, information, instructions,

and so forth, but how they can influence episodes of social interaction, and schemes of social organization". Policy documents indicate the organisation's intentions towards staff and patients, establishing the framework of how services should be delivered. Indeed, Laschinger et al (2001) report that support, resources and information constitute organisational antecedents to an empowered workforce, thus arguing, by implication, that structures and policies impact upon individual experience. Critical realist research seeks to uncover the connections at work between the empirical, the actual and the deep or real levels of knowing (Ackroyd and Fleetwood, 2000). Thus documents, including policies and strategies, may affect social interactions within an organisation, in that they may exert both direct and indirect influence on employees. The organisation's commitment to employees may not be synonymous with employees' perceptions of organisational commitment and support.

5.5.3 Field notes and research journal and reflexivity

This reflexive process is of great importance and arguably has two strands to it: researcher subjectivity and reflection through the research process. The first is centred around researcher subjectivity and bias. A researcher's own biases, feelings and thoughts need to be recognised and taken into account (Maxwell, 2012). Ormston et al (2014, p22) propose that whilst researchers seek to avoid "obvious, conscious or systematic bias ... this aspiration can never be fully attained". Maxwell writes about a process, akin to 'bracketing', to set aside presumptions, assumptions. Through this process researchers should learn about themselves, see their own prejudices more clearly and be open to areas in which

their beliefs and values may relate to the research in question and identify any influence of these beliefs on the research process itself (Ormston et al, 2014).

The second element of reflection is that which takes place throughout the research concerning the process, data collection, data management and analysis. Reflective writing and reflective discussions with peers and supervisors support and challenge this process, enabling the researcher to identify preconceptions and beliefs which may be influencing the research conduct and data management and analysis processes.

5.6 Determining rigour

Morse et al (2002, p14) have posited that “without rigor, research is worthless”. Notions of reliability and validity, fundamental concepts for the requirement for ensuring rigour and of generalising from research, originate from natural science and then by extension were adopted in quantitative social science research (Lewis et al, 2014). Reliability refers to the consistency of the instrument utilised for research; thus its replicability. Validity refers to whether the research instrument is measuring what it sets out to measure. Four major criteria for testing the quality of any social science research have been long discussed; construct validity, internal validity, external validity and reliability. Yin (2009) proposed that through case study research, external validity is judged through the research design phase. Construct validity and reliability are demonstrated through data collection, whilst internal validity is judged through the mechanism and transparency of data analysis.

The applicability of these terms to assess the quality and rigour of qualitative research has been questioned however with qualitative researchers considering it too closely affiliated with the positivist view of one single view of truth and reality (Holloway and Wheeler, 2002; Maxwell, 2012).

For more than twenty years now, rather than illuminating how rigour has been attained (Morse et al, 2002), qualitative researchers have been broadly influenced by the view that credibility, transferability, dependability and confirmability should replace the usual positivist criteria of internal and external validity, reliability and objectivity (Denzin and Lincoln, 2005). Various frameworks have been presented for assuring trustworthiness and rigour; Tracy (2010) presents one example of this, establishing a broad approach that can straddle varying philosophies and methods within qualitative research and can be transparent and understandable to the reader. The 'big tent' of quality criteria consists of eight tenets; worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethical and meaningful coherence (Tracy, 2010). Other variations have been suggested, for example, Holloway and Wheeler (2010) have proposed a modification of Tracy's big tent approach, suggesting a focus on rich rigor, credibility and meaningful coherence. Despite the widespread acceptance of trustworthiness, credibility, dependability and confirmability assess the quality and utility of qualitative research, criticism of these approaches is evident.

Whilst expert nurse researchers have entered into the public arena, arguing that their own preference for research paradigm is the correct lens with which to

explore rigour in qualitative research (Porter, 2007; Rolfe, 2006, 2007), Tracy has argued for the need to discriminate the research ends from the research means. Tracy (2010) proposed that it is possible to generate a concept where qualitative researchers can agree on generic features of quality without “tying these markers to specific paradigmatic practices or crafts” (2010, p839). Maxwell (2012) has argued however that the primarily constructivist stance that views all knowledge as socially constructed, is problematic for critical realists, as is the positivist view that reality must inevitably be observable and measurable. The research paradigm must inevitably influence the means through which to explore rigour. Critical realists view that there may be multiple accounts of the same experience, but that there is a reality even if people do not know or see it.

Morse et al (2002) emphasised the need to assure rigour in research but considered that the accepted means of doing so in qualitative research were flawed and utilised uncritically and with little clear conceptualisation of how these measures “ensure the quality of inquiry” (Morse, 2015, p1212). Indeed Morse (2015) has argued that trustworthiness as a concept is only of value to the reviewer of research once the product is finished, offering little help to the researcher during the process of research, citing Tracy’s ‘big tent’ approach (Tracy, 2010) as one such means of evaluating the end result. Morse et al (2002) and Morse (2015) have therefore challenged the proposition by qualitative researchers that reliability and validity have no place, and they have argued for both a return to these terms and a critical approach to the means of applying them to qualitative research. Lewis et al (2014), and Maxwell (2012) advised for

the continued use of the terms reliability and validity, albeit with some modification.

Morse (2015) has made recommendations for a more appropriate use of strategies to accomplish rigour. She has contended that rigour, comprising both validity and reliability, is achieved by the researcher during data collection and analysis but warns that the established practices for achieving this may be unhelpful and lack reliability themselves. Lewis et al (2014, p356) suggested that reliability cannot be overlooked, but that in the terms of qualitative research, “there needs to be a confidence that the internal elements, dimensions ... found within the original data, would recur outside the study population or among a different version of the study sample”. Additionally there must be confidence that data “have been consistently and rigorously interpreted” (Lewis et al, 2014, p356). Without this, they argue that research findings could have little interest to policy makers, who might view study findings only applicable to a particular group of subjects in a very specific context.

Morse et al (2015) have proposed that rigour can be obtained through techniques of verification concerned with the methodological coherence, appropriate sample, concurrent collection and analysis of data, and theory development that moves between the micro and macro perspectives. Morse (2015) has subsequently added to this thinking by summarising recommendations for strategies to establish rigour in qualitative research, but within this she acknowledges that the value and utility of techniques is dependent upon the

nature of the research. She has recommended that for qualitative research utilising thick description is of value for assuring validity for research using unstructured interviews, triangulation is of value for mixed methods research, researcher bias may be eliminated if the researcher is reflexive and responsive, negative case analysis may be of benefit and peer review or debriefing may be helpful. In contrast Morse (2015) cited that development of an a-priori coding system is only helpful with semi structured interviews, and that there is no value for member checking and external audits for establishing either validity or reliability.

Triangulation has been considered as a means to verify findings but this has been contested (Ritchie and Ormston, 2014). Critical realists argue that there is no single correct perspective, no absolute truth, thus endeavouring to verify a truth is problematic. Ritchie and Ormston (2014, p41) additionally argue that various methods of data collection are not guaranteed to produce “concordant evidence”. McEvoy and Richards (2006) reflect that triangulation from a methodological point of view is intended to achieve confirmation of results, completeness of results and retrodution. Confirmation of results is problematic however for critical realists who hold with a realist ontology and an interpretivist epistemology: realists may assume that a tangible reality exists whereas interpretivists consider that there is no one absolute reality. The goal of completeness is to gather a more complete understanding through using more than one perspective, although Ritchie and Ormston (2014, p41) caution that the “security that using multiple methods provides is by giving a fuller picture of a

phenomenon, not necessarily a more certain one". Retroduction, or abductive inspiration is considered valuable for critical realists who seek data which support "making retroductive inferences about causal mechanisms" (McEvoy and Richards, 2006, p72).

The means through which rigour has been demonstrated through this research study has been demonstrated in subsequent sections: thick description has been attempted through the presentation of study findings in Chapter 6, triangulation has been addressed through interviewing participants over time and key informants accompanied by documentary and website review. The potential for researcher bias is ever present but I have attempted to address this by a transparent account of the research evolution and process and the subsequent analysis process and demonstrating reflexivity throughout the process. Peer debriefing with colleagues and critical supervisors has supported this endeavour. Attention has been paid to missing responses to gain an understanding of potential negative cases. Section 5.10 sets out in summary how rigour has been maintained through this research.

5.7 Ethical approval

This study took place within one NHS hospital – at the time of preparing the application for ethical approval, this process was managed by the National Research Ethics Service (NRES) for the National Health Service. All research proposals at this time, whether investigating employees or patients and service

users, were required to undergo the approval process governed by NRES. The research protocol was developed and approved by the NRES Research Ethics Committee in March 2011 (Appendix 5 NHS Ethics Approval) and by the NHS Hospital's Research and Development governance process (Appendix 6).

Permission to commence the study was granted and a letter of access granted for the purpose of undertaking the research.

Following the initial meeting with the Ethics Committee, a number of queries arose that required addressing as preconditions for approval. The concerns raised and responses to them are detailed in Table 5.1.

Table 5.1 Points raised by ethics committee and how addressed

Points raised	Means of addressing these points
To consider recruiting participants from another Trust in order to make comparisons	Persisted with the focus of this study as a single site case study.
Loss of objectivity because I, as the Chief Investigator would be known to participants from the leadership development programme	Researcher objectivity and open mindedness is a challenge for all researchers. The role of the qualitative researcher is complex and researchers may be known to participants. Reflection and reflexivity, research journaling all help to challenge the researcher to identify biases and pre-conceptions and put them aside.
Concerns were expressed that there is the potential for an element of coercion in obtaining consent from participants	I gave a verbal early briefing about the study to potential participants. Potential participants were then emailed with an invitation to participate by their Education department. Responses to this invitation were to be sent to the Education department who would then contact me.
The need for the location for interviews to be a different venue/location from the venue used for the leadership development programme	Venues for interviewing which had not been used before were located with the help of the local contact.
Concerns at the proposed duration of telephone interviews -45 minutes to 1 hour	A time limit for interview was not predetermined as this could inhibit the interview and result in the loss of valuable discussion. At the outset of telephone interviews, consent was obtained and participants were told of the likely time length. Participants were able to bring the interview to a close if they needed to at any point.

5.8 Research methods

The study consisted of three overlapping data collection episodes:

1. Interviews repeated over time with a group of nurses at band six (senior staff nurses or junior ward sister/managers) who had undertaken the leadership development programme during the previous year.
2. Interviews with key informants (senior nurses/midwives) who were people identified for me by participants, or in key roles within the NHS trust

3. Review of documents and policies linked to the recruitment and retention of a valued workforce

Figure 5.2 provides an illustration of the timings of these overlapping data collection episodes.

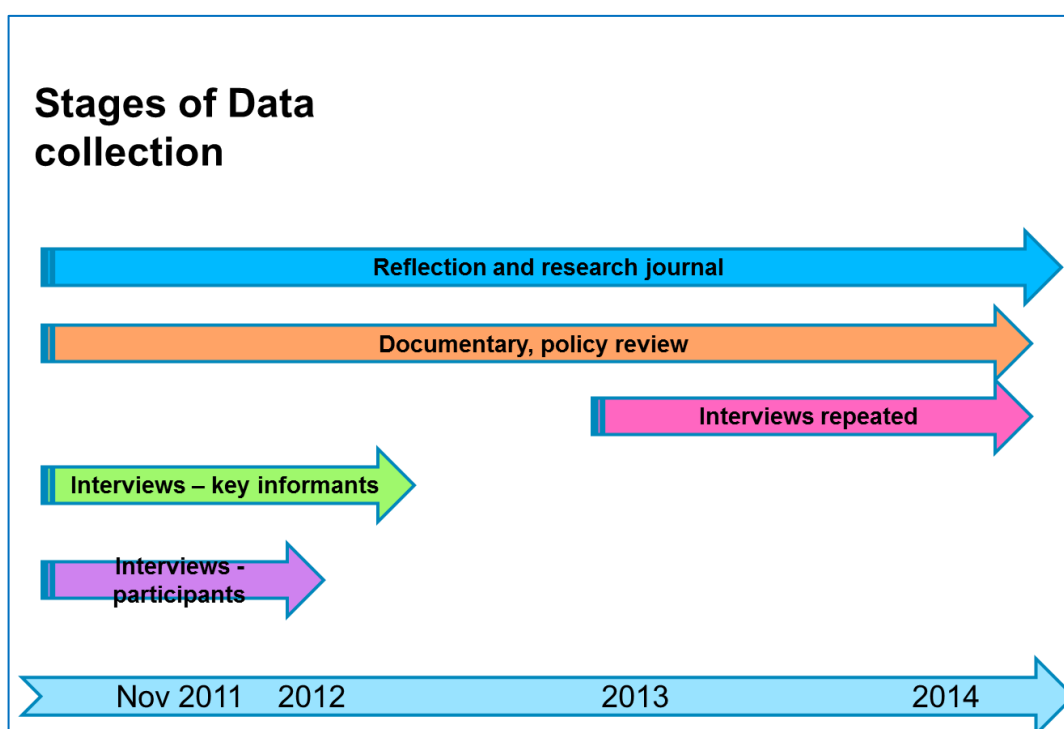


Figure 5.2 Stages of data collection

5.8.1 Procedure

5.8.1.1 Sample – Identifying research participants and key informants

Participants were recruited from the previous intake of the leadership development programme. The leadership development programme was available to any staff nurses, aspiring or newly appointed ward sister/managers in the Trust, across both trust sites. Staff members could apply for the programme with their manager’s support and applications were considered by the Trust’s clinical

education team. The development programme consisted of seven face to face workshops, run over six months on the Trust site. Participants were given full study leave to attend the programme. Participants all undertook an accompanying piece of academic work focussed on identifying and planning for a change to improve service in their area of work. The researcher was one of two specialist University nursing academics who led the programme. The intention was not to evaluate the development initiative, but to use this as a means of identifying potential participants who might be in transition between staff nurse and ward sister/manager roles.

Key informants were identified via two different routes. The first route entailed asking research participants to recommend one or more of their colleagues, at the same level of senior to them, who might be willing to participate in the study. The second route entailed identifying senior nurses in the organisation with a remit for either education and training, or those with a strategic leadership role for some or all elements of the nursing workforce.

5.8.1.2 Approaching participants

Participants on the latest leadership programme in 2009 were informed during the final workshop of the programme that this research study would be taking place and asked if they might consider participating. Once ethical approvals were received, an information letter (Appendix 7) and request for participants in the study were mailed electronically to staff via the Clinical Education Department. Interested participants were asked to notify the Clinical Education Department or

to respond to me directly via e-mail. In view of the fact that the researcher was known to potential participants it was paramount that they did not feel pressured or coerced in any way to participate and thus the indirect recruitment route was developed. Six nurses replied and agreed to take part in this phase of the study.

Once I had received an expression of interest, I contacted potential participants by e-mail with a repeat of the study information and a request to arrange an interview. Interview dates were arranged with participants at times of mutual convenience. Participants were contacted via email between six and nine months after the original interviews to ask if they would participate in a further interview. Five out of the six participants responded and, ultimately, three interviews were agreed on.

5.8.1.3 Approaching key informants

The second data collection episode in the study involved interviewing others in the organisation: either those in senior nursing positions in the organisation or individuals identified to me by participants as individuals who might be able to inform me in the research study.

I made contact with these individuals directly via e-mail, sending them the study information sheet (Appendix 8) and a letter of request to participate in the study. Overall, ten individuals were directly invited to participate in this episode of the study. Seven people responded to the initial request and agreed to take part in an interview.

5.8.2 Consent

The six nurses who had agreed to take part, all agreed to participate in an interview. Written consent was obtained at the start of each interview meeting (Appendix 9). Consent was obtained similarly for key informants, written consent being obtained at the start of face to face interviews and verbal consent being taken at the start of telephone interviews.

5.8.3 Data collection procedures

5.8.3.1 The interview itself

All interviews began with an introduction to the research topic and a request to continue. Participants were assured of anonymity and confidentiality; they were assured that no specific feedback would be given to the Trust about any individual comment at interview and that in the eventual research publication, any quotations would be sensitively included to ensure context and comment could not identify an individual. Participants were informed that they could stop at any time during the interview if they wished and that they could ask to have their data withdrawn from the study at any point.

The interview location was at times selected by the participant and at times situated in a room that was made available for the purpose of the interview, by the Education team. The necessity of utilising a variety of spaces meant that each space had to be used in as best way as possible. Some interview rooms were uncomfortable and lacking in heating, but all were private and allowed for a

private interview, undisturbed by others. The interviewing space was made to be as comfortable as was possible given the constraints of the venue and furniture provided.

A small digital voice recorder was used with a microphone that was placed on a hard surface in front of the participant. Sound pickup was excellent, which was disadvantageous in one room as the background noise of cleaning was picked up and made some difficulties in isolating the interviewees' expressions at times.

The interviews were generally opened with a broad request for participants to 'tell me what your role is now'. A broad interview guide had been developed in the early stages of developing the research proposal (Appendix 10) with the purpose of guiding but not restricting the topics and areas discussed (Legard et al, 2003). Throughout the interview it was paramount to maintain concentration and for this reason although a note pad was always available, very few if any written notes were made. It was necessary to maintain absolute concentration in order to be able to follow any particular lead and then to redirect the interview if necessary, thus maintaining the interactive nature of the interview (Legard et al, 2003).

5.8.3.2 Interviews: participants

All six interviews took place on the main hospital site, some in a small education office, one in a classroom, two in a ward side room. All interviews were recorded and the recordings were transcribed verbatim. Transcripts were anonymised and

participants were allocated a pseudonym to allow the subsequent use of verbatim excerpts by giving a pseudonym to each participant. Female names for the participants, all of whom were female, were chosen from a list of most popular girls names from the internet.

5.8.3.3 Interviews: key informants

Six individuals took part in individual interviews. One additional individual agreed to an interview date but did not attend or respond subsequently. Invitations to participate in the research were repeated once. Three individuals did not respond to the request to take part. Repeat requests were sent to these three individuals but they did not respond to this. Of these six interviews, five took place in the main hospital site, one took place by telephone. All interviews were recorded and the recordings were transcribed verbatim (Appendix 11 for the Interview topic guide).

5.8.3.4 Interviews repeated over time

These took place over the telephone at participants' request. Verbal consent was obtained before the interview commenced. All interviews were tape recorded and transcribed verbatim (See Appendix 12 for this Interview topic guide).

5.8.4 Documents, policies and web-based material

An initial list of policies of interest was compiled: materials that I considered may be of value and those suggested by my key hospital contact. Initially this entailed the hospital's workforce development policy and education policy and job

descriptions for bands six and seven. These documents were requested from my local contact. Some additional policies or strategy documents were identified in the interviews, and thus requested. Documents and leaflets readily available in the Trust site were collected. I was given permission to access for scrutiny, the hospital's intranet site. In addition I explored the outward facing Hospital Trust internet site on a number of occasions to give additional context to the policy and strategy data collected. The publicly available National Health Service Staff Satisfaction Surveys were accessed for this hospital trust for the period from 2011 to 2013. See Table 5.2 for detail of the number and variety of documents examined; document titles have in some cases been amended to reflect the content but protect the identity of the organisation.

Table 5.2 Document, policy and website search – retrieval date order

Document title	Document type	Date of document	Date of access
Workforce strategy 2008/9-2011/12	Strategy document	31/03/2008	01/11/2011
Recruitment toolkit 2010	Other-toolkit	01/08/2010	Nov-11
Employment history and reference checks	Policy	01/02/2010	01/11/2011
Education and Development policy	Policy	01/10/2008	01/11/2011
Annual Review 2011/12	Strategy document	01/06/2012	01/08/2012
Proposed merger document	Strategy document for public view	01/11/2011	01/11/2011
Web site-about us	Public view - about us	No date	01/03/2012
Web site - proposed merger	Public view - merger strategy	No date	01/03/2012
Web site - mission and values	Public view vision	No date	01/03/2012
Band 6 - Team Sister/charge nurse role profile	Job description	No date	01/09/2012
Band 7 Job Description (Clinical Ward sister/manager)	Job description	No date	01/09/2012
XXXXX Hospital Trust Annual Review	Annual review 2012-13 publication	Jul-13	Nov-13
XXXXX news	Magazine for the XXXXX Hospitals Trust	Summer 13	Nov-13
NHS Staff Satisfaction survey	Excel data sheet	2011	07/02/2015
NHS Staff Satisfaction survey	Excel data sheet	2012	19/02/2015
NHS Local area Operating Plan	Op plan publication	2012	07/02/2015
Staff handbook for Trust		2011	07/02/2015

5.8.5 Field notes

Field notes were recorded during site visits and before and after interviews (Ward et al, 2013). An opportunity was made available for the research outline to be

presented to a group of band seven ward sister/managers. Field notes were made after this meeting about both the spoken content and the setting and atmosphere of the meeting. Meeting attendees were offered information sheets about the study and invited to contact the researcher afterwards for further information or if they wished to participate in the study. One attendee expressed an interest to participate in the study at the time.

5.8.6 Research journal

A research journal was maintained throughout the data collection and analysis phases to make comments, ask questions and promote reflection in and on practice which contributed to the iterative process of data analysis and ultimately development and construction of themes (Smith and Firth, 2011). Journal entries were not in themselves analysed as this was not primary data (Spencer et al, 2003). Reflections and considerations within led to insights and developments in the data analysis process however.

5.8.7 Triangulation of data

Triangulation in this study thus entailed interviews with participants, repeated over time, interviews with key informants, documentary and website analysis and reflective journaling. The extent of data collected (total duration of interview time, number of documents, policies accessed) is displayed in Figure 5.3.

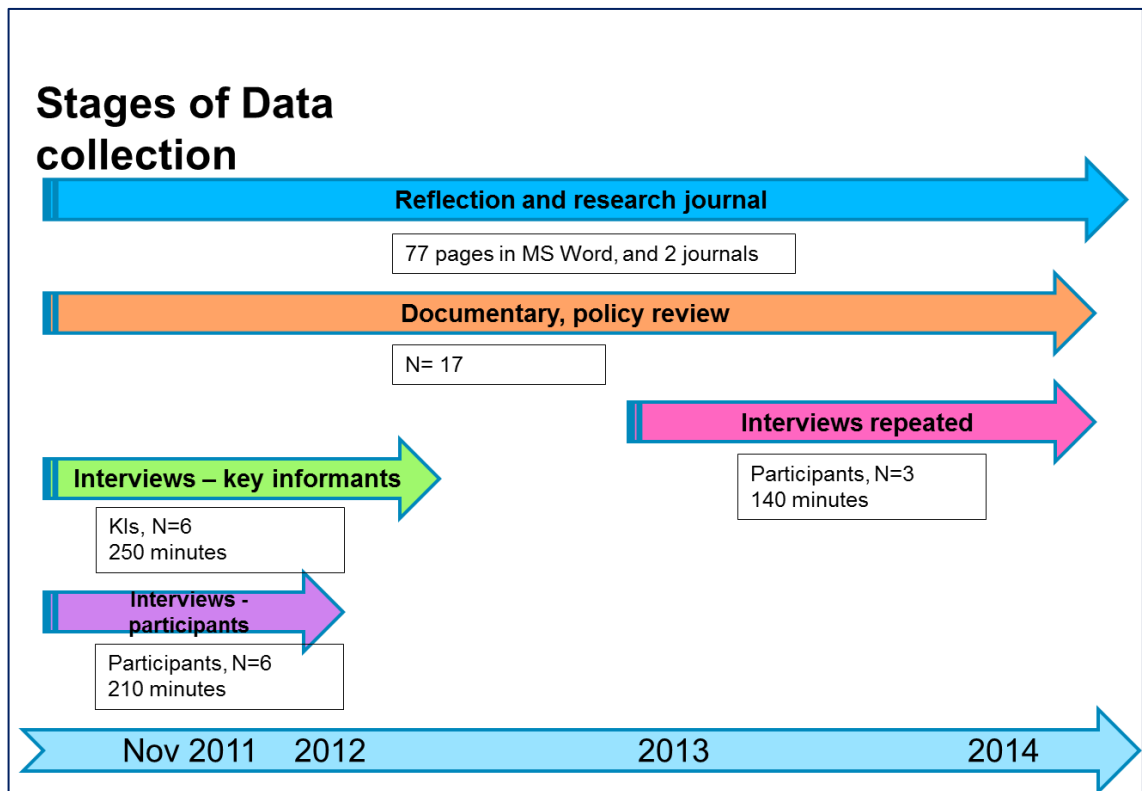


Figure 5.3 Details of data collected

5.8.8 Introduction to the research participants and key informants

The research participants and key informants in this study formed two distinct groups; those who were in early or aspiring ward sister/manager roles, referred to broadly as participants, and those who were looking back at this role from a more distant perspective, referred to as key informants. (See Tables 5.3 and 5.4 for participant demographics). Participant stories are set out in the findings chapter, in section 6.1.

Table 5.3 Summary of all participants

Summary Data	Length of qualified experience [range]		length of experience [mean]	Band at time of interview 1 [n=6]	Band at time of interview 2 [n=3]	band at time of interview 3 [n=1]
	Minimum	Maximum	Mean			
Participants [n=6]	4 years	35 years	14.3 years	Band 6 [n=6]	Band 7 [n=2], Band 6 [n=1]	Band 6 [n=1], pending upgrade to 7
Key informants [n=6]	10 years	20+ years	15 years	Band 7 [n=4], Band 8 + [n=2]		

Table 5.4 Individual levels of experience at time of first interview

Participants	Qualified	
	10 years or less	11 years or more
Number of participants	4	2
Number of key informants	1	5

Of the six key informants for this study, five were female and one was male. For this reason, pseudonyms were not given to each one to protect the identity of the sole man. Two senior nurses who were purposefully recruited, worked in strategic organisation-wide roles in positions to influence policy, practice and the strategic direction of the organisation. The remaining key informants were identified as potential respondents by other research participants. These four key

informants were employed at the grade of Band 7 nurses (See Figure 1.1) within the hospital, two of them in ward sister/manager positions, one in a clinical specialist role and one worked in an organisation-wide role, in a position with some influence over practice.

The interviews took place in neutral environments for five of the six research participants. For the sixth participant, the agreed interview took place during her clinical shift and in her ward's day room. She shared her experiences freely to a point but was clearly very attuned to the ward noises outside the door and although she had agreed to the interview, her mind was clearly elsewhere and it appeared not to be a time conducive to deep reflection and thought.

5.9 Data analysis

Framework analysis was developed by social policy researchers in the UK (Ritchie and Spencer, 1994; Ritchie et al, 2003) as a pragmatic approach to real world investigations (Ward et al, 2013). This analytic method "Framework" described as a matrix based analytic system, was developed to enable rigorous and transparent data management (Ritchie et al, 2003). This Framework approach to data analysis is a method rather than a research paradigm; it has no explicit links to a particular paradigm, but fits loosely within subtle realism (Ward et al, 2013). The nature of this analysis tool albeit under the umbrella of social science, deems it applicable for this study. This Framework approach was used to structure and guide the data analysis process in this study. See Table 5.5 for an overview of this process.

Table 5.5 Overview of the Framework approach (after Ritchie and Spencer, 1994, Spencer et al, 2003, Spencer et al, 2014)

Stage	Data Processes	Iterative processes
Data Management	Raw data	Generating themes and concepts Assigning meaning Refining and distilling more abstract concepts Assigning data to refined concepts to give meaning
	Identifying initial themes	
	Labelling/tagging data category and theme	
	Sorting data by theme	
	Summarising or synthesising data	
Descriptive accounts	Identifying elements, dimensions, refining categories	
	Establishing typologies	
	Detecting patterns	
Explanatory accounts	Developing explanations	
	Seeking applications to wider theory and policy	

Data analysis is an iterative process involving cycles of exploration, labelling and tagging, sorting, summarising, expanding elements, refining elements and categories (Smith and Firth, 2011). This process facilitates a detailed and thorough investigation of the data and ensures constant reference to the original context and content of the raw data. In addition it promotes a transparent approach to data analysis and the generation of higher level themes and abstract concepts.

The analogy of scaffolding best illustrates the process of data analysis throughout the stages of data collection and subsequent exploration and analysis. Data from

interviews with participants were then added to by data from the key informants' interviews. Documentary analysis and reflections provided differing perspectives that could then be interwoven with the themes and concepts arising from interview data (See Figure 5.4).

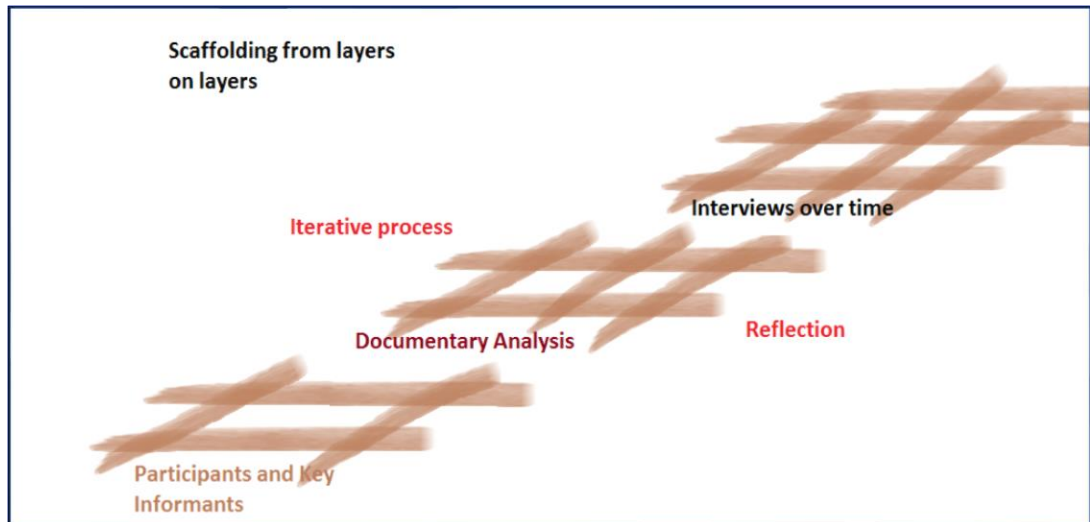


Figure 5.4 Scaffolding the layers of data

5.9.1 Data management of documents, policies, web based material

Evidence does not exist for a universally acclaimed protocol for documentary analysis, thus a preliminary framework was developed to support this task (Prior, 2008). Each item located was logged and labelled; documents, policies and web pages and web links. The facets that were logged included: titles, authors, date of production, date of review, and the means and ease of acquiring the material. Material was read and re-read, text was tagged with notes and comments. Emerging codes and categories were devised and their inclusion or addition to the data matrix was reflected upon. Whilst Ritchie and Spencer refer to the Framework process of data management as being all encompassing and able to

take data from multiple sources, in practice it proved difficult to integrate this data from documents and policies into the spread sheets with interview data. An alternative process was sought; this entailed highlighting significant elements of text on paper or websites, noting its presence and likely categories in the research journal. Reflections on the nature of the contribution of this data were thus intertwined in the iterative cycles of reflection, analysis, development and synthesis of ideas.

5.9.2 Data management of interview data

This initial stage of data management involved transcribing the interviews. All interviews were audio recorded via a digital recorder and were transcribed verbatim. Interviews had lasted between thirty and sixty minutes, the sum total of interview time being illustrated in Figure 5.5. Interview data were anonymised, with participants being assigned a number from 1-12 for the purposes of data management and identification. The date of each interview was entered on the transcription to ensure a clear data trail. Transcripts were re-read against the audio recording to assure the researcher of accuracy of transcription.

Transcriptions were not returned to participants for checking; the challenges and pitfalls associated with member checking are set out in section 5.6. Sandelowski (1993) argues that member checking may not be as simple as it sounds and Morse (2015) argues that it does not have use for ensuring validity and reliability in qualitative research. Participants may feel uncomfortable with the transcript because it reflects a discussion that they do not clearly recall; participants may ask for the removal or amendment of passages or sections. The researcher is then

left with a dilemma as to whether they should alter the transcript at the behest of the participant because on further consideration they wish to make their thoughts look different somehow (Sandelowski, 1986).

The first stage of analysis was to assign labels to the transcripts in the form of comments that were automatically numbered and visible in the margin of the document. This was carried out for the first four interview transcripts. This created a vast array of labels and these were entered manually into an excel spreadsheet created for the purpose. A rigorous approach ensured that each label was entered into a separate row of the Excel spreadsheet and was identified according to participant number, comment number and the page on the transcript. One hundred and sixty six labels had arisen from the first four transcripts. These labels were not discrete entities, occurring only once or only for one particular participant, but were applied wherever it was deemed pertinent according to the data. The hierarchy of terms used is illustrated in Table 5.6 and an excerpt of this initial sheet is included in Table 5.7.

Table 5.6 Hierarchy of terms (adapted from Smith and Firth, 2011)

Labels	A label or tag given to a unit of data which may be a word, phrase or whole sentence
Codes	Labels that broadly sit together
Categories	A group containing codes about the same topic
Themes	Categories linked together into broad themes
Dimensions	Ideas that link themes

The first attempt at creating codes took place before the investigation of the next two transcripts. After the first four interviews had been transcribed and labels entered onto the Excel spreadsheet, the first attempt at creating an initial index took place. Looking through the long list of codes for patterns, similarities and differences led to the development of initial codes. Codes were then grouped together as initial categories. By utilising the alphabetical sorting facility in excel, the labels were then regrouped category by category. Framework analysis allows for contemporaneous data collection and analysis in this way (Srivastava and Thomson 2009). Two hundred and fifty labels were noted from transcripts one to six.

Table 5.7 Excerpt from the first data coding sheet

Initial labels	Participant	Comment number	Page in raw data	Date
Matron controls the budget	1	E38	10	17.11.11
Frustrating that matron has to authorise things	1	E39	10	17.11.11
a bit of input or training before you take on the job	1	E40	10	17.11.11
3 months in the role with full responsibility, don't have to take it though if you don't like it	1	E41	10	17.11.11
I'm doing a lot of band 7 work	1	E42	11	17.11.11
need to have authorised management day	1	E43	11	17.11.11
I feel ready to move up the ladder	2	E1	1	24.11.11
I'll go for it [Band 7] 200 times until I get it	2	E2	1	24.11.11
	2	E2	1	24.11.11
The support is there for people to develop	2	E3	2	24.11.11
We get many people coming from outside [the Trust]	2	E4	2	24.11.11
If you have the desire, the driving force, someone shows an interest, it needs to be considered	2	E5	2	24.11.11
Had feedback from my matron	2	E6	3	24.11.11
I'm very determined	2	E7	3	24.11.11
when I didn't get the job they gave me a plan	2	E8	3	24.11.11

Transcripts from interviews five and six were then reviewed and labels from these were added to the Excel coding sheet. Labels were again sorted to include the data from all six participants. The resulting list of two hundred and fifty labels was reviewed and grouped into codes. Codes were then grouped together under forty

three categories within eleven themes. This process involved re-reading the transcripts to ensure that meaning and context was not lost, thinking and reflecting on the data and the initial categories developed and rigorously labelling Excel sheets to reflect the developing index. Notes and evolving thoughts were entered into the research journal during this process (Arthur and Nazroo, 2003). An example of how labels became codes, and these became categories and categories were grouped into initial themes is illustrated in Table 5.8.

Table 5.8 Illustration of the development of the hierarchy of terms

FW version 1.1a	Item	Codes	Category	Theme	Participant and text location
	I'm doing a lot of band 7 work	Doing the role already	Doing it already	Preparation for the role	P1, comment E42
	I'm doing everything the post requires	Doing it already	Doing it already	Preparation for the role	P4, comment E8
	I'm not a band 7 but work behind the scenes to do everything	Doing the role behind the scenes	Doing it already	Preparation for the role	P2, comment E15

Once the first index was created, each category and theme were given a unique number and then systematically each transcript was reviewed and the unique number for categories and themes were added as a comment at the appropriate point in the text. An example of this indexing to the transcript is shown below in Figure 5.5.

always let me do that and they always correct me where I went, um with
 like mistakes and wherever I, and they always point out where I am weak,
 where I have to improve, ~ everything. ¶

And do you have to ask for that feedback or has that come? ¶

Sometimes I do ask after the late main handover and the sister in charge is
 handing over so they will be there to listen. So sometimes they say
 comments without asking, sometimes I ask them how was it, how was my
 handover was that okay, was it very brief, or it was too much or something..
 So they always give me right feedback, very supportive. ¶

Do you think you might look to a Band 7 post at some point? ¶

In future I do. ¶

**What do you think you would want to have experienced or prepare
 before moving on to that next stage? ¶**

Education wise I have to finish my degree course, I haven't done degree
 yet, so I'm looking forward to that and I have to um, to do more, more to the
 unit like more actively participating in teaching and I have to discuss with

Comment [E15]: 3.10.3 ¶

Comment [E16]: 3.10.3 ¶

Comment [E17]: 3.10.3 ¶

Comment [E18]: 3.10.3 ¶

Comment [E19]: 1.2.1, -3.10.3 ¶

Comment [E20]: 1.3.3 ¶

Comment [E21]: 3.10.7 ¶

Comment [E22]: 1.3.3 ¶

Figure 5.5 Sample from one interview transcript, illustrating indexing

Transcripts from key informants, labelled P7 through to P12 were similarly analysed. Labels identified from the transcripts were systematically entered onto a dedicated spreadsheet. These labels were grouped together into codes which enabled the data to be reviewed with more ease. A number of new codes and subsequent categories emerged from the key informant transcripts and these were added to the existing codes (Table 5.9). The first data matrix was thus developed.

Table 5.9 New and emerging codes and categories from key informants

FW version 1.1a	Item	Codes	Category	Participant and text location
	You have an absence of a Band 7	Presence of WM	Absence/presence of leadership	P8, comment E64
	We have lost this person who has an overall understanding of what's going on	Presence of WM	Absence/presence of leadership	P8, comment E66

5.9.3 Evolving development of the theoretical framework

Sorting the data by theme was vital to enable the data to be examined by theme across the data set. Creating thematic charts was the first stage of summarising and synthesising the data. Thematic charts were created using Microsoft excel (Swallow et al, 2003) and each main theme and related categories were compiled into separate thematic charts (Ritchie et al, 2003). Rows were allocated to participants in chronological order and this order maintained across all other data spread sheets. Columns were allocated to categories, which were grouped together within themes. Ritchie et al (2003) commented on the need for consistency in column width and row height across individual spread sheets to give equal consideration to all the data therein. In practice this proved difficult to comply with. Maintaining consistency of row height and column width created spread sheets too large for easy exploration on the computer and for excessive sized printouts. Adjusting column width and row height to match the content of each cell allowed for improved management and accessibility of the data. Great

care was taken therefore to give all data equal consideration despite the variation in size of cells containing it. Thoughts and reflections on this as all the research processes were noted in the research journal.

Each transcript was then examined and each relevant item of text was entered into the relevant column for every individual category within themes. This was a laborious and time consuming process and required attention to detail and cross checking to be assured that the data attached to each code were entered into the relevant column in the relevant data sheet. Each excerpt from the transcript was identified with the comment number and page number for ease of subsequent checking and referral back to the original source for meaning and clarity if necessary (Ritchie et al, 2003). Meticulous effort was taken to ensure that wording stayed as close as possible to the language of the participant. Once all the coded data were entered onto the spreadsheets, these were printed out to allow for theme by theme examination and consideration.

An example of the data under the theme for Influence of role model from the first index version is included in Table 5.10. In this illustration, the theme concerned is that of the influence of role models and each participant occupies a separate row. Textual excerpts are included in the columns relevant to the category the data sit within. The categories of 'presence/absence' (of role model), 'philosophy of work' and 'positive/negative role models', are illustrated. At this point an additional column was set out entitled 'other' for data that could not, at that point, be linked to any particular category.

Table 5.10 Excerpt from the theme –Influence of role models, including data from participants 1-3

Thematic chart 9 of 11		Influence of role models		
	9.1	9.2	9.3	9.4
	Presence , absence	Philosophy of work	Positive/negative role models	other
Serial/participant number				
P1	(WM) doesn't just sit in an office, WM's got clinical days, 2-E30 sounds like a really collaborative relationship with WM -I can't fault the WM, 2_ E35 WM's in other areas are mainly office based, 3-E41 My Wm - I can ring WM any time, 4-E79 Our matron's quite approachable, 5-E83 Wm advised me on modules to take re MSc, 8-E125	we (me and WM) half and half the managerial workload, 2-E31 (WM's) constantly teaching nurses that work with us, 3-E49 (WM's) very good, ..I take junior staff to one side to teach, help, 3-E50 WM's a role model for me, 3-E52 it sounds like WM's quite influential - yes, 3-E53 they (the staff) know my work ethic, 4-E75	(WM's) been excellent at training up all the staff, 2-E36 (WM's) one of the best I've worked for, 3-E39 (WM's) very knowledgeable you know, 3-E46 (WM's) constantly teaching nurses that work with us, 3-E49 (WM's) very good, WM 'll take junior staff to one side to teach, help, 3-E50 WM's a role model for me, 3-E52 My WM - I can ring them any time, 4-E79, 80 Wm advised me on modules to take re MSc, 8-E125	<i>Has WM influenced your thinking re a band 7 post - yes, 3-E40</i>

Influence of role models	9.1	9.2	9.3	9.4
	Presence , absence	Philosophy of work	Positive/negative role models	other
Serial/participant number				
P2	my manager at the time was very helpful (when I forced myself to shadow, 3-E26			
P3	how compassionate my seniors are, 3-E7 I keep watching when someone else/sister in charge is dealing with a different situation, 5-E26	in this culture, how we blend ourselves, how we approach with society and staff, 3-E6 she'd take me (with her) when dealing with the families, 4-E12 our manager is very supportive and encouraging, 4-E11 I feel very contented with how (my seniors) care for the patients, 11-E70 if every person thinks of the patient at the centre, they put their patients first, 12-E74 In the NMC code of conduct is says the pt is first priority, 12-E75 She (manager) was able to be present and prepare the family, 4-E13	our manager is very supportive and encouraging, 4-E11 she'd take me (with her) when dealing with the families, 4-E12 I'd sit back and watch how one deals with a situation, 4-E14 I keep watching when someone else/sister in charge is dealing with a different situation, 5-E26 I feel very contented with how (my seniors) care for the patients, 11-E70	

Ritchie et al (2003) have referred to the three processes of detection, categorisation and classification which comprise refining elements and refining categories. Elements are identified as key portions of data that need to be noted; these elements may then be situated within existing or new categories. This process involved setting out the data in a way that is “conceptually pure” (Ritchie et al, 2003, P237), exploring each category within each theme one by one. One spreadsheet was developed for each category. Each category was explored in depth in this way. Each participant was allocated a dedicated row in chronological order. Column one was utilised for the data for the individual categories. This enabled me to look across all participants and key informants within the category and highlight the range of behaviours, ideas or concepts that had arisen. These were entered into the second column on the spread sheet in a manner that remained close to the original data. The second stage then involved “sorting and distilling” (Ritchie et al, 2003, p238) these elements to identify both broader and more refined categories. These were then entered into the third column. An example of this is included in Table 5.11 using an extract from the influence of positive and negative role models.

This analytic process involved expanding and refining categories and subsequently themes such that the original eleven themes and fifty three categories expanded to comprise five hundred and thirty categories. Printing this out to allow investigation on paper proved invaluable. Ward et al (2013) noted the time consuming nature of this activity but support the flexibility that this

brings. In reality spreading the paper sheets out over the floor proved to be the only reliable means of looking at the whole data set for each category.

An iterative process was utilised to develop the second version of the framework.

I noted reflections, thoughts and insights in the research journal as this process continually evolved. Continued reflection on the evolving structure led to the ultimate refinement to seven themes and twenty five categories, with a subsequent revision of the indexing system.

Table 5.11 Illustration of Defining elements and refining categories

Thematic chart 9 of 11	Influence of role models			
	Positive, negative role models	Elements identified -in order identified in chart	Categories (new and existing)	Notes
Serial/participant number				
P1	(WMs) been excellent at training up all the staff, 2-E36 (WMs) one of the best I've worked for, 3-E39 (WMs) very knowledgeable you know, 3-E46 (WMs) constantly teaching nurses that work with us, 3-E49 (WMs) very good , WM will take junior staff to one side to teach, help, 3-E50 (WMs) a role model for me, 3-E52 My Wm - I can ring WM any time, 4-E79, 80 Wm advised me on modules to take re MSc, 8-E125	WM trains/teaches staff WM very knowledgeable WM helps staff Role model for me WM – phone anytime>> move to 3.9.1 Academic advice giving >> ? move to 3.9.1	WM as trainer/teacher WM knowledgeable WM helps staff WM as role model	Should many of these WM items be combined under WM attributes and skills and behaviours?
P2	No data			

	Positive, negative role models	Elements identified -in order identified in chart	Categories (new and existing)	Notes
Serial/participant number				
P3	our manager is very supportive and encouraging, 4-E11 she'd take me (with her) when dealing with the families, 4-E12 I'd sit back and watch how one deals with a situation, 4-E14 I keep watching when someone else/sister in charge is dealing with a different situation, 5-E26 I feel very contented with how (my seniors) care for the patients, 11-E70	Manager supportive and encouraging Takes me with her to show me Seniors put pts at centre>> move to 3.9.2	Manager supportive Manager shows me Observing others	
P4	WM was very popular, very personable, everybody loved her, 4-E29 you speak very highly of her (former WM), 9-E63 Former Wm was a fantastic manager, 14-E130	WM was a fantastic manager WM very popular, personable	WM fantastic WM popular	
P5	I was with her (senior sister) but she was always advising me, 5-E36 motivating people is a big part of my role, 10-E71 here I can see how my seniors are dealing with different situations, 10-E76 I have a senior sister in mind (who has been involved in moving people on/up) she's (senior sister) very active, she was very helpful for me, 11-79	Seniors advising me Motivating others>> move to 1.2.2 or to section on its own Observing others dealing with different situations Senior very helpful for me	Advice giving Seniors helpful for me	
P6	No data			

Having established the second version of the thematic data matrix, the now revised indexing was applied to all the interview transcripts. New thematic charts were developed in the same way as before for the new second version of the data framework.

Once again, these themes and categories were examined to identify emerging elements and refine categories and themes. The seven themes and twenty five categories of version 2.0 of the data matrix were expanded through this defining and refining process to include a total of three hundred and nine elements. Subsequent reflection, contemplation and review led to the refinement of this, such that elements were combined into categories, resulting in eight themes, twenty eight categories. It transpired that some categories needed to contain smaller entities, of which there were fifty one. These entities were classified as sub-categories, being more refined than codes but less refined than categories. The hierarchy of terminology thus evolved (Table 5.12).

Table 5.12 Evolved hierarchy of terms (adapted from Smith & Firth, 2011)

Labels	A label or tag given to a unit of data which may be a word, phrase or whole sentence
Codes	Labels that broadly sit together
Sub-categories	Smaller entities of categories
Categories	A group containing codes about the same topic
Themes	Categories linked together into broad themes
Dimensions	Ideas that link themes

The analytic process involved working through cycles of exploration, identifying and expanding categories, then distilling and refining to produce fewer more precise categories and more abstract categories and themes. Throughout this process each coded excerpt of data from each participant remains labelled according to its place in the original transcript. Excel data sheets were used carefully and laboriously to follow the evolving categories and the movement of data from one category to a more refined category. Thus data could be tracked from its original location, through the evolving data analysis frameworks. Detailed accompanying notes and reflections were made in my research journal to detail this journey. This complex series of stages and cycles following the Framework process, involving repeated exploration, expanding and refining is illustrated in Figure 5.6

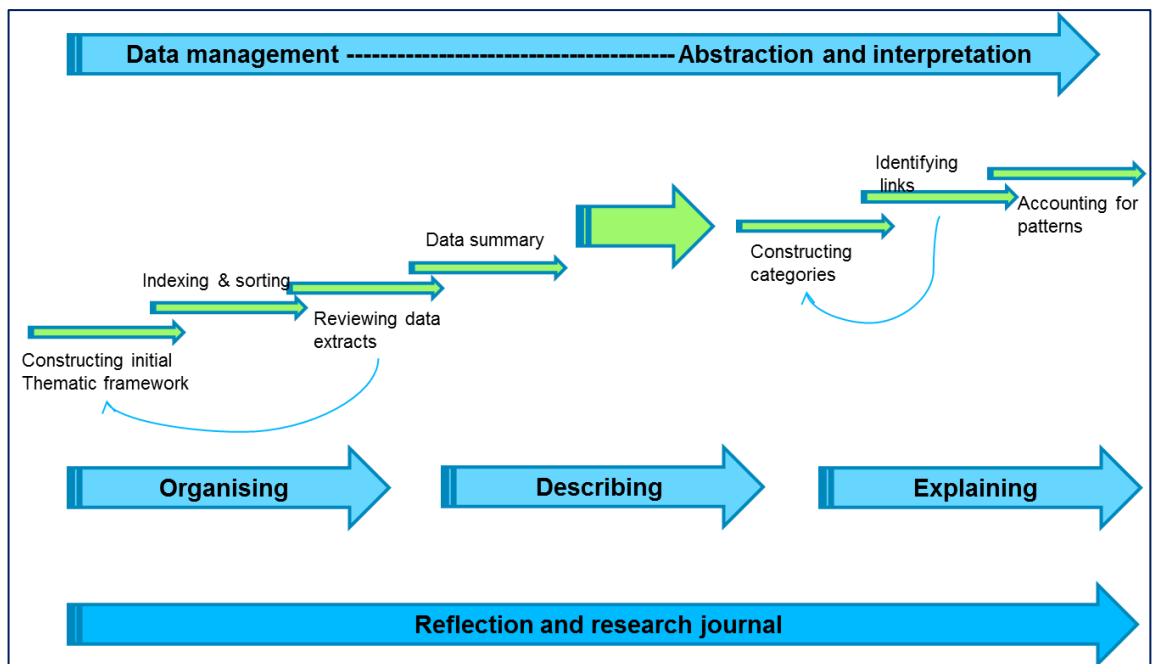


Figure 5.6 The analysis process (adapted from Spencer et al, 2014)

This time-intensive, absorbing iterative process, continued throughout the subsequent year and beyond. With each reflection and reconsideration, themes and categories were considered, reconsidered and changes made to positioning, hierarchy and terminology. Emerging themes were captured, at times lesser themes and categories merged or were subsumed. With continuing reflection, absorbing myself in the data, challenging myself to justify emerging themes and categories, mapping them to the original data, the iterative process continued and thematic models evolved. The thematic structure for the data moved through five iterations before reaching the final version. This sixth version of the thematic data matrix, termed from here the thematic map, comprised twelve themes, twenty six categories and thirty five sub-categories.

The theme of 'Journey of development' elicited in early versions of the thematic data matrix serves to illustrate this evolution and expanding and merging of themes and categories. This was not represented as a discrete theme in the first two versions of the thematic data matrix. It was created in the third version of the matrix and remained through versions four and five. At the point of refining to form the sixth version of the data matrix, 'the journey of development' no longer seemed valid as a theme and was emerging as the whole entity, although better termed the journey of transition; in other words, the framework itself represents this journey of transition, rather than the journey being an element of an unspecified whole.

Ultimately, the twelve themes identified, coalesced under four dimensions (see Figure 5.7 for an illustration of this thematic map). This illustration is inevitably a simplified version of the thematic data map; the entire matrix is illustrated in Appendix 13. In Figure 5.7, the double ended arrows connecting one circular dimension to another, in arc form and in the centre of the figure, signify interrelationships between each dimension, rather than each dimension sitting in isolation with themes unrelated to those in a neighbouring dimension. The varying size of text boxes was a necessity to accommodate the text within them, rather than signifying magnitude of importance of the particular theme.

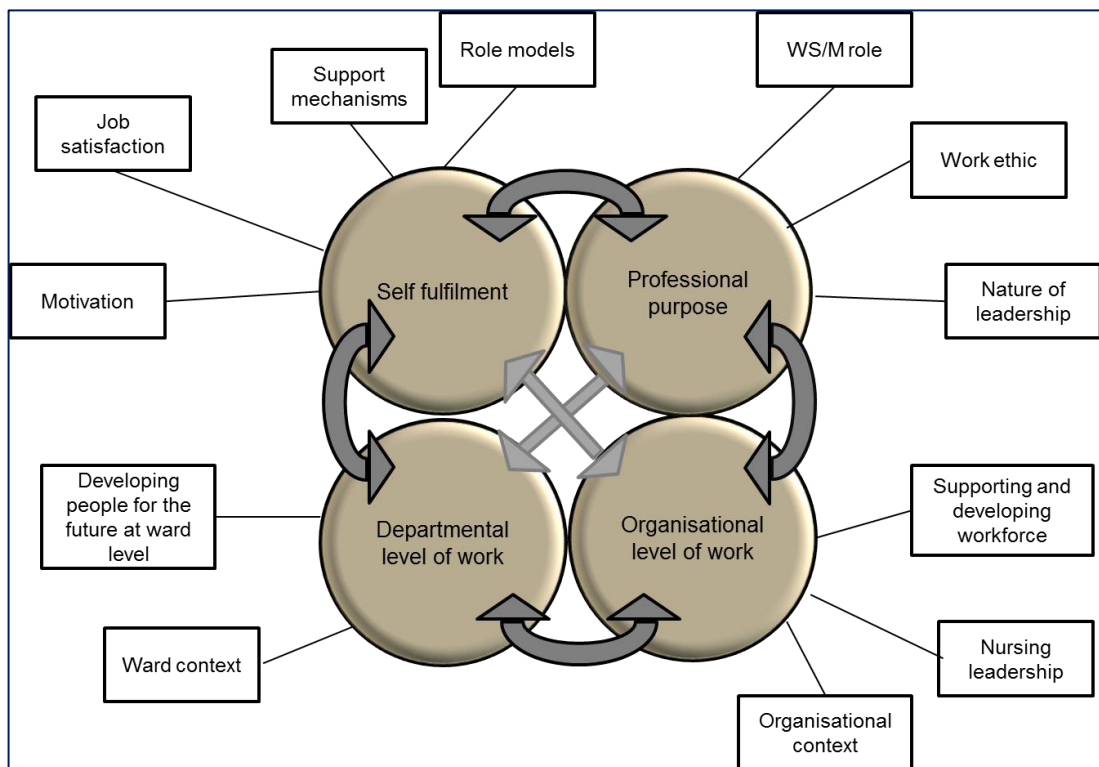


Figure 5.7 The thematic data map, version 6

The thematic data map that has been developed (Figure 5.7) is, through necessity, presented as a two dimensional structure. Analysing the data as a

whole resulted in the development of this thematic map that has evolved through this study. The reality is that the four dimensions: self-fulfilment, professional purpose, the departmental level of work and the organisational level of work, moved and shifted in a dynamic relationship. All participants tended to understand these dimensions and themes differently.

5.10 Adhering to the tenets of rigour

Some of the debates surrounding reliability and validity as opposed to criteria of trustworthiness were set out in section 5.6. I have addressed rigour through presenting explicit detail of the study sample and the appropriateness of the sample to enable the research question to be answered. The context has been established in the introductory chapter and in section 5.3 of this chapter. The data collection and analysis process has been presented in detail, thus demonstrating honesty and transparency.

Tracy (2010) proposes that self-reflexivity on the part of the researcher is a marker of sincerity and Morse (2015) has called for peer review or debriefing to assist with reducing bias as well as concept development. The use of a research journal throughout the research journey, encompassing data collection and analysis has supported my reflexive thinking. The presence of an encouraging yet challenging supervisory process and support system throughout the research process has added and deepened the self-reflexivity. Triangulation within the research has been achieved through conducting interviews with participants and key informants, in order to gain differing perspectives on the transition from staff

nurse to ward sister. Interviews with three of the participants at subsequent time points and documentary analysis of policy and strategy, accompanied by and website analysis have added additional layers to the data gathered to enhance the number of perspectives available.

Tracy (2010) has asked whether a study has meaningful coherence and whether the study achieves what it aims to achieve. The former point is of great significance and for Morse (2002, 2015) may be used as evidence to demonstrate researcher responsiveness and the alignment between the research topic and research design. Tracy's latter point is arguably a question for the reader to judge, and indeed Morse has argued that Tracy's big tent approach is only of value for the auditability by the reviewer. I have endeavoured to demonstrate congruence between the research objectives established in chapter one, the research questions and the methods and procedures undertaken, set out earlier in this chapter. The ultimate test of meaningful coherence is that the literature, research questions, findings and interpretations meaningfully and synergistically interconnect. I have strived to achieve this through the subsequent chapters detailing research findings and then bringing this together with the literature in the ensuing discussion chapter. I acknowledge however that the final arbiter will be the reader and the wider nursing profession for whom the study is intended to contribute to the development of new knowledge.

5.11 Chapter summary

In this methodology chapter I set out the philosophical basis for this research, situating it firmly within a critical realist approach. The use of the case study as a valid research approach to research has been justified and the links established between critical realism and case study investigations. The case in this study has been set out and justification for the methods selected has been included. The research methods employed have been detailed, setting out the process for selection recruitment and selection, interviewing and document selection and analysis. Data analysis has been explored in detail and the elaborate and detailed coding process established. Excerpts from the coding matrices and evolving data frameworks have been discussed. Approaches to maintaining trustworthiness and rigour have been elaborated on.

In the next chapter the findings from the study have been presented.

Chapter 6 Findings

In the previous chapter, methodology and methods were established; the process of managing and analysing the data collected were presented in depth. In this chapter, findings are presented which contribute to addressing the research objectives established in 4.7.1 and reaffirmed here.

1. To explore the experience of transition from staff nurse to ward sister/manager
2. To understand the impact of organisational factors on that transition

In presenting the findings from interview data, participants' own words are used to enable the reader to hear their voices and, in turn, understand the significance of the themes derived. Presenting the participants' words is not necessarily straightforward; an excerpt of text can convey expression and sentiment but the depth of feeling, vehemence of expression and thoughtfulness over the conversation is missing. For this the reader must rely upon the honest, critical and searching reflections of the researcher. Hence reflections in the research journal documented the highs and lows of the research journey; through the iterative process of research, reflection and analysis, these reflections informed the ongoing data analysis.

6.1 Participants in the study

In order to display the participants as individuals with a story rather than as a number, a pseudonym was selected for each participant to enable the reader to

follow the story of individual participants through this chapter. An introduction to participants has been included in the next section. In contrast, key informants have been referred to throughout as 'senior nurses', numbered 1 to 6. Names could not be used for the key informants to protect the identity of the one male respondent.

6.1.1 Participant introductions

At the time of first interview, all were employed at the grade of Band six. Alice, Evelyn and Maria had been qualified for seven years. Ruby, Hannah and Maryam had all been qualified in excess of eleven years. Ruby, Maryam and Maria had initially trained as nurses outside of the United Kingdom. Alice, Evelyn and Hannah participated in follow up interviews, Ruby, Maryam and Maria were interviewed once. Descriptions of participants have been presented here such that their narrative is clear within the data presented subsequently in this chapter.

Alice: Senior sister, two years at band six

Alice was interviewed twice; at the second interview two years later, she was a band seven clinical nurse manager. She held the title of senior sister as a band six nurse in a specialist area at the time of the first interview. Alice believed that she was developing and taking on responsibilities that her contemporaries in other areas were not. She was confident about taking on new roles to develop herself and achieve a senior position when it became available. Her commitment to nursing came through the interview; she was proud of her clinical skills and

passionate about developing junior staff to be able to deliver safe and quality care. She presented a self-determined, confident, self-assured image at the time with a keen sense of her professional duty.

Evelyn: Band six in a specialist area, qualified as a RN/midwife, two years at band six.

Evelyn was interviewed twice; at the second interview eighteen months after the first, she is a band seven. Evelyn talked about showing great persistence even in the face of adversity. She had been unsuccessful at the first application for a band seven post, but was determined to learn from this and be successful the next time. She talked openly about balancing work and family priorities and the need to supplement this with higher academic study to achieve a master's qualification. She came across as confident with a quiet self-assurance.

Hannah: Band six junior sister, six months at band six

Hannah was interviewed three times in total; at the second interview after thirteen months she had a new post as a band six specialist nurse. At the third interview eight months later she was still a band six clinical specialist waiting for her band seven to be awarded. Hannah expressed concern, hesitation and anxiety, worried that she was saying what was helpful at interview, worried that she was managing in practice. Her worries were sometimes conveyed in words, sometimes in expressions or hesitations in conversation. She appeared quietly thoughtful, taking time to think about her responses to questions. Her wry laugh

lightened the tone of anxious conversation at times, but conveyed a sense that she was trying to play down a difficult situation.

Ruby: Band six junior sister, qualified as a RN/midwife for more than thirty years
Ruby was interviewed once. Ruby shared her experiences of working in a range of roles and in a number of countries. She observed colleagues, both senior and junior and reflected on their skills, knowledge and attitudes. She noted and was frustrated that the patient did not always appear to be at the centre of some nurses' practices. She came across as quiet, thoughtful, striving to do her best for her patients, striving to learn from others.

Maryam: Band six sister, 16 months as a sister

Maryam was interviewed once. Maryam talked about being supported to gain the experience necessary for the post she was now in. She talked about being open to feedback and seeking it from colleagues when she undertook a new task or responsibility. She was determined to undertake more studies to complete her degree. She was quietly confident in her role, which she saw as quite different from a staff nurse role.

Maria: Band six ward sister, 18 months at band six

Maria was interviewed once. Maria was on a busy shift on the day of the interview. She spoke confidently about her role but her attention was partly focussed on the interview and partly on the sounds outside the day room. She was confident about her practice, proud that her standards were high and

frustrated with those who did not appear to share her high standards. She was clear about her roles and responsibilities in her current post but uncertain as to what she might need to deal with in a more senior post. She appeared to be assertive, determined to get colleagues and students working for the ward to run smoothly.

6.1.2 Key Informants' introductions

Key informants were working within the organisation in ward sister/manager positions, clinical specialist roles and organisation-wide roles. All of these senior professionals conveyed a passion for their job, and a desire to develop their services, whether at a local level or across the organisation. Those key informants who worked across the organisation showed insight into the needs of the whole organisation and workforce, whereas participants who were all ward-based, were focussed on their own needs and those of their department. Key informants generally offered a broader view of the ward sister/manager role and development needed to reach and thrive in that role.

6.1.3 Participants over time

All three participants who were interviewed on more than one occasion, had moved into more roles with enhanced responsibilities, although not all of them experienced a promotion in terms of grade during this time. Their evolving thoughts and ideas contributed synergistically to develop the thematic data map (Figure 5.7).

6.2 Recounting the story of the data

The data supported an interlinked and overlapping quartet of dimensions related to the self-fulfilment, professional purpose, local and organisational levels of work. The interplay between and, the emphasis of these dimensions varied from participant to participant. Producing a figure or map that illustrates this interplay has proved complex to achieve; computer based software packages, each with their own merits, have proved cumbersome in the hands of a design novice. A conceptual map for the participants has been produced, however, and is presented at the end of this chapter, as an illustration of the culmination of the findings presented. Twelve significant themes have arisen from the four dimensions and are presented in list form in Box 6.1.

Box 6.1 Dimensions and themes arising from the data

The dimension of self-fulfilment encompassed:

- Motivation
- Job satisfaction
- Support mechanisms
- Role models

Professional purpose encompassed themes of:

- The ward sister/manager role
- Work ethic
- The nature of leadership

Department level of work comprised themes of:

- Developing people for the future at ward level
- Ward context

Organisational level of work encompassed themes of:

- The organisational context
- Nursing leadership
- Supporting and developing the workforce

The term 'ward sister/manager' has been used here to maintain consistency throughout the thesis. In this particular organisation the term ward sister/manager was used to represent the ward sister/manager, the senior nurse figure on the ward with twenty four hour responsibility for staff and patients, thus the term 'ward sister/manager' is noted in the narrative excerpts from participants. Some themes were more prominent for participants themselves, some themes arose from ideas and issues from the key informants.

On an individual level, participants and key informants considered their own experiences which framed their journey to this point and had influenced the career choices made in many cases. Participants talked about the departments in which they worked and occasionally, the wider organisation in which these departments were situated. Key informants tended to have a wider view of the role of ward sister/manager and how that fitted into the organisation as a whole.

The data are presented here in a series of layers, unavoidably in a linear fashion, coming together as a form of scaffolding, with each layer playing its part in creating the whole. The reader is taken on a journey along this route which, in reality, did not form a straight line. It progressed through a series of loops twists and turns to create the whole picture.

In presenting the data, my aim is to convey rich data that support the development of dimensions, themes and the categories within them. Inevitably, large quantities of data were collected, and only a proportion of that can be included here. To achieve this, excerpts from interview transcripts are included from the range of participants and key informants to illustrate points and support the coalescence of ideas and synthesis of themes. Data from the longitudinal interview element of this study are interwoven through this section, and noted as from interview two or interview three. Quotations are included verbatim from the transcriptions, unless interrupted with three ellipses indicating material that was not directly pertinent has been removed. Inclusions in brackets indicate that

material has been removed to protect the identity of either the participant, key informant or an individual that they referred to.

Data are presented in sections which appear discrete; in reality some themes are intertwined. The reader is taken on a journey from inside to out, micro to macro starting with the central core of self-fulfilment - a centre of personal meaning and feelings, specific to each participant, presented in section 6.3. The next layer is that of professional purpose; encompassing the role of the ward sister/manager and work ethic, presented in section 6.4. Following that, section 6.5 presents the next layer is that of the local world, the departmental level of work. The outer most layer is that of the wider organisation, the organisational level of work and this is presented in section 6.6. The data are presented in this fashion and order as this supports answering the research questions which framed the study. The dimensions of self-fulfilment and professional purpose relate specifically to the experience of transition from staff nurse to ward sister/manager. Both departmental and organisational layers of data have relevance because of their impact on the role of the ward sister/manager and the experiences of those in transition to this role.

6.3 Self-fulfilment

Self-fulfilment as a dimension comprised four themes: motivation, job satisfaction, support mechanisms and role models. This dimension is considered first here to reflect that it functioned as a form of central core, around which, other dimensions were situated. These factors were all very personal to

participants, reflecting an inner core of factors that influence their approaches to the other aspects of their role and their identification with the organisation.

6.3.1 Self-fulfilment - Support mechanisms

Support as a concept is inevitably subjective, what one individual might consider supportive may not be considered helpful to another. The focus of participants, prompted by the line of questioning and discussion during the interviews was what they, themselves, considered supportive. These support mechanisms identified were all attributable to relationships with significant individuals who were almost always but not exclusively, participants' senior colleagues:

One of my senior sister she always ... help[s] me,
Maryam, page 5, comment 32

Key informants also reflected on those who had supported them in their roles as band six or band seven nurses; ward sister/managers were significant, remembered for their contribution of support and encouragement:

Certainly from when I was a Band 6 I know my ward sister/manager then did give me a lot of support,
Senior Nurse 3, page 3, comment 23

Key informants and some participants demonstrated an awareness that support was not universally present, not all colleagues would have a ward sister/manager or senior nurse that they could gain support from:

Not everyone will have a good relationship with their ward sister/manager,
Alice, page 8, comment 118

Everyone needs support and you have to be open to that ... we know where to look [for support] but it's made obvious that they [senior nurses] don't have time for that sort of thing.

Hannah, interview 3, page 3, comment 31

Hannah's conversation conveyed that those in a position to offer support and leadership might choose to make themselves unavailable; this lack of availability was compounded by geographical distance with senior nurses in this instance being based at another site. A lack of wider support networks left one participant vulnerable to the loss of a significant individual. When one ward sister/manager left, leaving the participant running the ward with matron for support, the changing level of support was noted and commented upon. Alice described appreciating the support from her matron in addition to the supportive ward sister/manager. Other participants tended to be ambivalent about the role that their matron might have in supporting and encouraging them, although the more tenuous underlying implications of feedback were experienced by Hannah:

But I think she [Matron] wants somebody more dynamic for the post basically and what she said to me was that basically your money wouldn't be anymore and you'd have to go for interview, and you'd have to have an interview and everything else, because she knows I hate interviews. So basically saying well you know it's probably not a good idea for you to go for it without actually saying that, not encouraging me to apply [for the ward sister/manager post],

Hannah, page 2, comment 8

Participants did not mention formal coaching and mentoring strategies or relationships, although some identified informal mentoring relationships which were proving valuable. Key informants viewed mentoring as a valuable addition to the support mechanisms available for aspiring ward sister/managers, although

several acknowledged that there were insufficient role models and mentors in the organisation:

We could ... do with a stronger mentor pool, so people could actually go to mentors who actually had, who had been through you know, leadership and management courses and skills and had actually had the work based learning experience. So they that had mentors in practice that they could actually go to and talk to about or reflect upon a particular issue or problem.

Senior Nurse 5, page 9, comment 62

6.3.2 Self-fulfilment -Role models

Whilst participants and key informants talked about a general sense of support, the need for this and the individuals who provided this support, participants also talked about certain senior colleagues who served as role models. Participants reflected on those individuals, almost always senior to themselves, whom they watched, whom they looked up to. In some instances, these individuals were giving active support and some were recognised as supporting people for their next career move. Facets of these senior individuals' roles were recognised and generally admired; participants talked about observing particular skills and handling of situations. Role models were appreciated for their patience, their teaching, their ways of working with both staff and patients. Ruby talked with enthusiasm, seemingly inspired by the more nuanced aspects of expert practice:

I keep watching when someone else is the sister in charge, or when she is dealing with a different situation, I just open my eyes, my ears and keep a watchful thing around what's happening and how they are being and then I talk to them [I] ask them how did you go about with the situation,

Ruby, page 5, comment 26

Encouragement and positive feedback from role models was greatly appreciated by participants and this could reinforce their sense of confidence and self-esteem:

She [former ward sister/manager] gave me a lot of confidence in myself.
Hannah, page 9, comment 65

Some participants recognised that senior colleagues were attempting to balance the clinical and managerial requirements of the role: the mechanisms of management were readily identified. Participants did not appear to recognise the multi-faceted aspects of the leadership and management role. Whilst a need for leadership was inferred, participants did not themselves articulate the need for a strong leadership figure. It was evident, however, that participants had an appreciation of their ward sister/managers' approach to work.

Evelyn, alone, reflected on learning from negative role models as well as positive role models in her area of work, commenting on how she would do things differently when she got the post.

... not to be afraid to approach people who put you down, ... I'm a band 6, I'm working, you've come in the room the doctors arrive, you've come in the room and actually made me feel like a termite, ... I'll come out of the room and speak to you –please don't do that because you make me feel nothing and I don't need that from you, I do that anyway.”
Evelyn, page 9, comment 60a

6.3.3 Self-fulfilment - Motivation

Discussions during the interview revolved around participants' current role, their journey to that role, their understanding of the ward sister/manager role and their hopes and aspirations for that role. Motivation to work hard and to do their

best for their service was clear from all participants. The mechanisms behind that motivation were less clear – some participants had made active career choices to be in the positions they were now, some expressed structured career plans that led them to the current post and was influencing their decisions about the next step. For most of the participants this strong sense of personal motivation emanated through the conversations; this appeared to be intertwined with a strong sense of self, a confidence, a sense of belief in their own ability and following their chosen career path. A sense of direction was expressed, vehemently in some instances:

If I don't aspire to get to my destination, it doesn't give me that job satisfaction that I need ... I'm working towards a band 7 ... I feel ready for the position,
Evelyn, page 1, comment 7; page 2, comment 4

While Hannah demonstrated the motivation to progress through her active career choice to take the role of junior sister, this sense of motivation did not allay the fears and doubts she experienced. However much doubt she experienced, Hannah talked about persevering with the role of junior sister and at the point in time of the interview, she expressed the self-belief that she could at least wear the uniform required when on her management days:

because when I was first made the junior sister, I still don't wear the uniform, I only wear it on my management days, which is only two days a month. It's only now really that I feel confident enough to wear it ... but at first I just felt clearly I wouldn't wear it. I don't know why, I just didn't feel confident enough I suppose to be seen as a manager of the unit and I've always felt happy being one of the staff and I see being a manager and one of the staff as different levels and you are in a different place and you are seen differently,
Hannah, page 12, comment 91, 92

Some had sought promotion for the position they were currently in but did not have a formed career plan going forwards. For Maria, the move to a more senior role came about almost by chance, not sought or chased, but taken up with mixed feelings:

I would never have imagined myself as a ward sister ... then this came up and I thought I may as well go for it,
Maria, page 1, comment 6

Participants talked about developing their knowledge of skills and tasks that they identified as significant in developing their management skills. Ruby was the only participant to talk specifically about developing her knowledge and her nursing practice, and was passionate about continually developing her knowledge and that through this she could share her knowledge with others:

I have a strong sense of motivation to develop, to find out, to know more ...
Ruby, page 6, comment 30

6.3.4 Self-fulfilment - Job satisfaction

All participants talked about factors, tasks and situations that gave them a sense of satisfaction. Job satisfaction came in different forms for participants; some reflected upon the importance of knowing one's own competence and limitations, some articulated the essence of their work ethic. The need to feel appreciated was a theme touched on by all participants. Feeling valued and approved of was especially significant to some participants; this sense of being valued arose from the actions as well as words of others and was expressed both directly and indirectly:

Staff have already approached me and said, oh we hear [the ward sister/manager is] going to ... retire, ... and said, oh you'd better be going

for [the] position , and I said why, and well if some outsider's coming in, we're leaving , if you're not the band 7 ... so I do feel valued,
Alice, page 4, comments 72, 77

Hannah conveyed a sense, almost of hopelessness at times. During the interview Hannah frequently smiled and laughed and yet the laugh was a nervous laugh, not one really of humour, more a laugh of irony. Through transcription this element could have been lost, it seemed important to note however. Laughter occurred at several points during the interview and yet the talk itself was not humorous. She reported that she did not feel valued by her senior colleagues at the current time but she did reflect with a slight smile that her promotion had been noticed by colleagues out of the ward area and this appeared to be giving some small sense of satisfaction:

The last few months I've been in this covering post, you know more people are getting in touch with me, hearing that I'm the covering manager and phoning the ward saying well can we see about such and such and can I come and meet you about this and that and I'm thinking well you know it is picking up in that way, people are getting to know me as the ward sister,
Hannah, page 2, comment 14

Working with patients directly was noted by all participants as giving great job satisfaction, but was clearly expressed by Alice:

I like looking after patients and I like my basic nursing care and my little old ladies and little old men and helping them wash and shave or whatever it takes in the morning,
Alice, interview 2, page 3, comment 22

6.4 Professional purpose

Three themes came together to form the dimension of professional purpose: the ward sister/manager role itself, and two other themes, the nature of leadership

and work ethic. Whilst the nature of the ward sister/manager role itself came under considerable scrutiny from key informants, participants tended to focus more upon the tasks that the ward sister/managers carried out. Within this dimension of professional purpose, data supporting each of the three themes are presented. Within the theme of the ward sister/manager role, categories of the evolving ward sister/manager role, and learning on the job are presented.

6.4.1 Professional purpose - The Ward Sister/manager role

The role of the ward sister/manager was the focus of the discussions with senior nurses. The pivotal nature of the role was commented upon; the ward sister/manager as a leader, as a role model, was seen as imperative for the smooth and effective running of wards providing a high quality service. The loss of clinical contact in combination with the level of responsibility associated with the ward sister/manager post was seen by many as a significant disincentive to more junior nurses:

In this organisation, a lot needs to be done to recreate the [WM] role as an attractive one, ... recreate it in a way so that it becomes an attractive role to aspire to, from a career perspective.

Senior Nurse 2, page 2, comment 20

A lot of band 6s are frightened to go into the post [because of the responsibilities],

Senior Nurse 3, page 14, comment 101

With one exception, participants talked positively about the ward sister/manager position overall. Maria alone expressed her reservations, which related to the workload and responsibility held by ward sister/managers:

I know at the moment I certainly wouldn't go for a Band 7. First of all I don't think I would be ready and you know it's just a bit too busy, but

there are so many staff shortages and cut backs that you wouldn't have the scope to do what you wanted to do,
Maria, page 5, comment 57

Key informants could identify that the loss of patient contact, the erosion of this fundamental aspect of nursing served as a disincentive to junior staff and a frustration to ward sister/managers. The role appeared to create a conflict between the desire to advance one's career and the desire to remain close to the patient. Delivering patient care was clearly viewed as the very essence of nursing, and it appeared significant as a reason to continue working in stressful areas and organisations, the aspect of working with or close to patients:

Sometimes junior sisters don't move up to [ward sister/manager] because they know they are getting further away from the patient.
Senior Nurse 1, page 11, comment 116

Alice and Hannah both talked about their desire to keep the clinical components of their roles, staying close to the patients. Alice expressed concerns that managerial roles required nurses to move away from patient care and this conflicted with her passionate desire to deliver hands-on care. Hannah pondered over whether she would be allowed to keep this clinical work in a managerial role.

I'm hoping that I'll still be allowed to be a nurse, because when you get to a certain level there isn't any patient contact ... I would hate to lose that side [patient care] and be stuck in an office all day,
Hannah, page 12, comment 103, 107

Senior nurses considered the motivation for nurses undertaking ward sister/manager posts, reflecting on their own experiences. Self-belief was

considered to be a key component. Drive and vision was significant, the concept that things could be changed to improve things was a key driver for some:

It's a feeling of passion that you can do things better,
Senior Nurse 1, page 4, comment 62

Structured career progression and development was not evident for all in senior positions, despite the assertions in the workforce development strategy about talent pipelines. It was noted by a number of senior nurses that some individuals came into their leadership positions by chance almost. These individuals might have been working in temporary or covering positions before being appointed permanently to the role. They conveyed a sense of dismay through this, an acknowledgement that nurses could end up in a position that they were not necessarily skilled or prepared for:

Some people don't have the skills of managing the time and their workload,
Senior Nurse 1, page 3, comment 42

Some have been put into acting up positions ... they have almost slipped into a Band 7,
Senior Nurse 2, page 5, comment 52

Alice was clear that the ward sister/manager should be a 'clinical expert', in her words. Ruby alone talked explicitly about skilful nursing care undertaken by her senior colleagues. Ruby reflected on watching her senior colleagues dealing with different situations and valuing the nature of their nursing care. Ruby focussed upon the very essence of skilled nursing care that her senior colleagues delivered.

Participants reflected upon their own knowledge and skills in their current role and the knowledge and skills required by a ward sister/manager. These ward sister/managers were identified as needing to be calm, flexible, efficient, and to be credible clinical role models demonstrating clinical expertise and leadership:

[the ward sister/manager] doesn't just sit in an office, [they've] got clinical days,
Alice, page 2, comment 20

When exploring and reflecting on the ward sister/manager role, participants focussed upon the more managerial components of the role. Participants highlighted the tasks that they saw the ward sister/manager performing: doing the off duty rota, ordering equipment and stores, dealing with complaints. Compiling the off duty rota held particular significance for both Alice and Hannah. Hannah specifically identified this task as being fundamental to the role of the ward sister/manager. Alice talked about her own ward sister/manager's endeavour to keep all the staff trained appropriately. Participants focussed almost exclusively on this task driven view of the ward sister/manager role. Any the finer nuances of skilful being, with either patients or staff was apparently unnoticed or lacking. Ruby alone explicitly identified a broader, more encompassing role for the ward sister/manager:

So if it's a good umbrella there are no leaks,
Ruby, page 8, comment 46

Whilst not specifically articulating the multi-faceted nature of the role, several senior nurses commented on the need for leadership in addition to managerial tasks. One senior nurse considered that there were natural skills, although this line of thought was not developed:

[they] don't always have the natural skills,
Senior Nurse 1, page 4, comment E56

[the ward sister/manager role is] all about leadership, someone who demonstrates an ability to organise, communicate.

Senior Nurse 2, page 10, comment E107

The nature and extent of leadership required was alluded to but not given in detail, although one senior nurse commented on the need to be convincing to persuade others. The frustration of not being heard however was also clear:

You do have to be very convincing and need to make sure that people hear what you want ... I thought, is there anyone out there who hears what I'm saying,

Senior Nurse 3, page 15, comment E112

6.4.2 Professional purpose – WS/M role – evolving nature of the role

The evolving nature of the role was noted primarily by key informants rather than by the participants. A rebranding process for the band seven ward sister/managers had taken place during the research study. Two of the key informants reported that the Director of Nursing had wanted to support the ward sister/managers in developing a clear identity that was separate from their junior colleagues. The similarity of existing uniforms and confusion over titles had led to discussions about the impact of this on ward sister/managers themselves:

Ward sister, ward manager and band 6s all wear a blue uniform,
Senior Nurse 2, page 4, comment 41

Participants and key informants alike had referred to a multitude of titles used by nurses in this trust at band six and seven. The significance of this varied across participants, some feeling that it was unhelpful, some unsure that it had any

impact. There was no evident thought about why the many titles had arisen or whether there should be a reassessment of the titles:

I think it can be confusing for patients sometimes especially the older generation because they're used, you know at one stage there was the Ward Sister and that was it, there was none of all these different uniforms,
Maria, page 8, comment 79

One of the senior nurses who was a band seven considered that whilst the title might be confusing it did not impact on either what they did on a daily basis or how they introduced themselves to the patients in their area:

If you have different uniforms I think people should know what they represent ... for me it's not a big deal,
Senior Nurse 3, page 7, comment 64

Senior nurse 2 shared that through the Band Seven (Ward sister/manager) Council, a democratic decision was sought for the future of the role in terms of both title and uniform. The title held by the band seven ward sister/managers was viewed as being crucial by those in the forum and by the senior nursing team in the organisation, and a new title was negotiated:

They've done it themselves [agreeing a title and uniform]- helps to shape their identity,
Senior Nurse 2, page 4, comment 50

Most of the key informants knew about these changes and two of those with an organisational remit were particularly knowledgeable about this and involved in the process. One senior nurse was unaware of these changes until asked about them during the interview, and sceptical during the discussion about them, expressing incredulity that a uniform change could make a significant difference to either patients or the staff:

Why would you need to change the colour of someone's uniform to make the more identifiable ... I don't understand, is something magic going to happen [if you change a person's uniform]?

Senior Nurse 5, page 8, comment 56

6.4.3 Professional purpose – WS/M role - Learning on the job

Participants talked about learning on the job, especially the tasks and skills that they were learning. Being tasked with, or allowed to 'do the off duty' was considered as a measure of success, almost a rite of passage. There was a palpable acceptance that learning through doing was invaluable. This process of learning on the job appeared to be viewed in a positive light, inevitable but welcomed and proudly discussed. For most participants, this learning on the job was encouraged, even masterminded by the ward sister/manager. There was more a pragmatic reflection that some things had to be experienced to be learned; managing the team was talked about by Maryam; learning to manage difficult individuals was a matter of importance and concern to Maria. Ruby talked about learning to take up more responsibility.

Whilst most acknowledged the positive aspects of learning through doing, this was a qualified sense however, and some participants talked with frustration about the sense of being handed or delegated responsibility inappropriately. Participants expressed caution and frustration at the thought of being 'dumped in it'. For Hannah, learning on the job did not seem to offer any positive aspects. Her conversations conveyed a sense of being left to manage unsupported and alone.

Learning on the job could be made smooth and positive by those senior individuals in the clinical area. Three participants talked specifically about having opportunities to shadow senior colleagues. Ruby and Maria referred to undertaking acting roles to develop their skills, knowledge and experience:

Before I took up this role I was given the chance to do it like an acting person ... I felt it was a challenging thing and it's quite you know, it's an opportunity to grow,
Ruby, page 6, comment 31, 32

Evelyn sought opportunities to shadow senior colleagues who were coordinating the unit but conveyed a personal cost to this act of shadowing. Her use of the phrase 'forcing myself to shadow' used on several occasions during the interview was possibly insightful, conveying pressure and a need to have resolve, determination and persistence in the face of opposition or anxiety.

I've forced myself to shadow ... my manager was very helpful when I forced myself to shadow,
Evelyn, page 3, comment 25, 26

Shadowing was seen as a positive support strategy for ward sister/managers in post, which some of the senior nurses themselves had been able to experience. The opportunities to undertake shadowing were welcomed and considered valuable. Two participants had experienced shadowing but these appeared to have been ad hoc arrangements. One senior nurse commented on the perceived lack of appropriate role models for aspiring or current ward sister/managers, which may have impacted on the lack of shadowing opportunities:

I fortunately had the opportunity to shadow,
Senior Nurse 4, page 3, comment 16

Maryam was given shadowing opportunities to learn appraisal skills; only Alice, of all the participants, was dealing with off-duty. She alone was involved in recruiting more junior staff, although Maria identified this as a facet that she needed to learn about. Senior Nurse 3, reflecting on experience as a staff nurse noted that support continued on becoming a ward sister/manager; however it was acknowledged that this was not always sufficient:

My [former] ward manager told me more stuff when I came into this post.
Senior Nurse 3, page 15, comment 118

6.4.4 Professional purpose – Work ethic

Work ethic was a prominent feature of discussion with some participants and key informants:

I treat people the way I would like to be treated and that's what I stand by,
Senior Nurse 6, page 9, comment 39

One participant discussed having pride in their own work ethic, and occasionally experiencing frustration in the work ethic of others:

I have very little tolerance for poor nursing standards ... suppose I expect everyone to be the same [as me],
Maria Page 3-comment 18,

For one participant, a difference was perceived between an older generation of nurses compared with the younger generation. This view of the compassionate nature of nurses was not shared by others however:

Nursing really seen with [older generation rather than younger], the caring, compassion,
Ruby, page3, comment 8

Newer nurses do it [caring] because it is part of their duty, not that they are committed to it.

Ruby, page 11, comment 73

This change in approach linked to the generation of nurses was not explicitly recognised by others however. Maryam and Ruby were critical of an attitude amongst some colleagues of 'just doing their job and then going home'; just doing their job being stated as a criticism. Senior nurses also recognised that not all nurses shared a passion to develop themselves and a passion for nursing:

Some people are not interested; they just come to work and go home.

Senior Nurse 4, page 3, comment 21

Younger more newly qualifieds are more confident not the same amount of respect,

Maria, page 5, comment 44

6.4.5 Professional purpose - The nature of leadership

The means through which leadership manifested itself was considered in a number of ways. One key informant commented on personal enthusiasm to undertake the leadership role:

There's the passion and the drive –that's what makes me want to lead a team,

Senior Nurse 1, page 4, comment 62

Another key informant reflected upon learning together with the staff nurses and junior sisters in the department,

I meet with my Band 6's and we discuss clinical issues and we discuss management things. Sometimes we don't get a chance to meet, but when we set out a sisters meeting ... we would make sure we would look at policies where you don't understand, we have to pull out the policy and look at it together

Senior Nurse 3, page 4, comment 36

This concept of learning together was identified by one of the participants when referring to the manner in which she supported junior colleagues:

the way that I shared my knowledge when they need support and things went wrong

Ruby, page 5, comment 21

The specific nature of leadership skills was deemed challenging to isolate:

Have people got leadership qualities, leadership skills ... when you talk about leadership qualities or leadership skills or managerial skills, how are they quantified or ... how does anybody say well this person has leadership or managerial skills above another person?

Senior Nurse 5, page 4, comment x1

This key informant reflected on an element of subjectivity in deciding whether a team member possessed the necessary skills to lead their team of nurses:

Well it is very subjective ... your observation of somebody as a team leader, ... are they actually leading a team, are they ... advocate for the patients and so on

Senior Nurse 5, page 4, comment x2

The essence, the very nature of leadership, was alluded to in the second round of interviews with participants. On an individual level, several participants experienced empowering support and development and talked about supporting their more junior colleagues in a similar manner. One participant recognised the nature of leadership that she wished to follow:

You need to know how to communicate [that I am leading from the front]. Balancing that role of leadership, knowing that if they don't function, you don't function.

Evelyn, interview 2, page 4, comment 45

For others, there was evidence of insight into developing leadership roles but a vision for leadership was expressed only by implication:

I usually ask them [my nurses], well how do you think I am doing as your ward manager, do you think there's anything I could improve on?
Alice, interview 2, page 9, comment 80

6.5 Departmental level of work

The departmental level of work comprises two themes: developing people for future and the ward context. The first part of this section highlights the practices in place and the ad hoc nature of support provided for those aspiring to the ward sister/manager role. The second part of this section then explores the significance of the nature of the ward or department itself for creating the environment in which the development of staff could take place.

6.5.1 Developing people for the future

That role models were preparing participants for the next step was expressed by Hannah and Alice. Alice talked about being prepared for the transition to the ward sister/manager role. Her ward sister/manager was supporting her to develop necessary skills through role modelling, teaching and delegation. In turn, Alice was preparing a band five nurse to move into a band six post in the future. One of the senior nurses, however, was uncertain that there were sufficient positive role models for the band six nurses to enable them to understand the possibilities of the ward sister/manager role:

How many good role models are there for band 6s to aspire to?
Senior Nurse 2, page 1, comment 9

Participants were asked about the transition from band six to band seven (or staff nurse/junior sister to ward sister/manager). Some identified the challenges they perceived with this. Some talked about being prepared for the next step: taking

on new roles and responsibilities was highlighted by some, learning on the job was noted, and planned development initiatives were set up by some ward sister/managers. Alice commented that there was a lack of preparation for this transition by the Trust, with nothing to prepare her to deal with problem staff; the need for training and preparation before moving to a ward sister/manager post was apparent to her:

And like the conduct and capability policy, and how you deal with problematic staff. You don't know any of these things til you have to deal with it and then you've got to go and read a policy and actually understand it yourself. There's no training as such to kind of prepare you
Alice, page 7, comment 109, 110

Participants reflected on development opportunities that might help with the transition to the next role. One or more individuals were referred to as assisting with this preparation. Hannah talked about her ward sister/manager delegating jobs and responsibilities to her to facilitate a smooth transition to the ward sister/manager role. Maryam identified one senior colleague who was supporting her in her current post and in preparation for the next stage in her career.

Participants identified challenges in making the transition to the more senior role, especially when it is within the same department. Not being respected initially was identified by Hannah, who noted a need to build up that respect amongst colleagues and former peers. Evelyn reflected on the need for support and preparation for the next role to prevent the feeling that everything had been thrown at you on getting the promotion.

The need to prepare practitioners for taking on a ward sister/manager role was identified. Three of the senior nurses had themselves undertaken the same aspiring leaders programme, in earlier years, that participants had undertaken:

We need to put in a structure that says to 6s, we want to develop you into 7s [Ward sister/managers],
Senior Nurse 2, page 8, comment 84

All participants had undergone a leadership development programme in the year preceding this study, a leadership development programme developed by the former Director of Nursing with a University partner, and delivered by expert facilitators from the University partner. The role of this programme in readying participants for the ward sister/manager position was highlighted by two participants. Others appeared to view this development programme as separate, somehow, from the hospital's provision of support and training. Participants looked to their ward sister/manager or other senior colleagues to support them and encourage them in their development. Hannah described feeling that the training and development department could have instigated development study days for those in transition, either moving from band five to six (junior staff nurse to more senior staff nurse or junior sister) or moving from band six to ward sister/manager at band seven. There was a general belief amongst participants that the organisation did not offer specific help and support for those applying for ward sister/manager positions and for newly appointed ward sister/managers.

Participants talked about appraisal as being a means of getting feedback. Hannah talked about getting feedback from colleagues. The link between appraisals and development opportunities was identified by Ruby.

Mentors and supervisors were also noted as key individuals to provide support. This could be in the form of a more traditional hierarchical sense with a mentor there to help individuals reflect, or through a form of buddying system:

A mentor is there to help you reflect on things ... to unpick things for you as well.

Senior Nurse 5, page 10, comment 66

6.5.2 Departmental level of work - Ward context

The local clinical area that participants worked in was significant in many ways; participants' world view mostly stretched as far as the clinical area and not beyond, and their experiences were situated within and influenced by this context. A broad approach to developing staff was noted in most clinical areas. The role of the ward sister/manager (or senior sister) in giving support and encouragement to all their team members was noted by key informants. These senior nurses talked both about a more general need for the ward sister/manager to be a supportive enabling and facilitating figure.

Alice talked about getting everyone trained up and helping to develop others. Getting study leave was discussed by almost all the participants; no one was ever turned down for study leave was a frequent comment. This was welcomed, celebrated almost, but there was little sense of how that study leave enabled practitioners and colleagues to develop their clinical areas. A broader approach to supporting and developing junior staff was recognised by Alice and Maria, who understood the need and the significance of supporting more junior colleagues:

In our unit we're fully supportive of our staff ... my ward manager wants everyone trained up to the max,
Alice, page 8 comment 123

We try and meet with the staff [in our team] once a month on an individual basis,
Maria, page 8, comment 69

Participants identified individual areas of good and great practice with regards supporting and developing the next generation of aspiring ward sister/managers at both junior and senior level:

My nurse that I'm working on at the moment, she's always on shift with me, I'm giving her ample opportunity to be in charge.
Alice, interview 2, page 7, comment 61

Despite the fact that participants highlighted areas of positive development for themselves and their teams, this appeared to operate in isolation. Participants showed no specific awareness of staff development practices in other areas. Senior Nurse 5 considered that the organisation's remit for developing staff into the ward sister/manager role was not one of organising shadowing or mentoring however. The view that ward sister/managers should support and develop their own staff and were clearly doing so, was vehemently expressed. Senior Nurse 5 pondered over the possibility of supporting practitioners to develop a timeline for development rather than any specific development programmes.

6.6 Organisation level of work

The dimension of the organisational level of work is comprised of three themes: an organisation-wide approach to supporting and developing the workforce, nursing leadership and the organisational context. Within this dimension, the organisational context theme refers to the whole organisation rather than just a

department in which a practitioner works. This organisational dimension reflected the wider context in which participants and key informants worked, and thus impacted upon their experiences, whether or not this was explicitly recognised.

6.6.1 The organisational context

The review of policy documents, strategy documents, publications and from exploration of the hospital trust's outward facing website and internal intranet as a means of communicating to internal and external stakeholders, are presented here in addition to the interview data from key informants and participants. Data obtained from the NHS staff satisfaction surveys from 2011-2013 for this organisation have contributed to these findings.

The policy documents reviewed in 2011 and 2012 presented a picture of a large and exciting organisation with a diverse and skilled workforce. The intention to support and develop the workforce was apparent, with strategies in place to facilitate this from recruitment and retention, sickness and absence strategies and policy through to educational support and development. Exploration of the hospital's intranet site allowed access to policy and process documents, all located for apparently easy access for staff. Team, individual and departmental success was noted publicly and celebrated both in staff newsletters and glossy publications available to all stakeholders. Staff newsletters were referred to on the hospital intranet and newsletter and publications for the general public were available in the hospital foyer and on the hospital's public website.

This was a large NHS organisation with a workforce of more than 4,500 employees, of whom, in excess of 30% were nurses. Data obtained from the Trust Annual review publications from 2011-12 and 2012-13 sets out these basic levels of workforce data (Table 6.1). Employee numbers have been rounded to the nearest hundred to aid protecting the identity of the organisation.

Table 6.1 Workforce data (Data obtained from the Trust annual reviews, 2011-12, 2012-13)

Year	Number of employees	Number of Whole Time Equivalents [WTEs]	Vacancy rate	Nursing employees as percentage of workforce	Percentage of sampled staff having appraisal in last year	Sickness [total days lost, rounded to the nearest hundred]
2011-2012	4900	4400	9%	34%	66%	24,600
2012-2013	4800	4300	9%	37%	60%	44,000

Details of the sample number used in investigating appraisal uptake is not disclosed.

Data from the NHS Staff Satisfaction Survey for this Trust in 2011 and 2012 was reviewed. The number of respondents to these surveys ranged from two hundred and three hundred and sixty, no details were available of the selection process for potential participants. From the survey data available in the public domain, it was not possible to identify the range of staff groups who have completed this survey. The NHS Staff Satisfaction website does not give detail of the number of survey requests distributed, nor the participant selection methods. The hospital annual review comments that for 2011/12 a 43% response rate was

noted. The response rate for 2012/13 was 27% with only two hundred and sixteen staff responding (Table 6.2).

Table 6.2 Excerpts from the NHS Staff Satisfaction survey for this NHS Trust

Statement	Agree/strongly agree [Figures as percentage]	
	2011	2012
Care of patients/service users is the top trust priority	64	69
That they know who the senior managers are	73	83
Senior managers try to involve staff in important decisions	33	33
Senior managers where they work are committed to patient care	57	54
Communication between senior managers and staff is effective	32	42

The data presented highlights that, broadly-speaking, responses followed a similar pattern in 2011 and 2012. Slightly more than 50% of respondents considered that their senior managers were committed to patient care. Slightly more than 60% of respondents considered that care of patients was a top priority for the organisation. These figures allude to a gap, a difference between the espoused values of the organisation and the values that staff members recognise.

The vision and values of the trust in 2011, located on the outward facing website talked primarily to patients and service users:

We have adopted values to ensure that all our patients are cared for with dignity and respect whilst ensuring that we deliver excellence and professionalism in all that we do.
Trust values, accessed 1/3/2012

The vision and values for staff were explicitly set out in the workforce strategy.

This 2008-2011 strategy was made available to staff electronically via the Trust's intranet site. In late 2011, this document remained the only workforce strategy available with no explicit mention of either review and evaluation or an updated strategy for the future. This document set out the organisation's strategy in the context of wider NHS policy drivers at the time and the '10 High Impact HR changes' published by the Department of Health in 2006 and the organisation's journey to become a Foundation Trust. The desire to develop and support the workforce was explicit. The link between organisational culture and style, and organisational success was noted and an objective of developing a values-based leadership approach across the organisation was stated:

[providing] a framework for making values and values-based leadership a reality through every stage of the employee pathway [accompanied by] an engaging, involving and listening style of doing business,
Workforce strategy

Making the strategy a reality was clearly stated, although data collected through this study found little if any evidence that this was a living and meaningful document:

The strategy clarifies the roles and responsibilities of every employee ... in making the strategy happen,
Workforce strategy

A picture is thus set out of an organisation, wanting to be seen as caring in its approach for staff. Clarifying roles and responsibilities appears key, values-based

leadership is lauded and championed. Service users can expect to be cared for with dignity and respect and professionalism in all that staff do is the hallmark of the organisation. This is set in the context of an organisation where the workforce development strategies available via the organisation's intranet were outdated, and evaluation or review data were absent.

Whilst leadership was discussed by some key informants in a broad sense, the lack of discussion about values-based leadership, either explicitly or implicitly, by participants and key informants in this study was notable:

I suppose the nursing strategy does have a very clear view of what leadership will be. The HR and Education Subcommittee have a clear view of what they want for leadership,
Senior Nurse 1, page 3, comment 45

6.6.2 Organisational level of work - Nursing leadership

The Director of Nursing had been in post for almost one year at the commencement of the data collection for this study. The organisation's intranet consisted of a range of information from policy and protocol documents to the executive bulletins and organisational newsletters. No reference to the Director of Nursing was found on the intranet in the staff news section or executive bulletins, which might suggest that either the role was not an integrated and valuable one, which would appear unlikely, or the intranet was not a live means of communication for the organisation.

Key informants were more likely than participants to identify nursing leadership permeating from executive to ward level:

I think [the Director of Nursing's vision] underpins the philosophy behind the nursing approach now, not only from the Director of Nursing but from the whole of nursing as an approach, you know so it's actually patient focused and the standard of nursing is achieved. So I don't think it's just from the Director of Nursing, I think it's an organisational approach, Senior Nurse 5, page 5, comment 35

Whilst key informants could generally identify a clear and compelling nursing vision for the service, participants did not explicitly recognise this. Most participants noted an apparent lack of engagement and visibility of the senior nursing team. Despite repeated attempts, it proved impossible to engage the wide body of senior nurse leaders in this research study. Participants in this study made no mention of nursing leadership at a level above their matrons, and there appeared to be no sense of leadership of nursing. When asked specifically about a nursing strategy or vision for the hospital, Maria, qualified for over five years, and had worked in the organisation for just over three years, could not identify one. She did not know, in the sense that she had not met, either the former or current Director of Nursing, did not know what they looked like. The Director of Nursing role appeared to hold little meaning for her, just a senior individual whose work did not affect or influence what was happening at ward level. Maria clearly articulated that it was up to the Director of Nursing to make herself known to her staff, to have visibility in other words.

Despite the relative seniority of the key informants, one of the more junior practitioners amongst them struggled to remember the name of the Director of Nursing. This did not prompt any visible consternation, no sign of embarrassment. Other key informants were more knowledgeable, however

another of the more junior key informants lacked conviction when talking about the role of the Director of Nursing.

So does the vision of the Director of Nursing filter down to you and make sense to staff ... ?

Probably yes.

Senior Nurse 4, page 7, comment 38

Overall, nursing and nurse leadership did not emerge as having a strong identity; a 'nursing' section on the intranet consisted of a policy on e-rostering and an old, out of time, nursing strategy document (2007-2010) with no mention of a review or replacement strategy. In March 2012 a further opportunity presented to scrutinise the Trust intranet. A nursing vision was at this stage 'under development', a picture of the Director of Nursing was now included but was the only item in this web section.

Reflective journal notes, compiled at the time, reflect considerable curiosity at this. The absence of presence of the Director of Nursing was striking. No web page was assigned to the post-holder; there was no mention of the name. The change-over of Director of Nursing was not apparent on any document or policy located via the intranet. There was no mention of the Director of Nursing in the news letters at the time either.

6.6.3 Organisation level of work - Supporting and developing the workforce

Broad supportive mechanisms and processes as identified through the various data collection episodes are detailed in Box 6.2.

Box 6.2 Supportive mechanisms and process available in this organisation

Regular Open forums with the Chief Executive
Best practice is shared via the intranet and regular news letters
Policies, including a workforce strategy and an education and study leave policy enables individuals to undertake pertinent training and education with varying degrees of support from the organisation, are available via the local intranet
The clinical education department coordinates education and training initiatives
Appraisals should be undertaken annually for all staff by their line managers
Ward sister/managers are expected to support and develop their staff
A support and network forum has been established for the Band 7 ward sister/manager grade
Leadership development programmes provided by one or more academic partners are available for band 6 or newly appointed band 7 nursing, midwifery and allied health professionals.
Mentor training to support pre-registration students, a requirement of the Nursing and Midwifery regulatory body, is available via local academic partners.

The avowed intent to develop human resource processes was evident in a policy established to focus on the workforce:

As with any organisation that delivers service [rather than manufactures products] it will be people, in the right numbers with the right skills and attitudes that will need to be inspired by the vision and motivated to deliver the objectives,
Workforce strategy

The development of an 'employee pathway' was seen as an essential part of the journey to becoming a Foundation Trust with a lean thinking approach. The employee pathway set out proposed practices from pre-recruitment through recruitment to employment and a learning and education approach. Benefits for staff and patients were set out clearly for each stage of this pathway.

Stated measures of success for these pathways include:

Staff survey results showing continuous improvement

No-blame culture
High performance is genuinely celebrated
Staff rarely say 'I didn't know about ...'
Right staff with the right skills at the right time
Improved morale and retention of staff
Workforce strategy

The commitment to develop staff into future roles was established in the strategy:

The trust is committed to recruit, nurture and develop talent ... this will be balanced with a commitment to offer a rich range of experiences for staff who demonstrate talent so that they are prepared for internal succession opportunities.
Workforce strategy

This preparation for succession opportunities within the organisation, referred to as the talent pipeline was illustrated (see Fig 6.1)

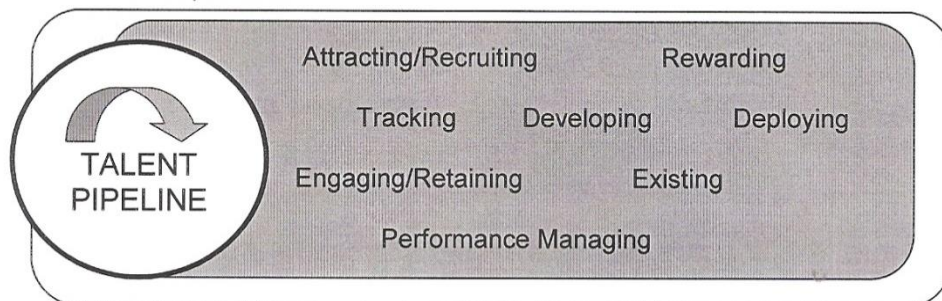


Figure 6.1 The Talent Pipeline - Workforce strategy, section 6

This concept of a 'talent pipeline' was referred to only by the two most senior key informants:

There is a drive to look at talent management. [The trust was] involved last year with NHS London talent management scheme and that was primarily looking at director, assistant director, deputy director level, that kind of thing,
Senior Nurse 1, page 2, comment 11

Participants and other key informants did not comment on this or refer to an established process for succession planning in the organisation. Two senior nurses talked in a general sense about supporting their colleagues and developing staff for future roles in their own clinical areas.

The Trust's learning education and development policy available in 2011 was an old and out of date version, written in 2008 with a stated review date of 2010. A review of this document and updated learning and education policy was not evident on the intranet. This out-dated policy document talked about the need for the organisation's business plan to be supported by a learning, education and development plan and that the organisation's vision, values and strategy needed to be embedded through this learning education and development plan:

The Trust Board are committed to the principles of a learning organisation and are clear that investment in learning, education and training enables staff to reach their full potential and continually improve performance ...
Education and Development Policy 2008

Line managers, according to this policy, are required to create a learning environment where skills, knowledge and behavioural change are aligned to service improvement. Leadership and management development is identified in the learning, education and development policy as one of six categories of learning. Key aspects of management development are highlighted and it is proposed that the activities required:

are determined by employees and the manager in accordance with current role requirements and future aspirations,
Education and development policy, 2008

The role of coaching, mentoring and shadowing activities is acknowledged in the policy, in conjunction with taught programmes. One key informant identified this more as a need than an established strategy or provision within the trust:

Maybe we need to ... to put a structure , or a framework in place, that actually says to the Band 6 we want to help you develop into a Band 7. There's too much that they go in and ... some of them have done their courses, but it isn't just about that, it's about the mentoring , the buddying up and I'm not aware that there is anywhere where you might give somebody, another Band 7 that's been, you know an experienced Band 7 that maybe is their buddy, their confidante.

Senior Nurse 2, page 8, comment 85

Senior Nurse 5 identified a potential need for more mentors but this was expressed as personal opinion; links to a formal strategy for mentoring to support leadership development were not referred to:

we could possibly quite do with a stronger mentor pool, so people could actually go to mentors who actually had, who had been through you know, leadership and management courses and skills and had actually had the work based learning experience.

Senior Nurse 5, page 9, comment 62

Senior Nurse 2 talked specifically about coaching one particular individual, but coaching as a more general theme was not mentioned by participants or key informants.

Leadership and management e-learning modules, referred to in the policy document, were available for staff as e-learning opportunities via the staff intranet, requiring two hours of invested time. These modules comprised modules on assertiveness, effectiveness and delegation skills. One programme was mentioned for developing people management skills was alluded to on the intranet; nine half day workshops make up this programme. No details were

found elsewhere of this programme. Participants did not refer generally or specifically to these learning resources. Of the key informants, only the two key informants with an educational remit were aware of these opportunities.

The lack of a current learning, education and development policy appeared striking, incongruent with the espoused values in the workforce development strategy. This workforce development theme was clearly set out as a corporate objective in the Annual review for 2011/12. This annual review document was a brochure type publication available for members of the public in the hospital main entrance. A summary of findings from trust staff in the NHS Staff Satisfaction Survey was summarised. Areas of strength, areas with improving scores and areas scored lower than in similar trusts were highlighted.

This hospital trust compared more favourably with similar trusts in

- Percentage of staff feeling satisfied with the quality of work and patient care they deliver
- Percentage of staff reporting good communication between senior management and staff

Improvements were noted in the number of staff appraised with personal development plans in the past year. However appraisals were noted as an area in which the hospital scored less favourably than similar trusts.

Whilst key informants tended to look outwardly and have a wider scope of work and view point, the participants' focus was invariably to their role and their ward

area, inward looking almost, showing a self-absorption. Whether through lack of time, opportunity, or interest, little if any comment was made about the wider organisation, almost as if it was unseen. Hospital-wide policy and strategy were not discussed. Ruby alone, talked about being able to locate policies on the staff intranet if needed, she had identified policies that she thought could be of value to her; the managing sickness and absence policy for example:

Because we have got on the intranet about sickness policies, about, and whatever we need for education for management, maternity leave, flexibility in the working hours, everything [it's] on the intranet,
Ruby, page 10, comment 57

One of the key informants referred to the organisation's open forum as a point for communication with the senior team. Of the participants, only Maria talked about an 'open forum for staff' being held monthly by the Senior Executive team. When asked if this was a forum she could attend, she appeared dismissive, derisive almost, talking about dealing with more pressing issues than attending a staff forum.

The changes occurring across the hospital trust as a whole had wide ranging impact. The effect on staff morale and motivation was noted by one senior nurse who was based on the smaller hospital trust site:

How do people cope with the uncertainty? They are very let down, loss of motivation,
Senior Nurse 4, page 9, comment 54

Two of the three participants based at the second and smaller hospital site talked about their uncertainty about the future for their hospital site. A feeling of 'them and us' was shared- the larger hospital site being the one where decisions

were made affecting the whole hospital trust. Not knowing what the future held for them was unsettling for Hannah and Maryam.

Two participants considered that the matron's role added a layer of unnecessary bureaucracy; decisions about spending should have been taken by their ward sister/managers, but authority for this was not delegated to them. Maria expressed the view that the roles of matron and head of nursing blurred, talking about too many leaders and not enough workers.

The need for continuing support for ward sister/managers across the organisation was commented upon by key informants. A newly developed support forum for ward sister/managers was established to provide a support network across the organisation. This forum, the ward sister/manager's council, designed to enable networking and support, had been conceived by the Director of Nursing but established by another senior executive nurse in the organisation. The potential of this forum to support was recognised by two key informants:

That [WM council] is very useful ... I network with a lot of other senior WMs,
Senior Nurse 3, page 5, comment 40

If you share something [at the WM forum] someone may have had to deal with that already.
Senior Nurse 2, page 11, comment 122

It was noted that this forum was not mentioned by any participants during the first round of interviews. When asked about support for development for aspiring leaders, beyond the local area of practice, no one identified this forum. Amongst

the other key informants, one, although a ward sister/manager, had not heard of the forum at all. Another of the key informants viewed this forum as an opportunity to convey information over to the ward sister/managers. A development and supportive focus was not identified. One key informant, Senior Nurse 3 who was a ward sister/manager, had attended this forum and considered it helpful in sharing problems – the focus appeared to be on working with and solving process issues. At the time of the final interview meeting in 2013, Alice, who was now a band seven and participating in this forum highlighted the less positive aspects of the forum:

if they've put the meetings a little bit too close together then people haven't got serious concerns, they generally just come to whinge about something,
Alice, page 5, comment 41,

The potential of this forum to offer support and encouragement, role modelling and examples of best practice appeared to be reduced to a more mechanistic approach to dealing with problems – for example how to order water for the water coolers.

6.7 Evolution of a model of transition

The themes presented in this chapter reflect the different components of knowledge and understanding for participants and key informants. The existence of guiding policy and strategy has been examined; the relevance of this for participants and key informants explicated. The significance that this knowledge and understanding has had for individuals has varied. The thematic map was first introduced in the methodology chapter at the end of section 5.9.3. This thematic

map, which emerged through the data analysis process, has supported the presentation of data from the case study. This has been insufficient however to explain the evolving relationships and interconnections between themes.

Through the iterative process of data analysis, supported by entwined reflection and reflexivity, alone and with the support of critical supervisory input, I have conceived a conceptual model to illustrate those relationships and interconnections that affect the experience of transition from staff nurse to ward sister/manager. Reflections detailed in my research journal enabled me to engage in a continuing reflexive dialogue to uncover the patterns and relationships between themes and to create a means of communicating that to others. What has been constructed through this process is a model of the transition from staff nurse to ward sister manager in the context of this case. This model reflects the very complex interplay of dimensions and themes that comprise this transition (Figure 6.2) and its composition has been detailed in the remainder of this section. This figure may be read from the bottom up or the top down. If read from the top down, each level (or dimension) impacts or influences the level below. If read from the bottom, then level one, the level of self-fulfilment serves as foundational level, upon which level two, the level of professional purpose, impacts and influences. The departmental level of work then impacts upon the levels below and in turn, the organisational level impacts upon the departmental level.

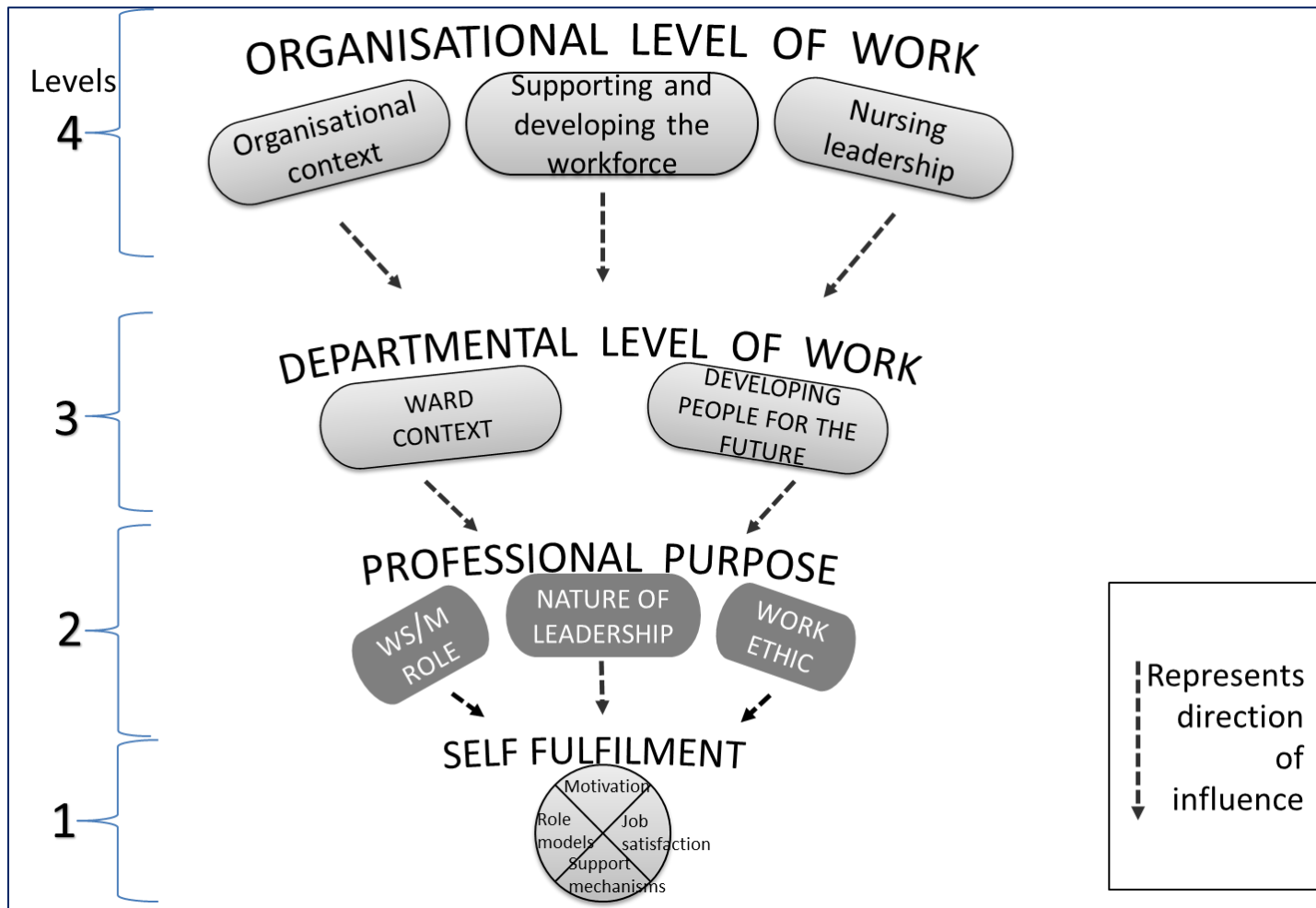


Figure 6.2 Model of the transition from staff nurse to ward sister/manager

In the initial thematic map presented in Figure 5.7, self-fulfilment was visualised as one of four dimensions. What has evolved however, is that rather than sitting as one of four equal dimensions, self-fulfilment appeared to be the very essence, almost the foundations of the conceptual model and that is how this has been interpreted. This has been configured as level one in Figure 6.2, to reflect its foundational status. This dimension of self-fulfilment consists of themes: motivation, job satisfaction, the place of support mechanisms and role models. These themes sit together, side-by-side, and perhaps surprisingly, comprise both internal and external factors. Motivation and job satisfaction, which might be considered as internally driven factors, sit in close proximity to support mechanisms and role models which were factors external to the participants. What was demonstrated through the empirical evidence was that these internal and external themes coalesced to varying extents to contribute towards self-fulfilment. Whilst these themes have been envisaged as consisting of similar size, the interplay between these themes inevitably varied from participant to participant. From the empirical evidence, it has not been possible to identify a hierarchical relationship between these four themes, they sit together more as a foundation level, although one segment may be stronger, having greater resonance for some participants and at one time rather than another.

Themes relating to the professional purpose, established in the thematic framework, comprised the ward sister/manager role, work ethic and the nature of leadership. These themes sit around the foundational dimension, identified in Figure 6.2 as level two. The three themes comprising this dimension; the ward

sister/manager role, work ethic and the nature of leadership have been conceived as equal components of the framework, although they may appear differently sized to accommodate the length of text in the titles. Their significance may vary from participant to participant, from department to department, however. These themes are intentionally portrayed as sitting side by side, touching perhaps, but not enclosing, the foundation level, the significance of which is explored in the discussion chapter.

The dimension of the departmental level of work is situated above dimensions 1 and 2, almost as a ceiling. This dimension consists of the themes of the local context of work, the ward or department and the local approach to developing people for the future. The presence of this layer reinforces the fact that the core of foundational level of self-fulfilment, and the level two dimension of professional purpose are all situated within the departmental level of work. This level constitutes the local environment in which participants work, and influence their experience and is influenced by them. Although it is conveyed as a solid structure, it is not immune or impassive to the influences of the organisation. Thus the organisational dimension sits over the departmental level influencing the themes below it. This organisational dimension comprises the organisational context, nursing leadership, and supporting and developing the workforce. These themes are depicted as separate themes, situated in close proximity, but not touching. The lack of connection between these themes appears significant, and this is explored further in the discussion chapter. These four dimensional layers of the conceptual model, thus described, then come together to form the composite

model which reflects the navigation of the transition from staff nurse to ward sister/manager (Figure 6.2). Individual components of this model may vary in intensity and personal meaning, the local area of work may have greater significance in some areas and the organisational level of work may have overwhelming significance in others. The model itself represents the interplay between themes and dimensions that emerged from the data. The relevance of both the individual levels and the entire model are explored in chapter seven.

I have conveyed, in my narrative, the possibility of variation in this model and that is indeed the case. This variation exists in terms of the relative significance of themes, rather than whether the individual themes are pertinent. The themes themselves are a stable part of the model. The model may be re-drawn, illustrating its significance for each individual participant. This model might then show variation at all levels; with motivation depicting itself differently from one person to another, job satisfaction having greater or lesser significance, the department supporting aspiring leaders, or merely accommodating them. The nature of support that is needed and available to participants is varied. That is not to say that variations occur solely at the level of individual participants, dependent only upon the intrinsic motivations and abilities of those individuals. The nature, the essence of the department or ward, effects, supports or even undermines the attempts of those within it to perform and develop. The organisation is situated at the edge in this model, however this impacts directly and indirectly at both the departmental and individual level.

6.8 Chapter Summary

Throughout this findings chapter, the richness and variety of data has been presented. Themes presented in the findings chapter are both explicit and implicit and these will be further developed and analysed in order to bring an answer to the underlying research questions in focus.

Reported in the findings chapter of this thesis is a portion of the detail, some of the underpinning material that supports the development of themes and concepts. I have strived to demonstrate, to illustrate through the findings chapter how codes emerged from the data and I have endeavoured to illustrate the manner in which codes became categories and categories evolved into themes, and themes into dimensions. In reality this has been an iterative process, a complex endeavour and conveying this in writing has not been straightforward. The writer must represent, what is in effect, an evolving process as something a little more flat and linear. Whilst the written word presented here may give the impression of a smooth and seamless process, the journey for the researcher has been complex and far from streamlined. Maxwell (2012) has reported the challenges of moving from data analysis to synthesis. He referred to the difficulties of analysis using a thematic approach that has a tendency to enable the researcher to have a micro focus but lose sight of the whole picture. To counter this risk, the researcher moves between micro and macro focus, from convergence to divergence, in a continual cycle of evolving analysis. This fluid cycle of convergent thinking and divergent thinking has continued throughout the writing of this research thesis. The nuances of the data analysis, moving back and

forth in this way can be confusing and yet a spark of enlightenment is possible, that glimmer, that something that makes the researcher feel that they have elucidated a hitherto unseen or unknown concept. In the next chapter, these findings are explored in the context of the literature.

Chapter 7 Discussion

7.1 Introduction

From my matrix of data, I have offered a conceptual model as a way of describing what is occurring in this transition from staff nurse to ward sister/manager in the previous chapter. This chapter is presented in four main sections to answer the research questions which framed this study, utilising the conceptual model to facilitate this. The experience of transition from staff nurse to ward sister/manager is considered first in section 7.2. Section 7.3 then considers the ward sister/manager role itself, from the perspectives of participants and in relation to the configuration of the role. Following this, the third main section, section 7.4, considers the culture of the organisation in which the aspiring ward sister/managers work. The fourth and final section, section 7.5, considers the impact that these factors have on the process of transition from staff nurse to ward sister/manager. In this chapter, I have provided, created and developed the links between the study findings and the literature reviewed and beyond, resulting in a critical depiction of what is known and what is not known. Synergies, syntheses and variations are presented and argued. The new contribution to knowledge uncovered through this study is presented in the concluding chapter.

The case that has been the focus of this study (Figure 5.1), is that of an NHS organisation, consisting of two hospital sites, within which the explicit focus of interest has been the key actors associated with the transition from staff nurse to ward sister/manager.

7.2 What is the experience of transition from staff nurse to ward sister/manager

This experience of transition from staff nurse to ward sister/manager is presented through four sections, the first being the nature of transition. The second section considers the experience of self-fulfilment, the third being motivation and job satisfaction and the fourth being the presence or absence of supportive role models. For participants, the personal sense of what is satisfying and gives personal fulfilment, thus shaping development, aspirations and drive for the future was noted. Motivation and self-fulfilment have been identified as significant themes in this study, although not evident in the extant literature reviewed in chapters three and four, thus relevant literature has been introduced to support and challenge the data obtained.

7.2.1 The nature of transition

A transition is a relatively brief passage from one role to another, something that might be navigated seamlessly. The significance of a more encompassing view of role transition is not something immediately visible or explicit to participants. Indeed, critical realists seek to uncover processes and structures which are not easily identifiable or visible to others: the processes involved in a complex transition from one role to another, being invisible to those undergoing this transition. The literature exploring the challenges and potential lack of appeal of the ward sister/manager position, however, supports that this transition process has warranted in depth exploration and understanding.

The process of role transition has had a considerable focus in the psychological literature but less so in the nursing literature, and indeed was primarily unremarked in the literature pertaining to ward sister/manager development. Early work by Schumacher and Meleis (1994) identify three aspects to the transitions literature relevant to nurses and nursing, of which the situational and organisational approach to transitions is most relevant to the role transition considered here. The focus of nurse researchers has mostly taken two directions: that of illness transition (Meleis et al, 2000; Schumacher and Meleis, 1994), and that of the transition from student to qualified nurse (for example, Edwards et al, 2015). Transition as a concept has not been widely used to refer to changes in job role after qualification unless moving into a completely different dimension; for example from practitioner to educator (Manning and Neville, 2008) or from qualified student to community nurse (Ewens, 2003).

Ashforth (2001) situates the 'role' alongside the 'role set', the 'others' upon whom one is dependent and interdependent. The role set of the ward sister/manager thus consists of relationships with junior and senior nurses, therapists and medical colleagues alongside those of service users, carers and, or relatives. Through this lens of interpretation, role transition is not simply a linear move from one boundaried role to another. It is the process of moving and being given permission to move, to change from one role to another and being supported in enacting all stages of this transition. Ashforth (2001) proposes that the process of role transition can be examined with the help of Kurt Lewin's Field

theory (1951), suggesting that the three stages of unfreezing, moving and refreezing can be readily applied to role transitions.

A three-staged approach to transition, following Bridge's transition theory (2003, 2009) was utilised by Manning and Neville (2009) and Duchscher (2009) to situate their research findings. The stages of ending, the neutral zone and beginnings, would appear to be closely linked to Kurt Lewin's stages of movement and equilibrium. Participants in this study talked about components widely accepted as being part of the role transition process, although the language of transition did not necessarily appear to resonate with them.

Changing identities as a key component of transition was highlighted by Spehar et al (2015), who argued that a lack of identity change can impede the transition. Identity was defined as "one's perceived self, (whereas) a role is defined by a position in social space" (Spehar et al, 2015, p354). Ewens (2003) conflated the two terms referring to role identity when exploring the change from student to community nurse practitioner. The ending stage, characterised by letting go, exiting the old role (Ashforth, 2001; Bridges, 2003, 2009), was not something apparent in the language from key informants or most of the participants. One participant, Hannah, appeared to be dealing with this as an unresolved challenge however; her reluctance to wear the new uniform appeared to signify her unresolved role exit state. This realignment of these identities was similarly highlighted by Spehar and colleagues (2015).

Principally, it might appear that the transition explored in this research is from one boundaried role to another, from staff nurse, or similar title, to ward sister/manager. Indeed neither participants nor key informants referred to the multiple roles that are widely recognised as constituent parts of the ward sister/manager role (Bolton, 2003; Firth, 2002; McCallin and Frankson, 2010; Pegram et al, 2015; Willmott, 1998). The ward sister/manager role has been identified widely as a multifaceted one however (Pegram et al, 2015), and this may compound the challenges of transition. Maxwell et al (2013) and Spehar et al (2015) have suggested that clinicians may need to draw on different identities to be a manager. This may compound the difficulties of exiting the former role; the individual may be exiting the role in its entirety, as in the move from student to qualified nurse, or they may be retaining aspects of it. The role of clinical nurse, carer, and expert practitioner is retained with a new managerial and leadership component added in or intensified. Nurses' professional identity revolves around caring for individuals and it is acknowledged that many ward sister/managers continue to find the clinical practice component of their roles essential and fulfilling (Firth, 2002; McEwen, 2005). It is less clear whether the leadership and management components of the role are equally fulfilling.

From a critical realist perspective, the transition stages experienced and navigated were mostly invisible. Participants in this study who were at varying stages of this transition process could not evidently identify the transition stages that are recognised in the literature (Ashforth, 2001; Bridges, 2003, 2009).

Being situated in the midst of a process that is affecting oneself, it may be difficult to identify with any degree of detachment, the finer nuances of that transition process. Stages of letting go, movement and establishing the new roles were difficult to elucidate from either participants or key informants with only a few notable exceptions. Those participants who were interviewed at subsequent time points, Alice, Evelyn and Hannah, did not elaborate further on this process. No new insights were apparent to them with regards this transition process, when further through it. Whether this is a reflection on a lack of critical reflection, or merely the near impossibility of rendering the implicit visible is uncertain; identifying the nuances and processes underpinning the changing subtleties of daily practice would appear to be challenging for all.

This lack of awareness of the transition stages, suggest various potential avenues for consideration; the first is that participants' impressions of their developmental needs with regards the move to a ward sister/manager position, whether accurate or not, do not waiver over time. Thus, their perceptions of the development needs are quite accurate early in their leadership journey. A second possible avenue for consideration is that these processes involved with transferring to a new role, which are expected by those in the wider role set to be straightforward, are hidden to all but the most investigative and critically reflective minds, thus others overlook the complexity or fail to understand it. There may be hostility towards the newcomer, resentment that time and effort should be focussed on supporting a new generation of aspiring ward sister/managers when that was not the case previously, and practitioners had to

navigate the process in silence. Hostility within the profession, termed horizontal violence, has been referred to elsewhere in the literature (Roberts, 1983; 2009).

7.2.2 Self-fulfilment

For participants, aspects of motivation, job satisfaction and support mechanisms including role models, appeared to coalesce; this interplay or connection between these themes created the important, centralized theme of self-fulfilment. Self-fulfilment was not explicitly talked about and perhaps this is unsurprising. Maslow proposed that “self actualization is the desire for self-fulfilment ... the desire to become more and more what one is, to become everything one is capable of becoming” (Maslow, 1943, p382), but that motivational needs and the need for self-fulfilment are not always explicit and available for conscious evaluation. Critical realists conceptualise the ‘real’ level of ontology as consisting of hidden structures, causations and mechanisms that allow the empirical or observable, and the actual to exist. Self-fulfilment may perhaps be conceived in this manner. Nursing is generally seen as a selfless profession, characterised by caring for others (Bradshaw, 2010). It might seem that a focus on self-fulfilment conveys a kind of self-absorption or selfishness that would not be congruent with the values of nursing. It may be of course that self-fulfilment was really not specifically recognised by participants as a need. This is not to say that fulfilment was evidently achieved by all of them. Participants highlighted areas that did not give them satisfaction, and indeed one participant conveyed self-doubt and some insecurity perhaps, suggesting a lack of self-fulfilment. Maslow's seminal theory of self-actualisation demonstrates the now-

familiar pyramid structure, basic safety and security needs being the underpinnings without which higher level needs are almost irrelevant. Thus, for this particular participant perhaps the Maslow's lower level needs of safety and security were not met sufficiently. Maslow's theory suggests that self-actualisation is thus not achievable until these basic level needs can be met.

Whilst Maslow's work has been much critiqued since its inception (Kanfer and Chen, 2016), and motivation and engagement have been explored through varied and numerous theoretical lenses, there is a persisting intuitive appeal to his pyramid of human needs.

Whilst Maslow's concept of self-actualisation appears to receive little if any focus in the more recent ward sister/manager or nursing leadership literature, Boomer and McCormack (2010, p638) have used the concept of "becoming", and Miskelly and Duncan (2014) have highlighted the significance of developing professional maturity. Persson and Thylefors (1999) considered the development of both personal and professional maturity amongst ward sister/managers, commenting that well developed personal maturity was a precondition for professional maturity. Participants and key informants implied the need for personal maturity in this study, rather than explicitly acknowledging it openly.

Wider empirical evidence relating to the ward sister/manager role and development of the individual in this role, has often concerned itself with the nature of the role, the tasks and elements required to undertake the daily work (Locke et al, 2011; Pegram et al, 2015; Williams et al, 2001). Whilst Wise (2007)

and Sherman (2005), have commented that the role might no longer be an appealing one to more junior staff, it appears that researchers have not explored the degree to which self-fulfilment is important and the degree to which self-fulfilment may be achieved through this ward sister/manager role. The literature which explores ward sister/manager roles, and within that explores factors that give satisfaction or challenge, takes a necessarily individual approach (Pegram et al, 2015). Implications for employers may be suggested, but there is little evidence in the research literature that organisations are exploring motivating factors, or seeking to further understand the need for staff to achieve self-fulfilment. Indeed, whether the ward sister/manager position is configured to offer the prospect of job satisfaction and self-fulfilment, appears to remain unchallenged. In addition, authors refer to a key difference between the factors that may motivate an individual to seek a new post and the motivating factors that might keep them in post (Persson and Thylefors, 1999) and this has not been widely explored in relation to the ward sister/manager role.

7.2.3 Motivation and job satisfaction

As evidenced by the data presented in chapter six, all participants appeared motivated and, with the exception of Hannah, all reported experiencing job satisfaction. Motivation emerged from this study as a category within the theme of self-fulfilment; participants demonstrated their motivation through their commitment to learn, their commitment to develop in their existing role and in some instances their commitment to look to the next role. Motivation and job satisfaction as concepts have received much attention in the psychology research

literature (Maslach and Leiter, 1997; Maslach et al, 2001) and increasing interest in the nursing literature (Adams and Bond, 2000; Laschinger et al, 2001; Laschinger et al, 2014; Lee and Cummings, 2008). These concepts have been explored individually and synergistically and are connected with concepts of engagement and on a continuum with the concept of burnout (Maslach and Leiter, 1997).

Participants' work ethos emerged strongly, however there was no explicit discussion about how the individual work ethos might be used to support, teach or influence others. A number of participants did comment on their awareness and, arguably, their disappointment that all colleagues did not necessarily share the same values, but no clear suggestions as to how they might use their own influence to endeavour to change this. This sharing of values and the ability to work together as a team was correlated with job satisfaction in Adams and Bond's study (2000). Participants talked openly about their love for working directly with patients, and that their fulfilment came from this over and above anything else. Freeney and Tiernan (2009) reported similar findings from their focus group data, encapsulating this as intrinsic reward. They postulated that this may be important for a nurse's level of engagement.

Participants appeared empowered to develop their practice and do the best for staff and patients in their clinical areas. One participant alone, Hannah, did not appear to share this overt sense of empowerment. Hannah expressed real uncertainty about her right to be in the current role; the sense of powerlessness

and hopelessness was palpable at times and this has been acknowledged as a marker of burnout (Maslach et al, 2001), the antithesis to engagement (Freaney and Tiernan, 2009). Whilst participants and key informants conveyed an acceptance of their self-worth, for Hannah this appeared in doubt. Low self-worth has been linked to demotivation and inversely linked to job satisfaction (Laschinger et al, 2014). Self-worth has been linked with competence and capability to form the concept of core self-evaluation – (CSE) (Chang et al, 2012) and Laschinger et al (2014) in their longitudinal study have proposed a possible link between individuals with a high level on the CSE scale and job satisfaction. Indeed, Laschinger et al (2014) suggested that a managerial approach to strengthen nurses' CSE would appear to be as important as creating empowering work places that support high quality professional practice.

Whilst for most participants and key informants, the ward sister/manager role was valued in an almost unquestioning fashion, for Hannah, the value of the role of ward sister/manager was not quite so certain, and her occupation in that role, in an acting capacity, appeared uneasy. This relationship between an individual and their role has been termed as 'work engagement' (Schaufeli, 2013). Schaufeli (2013) has referred to confusion and thus conflation in the literature between the terms 'employee engagement' and 'work engagement'. Whereas the two terms refer to separate but related entities, "work engagement refers to the relationship of the employee with his or her work, whereas employee engagement may also include the relationship with the organization." (Schaufeli, 2013,p35).

In relation to engagement, it is necessary to consider both the micro, or local level and the macro, or organisational level. Hannah's commitment to her local workplace was strong. A passion, a commitment to do the best for patients in her clinical area, was clearly articulated. Commitment to the wider organisation was much less certain, evidenced by doubt, criticism, and dismissive news of the predominant culture. Other participants appeared to demonstrate work engagement as defined by Schaufeli (2013).

7.2.4 Role models for support

All participants highlighted the value and contribution of significant role models to their aspirations, their development and their progress. These aspirational role models appeared to be almost chance happenings however. It transpired as a lucky occurrence, when someone started to identify with their current ward sister/manager as a positive role model. Key informants, however, commented on an apparent lack of credible role models for these aspiring ward sister/managers. A view was put forward that many ward sister/managers who should be acting as positive role models to their team, were in fact not doing so, either because of lack of interest or ability.

Participants clearly identified negative role models and these had varying effects; for example, this was strongly motivating for Evelyn, striving to be different from the negative role models around her. For Hannah though, a lack of positive role models and a lack of constructive support from the role models around her

culminated in feelings of self-doubt, low self-worth and a lack of confidence in her ability to carry out her current position.

Role modelling to support aspiring ward sister/managers, as an active strategy, has not been explicitly explored in the literature pertaining to the ward sister/manager role. Authors have referred to ward sister/managers as being role models but this has been reported in a somewhat vague manner, often the result from a survey to explore the nature of a role (Bonner and McLaughlin, 2014; Carlin and Duffy, 2013; Pegram et al, 2015; Russell and McGuire, 2014).

7.3 The ward sister/manager role

In seeking to explore and understand the transition from staff nurse to ward sister/manager, comprehending the extent of the ward sister/manager role proved important. The nature of the ward sister/manager role, situated in the conceptual map under the dimension of professional purpose, influenced participants' views and thus their experience as aspiring ward sister/managers. The role, situated within a local department within the wider organisation, is impacted upon by organisational factors and processes. Discussion pertaining to the role is therefore subdivided into three sections: participants understanding of the role, the configuration of the role and the nature of leadership demonstrated through the ward sister/manager role. The culture of the organisation is explored in section 7.4. The impact of this culture upon the process of transition to the ward sister/manager role is considered in section 7.5.

7.3.1 Participant understanding of the ward sister/manager role

While participants in this study commented on the changing role of the ward sister/manager, none expressed the view that the role was irrelevant or superfluous. The ward sister/manager role was one that participants were still enthused by, although there were elements of this role that were evidently more attractive than others. The desire to retain direct contact with patients was articulated clearly as was the concern about losing time and presence in the clinical environment. Participants in this study were anxious about losing the clinical contact that most of them valued highly. In contrast, Pegram et al (2015) stated that ward sister/managers wanted protected administrative time, rather than protected clinical time. The potential contradiction is evident here, but a misunderstanding that might ensue perhaps stems from the failure of Pegram et al to clearly define and delineate what is meant by clinical time. Participants in this study conceived of clinical time as time spent in contact with, caring for or talking to patients. It is not clear in Pegram et al (2015) that a clinical component to the ward sister/manager role comprised actual patient care. This criticism of a lack of specificity can be levelled at a number of other papers exploring the ward sister/manager role; references are made to clinical role components but it is not clearly as to the exact nature of this component (for example Locke et al, 2011; Williams et al, 2001) . Whether this component involves being shift coordinator, assisting with direct patient care or caring for one or more patients is unspecified.

Russell and McGuire (2014) reported that supervising and evaluating local practice was key for the role of ward sister/manager (SCN in Scotland). Band five

(staff nurse) participants in Carlin and Duffy's study (2013, p27) identified that good ward sister/managers (SCNs) were good at caring for patients as well as their other role, but whether this was a regular role of their ward sister/managers is unstated. 'Good at caring for patients' does not necessarily imply that expertise was required or identified.

Participants in this study referred to aspects of their ward sister/managers' practice that they admired, although none of them talked explicitly about the ward sister/manager as a role model. Alice did refer to how the ward sister/manager taught more junior staff and was approachable, unlike ward sister/managers in other areas. Alice specifically talked about the manner in which the ward sister/manager carried about their work: the manner in which this individual supported junior staff and taught them but never humiliated them. Carlin and Duffy (2013) and Dierckx de Casterlé et al (2008) similarly noted the support and teaching provided to junior staff. Ruby talked about watching the way their senior colleague dealt with relatives in a situation that was difficult. She referred to watching and learning and reflecting on the experience to develop her own practice. The ward sister/manager's demonstrable caring role, through delivering patient care has been identified (Lewis, 1990; McEwen et al, 2005) and has been appreciated by junior nurses (Carlin and Duffy, 2013). Similarly, participants and key informants in the current study valued the caring role of their ward sister/managers in their earlier careers. Leading by example (Agnew and Flin, 2014) and offering advice and expertise (Firth, 2002) have been noted as part of the ward sister/manager role.

This singular focus upon patient care and patient contact is understandable; this after all has been the essence of nursing care that participants have been concentrating on since qualification. The delivery of skilful patient care has been the core component of nurses' professional identity (Croft et al, 2015; Currie et al, 2010). Participants and key informants were clear about this component of the role being the one that gives the feeling of satisfaction, which was similarly identified by Doherty (2009) and Pegram et al (2015). Stanley (2006a) proposed a dissonance between the clinical and managerial components of the 'clinical leadership role', with conflict and confusion and challenges to clinicians' values and beliefs being manifest.

Whilst the concept of ward sister/manager as expert has been long established (Lewis, 1990), participants, with the exception of Alice, did not specifically identify clinical expertise as a major requirement for the ward sister/manager role. However, those in specialist areas did reflect on the knowledge that was shown by their ward sister/managers, and how important this was. This component of clinical expertise would appear to have been lost from the translation of the role in more recent years with the managerial aspects of the role taking precedence over clinical expertise (Bolton, 2005; Bonner and McLaughlin, 2014; Hewison, 2012). Russell and McGuire (2014) however, refer to SCNs providing clinical expertise as part of the Scottish Leading Better Care policy. McEwen et al (2005) reported that three quarters of the ward sister/manager sample considered providing direct clinical care was one of the most important

components of their role, however the majority of their ward sister/managers reported they had insufficient time to evaluate the clinical practice in their areas. It is unclear from this and from other studies whether ward sister/managers are undertaking any direct care themselves.

Pegram et al (2015) noted that the majority of their ward sister/manager participants - 87.7%) reported strong agreement that leading by example was part of the role, however only 75% of participants reported strong agreement that clinical expertise was part of the role. How leading by example could be achieved without the existence of clinical expertise is uncertain. To put Pegram et al's (2015) findings into context however, their sample of seventy five participants reflected a 34% response rate from their target population, and of those respondents, only sixty four actually responded to this item.

The ward sister/manager role, from the perceptions of participants in this study, was one of overseeing and one of control as with Russell and McGuire (2014) who identified this as a supervisory role. Ericsson and Augustinsson (2015) reported that ward sister/managers have become far more managerial through changing reforms, the direct supervisory component from previous years lost in what has become a purely managerial role. Pegram et al (2015) also reported similar results from a survey of ward sister/managers in one NHS hospital. The nature of the ward sister/manager post encompassing multiple roles, has been reported across the United Kingdom and beyond. It should be noted however that in Pegram et al's (2015) study, ward sister/managers were asked to complete

multiple surveys, one of which was to seek agreement on predetermined roles. It is possible that if the ward sister/managers themselves had been interviewed, they might not have spontaneously identified all of these roles. These multiple roles created tensions at times with the clinical component of roles being subservient to the managerial components. Locke et al (2011) refer to the administrative burden of the role and, in parallel, ward sister/managers in one study reported a lack of clerical support for administrative tasks (Williams et al, 2001). Ward sister/managers in Bolton's study (2003) had mixed feelings about this, some finding these multiple roles challenging and some rewarding. Pegram et al (2015) report that ward sister/managers in their study generally valued the many roles that they took on, although in their rating tool, this aspect achieved a mean score barely above the half way point, thus the comment that most ward sister/managers valued the variety of roles' is perhaps overstated, as 30% of their sample specifically disagreed with this point.

Managerial requirements associated with the ward sister/manager role were referred to but were not disputed by participants; the need to undertake them was never in question, although this was not relished. The exact nature and purpose of these managerial roles was not obviously considered. Besides completing duty rosters and overseeing staffing and equipment ordering, participants did not identify a greater purpose behind these administrative and managerial responsibilities. One key informant noted with irony that ward sister/managers complained about completing audits that were designed to enable them to evaluate and benchmark their service. This lack of a wider vision

for the role and for their practice area was evident from all participants whose focus tended to be inward looking and somewhat insular. Key informants with trust wide roles through necessity displayed strategic thinking. In contrast, Ericsson and Augustinsson (2015) noted that first line managers in Sweden (ward sister/managers) were part of the management system, but integrated with the nursing team. Despite being part of the management system, these ward sister/managers reported that they were at times, in effect, excluded from it, feeling in limbo between the two systems (Ericsson and Augustinsson, 2015).

Participants in this study did not articulate any clear separation between leadership and management skills, in line with much of the nursing literature. Indeed, most of the role tasks that participants talked about, associated with the ward sister/manager role, were primarily managerial. Leadership as a discrete concept was identified only by two of the key informants. In view of the lack of clarity in the literature about the distinction between leadership and management, it is unsurprising that these participants were no exception. Nuances of leadership were identified by a number of participants, but this was not recognised as leadership as such. This is further explored in section 7.3.3.

7.3.2 Configuration of the ward sister/manager role

Several of the key informants talked specifically about the need for the ward sister/manager to act as a positive role model for their team of nurses. Key informants reported that taking on a senior team role and subsequently leading the team, appears to happen by chance for many, and consists of a skill that is

expected to be acquired through doing, entirely dependent on the leadership that has been experienced. This is a development that requires further consideration. Skilled ward sister/managers may be seen as needing to be skilled at delivering clinical practice, but whilst researchers and practitioners articulate the need for ward sister/managers to be better leaders in broad terms, it appears that developing expertise in leadership itself is not evidently recognised as a need. This was highlighted by one of the key informants referring to ward sister/managers almost 'slipping into roles', similar to findings from Spehar et al (2012), who referred to participants being thrown into the job and learning on the job. The assumption appears to be, therefore, that the ward sister/manager is predicated on expertise in practice, but that the leadership skills required must be learned in the role; for example the skills to inspire the team and to develop the next generation. Indeed this extrapolation is not unreasonable, considering that most reported leadership development programmes for nurses are offered to those already in ward sister/manager positions (Boomer and McCormack, 2010; Cunningham and Kitson, 2000a, 2000b; Dodwell and Lathlean, 1987; Duygulu and Kublay, 2011; Jasper et al, 2010; Martin et al, 2012), rather than to aspiring ward sister/managers.

Changes to the ward sister/manager role over time were reported by participants. These views support others who have commented that the ward sister/manager role has undergone considerable change over the past 30 to 40 years (Bradshaw, 2010; Lewis, 1990; Locke et al, 2011; Williams et al, 2001; Willmot, 1998). The ward sister/manager has taken on additional roles that are

primarily concerned with management. This change, whilst welcomed by some (Pegram et al, 2015) is reported as unwelcome by others who view that the move to a managerial role devalues the clinical expertise associated with the role and replaces it with an administrative function (Willmot, 1998; Bolton, 2003, 2005; Hewison 2013). These views resonate with those expressed by key informants; for example Senior Nurses 1 and 2 considered that the post was not a particularly attractive one, and not necessarily one that nurses would aspire to because the increased administrative burden was excessive, the ability to deliver and role model hands on care was reduced. In addition, the remuneration for the post would potentially decrease, due to the loss of additional payments associated with unsocial hour working.

7.3.3 The nature of leadership demonstrated through the ward sister/manager role

Participants did not readily explore the nature of leadership taking place in their areas of work, although several participants provided examples of good practice. This could be because good and significant leadership behaviours were not witnessed, not visible, or perhaps because behaviours were identified but not isolated as facets of leadership. Indeed, newly qualified staff in Carlin and Duffy's (2013) study could not identify leadership activities when asked, instead listing managerial tasks. This lack of visible leadership may be linked to a more general lack of visibility of the ward sister/manager figure. This lack of visibility of ward sister/managers was identified by staff nurse participants in Carlin and Duffy's (2013) study and by Ericsson and Augustinsson (2015). This challenge with

identifying leadership is indirectly reflected by Stanley (2006a, 2006b) who reported that clinical leaders in one organisation were identified amongst practitioners at grades E, F, G (staff nurses, senior staff nurses and ward sister/managers) and matron level, but most often were identified amongst F grade nurses (See Figure 1.1). Russell and McGuire (2014) commented on the improved relationships developed by SCNs who had increased their visibility and had more time in contact with patients. The visibility and nature of leadership were seen as vital for the success of a productive ward improvement programme in Clarke and Marks Maran's study (2014). Persson and Thylefors (1999, p70) have referred to "consideration and people orientation" as being essential for ward sister/managers.

While values-based leadership was espoused through the organisation's workforce strategy, neither participants nor key informants discussed any particular theoretical approach to leadership. The intention to develop transformational leadership approaches has been noted, especially in those development initiatives that utilised validated leadership assessment tools such as the LPI (Duygulu and Kublay, 2010; Fealy et al, 2015; McNamara et al, 2014; Martin et al, 2012; Patton et al, 2013).

7.4 Culture of the organisation

The empirical evidence presented in chapter six identifies components of the culture of this organisation at both the departmental level and the level of the organisation itself. This section comprises four sections, the first of which is a

consideration of the departmental level. The three remaining sections consider the organisational level, comprising nursing leadership within the organisation, the organisational approach to supporting and developing the work force, and approaches to succession planning for the ward sister/manager position.

7.4.1 Departmental level

In the local area, the level of the department or ward, the focus was upon what support mechanisms had been available for participants themselves and what they identified in their wards and departments that supported others. A number of supportive mechanisms were identified by individuals: shadowing, learning on the job, support with education, leadership development programmes and having a supportive ward environment. Amongst the participants, Alice alone referred to a purposeful process to support her to succeed her ward sister/manager and, in tandem with this, a process to support her successor. Her acknowledgement of the need for this succession planning process across the wider team was not recognized specifically by other participants.

Ruby talked about undertaking a short term acting position, although these opportunities were realised on a shift by shift basis, unlike Brunero et al (2009) who reported on short term relief positions of six months or longer. Valuable shadowing opportunities were undertaken by Evelyn and Senior Nurse 4 but unlike reported initiatives from Abraham (2011) and Coughlin and Hogan (2008), these were not part of a broader succession planning initiative. Shadowing was not identified either by other participants or key informants. Senior Nurse 2

noted the existence of acting positions, however reflecting that the individual may slip into the ward leadership role from an acting position without having the appropriate skills. The lack of structure was arguably more of a concern than acting positions themselves.

Participants did not identify mentoring at anything other than an individual level and there was no discussion of ward based strategies to mentor qualified staff with a view to supporting development. Whilst two key informants considered that there was a value to a more organisation wide approach to mentoring, Senior Nurse 5 was firmly of the opinion that mentoring needed to be implemented at a local level and was the responsibility of the ward sister/manager. Participants did not all appear to recognise a ward/department level approach to supporting and developing junior colleagues, although Alice discussed her broad approach to supporting staff in her area and Maria talked about endeavouring to meet all her team members on a monthly basis. Formal mentoring strategies and the allocation of mentors to support development were reported on by Coughlin and Hogan (2008) in the succession planning literature, and mentoring and coaching were also reported as part of development initiatives by a number of authors (Boomer and McCormack, 2010; Duffield, 2005; Jasper et al, 2010; McNamara et al, 2014).

7.4.2 Organisational level - Nursing leadership, values and vision

Senior Nurse 5, talked explicitly about a clear strategy of what nursing leadership should be in this organisation, although no written evidence of a current strategy

was located. Another of the key informants considered that the vision from the Director of Nursing 'probably' filtered down to staff. Participants themselves made no comment about a nursing vision or strategy within the organisation. An old, two years expired nursing strategy written by the former Director of Nursing was located on the organisation's intranet, but no updated policy was available or referred to. There was no mention of a nursing vision or strategy on the outward facing public website. Alice, in line with other participants had not appeared to be aware of a broad vision for nursing in the first interview. In a subsequent interview, two years after the first, she talked about the presence and attitude of the Director of Nursing and how she could relate to this. Whether this was because of developing professional maturity and a wider focus of interest or because the Director of Nursing appeared more directly involved with her, was uncertain.

It was not possible to engage with any of the matrons in this study despite initial promising contact with a number of matrons. This challenge has been reported elsewhere (Enterkin et al, 2013). Neither was it possible to engage with the most senior nurse executive, the Director of Nursing, thus the views of the most senior nurse in the organisation about the vision for nursing remained unknown.

Participants' lack of awareness of any nursing strategy in conjunction with the documentary and website evidence of the absence of a contemporary vision and strategy for nurses and nursing, suggests disengagement between the nursing workforce and the senior executive team. This apparent disconnect between the

senior executive team and the wider nursing workforce is not unique to this organisation, having been identified elsewhere (Koivula and Paunonen-Ilmonen, 2001). It does however highlight a challenge with developing and communicating a vision for practice that can resonate with all practitioners and be embedded across the organisation.

The organisation's vision and values, as set out on the outward facing website, were not referred to directly by any of the participants or key informants. Neither was there any mention or acknowledgement of the workforce strategy document which outlined the place for values-based leadership, and stated that this would be embedded across the organisation. That this workforce strategy had expired, appeared unnoticed by participants and key informants alike. In view of this apparent lack of integration of this document into the realities of staffs' working lives, the evidence suggests that it would appear to be aspirational document rather than an objective with a clear plan of action. Argyris (1976) has termed this the gap between espoused theories and theories in action, which may contribute to the presence of single loop rather than double loop learning.

7.4.3 Organisational level - Supporting and developing the workforce

The intention to recruit, support and nurture staff was identified in the workforce strategy, but the suitability of leaders and managers as role models and how that concept of the role model may be personified was raised as a concern by Senior Nurse 2. This questioning of the suitability of role models does not appear to have been discussed in the nursing literature.

Support mechanisms for aspiring or developing ward sister/managers are not explicitly explored in the literature, and where they are highlighted, there is little consensus (Duffy and Carlin, 2014; Enterkin et al, 2013; Porter et al, 2006). This is evidenced by the variety in shape and form of development initiatives for ward sister/managers. The duration of programmes has been variable, shadowing has been mentioned, coaching and mentoring may be offered formally or informally, and work assignments linked with the programme may have been linked to academic credit in some instances. Integrated approaches to leadership development were reported by Jasper et al (2010) and Fealy et al (2012). Evaluations from the all-Ireland project have been reported recently and have highlighted outcomes at both individual and organisational levels, indicating the benefits of this approach (Fealy et al, 2015; Patton et al, 2013).

As highlighted in chapter six, a number of development and supportive elements were provided for staff in this organisation (Box 6.2). In terms of provision, this could be considered valuable, even successful. Evaluating the success of support and development interventions is known to be challenging, most often consisting of monitoring participation and completion rates. Regular audits of training and development achieve just this. In good faith, this organisation had provided a range of opportunities and facilities to support staff, some of which might be assumed to be of value to new and aspiring ward sister/managers in making their transition to a full ward sister/manager role (Box 6.2). A coordinated strategic approach to staff development was not evident in practice although it was

espoused in the outdated workforce strategy and outdated education policy. The benefits of an embedded development focus were acknowledged by Paterson et al (2010, p80) who commented that modelling of leadership behaviours contributed to a “positive workplace culture in which learning and leadership are embedded”.

Support networks, both formal and informal, have been considered to be beneficial and may enable participants to benefit from peer support. They may support participants in making sense of the constantly changing world around them. Participants in this study experienced support networks in different ways; participants tended to rely upon the support of peers and colleagues and their immediate managers. It was noted that the support forum initiated for ward sister/managers was unknown to some. Ericsson and Augustinsson (2015) drew upon Weick’s work (Weick et al, 2005) on the imperative for sense making for their ward sister/managers. They noted the value for ward sister/managers in having the opportunity for dialogue together, to enable them to make sense of the complexities and ambiguities associated with their work. Ward sister/managers in Ericsson and Augustinsson’s (2015) research shared their frustrations with their role; the interpretation of which was a sense of inadequacy and a resultant loss of meaning. This was mitigated, in some measure, by participating in facilitated discussion groups over a period of time. From the evidence presented in this study, it is not certain that the support network served this particular purpose.

Coaching and mentoring have become established as means of support, but there was no discussion of coaching or mentoring from participants in this study, although several of the key informants considered the place of mentoring to support staff. The relative paucity of literature concerning mentoring and coaching for professional development in nursing perhaps conveys a conceptual issue within the nursing world that the place of mentoring is solely for working with pre-registration nursing students and midwifery students. This mind set of mentoring linked with students thus arguably blinkers individuals and organisations to the possibilities of professional mentoring beyond initial registration.

Whilst mentoring has been identified to varying degrees at a local departmental level, formal coaching in healthcare organisations has tended to be reserved for the executive tier of staff or those recognised in a talent pipeline that has not traditionally included this level of nursing staff. Whilst the absence of discussion from participants about the value of coaching is perhaps unsurprising, its absence from organisational strategy is striking. This fact, in combination with workforce development strategies that had expired, suggests that coaching was not valued as important at this time. Similarly, mentoring for qualified professional staff was absent from the strategy and policy documents, but was referred to by Senior Nurses 2 and 5 as being valuable.

Coaching and mentoring as means of providing support has been used in a number of development initiatives for aspiring ward sister/managers, ward

sister/managers and all nursing staff, respectively (Boomer and McCormack, 2010; Coughlin and Hogan, 2008; Duffield, 2005; Jasper et al, 2010; McNamara et al, 2014), and indeed the role of coaching and mentoring in staff support and development beyond healthcare organisations has been well established. McNamara et al (2014) reported on the embedded mentoring and coaching support in the Irish leadership development initiative. Jasper et al (2010) commented however that the mentor support that was built into the ward sister/manager development programme was hampered by mentors' lack of knowledge and experience, and this was echoed by participants in Greenwood and Parson's (2002b) report. Data from both of these initiatives confirmed that strategies to develop and support mentors were necessary.

The empirical evidence presented has illustrated that a variety of support mechanisms have been provided; a workforce development strategy was available but evidence suggesting interconnections between mechanisms, and evidence of systematic evaluation was missing. This apparent lack of connection, monitoring or evaluation processes infers that the responsibility for development rests with the individual. The equality of opportunities to participate in development initiatives was not discussed by participants or key informants. Indeed, Platt and Foster commented (2008) that despite the embedding of a management culture in the NHS, development of nurse managers was inherently self-directed, characterised by self-development activities rather than more systematically organised initiatives to meet professional and organisational requirements.

7.4.4 Approaches to succession planning for the ward sister/manager position

Succession planning strategies, as identified by Griffith (2012) and Titzer et al (2013), were not evident in this organisation. Key informants with a broader organisational view were noted to have a view on succession planning but this was aspirational rather than factual in this organisation. This does not necessarily imply that the organisation was disinterested in succession planning; rather that the interventions provided were isolated and not part of any evident systematic strategy.

Leadership development programmes for aspiring ward sister/managers were identified as valuable by both participants and key informants. All participants had undertaken a leadership development programme within this organisation; however in this study they were not specifically asked to evaluate that particular development programme. Individuals appreciated, even valued the support given by the organisation that enabled them to undertake a leadership development programme. The leadership development programme appeared to be viewed in isolation by participants. No broader strategy was identified by participants or key informants for using any particular development programme to support aspiring and developing ward sister/managers.

There was no articulation of the development initiative in the context of the local practice area. Neither participants, nor key informants, apparently considered any need to situate this learning and development in the context of either the

local, departmental level or the global, organisational level. A form of egocentricity is understandable in junior staff, with their focus being inward-looking. The need to work in a more interlinked environment, seeing the connections between different parts of the organisation appeared unrecognized. In contrast, participants in Ericsson and Augustinsson's (2015) study considered that they represented their wards externally within their organisations.

Key informants referred to the value of developing staff, but beyond this, there appeared little recognition of a broader strategy of which the leadership development programme for aspiring ward sister/managers was a part. Of the evidence included in the literature review chapters concerning the development of ward sister/managers, most papers presented small scale local development initiatives. Most of these initiatives were established as discrete entities rather than part of a systematic strategy to develop the ward sister/manager or aspiring ward sister manager, although organisation-wide strategies for the inclusion and embedding of a ward sister/manager development initiative were detailed by Dodwell and Lathlean (1987). The connection between the organisational vision and objectives with leadership development initiatives was also reported by Phillips and Byrne, 2013.

Where explicit links of the development initiative to a wider strategy were lacking, implicit linking to a broader purpose could be extrapolated through the involvement of the Directors of Nursing. The explicit involvement of Directors of Nursing was noted through the selection of candidates for development (Dodwell

and Lathlean, 1987; Greenwood et al, 2002a) and through participation in post-initiative project presentations (Platt and Foster, 2008). In other development initiatives, the involvement of the Directors of Nursing was implicit through the commissioning and development of development initiatives for nursing staff were taking place within their organisations (Enterkin et al, 2013). A clear illustration of this was evident in the initiative reported by Dierckx de Casterlé et al (2008), to evaluate a clinical leadership programme which had been implemented across two hospitals initially and then across twenty four hospitals in Belgium.

Jasper et al (2010) in Wales and Fealy et al (2009; 2012; 2015) in Ireland presented national initiatives to develop leadership amongst nursing and midwifery practitioners. Scottish programmes to develop aspiring and established ward sister/managers followed the national nursing initiative; however the projects reported in the literature tend to be local or regional projects rather than national ones. Outcomes from papers referred to in the literature review tended to focus on participant satisfaction with the programme, feelings of empowerment, and on occasions, career position in subsequent years. More general organisational outcomes tended not to be addressed with the exception of Fealy et al (2015) who noted that participants and their managers could identify service improvements resulting from projects that were implemented. This omission of outcomes with organisational impact is unsurprising in view of the lack of any consistency in programme length or programme duration, constituency and strategy.

7.5 The impact of organisational culture upon the process of transition

Maxwell (2012, p161) reports that realists consider that “meaning, behaviour and social structure are all real phenomena, and that the relationship among them are ... ones of interaction and interdependence”. This interaction and interdependence would appear to be significant. The impact of the organisational culture on the transition process is discussed here through four sections, the first being that of job satisfaction and perceptions of organisational support. The second and third sections focus on role clarity and role identity respectively. The final component of this section considers the preparation for the ward sister/manager post.

7.5.1 Job satisfaction and perceived organisational support

Findings from this study suggest that the organisation has a marked influence and those organisational structures and processes have a noticeable bearing on the job satisfaction of participants. This is in part supported by findings from Adams and Bond (2000) who reported that job satisfaction amongst staff nurses was associated with ward organisational features and team cohesion. Adams and Bond did not however identify the impact of the wider organisation on their participants’ perceptions of job satisfaction.

In this study, participants referred to the support mechanisms available to them; most of these were individually sourced. They relied upon proactive supportive ward sister/managers, and a strong individual sense of purpose and direction. In

parallel, role modelling followed this pattern of individual procurement. Similarly, Laschinger et al (2006), in their exploration of nurse managers' perceptions of organisational support, identified a predictive relationship between Type A behaviour, characterised by strong drive, ambition and organisation and perceived organisational support.

The nature of motivation as an individual attribute or characteristic is empirically established: one individual may be primarily internally motivated; another will need more external motivation. Motivation may be dismissed as an individual facet with little relevance at an organisational level, but Laschinger et al (2006) have highlighted that motivation was an antecedent to perceived organisational support, and in turn, the effort put into work and the quality of care delivered were significantly related to perceptions of organisational support. Engagement and its antithesis, burnout, was the focus of Freeney and Tiernan's (2009) research amongst Irish nurses; their findings supporting Maslach and Leiter's (1997) model of the six areas in organisational life that are most linked with the development of burnout and thus the erosion of engagement. The research evidence related to burnout clearly highlights the contribution that organisations make wittingly or unwittingly, that create an environment in which burnout is more likely (Freeney and Tiernan, 2009).

Shuck and Woolard (2010) focussed only upon employee engagement and define this as "an individual employee's cognitive, emotional, and behavioral state directed toward desired organizational outcomes" (p103). Participant

engagement with their local department was generally clear, their engagement with the organisation as a whole is much more difficult to identify. Indeed participants and key informants who were based on the smaller hospital site, expressed concerns and anxieties about the direction of the organisation as a whole, and they expressed feelings of being left behind, the less important relative. Their worlds, almost egocentric, left little space for engagement with the organisation, and yet clearly the organisation, its nature and way of being, has a direct impact on the local work area. Whether this egocentricity stems from professional immaturity, early developing professional maturity (Miskelly and Duncan 2014), and naivety, or whether it serves as a protective barrier against wider forces over which the individual has no control warrants further investigation.

7.5.2 Role clarity or uncertainty

A lack of role clarity was not specifically expressed by participants or key informants in this study, although it has been reported elsewhere (Ericsson and Augustinsson, 2015; Firth, 2002; McCallin and Franklin, 2010). Role uncertainty amongst ward sister/managers was evident however, arguably manifesting itself in a quest for reaffirming the identity of the ward sister/managers in this case. While this study was underway, ward sister/managers across the organisation were given an opportunity to consult on a change in title for their role and a change in uniform. One of the key informants, Senior Nurse 2, referred to this in some detail, having been instrumental in coordinating some of these discussions. Ward sister/managers were reputedly feeling a lack of role clarity and blurring of

their roles with their band six (senior staff nurse and junior sister) junior colleagues, although this was not a theme identified from the research participants themselves. Indeed, Bonner and McLaughlin (2014) reported confusion over the lead clinical role and who should hold that position and Stoddart et al (2014) reported a lack of role clarity for ward sister/managers in Scotland had been removed through the implementation of the new replacement SCN role.

7.5.3 Role identity as the ward sister/manager

A number of participants and key informants highlighted the multiplicity of titles for band six nurses in the organisation and how this might seem confusing to staff and patients, the terms in use being staff nurse, senior staff nurse, junior sister, sister and senior sister. The study participants and a number of the key informants were unaware of this proposed change to the title and uniform of the ward sister/manager, suggesting that the discussions around role clarity for ward sister/managers was confined to a limited group of individuals. This suggests a chasm between the role identity of a central group of ward sister/managers in the organisation, and other colleagues, senior and junior to ward sister/managers. Ashforth (2001) has defined role identity as being what the actor themselves feel for the role, whereas role legitimacy is given by others in the role set. The rebranding exercise in this case had seemingly addressed the role identity issue but had not clearly addressed the perceived legitimacy of the role. The role refocussing suggested that ward sister/managers appeared to doubt their role, their identity and their legitimacy in that role; the rebranding

exercise did not appear to have addressed these uncertainties. Spehar et al (2015) have commented that changes in role identity and transition from clinician to manager were experienced differently between doctors and nurses. Whilst doctors moving into managerial roles appeared to enhance their professional identities, nurses were undergoing a change in professional identity from carer to manager. Currie et al (2010) have proposed that nurses enacting less-boundaried roles have experienced challenges at both individual and institutional levels in managing the role transition. Whilst the ward sister/manager role may not be considered un-boundaried, the confusion and role blurring associated with this role may compound the challenges.

Key informants generally identified strengths and weaknesses of the ward sister/manager, role but two key informants in particular expressed concerns that the role was no longer an attractive one to junior staff. This reflects wider published research findings that the nature of the role has changed and anecdotal reports that it is more difficult to recruit to. Bolton (2005), and Wise (2007) and others comment that for many junior nurses the ward sister/manager post is no longer an attractive one. Junior nurses are perhaps looking to more specialist roles for their career aspirations, the role of the clinical nurse specialist seeming considerably more attractive and less burdensome (Enterkin et al, 2013).

None of the participants in this study talked about the clinical nurse specialist role at the first interview stage. They did however highlight that they knew of colleagues who were more junior nurses, who were repelled by the managerial

load the ward sister/manager had and by the challenges of having twenty four hour responsibility. One of the participants moved into a clinical nurse specialist role some months after the first interview in this study, although the motivation for this was more opportunist than planned. Developments in new and specialist areas of practice, and taking on formerly medical roles, have become exciting opportunities for nurses (Currie et al, 2010) which may have detracted from the ward based managerial role (Carlin and Duffy, 2013; Currie et al, 2010; Pegram et al, 2015).

The experience of undergoing the transition from staff nurse to ward sister/manager may also be impacted upon by others in the role set. Indeed, the role set and the context of that role set, have been identified as giving a legitimacy to the role change that is necessary in navigating the transition (Ashforth, 2001). The significance of that legitimacy may vary from person to person. For actors with self-confidence and self-belief, the legitimacy of the role set conflates to enable a smooth transition, to submerge oneself in the new reality. Feelings of self-doubt, lacking self-belief or self-assurance, render the process more complex and prolonged and the new reality may remain elusive. The rebranding activity for ward sister/managers in this organisation could suggest that these ward sister/managers were still beset by self-doubt and had not completely moved into the new reality of their ward sister/manager posts.

Thus, the transition from the role of staff nurse to ward sister/manager encompasses much more than just a promotion, easily accepted and readily

digested. The person's own beliefs and feelings intersect with the values and beliefs of others in the role set, who give legitimacy to both the thoughts of, and process of that transition. All this occurs within a context that either supports or challenges the transition. When that transition process starts is difficult to judge; it may be early on in a nurse's professional career when they identify with a role model and aspire to elements or the whole of that role. It may start with the unexpected role change of another actor which then leaves a position to be filled. The end point of this transition is equally unclear; the point that the new reality is established is not readily apparent. Whether an individual needs to identify with all components of a role to consider that a transition is complete is a matter for debate. Pegram et al (2015) report that their ward sister/managers were, on the whole, satisfied with the multiple roles that they fulfilled. Stanley (2006a) and Townsend et al (2015) have suggested a conflict of identity stemming from the seemingly irreconcilable differences between the caring nursing role and the more managerial role of the ward sister/manager.

7.5.4 Developing people for the future - preparation for the ward sister/manager role

Preparation for and/or transition into the ward sister/manager role is situated within a department within the organisation and, as such, is subject to influences from the prevailing culture. Participants talked about learning through doing; the opportunity to undertake roles and tasks with support was a valuable source of development. In the main this was referred to as a positive opportunity, although it was acknowledged that delegation needed to be appropriate; for one

participant however, learning on the job was not seen as positive and was conceived instead as being left to manage unsupported. Evelyn also talked about the need for aspiring ward sister/managers to learn and develop key skills whilst supported, before being appointed into a senior position and having to survive. This concept of learning through doing, whilst intuitively appealing should not be viewed as inevitable or even as a panacea to learning. Participants and key informants in this study referred to those who come into work to just 'do the job'. This was indeed articulated as a criticism – those that just do their job and no more. It should not be surprising equally that some practitioners do not appear to learn from doing.

This learning through doing is not specifically recognised in the ward sister/manager development literature, although the supportive mechanisms that underpin the success of this approach such as mentoring and coaching are included by some authors (Boomer and McCormack, 2010; Duffield, 2005; Jasper et al, 2010, McNamara et al, 2015). Shadowing as a concept to support development into a new role has been discussed directly by and indirectly by Dodwell and Lathlean (1987) who referred to placements for ward sister/managers to develop their skills and knowledge, but this has not been part of development initiatives more recently, with the exception of Manning et al (2015) and Brunero (2009). Manning et al (2015) informed that placements were a part of their succession planning initiative, an underpinning methodological approach for this was not evident. Brunero et al (2009) reported using six month relief positions to support succession planning rather than placements or

shadowing. Whether this move away from placement experience reflects a lack of interest or a lack of funding to support it, is therefore uncertain.

McCallin and Frankson (2010) noted that clinical expertise was not sufficient preparation for management roles and this has similarly been recognised by others (McEwen et al, 2005; Townsend et al, 2015). Spehar et al (2012) similarly reported that nursing and medical colleagues were unprepared for their new management roles. Participants in this case study did not refer to this, although it was acknowledged by two of the key informants. The lack of training for new managerial responsibilities including the lack of training for human resource management has been highlighted (McEwen et al, 2005 ; Townsend et al, 2015; Willmot, 1998). Benner (1984) in her seminal work recognised that length of service and or years of experience did not necessarily correlate to levels of expertise demonstrated. Duffield (2005, p69) commented that in many instances formal educational qualifications such as Bachelors or Masters degrees did not inherently mean that recipients are well prepared for leadership positions, or able to “automatically demonstrate leadership abilities”. Pitkänen et al (2004) similarly noted a debate over what might be the appropriate academic level of education and training for ward sisters in Finland. This documented variation in the duration and nature of academic preparation or foundation for leadership implies that consensus in this area is still elusive.

Participants referred to the value of being able to think differently, or to try out things in new ways. The impetus for thinking differently stemmed from the ward

sister/manager development programme that had been undertaken, suggesting that learning through doing, supported by a development programme was a powerful and useful concept for individuals. This fits well with the educational approach of work based learning, an adult learning approach which recognises the value of the context in which a practitioner operates and identifies this as a potential learning platform.

Critical realists seek to uncover mechanisms and causal relationships that may exist but are unknown to participants. Pawson and Tilley (1997, p215) comment that “realists do not conceive that programmes work, rather it is the action of stakeholders that makes them work, and the causal potential of an initiative takes the form of providing reasons and resources to enable the participants to change”. The organisational context and professionals in the wider role sets affect the way in which any learning is rendered meaningful and thus this affects the likelihood that learning is reinforced and embedded in practice. The work context was central to the masterclass approach utilised by Duffield (2005), situating leadership development in practice for nurse managers in one project in New South Wales, Australia. Whilst Phillips and Byrne’s (2013) paper was excluded from the critical literature review on the basis of unsubstantiated findings (See Appendix 4), their inclusion of Argyris and Schon’s (1978) single and double loop learning is of interest. Phillips and Byrne (2013) reflected that skills learning on a development programme is a single loop process, but learning to apply the skills and knowledge is a double loop strategy. There is some validity in this claim, that double loop learning is more likely to take place if learning from a

development initiative is implemented in practice. Whether this can occur, unprompted is in doubt. The well-established research exploring the development of expertise amongst practising nurses acknowledges that years of experience have little or no bearing in the development of expertise (Benner, 1984). How a practitioner reflects on and utilizes that knowledge is key to it being useful as a development tool. Indeed, Boomer and McCormack (2010), situated their initiative in the context of the emancipatory practice development, that aims for development through empowerment, which can then result in the transformation of practice.

The need to be developed and supported, both in preparation for the new role and in the early stages in the new role, were discussed by participants and key informants alike. In line with Townsend et al (2015), Alice referred to the lack of preparation to deal with the personnel management side of the ward sister/manager role. Dealing with problematic staff members was a challenge that she did not feel adequately prepared for. Whilst Hannah discussed her apparent struggles with accepting her new ward sister/manager position, her colleagues assumed she would apply for the vacant ward sister/manager position. This seeming acceptance of the new identity by part of Hannah's role set did not appear to contribute to her own acceptance of the new identity. Ewens (2003) and Spehar et al (2012) have noted that practitioners have to reconstruct their personal identity.

7.8 Chapter Summary

In this chapter, I have considered the empirical evidence from this study, in the context of the extant literature, to answer the research questions which framed this study. Through this discussion chapter, I have reported the experience of transition from staff nurse to ward sister/manager. I have explored both the configuration of the ward sister/manager role in this organisation and participants' understandings of this role. I have established components of the culture of the organisation at the local, departmental level and at the organisation-wide level and have explored the impact of that culture upon the transition from staff nurse to ward sister/manager.

While role transitions from student to qualified nurse have been researched by educational researchers, the nature of the transition from staff nurse to ward sister/manager has not been explored. Participants in this case study identified with established components of role transition, such as letting go and reconstructing identity, whilst not evidently acknowledging it as such.

I have demonstrated that participants achieved job satisfaction from their work and this arose from clinical care giving. The need for self-fulfilment was identified as a need for all, but with the emphasis on constituent parts varying according to individuals. In line with the empirical evidence, aspiring ward sister/managers required support to develop and progress and significant role models played an important part in this. Support where it existed, was provided individually; there

was no evidence that local support mechanisms and initiatives were widespread or shared.

The changing nature of the ward sister/manager role was highlighted by participants and key informants alike; patient contact time appeared to be diminishing and this was frustrating to participants and key informants. The multifaceted nature of the ward sister/manager role that is widely reported was not specifically discussed. Participants' understanding of the ward sister/manager role concerned the primarily managerial requirements of the role, the tasks that had to be fulfilled. The leadership component of the role was not immediately evident and thus the route to develop expertise in leadership was not considered. Clinical expertise as a facet of the ward sister/manager role has been acknowledged by some authors, and was recognised by some participants.

Whilst participants and key informants considered the ward sister/manager role to be essential for local departments and the organisation as a whole, the rebranding exercise for ward sister/managers conveyed role uncertainty and questionable role identity. The role that the organisation played in developing roles that were appealing in a pathway of career progression was questioned.

I have provided a critical account of what is known and what is not known in the context of this study. In the concluding chapter which follows next, I will present a summary of the research presented in this thesis and offer my contribution to new knowledge.

8.0 Conclusions

8.1 Introduction

This is the concluding chapter of what has been a lengthy but enthralling journey. The origin of my contemplation of this transition was a long-standing interest in the development of those in ward sister/manager positions and those aspiring to be ward sister/manager. As one of the educational facilitators of a development initiative for aspirant sister/managers in this organisation, I was enthused to explore the challenges faced by these aspiring sister/managers in navigating the transition to the ward sister/manager position.

These transitions were taking place within the context of an ever-changing NHS and I wanted to examine these more closely. I was desirous of understanding what was happening, and to learn from professionals in the various roles what was facilitating them in these transitions. It was evident to me that there were tensions in the real world of practice, and thus I wanted to investigate what, if any, barriers might exist. Here in this closing chapter, I draw this journey to a conclusion.

This study set out to address two objectives; the first to explore the experience of transition from staff nurse to ward sister/manager, and the second to understand the impact of organisational factors on that transition. To answer these, I addressed three question areas, established first in chapter one and firmly established in chapter four.

1. What is the experience of transition from the role of staff nurse to ward sister/manager in an organisation?
2. What is the culture of this organisational as evidenced by structures, policies, work roles, power structures, and from the perspectives of staff nurses and senior trust team?
3. What influence do these factors have: do they contribute to, facilitate or hinder this process of transition?

The findings of this study in relation to the research questions have been discussed in chapter six. In the previous chapter I have considered the findings from this research in the context of the nursing and educational literature. In this concluding chapter I begin by summarising the research presented in this thesis to answer the research questions which framed this study. In the next section which presents a reflection on the thesis, I offer my personal reflections and my own identity transitions during this research journey. In the penultimate section in this chapter I will set out the contribution to knowledge which has been uncovered through this research. To conclude this thesis, I include recommendations for research, policy, practice and education.

8.2 Summary of the thesis

The case in this study (previously illustrated in Figure 5.1) was one metropolitan NHS organisation, consisting of two hospital sites, in which the transition from staff nurse to ward sister/manager was situated.

Developing an understanding of this transition process was undertaken through a case study exploration which entailed conducting interviews with aspiring ward sister/manager and senior practitioners, and was supported by the examination of organisational strategy and policy documents (Table 5.2). The constituent parts of this case have supported the investigation to answer the research questions established in earlier chapters and reaffirmed in the introduction to this chapter.

The findings from this study have been presented in chapter six, and discussed and reviewed in the context of evidence through the literature, in chapter seven. The empirical evidence presented suggests that the transition process from staff nurse to ward sister/manager is challenging, and the complexities associated with it are not readily recognised. Participants made use of a range of strategies to help and support them in their development: informal mentoring, working with and observing role models, shadowing opportunities, and acting role opportunities. Some participants made their own arrangements, while some had ward sister/managers who created opportunities for them.

The findings from this study highlight that this transition process is almost invisible to those undertaking it, and thus the challenges associated with it may be underestimated. This is supported by the critical realist understanding that of three modes of reality, the 'actual' represents aspects of reality that take place but may not be experienced, in the sense that people may be unaware of this.

The ward sister/manager role is one that participants and key informants considered to be a valuable one, contributing significantly to the quality of patient care. This role has been undergoing changes to become more managerially and less clinically focussed and this has contributed to some dissatisfaction for ward sister/manager themselves and difficulties in recruiting to the role. The managerial component of the ward sister/manager role was unquestioned, but there appeared to be little focus on how leadership could be embodied and how it could or should be developed.

The culture of the organisation, as evidenced by structures and policies was an ordered one; one that recognised the value of staff and presented strategy and policy designed to support the workforce. Review dates for policy documents were stated but reviews and updates were not evident. Existing policies had expired. Work roles, significant to this study, included the staff nurse role (by various titles), the ward sister/manager role (by various titles) and matron role. The role of more senior nurses was not specifically explored, but the existence of these roles contributed to the prevalent working practices and vestiges of power identified by participants and key informants. Senior practitioners in organisation-wide roles reflected on and identified with, the vision for nursing established by the most senior executive nurse. The more junior of the key informants and participants did not express an awareness of this vision. Policies and strategies to frame the development of the workforce were apparent and the organisation provided a number of support mechanisms and development opportunities (Box 6.2) but the evidence suggested that these items operated in isolation.

Aspiring ward sister/managers viewed themselves in a bounded manner, in their departmental context but not evidently part of the wider organisation. A disconnect was noted between participants and the nursing leadership team within the organisation as well as the wider organisation itself. The provision of support and resourcing of support appeared to depend upon the initiative and drive of the participant themselves and the enthusiasm and foresight of their existing ward sister/managers.

8.3 Reflections on the thesis

8.3.1 Reflections on the researcher journey

This thesis is the product of a prolonged journey for a novice researcher. The doctoral endeavour has comprised both process and creativity and at times the demands of these seemingly discrete entities has proved perplexing. Resilience and perseverance have been necessary skills to continue on this sometimes-tortuous journey.

My decision to utilise a case study approach was not an immediate one, but the case study methodology resonated as a highly suitable one for answering my research questions. The case study approach supported the collection of data from different perspectives and of different types allowing me, as researcher to explore the topic from a number of angles. That said, creating alignment between ontology, epistemology, methodology and method proved perplexing at times. In addition the case study faces many critics who consider the approach to

lack robustness, thus increasing my determination to produce a strong and well-argued defence of the case study approach to address my research questions.

The data collection stage proved refreshing after a lengthy period of preparation and approval seeking. Research texts advise that the researcher must be neutral, not leading participants, non-committal, not offering comment. As an experienced teacher, a facilitator of leadership development programmes, this need to maintain a non-responsive countenance, not to give opinion or reassurance was difficult and felt counter to my practice. The dichotomy between researcher and facilitator was notable. Support from supervisors during the data collection period and peer support from colleagues also undergoing the doctoral journey helped to think through this conundrum.

Data analysis proved to be engrossing – an opportunity revelled in, to immerse myself in the data, searching for ideas, themes and concepts. A more stimulating experience I could not imagine, and yet one that tests both creativity and rigour. My enjoyment of this stage was marred only by a constant quest for the answer to my question: I mistakenly believed that using the Framework approach would in itself provide all the answers. Some considerable time elapsed before I could truly see that the data matrices developed through framework served merely as a tool for logging data and enabling a means of handling large quantities of data.

This journey has appeared akin to roller coaster, flowing over peaks, troughs and more steady mid points. Much as the participants have pondered over the change in role, from one they consider themselves to be expert in to a new role

with new challenges, I have moved from the role of expert practitioner to educator, from experienced educator to novice researcher. This required, on my part, a forging of a new identity as developing researcher, passing through my own transition.

8.3.2 Strengths and limitations

Presented here are the findings from a single site case study which has allowed an in-depth exploration of the transition from staff nurse to ward sister/manager in a single organisational context. The case study methodology enabled a flexible approach to data collection, permitting the collection of different data through differing means. This view through various lenses supported the development of a more encompassing theory.

The strengths of this study are that it has examined the complexities of the ward sister/manager role, it has highlighted that this role plays a significant part in the organisation, and has emphasised that the process of becoming a ward sister involves an intricate transition process. An additional strength is that the critical realist approach has supported the exploration to identify structural processes and mechanisms that impact upon the participants, the aspiring ward sister/manager, thus helping to elucidate the relationship between structure and human agency which has implications for policy, practice and research.

This organisation existed with the backdrop of a potential merger during the research period. This context in a particular period of time will inevitably impact

on the findings that in themselves may not necessarily be generalisable to other, more stable organisations.

The number of participants accessed was small, this was, in part, intentional, to be able to work with and explore, in depth, the experiences of a core group of aspiring sister/manager. Participants had previously attended a leadership development programme, and this programme served as vehicle for recruitment to the study. Their participation in the development programme may have resulted in both anticipated and unanticipated consequences. Participants may have wanted to reflect and comment upon the programme itself and thus agreeing to participate in the study might have appeared appealing to them. Through their participation in the development programme, participants were already focussing upon their development for the next stage in their career, and thus might not necessarily be representative of a wider group of aspiring ward sister/managers within the organisation.

As often reported in longitudinal studies, not all participants took part in the second and third stages of interviews, although all initially expressed a willingness to do so, thus their views and understanding of their evolving roles is unknown.

The number of key informants was also small. The intention had been to engage widely with practitioners at senior staff nurse or junior sister level, who may not have been considering the ward sister/manager post, as well as more senior practitioners in the organisation. Participants were asked to suggest others who

might contribute towards the research and although it was suggested that this might be nurses who did not aspire towards the ward sister/manager role, these contacts were not provided. The senior practitioners who were recruited to the study gave a rich picture of the ward sister/manager role from both a personal and an organisational perspective. However, engaging widely with senior nurse practitioners and the executive nurse proved elusive; thus their voice is unheard. A more determined strategy for including and petitioning them to participate in the study may have been beneficial.

The voice of the participants is heard through the selected textual excerpts; this is only the voice of those who participated in the study. This has been the focus of much reflection; however, absent voices can only give cause for reflection on the part of the researcher.

I was previously known to the participants and the key informants in the capacity of educator and facilitator of leadership development support and I had worked with the participants in this study during an early iteration of a leadership development programme. Being known by participants had some advantages, in that a relationship is already present between researcher and participant.

Furthermore, I might be assumed to have some pertinent insider knowledge and thus possess some understanding of the challenges they faced. Being known may also have served as a disadvantage, however. Participants may have expected support or development through participating in this study. On a number of occasions, participants shared experiences or asked direct questions in the

interview that were potentially intended to illicit a response from my identity as facilitator and teacher, rather than from a researcher.

8.3.3 Contribution to new knowledge

There are two components to the contribution to new knowledge presented in this chapter that have arisen from the empirical evidence presented and the ensuing discussion in the previous chapter:

- Role transition, which has been reported amongst other groups, appears to be a process that aspiring ward sister/managers progress through to become ward sister/managers. This role transition requires a construction of the new identity of ward sister/manager.
- The organisation has a responsibility to support individuals in achieving job satisfaction and to establish the role that has legitimacy thus contributing to role fulfilment and thus self-fulfilment.

The subsequent sections of this concluding chapter explore each of the above points in turn.

Role transition to the ward sister/manager role is recognised

Empirical evidence from this study demonstrates that participants were undergoing a transition in roles in the move from a staff nurse role to a ward/sister manager role. This did not appear to be evidently a smooth change from a more junior role to a more senior role. This change in role appeared to have all the hallmarks and facets associated with role transition that has been recognised in other groups and other situations.

This was evidenced especially through concerns about changing identity. Gaining respect from peers and colleagues was not immediate or straightforward when changing roles within the same department. It was noted that an individual's feeling of comfort in their new role was impacted upon by the perceptions of others in the role set. It was noted by one participant that uniform played a significant part in this fulfilling a new identity, and wearing the new uniform was reported as being difficult initially. Evidence reported by key informants about changes to the uniform and the title of ward sister/managers supported the notion that ward managers were not secure in their identity as ward sister/managers. The start and end points of this transition were not necessarily clear for all participants. A planned career progression was noted by some, whilst for others the changing role occurred almost by chance. An endpoint of the transition was difficult to identify.

The commencement of any transition in role must start with a process of letting go, letting go of the old role. Empirical evidence in this study suggests that letting go took a number of forms: for one individual letting go was associated with leaving one uniform behind and picking up another uniform. For all participants, the language of letting go associated with less time for clinical contact and patient care.

The aspiring clinical ward leaders in this case study were undergoing a transition period, one of reformulating their professional identity as they developed into or

towards the ward sister/manager role. In order to embrace their new identify as ward sister/manager, nurses ostensibly need to leave their hands-on role behind them.

A notable body of literature exists about role transition; whilst the transition from nursing student to qualified practitioner has been extensively explored, navigating the journey from the aspiring ward sister/manager position (whether as a staff nurse or junior sister) to the ward sister/manager post have not been recognised as a transition in roles as such. The significance of identifying this progression as a role transition is that, like the noted transitions elsewhere, participants require considerable support and will need to re-establish their sense of identity in their new role. The empirical evidence from this study, which recognises this process as a transition in roles, forms a contribution to new knowledge.

Organisational responsibility for supporting individuals' opportunity for achieving job satisfaction

Job satisfaction was discussed by participants and key informants in this study.

Factors contributing to job satisfaction included supporting patients, supporting staff, a sense that an individual had made a difference on a particular shift.

Participants reported that loss of clinical time detracted from job satisfaction, and their concerns about developing seniority focused on losing more and more clinical time. Whilst some reported expertise in the clinical arena as a pre-requisite for the ward sister/manager position, for some that the language

associated with expertise was not evident. Key informants and participants noted that some elements of the ward sister/manager role were not attractive to nurses and did not give satisfaction.

The organisation has direct control over the nature and scope of the ward sister/manager position and has the potential to recreate the role as one that gives meaning to both the individual and the organisation. This constitutes the 'real' mode of reality, which according to critical realists, consists of deep structures and mechanisms which generate phenomena. The need for the organisation to work with ward sister/managers to create a more meaningful post that is more likely to give job satisfaction has not previously been articulated and this constitutes part of the contribution to new knowledge.

8.4 Implications for research, policy and for practice

Implications for research, education, policy and practice are established in subsequent sections, with implications related to the establishment of role transition from staff nurse to ward sister/manager being presented first. This is then followed by the implications for policy and practice for the organisational responsibility to support individuals to achieve job satisfaction.

8.4.1 Transition in role from staff nurse to ward sister/manager

Implications for research

No single tier, band or grade of nurses exists in isolation. Whilst this case study has explored the transition of aspiring ward sister/managers, furthering this

exploration to include more junior and more senior staff could offer deepening insights. Exploring the concepts of role identity and legitimacy of ward sister/managers and matrons in more depth would prove invaluable. This might be explored through a phenomenological study, investigating the lived experience. A case study approach incorporating participants from across the multidisciplinary team and integrating an observational element could add an additional perspective to the accounts of role legitimacy. An additional avenue for research would be exploring the mechanisms and processes behind sense making and evolving leadership wisdom amongst ward sister/managers.

The use of multiple sites could provide for comparisons. The case study approach has proved successful but there is clearly a question as to whether a comparative case study, exploring more than one organisation would have had merit in identifying whether these elements reside only in one organisation or whether they have resonance elsewhere. In addition, looking at alternative ways in which another organisation may have conceived of support may be insightful.

Implications for education

Development initiatives for aspiring and incumbent ward sister/managers are reported as having taken many forms, and evidence to date suggests that there is little consensus as to the nature, the content or the duration of such initiatives.

What is clear however is that practitioners report benefits from having development opportunities. This development could be part of an integrated provision of support that enables participants to learn, to question and challenge

existing practice and to reframe both this learning and their practice such that a new reality is conceivable. Whether this education is delivered by practitioners, educators or both is less significant than whether it forms part of a coherent development strategy.

8.4.2 Organisational responsibility for supporting individuals' opportunity for job satisfaction

Implications for policy and practice

With concerns about recruiting to the ward sister/manager role, the organisation might consider redefining the role such that it is clearly associated with leading nursing practice and is situated as part of a continuum of nursing from qualification to executive level. This is an area which warrants further discussion in the wider nursing profession. At a departmental level, ward sister/managers need support and guidance in order to develop their workforce and create an environment for learning that is congruent with the organisational vision for nursing and coherent with the organisation's vision and values.

These developments require strategies and policies that direct support and development initiatives should be time orientated but fit with processes that are embedded into the organisation. Organisation-wide mentoring or coaching support, aligned to the organisation's values and vision, to enable staff to make sense of these opportunities and embed the learning, is essential. Aligned to this all-embracing approach to supporting and developing the workforce, should be the vision for nursing practice. Strong nursing leadership which is transparent,

coherent and meaningful to practitioners across the organisation is needed. This vision then frames the development of the nursing workforce.

8.4.4 Dissemination

I have set out in the preceding sections, the implications for research and education and practice. These implications can only be considered more widely amongst clinical, research and academic partners with dissemination of the work. Dissemination of the findings has already begun, for example the initial findings from this research have been presented to the local doctoral student audience in previous two years. Findings and tentative conclusions have been presented to educationalists and practitioners to stimulate further interest and debate using professional conferences, such as the Royal College of Nursing's International Education conference in 2016. The presentation, to a full breakout room, generated considerable interest and discussion. Additionally, an abstract from this research study was accepted for the Royal College of Nursing's International Research conference in 2017, although presented to only a small audience, the work was well received with some valuable and interesting comments which prompted some inspiring dialogue with colleagues. Now is the time to be strategic in my approach to dissemination in order to reach all these audiences.

Publications and oral presentations are planned. Senior nursing roles, especially the ward sister/manager role, continue to be highlighted as crucial to clinical care. The focus of my research will be of interest to NHS stakeholder groups, as well as a wider audience in the UK: there is much learning to be shared. There are

some important messages with relevance for policy and practice; it will be important to use the right medium of dissemination to be of most use. I have been invited to collaborate with senior nursing colleagues who share a passionate interest in the ward sister/manager role; our joint focus is to utilise our empirical findings concerning the challenges faced by ward sister/managers, to influence the national policy direction in England. A meeting with England's Chief Nursing Officer to share collaborative findings and propose action to better support ward sister/managers is planned before the end of 2017.

In terms of publications, targeting the most suitable journal will be crucial. A main data paper is planned and will be submitted to a relevant high impact international journal. Once this has been accepted, a shorter paper for a management style journal is called for. Education and practice focussed conferences will be targeted in 2018 and beyond.

8.5 Summary

In this study, I have offered new insights into the development of the ward sister/manager role in one NHS organisation. The evidence presented here contributes to the understanding of the role transition from aspiring ward sister/manager to ward sister/manager. Findings from this research have demonstrated that the transition is complex and requires practitioners to forge a new identity as the ward sister/manager. Practitioners require support to navigate this process; that support may take many forms but is less likely to be sufficient if operating separately. Development initiatives are invariably valued

but appear to have greater utility when supported with shadowing and mentoring or coaching, and form part of a supported career pathway, aligned to a clear and meaningful vision for nursing, that has congruence and is identified with by nurses of all levels. The ward sister/manager role, long established and valued, has evolved and is increasingly associated with more managerial functions which link to conformity. Findings reported here suggest that the ward sister/manager post is one that is considered valuable but elements that give practitioners the most job satisfaction appear to be diminishing and this has not been recognised. Job satisfaction has been shown to be integral to developing self-fulfilment; the organisation plays a significant role in creating the culture at local and organisational level in which job satisfaction can occur. The organisation must consider whether the role in its current state is one that provides value and satisfaction to the individual as well as the organisation and indeed create policy and strategy to support and embolden the role rather than hinder it. Openly celebrating the value and significance of the ward sister/manager role may have the effect of strengthening the role and refashioning it as a highly valued role that is pivotal in the delivery of high quality of care delivered at a local level. Additionally, this may serve to promote an increasing sense of engagement with the organisation which may further contribute to the development of self-fulfilment and job satisfaction.

Whilst limitations associated with this research have been acknowledged, the strength of the work lies in uncovering the complexities of the transition to the ward sister/manager position that is situated within local and organisational

context which significantly impact upon the role, and suggesting the place that collaborative and synergistic development strategies have in supporting and enabling learning and development .

9.0 References

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Yukl, G., Gordon, A., and Taber, T. (2002). A hierarchical taxonomy of leadership behavior: integrating a half century of behavior research. *Journal of Leadership and Organizational Studies*. 9, pp15–32.

10. Appendices

Appendix 1 – Comprehensive search terms

- ward sister role
- ward sister and role
- ward sister/manager and role
- (charge nurse or ward sister or ward sister/manager) and role

- leadership role and development
- leadership role development
- developing (health care) or (healthcare) or (nurse) leaders
- developing leaders in healthcare
- developing leaders and (positive learning environment)
- (leadership development) and (positive learning environment)
- leadership development
- leadership development and healthcare
- leadership development and nurs*
- leadership development and nurs* and evaluation
- (leadership development) and (quality outcomes)

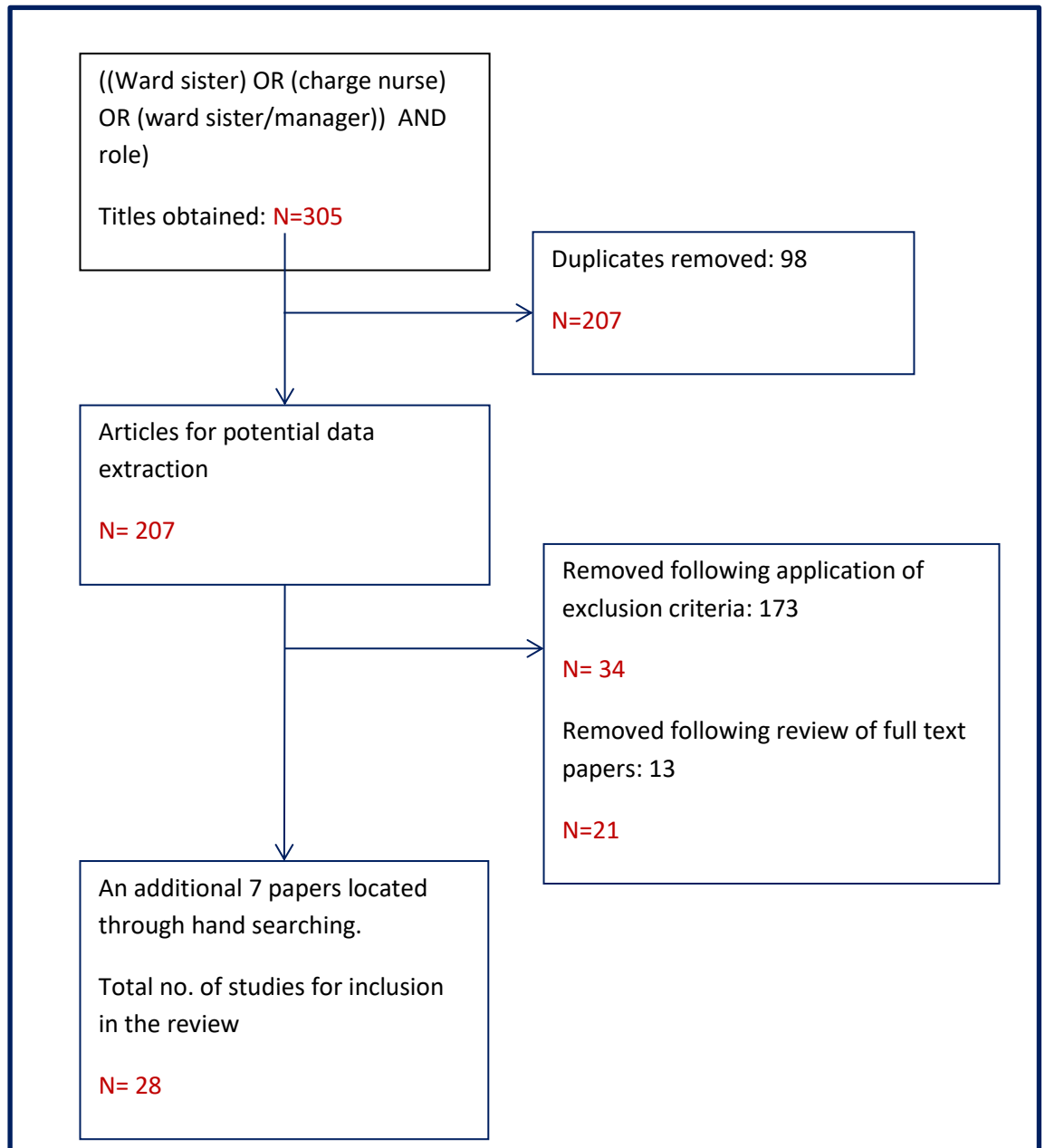
- leadership role and transition
- leadership and role change
- nurs* and leadership transition
- role change and (ward leader or ward sister or ward sister/manager or charge nurse)
- role transition and (ward leader or ward sister or ward sister/manager or charge nurse)
- role transition and nursing
- transition and charge nurse role
- transition and promotion
- transition and promotion and charge nurse
- transition and promotion and ward sister
- transition and staff nurse to ward sister/manager
- transition and ward sister
- transition to ward sister/manager
- transition and promotion
- transition and promotion and nurs*

- succession planning
- succession planning and nurs*
- succession planning and nurse leaders
- (succession planning MW and nurs*) **and** (leadership role and development) OR (leadership development and nursing and evaluation)
- (succession planning MW and nurs*) **or** (leadership role and development) OR (leadership development and nursing and evaluation)

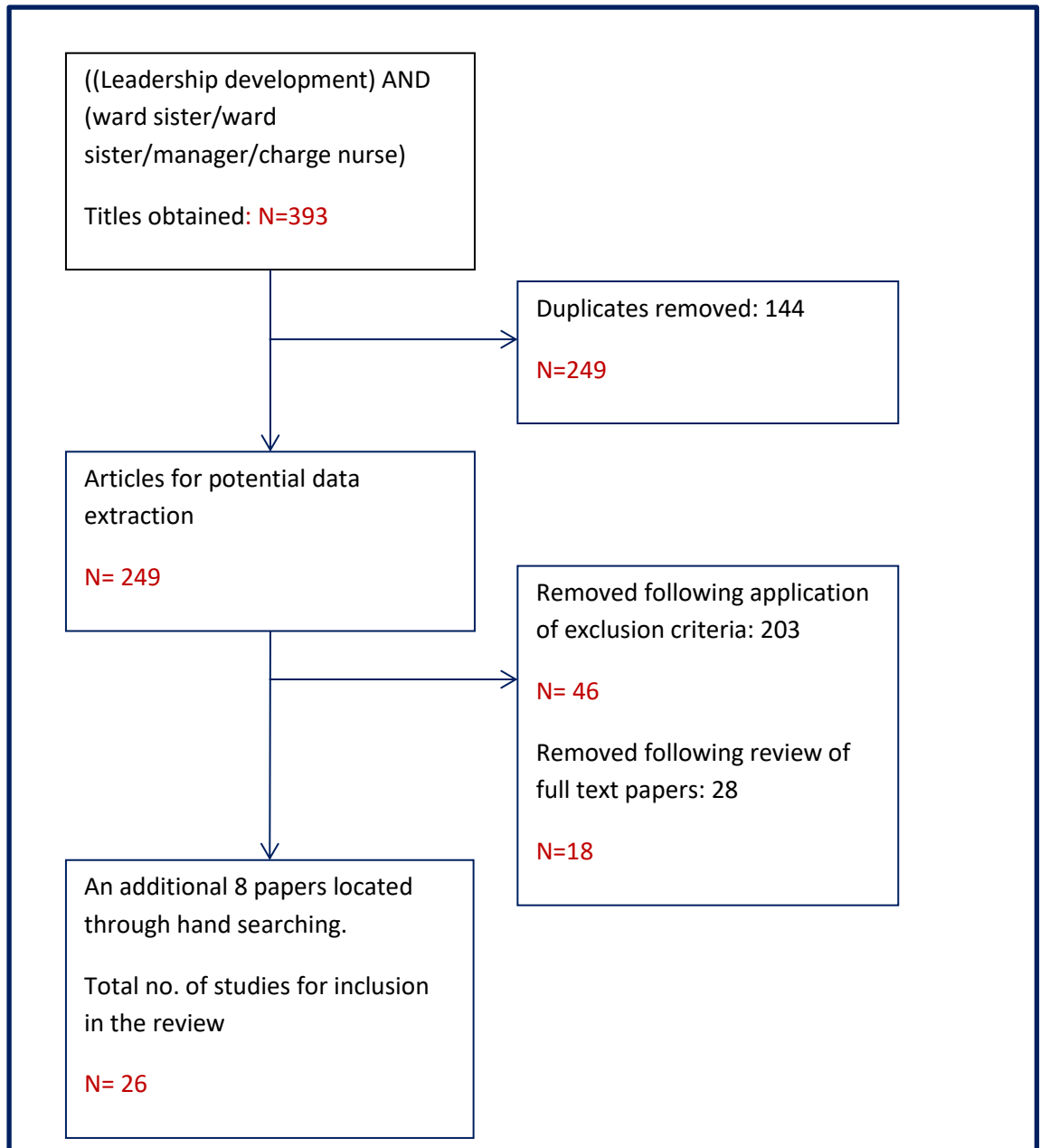
- leadership and organisational barriers
- leadership and organisational culture
- leadership and organisational influences
- leadership and (positive learning environment)
- organisational effects and leadership
- organisational influences and leadership
- organisational influences and leadership development
- organisational structure and leadership
- positive learning environment
- (clinical learning environment)

Appendix 2 – Search results and paper selection for the ward sister role and leadership development elements of the literature search.

Ward Sister Role



Leadership development



Appendix 3 - Details of included studies

Included Studies

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Fealy et al 2015 Ireland	To evaluate the service impact of a national clinical leadership programme	Case study design	Purposive sample of 70 Nurses and midwives participating in the clinical leadership development pathway, their managers and service directors	Not specified	Focus groups, group and individual interviews	Thematic analysis	Accounts of service development activities were evident. Subtle benefits such as improved working relationships, better ward atmospheres	Unequivocal	All positive data presented. Was there any negative data? Lacking confirmatory evidence. Long term impact yet to be evaluated.
Paterson et al 2015	To evaluate the developing leader programme	Longitudinal paper based survey -self report data	Purposive sample of those undertaking the developing leader programme, 79 after workshop 1, 28 after workshop 2, 31 completed all 3 workshops	Not specified	Survey - Leadership Capability Instrument at 3 time points and participant descriptive accounts	Descriptive stats and linear regression	Mean scores for each area of leadership capability increased significantly over the programme	Unequivocal	Only self-report data - no confirmatory data. Long term follow up issues and potential bias therefore of those still in study. No follow up data from those who did not complete the programme.

STUDY AUTHORS	RESEARCH QUESTION	METHODOL OGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
McNamara et al 2014 Ireland	To evaluate coaching, mentoring and action learning set interventions in a national leadership development programme	Multiple methods	Purposive sample of 50 participants, and mentors, action learning set facilitators and line managers [70 contributions in total]	Not specified	Focus groups, observation of action learning sets, 3 individual interviews	Thematic content analysis influenced by grounded theory, Glaser and Strauss	Mentoring, coaching and action learning sets were experienced positively by participants. Not all coaches were experienced and coaching took a while to establish for some.	Unequivocal	Mentoring, coaching and action learning were evaluated positively, Primarily self-report data. No evidence of how this learning is implemented in practice. No confirmatory evidence. How sustainable is this intervention? How was mentoring coaching or action learning selected for each participant? Did any participants participate in more than one of these support mechanisms?
Miskelly and Duncan 2014 New Zealand	To evaluate an in-house nursing and midwifery leadership programme	Mixed method	Purposive sample of those who had completed the development programme [60], 38 responded, Interviews with 7, focus groups with 11	Practice development theory	Questionnaire for quantitative data, semi structured interviews and focus groups	Grounded theory approach for interview and focus groups data. No detail of questionnaire analysis	Participants' self-confidence improved - leading to 'growing up', study participants appeared to have developed professionally and psychologically.	Unequivocal	Only interview/focus group data reported. Port response rate to interviews focus group - self-selection bias? Not clear how long after the programme the interviews took place. Findings presented all positive, any negative findings?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Enterkin et al 2013 England	To explore the extent to which the leadership programme had enabled meeting of the learning outcomes	Evaluation of an education initiative	Purposive sample of Band 6 nurses completing a development programme [60] in 1 NHS Trust. 36 respondents.	None specified	Semi structured questionnaires	Thematic analysis based on Braun and Clarke	Reported increased political, organisational awareness. Increased self-awareness. Increases in confidence noted and increased feelings of empowerment and ability to empower others.	Unequivocal	How were participants selected by the organisation? Political and professional context given. Referenced support for the mechanisms of the programme given. Self-report data only. Positive data reported, were there any negative comments or outcomes. Long term impact yet to be evaluated.
Patton et al 2013 Ireland	To evaluate individual level outcomes from the pilot of the national clinical leadership development framework and associated development programme	Mixed methods	Purposive sample of 50 nurses and midwives on the leadership framework and development initiative	Not specified	Questionnaires [LPI-self, LPI-others, bespoke clinical leader behaviours questionnaire], participant experience questionnaire, focus groups, interviews - individual and group [36 participants],	Analysis of the narrative data	Evidence of development of leadership competencies, improved capabilities noted and improvements in participants' professional and personal development.	Unequivocal	How were the 36 participants selected? Primarily self-report data but some manager data is reported. Unclear whether researchers were part of the team providing development support. How might local context affect the outcomes of individuals?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Hewison 2012 England	To investigate nurse managers' accounts of organisational change	Exploring narratives	Purposive sampling - 13 ward/departmental managers in one NHS Trust	None specified	Qualitative narrative interviews	Narrative analysis	Managers experienced change at increasing rate. Being effective communicators was key to implementing change. Hybrid nature of the role informed approach to change	Unequivocal	How were the ward sister/managers selected? Bias here? Are the findings generalisable within this organisation and wider?
Spehar et al 2012 Norway	To explore clinicians' journey towards management positions in hospital	Qualitative study	Purposive sample of 30 clinicians in middle or first line management positions in 2 health trusts	Organisational identity and commitment	In-depth interviews	Systemic text condensation according to Giorgi's phenomenological analysis.	3 phases in clinician's journey to management: development of leadership awareness, taking on manager role and experience of entering management. Participants have different journeys into management. Being thrown into management was common, learning 'on the fly'	Unequivocal	How generalisable are the findings? Only those currently in management positions were included - nothing heard from those who had left or did not want managerial responsibility. Motivation for entering management not completely captured by the sociological theories of professions or general management theories - what else then?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Martin et al 2012 Switzerland	To evaluate the impact of the adapted RCN Clinical Leadership Programme on development of leadership competencies	Mixed methods approach - sequential explanatory strategy	Convenience sample of 14 nurses	Kouzes and Posner theory of learned leadership behaviour	LPI at 3 intervals -start, end and 6/12 after the programme [from participants and observers]	Descriptive stats and multivariate analyses of variance	Nurse leaders demonstrated significant improvement in 'inspiring shared vision' and 'challenge the process' subscales of the LPI	Unequivocal	Presents only quantitative component thus qualitative data unheard here. 14 from 40 nurse leaders selected -comparison with those not on the programme could have been valuable. Nurse leaders selected own observers, thus bias possible. Set in one organisation thus not necessarily generalisable findings. Influence of researcher unknown
Locke et al 2011 England	To evaluate the impact of workload of the WM with the introduction of administrative assistants	Case study design	16 WMs, 12 WMAs in pilot areas and 6 senior nurse executives , from 8 trusts	None specified	Qualitative interviews, Quantitative data to measure WM workload and ward activity	Content and thematic analysis [after Miles and Huberman]. Descriptive statistics for quantitative data	WM reported spending less time on administrative tasks and increased time for leading staff and patient contact. Improved KPIs noted and increasing staff motivation.	Unequivocal	How generalisable are the findings within the organisation and to wider contexts. 2 WMs left during the pilot - what if anything can be made of this? The WMA post was structured differently in different organisations but this is not evident in the findings. Longer term findings would be valuable. Would be valuable to have data from staff nurses etc. about how they viewed the impact of these changes.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Duygulu and Kublay 2011 Turkey	To evaluate the effects of a transformational leadership programme on charge nurses leadership practices	Evaluation design	Volunteer sample of 30 Unit care nurses from 2 hospitals	Transformational leadership	LPI [modified] self and observer ratings at 4 points -pre, at the end, 3/12 and 9/12 after the programme	Analysis of variance	Leadership practices improved significant according to self and observer ratings. Self-ratings were significantly higher than observer ratings	Unequivocal	Volunteers completed a leadership programme, comparison with those not on the programme could have been valuable. Nurse leaders selected own observers, thus bias possible. Observer scorings consistently lower than self-ratings - this was not explored. Set in two organisations - results no presented by organisation. Two sites thus not necessarily generalisable findings. Influence of researcher unknown

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Doherty 2009 England	Do nurses perceive a contradiction between nursing as caring and technical tasks. Have they experienced a degree of work empowerment or intensification or a combination of these? What influence has government determined targets had for nurses working lives? Is the experience of nurses similar across diverse roles?	Qualitative	Purposive sample of ward sisters [10], specialist nurses [10] and staff nurses [10] from 3 hospitals in England	None specified	In-depth interviews	Content analysis	Staff nurses and ward sisters perceive they are losing nursing - affected by skill mix changes. Specialist nurses perceive greater empowerment following NHS reforms	Unequivocal	Purposive sample selected to ensure variety of specialities - could this bring in bias, is it representative of ward sisters across the organisation? All but 2 of the sample worked full time - again is this representative. 1NHS organisation is this representative.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Brunero et al 2009	To develop a local succession planning model and to evaluate the outcomes of the model	None specified	2 pilot sites, 25 participants	Using Rothwell's 4 part approach to succession planning evaluation	Questionnaires from all 25 participants, Survey tool for those who had a new role through the programme at 6/52 into new role. Descriptive stats for number of placements. Evaluation of the programme using checklist based on Rothwell	Descriptive presentation of data from participant questionnaire and programme evaluation checklist	31 relief positions were filled in the study period, 19 of those for NUM positions. 20/25 participants reported that the SP process was helpful to them, 18/25 reported that the PDP assisted with career planning. 20/25 had a better understanding of career options.	Unequivocal	Methodologically, no underpinnings set out. Rothwell's framework used in the evaluation but no discussion or explanation of the context of this. Difficult to follow the data collection tools. Participants were asked of their views on the succession planning project. No evaluation from colleagues, managers to evaluate the overall success of the strategy. Commentary about the career development of participants going forward would add to the findings

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Dierckx de Casterlé et al 2008 Belgium	To obtain descriptive information about leadership development and elucidate the mechanisms but which effective leadership influences nursing and patient outcomes	Single instrumental case study design.	1 nursing unit - Purposive sample of nurses working on the ward for 4+ years [17]	(Action learning approach)	Individual interviews, focus groups and observation	Thematic analysis	Leadership development an ongoing interactive process of leader and co-workers. The head nurse became more effective in self-awareness, communication skills, performance and vision. Benefits to the team through more effective leadership.	Unequivocal	Data collected from nurses about their head nurse retrospectively - possible recall bias here. Would they feel able to be honest if critical about their head nurse? Head nurse had 15 years' experience - would similar findings arise from a less experienced head nurse. Data centred around one head nurse thus how generalisable beyond this.
Woolnough and Faugier 2002 UK	To evaluate the impact of the LEO programme	None specified	Random sample from those who completed the LEO programme	Transformational leadership	Interviews with 109 participants , 6/12 after the completion of the programme	Not discussed	Mostly participants rated the course highly, although thought it too basic. Clearer understanding of leadership styles was reported. 67% felt leadership capabilities had improved. The 24% who did not have improving leadership skills also rated the programme as poor. Participants identified areas in which their practice had changed	Unequivocal	Self-report data only, nothing confirmatory. Data from a very small proportion of those completing the LEO programme ~.3% No demographic data presented - valuable to know if participants from similar organisations and regions experienced similar challenges.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Cunningham and Kitson 2000b England	To evaluate whether the intervention of the RCN Clinical Leadership programme improved the clinical leadership skills of participants	Pre and Post-test design incorporating action research	4 Senior nurses and 24 ward sisters from 4 acute hospitals	None specified	Pre-test using MLQ [given to participants and to 6 ward staff members], Organisation of care tool, Newcastle satisfaction with nursing scale and team roles effectiveness tool. Post-test readministered all the tools after the intervention.	Quantitative data analysed using ANOVA, thematic analysis [after Titchen and McIntyre] qualitative data collected from personal development profiles, workshops and action learning sets.		Unequivocal	Not all surveys produced usable data. Some significant differences found with scores improving between pre and post-test, but there was no discussion about why followers rated their leaders lower than leaders rated themselves Findings appear encouraging but this intervention of 18 months would be difficult for many organisations to replicate or fund. Limitation acknowledged that the principal data collector was the principle facilitator.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Persson and Thylefors 1999 Sweden	To describe and analyse the expanded managerial role of ward sister/managers with respect to motivators, content, skills and competence, problems and challenges.	(Mixed method study)	All Ward sister/managers in 1 hospital [33 out of 35 participated]	None specified	Interviews using predesigned interview tool, personal competencies questionnaire, leadership dimensions questionnaire	Descriptive stats and ANOVA for questionnaires . Content analysis for interviews	Motivators for the post -the challenge, personal growth, interest in leading and influencing. Positive feedback gave great satisfaction. Lack of time and resources was the main dissatisfier. Need for personal growth highlighted, balanced with personal maturity.	Unequivocal	Interview tool used, not detailed in paper. All self-report data. Nothing confirmatory. Discussion moves to personal maturity but this is not directly evident from the primary data presented.
Willmot 1998 Scotland	Evaluation of the changing role of the charge nurse	Mixed method study	Nurse managers [3], training officer [1] and 47 ward sister/managers/charge nurses in one hospital trust [36 responded]	(Change management theory)	Interviews with nurse managers [3] , one training manager and random selection of 9 charge nurses and questionnaire	Descriptive stats for questionnaire, content analysis for interview data	Most charge nurses supported the development of role. Most felt that the change process had not been handled well. Insufficient consultation, lack of preparation and support, lack of supernumerary status led to confusing and role conflict. New ward sister/managers unable to fulfil potential of new role	Unequivocal	Little if anything in the findings about evaluating how the change was implemented. Data excerpts from interviews all related to data from the questionnaire - did this restrict the views shared by the charge nurses. Supernumerary status was raised as an issue in the discussion but no primary data presented to support this theme.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Pegram et al 2015 England	To describe: job satisfaction, occupational stress, professional identification and organisational commitment of WMs. Perceived aspects of the WM role. The challenges and enablers of WM role	Cross sectional survey design	All WMs and Team leaders in one trust [231], 75 respondents	None specified	Questionnaire designed specifically and 4 validated instruments: job satisfaction scale, occupational stress scale, professional identification scale, organisational commitment scale	Descriptive summary statistics. Collation of mean values for validated instruments. Non-parametric test to compare demographic variables with scores for job satisfaction occupational stress, professional and organisational commitment	Variety in the role gave job satisfaction. Challenges of 'keeping on top of everything. Enabler- having protected managerial time	Credible	Low response rate - positive response bias can't be ruled out. Sample wards managers and team leaders -team leader not defined. Data collected about time since qualification but not time as WM/Team leader. Use of a validated instrument for job satisfaction might restrict responses and precludes elaboration and context specific responses. Responses to surveys were from fewer than the sample of 75, no way of knowing whether non-responders were the same of each question. No discussion about this - .Respondents from one organisation so generalisability to wider workforce uncertain.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Townsend et al 2015 Australia	To identify and explore key obstacles in preventing WMs from effectively performing HR responsibilities of their role	Intensive case study	Purposive sample of 10 [General manager, 4 directors, 5 middle managers]. Stage 2 purposive sample of 22 ward level staff	None specified	Semi structured interviews in two stages	Thematic analysis	WMs have critical role in maintaining and improving employee performance. Budget pressures and limits managerial skill development restrict effective performance	Credible	Study based in a private hospital - generalisability may not be straightforward. Sample of 4 wards in the 2nd stage - not clear how they were selected. Not entirely clear how many interviews carried out at which stage. Secondary data sources were used but unclear how this informed the findings.
Ericsson and Augustinsson 2015 Sweden	To describe the ward sister/managers' experience of their professional role, work and how they handle everyday practice	Action research and participative inquiry over 4 years	Ward sister/managers -5, Chief secretary -1 [all the WMs from one care unit]	Kira's regenerative work	Dialogue forum, observations, in-depth interviews	Inspired by narrative studies after Coffey and Atkinson	WMs made sense of their world through narratives that the research provided and the organisation did not provide for this	Credible	Does the FLM/WM reflect the role as experienced in other countries? Based in one organisation so questions about generalisability. Not clear at what point in the 3 year project the findings presented arise from. Findings from FLM/s - the views of juniors are unknown

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Manning et al 2015	To evaluate the impact of a succession planning programme for prospective nurse unit managers	Pre and post evaluation of a development initiative	All participants of the Future NUM programme (8)	None specified	Self-administered survey: demographics, ability to undertake the role, ability to undertake key managerial task, perceptions of own leadership (LPI), satisfaction with the programme	Descriptive stats for demographic variables, T tests to explore differences between pre and post test data	Apparent significant differences in confidence undertaking NUM role in 3 main categories -Pt care coordination, staff management and ward unit management. Significant differences in 11 out of 14 managerial skills. Significant differences in 3 areas of the LPI. Cost benefits- 1 appointed to NUM, 1 on long term relief post, 2 have left the org for NUM posts	Credible	Methodologically, no underpinnings set out. All self-report data collected with no verification from others. Statistical analysis appeared logical but with only 8 participants not possible to extrapolate from the suggested statistical significance. NO discussion about the non-significant data from the LPI. No broader hospital plan for succession planning identified thus this appeared to be little more than a development initiative for a small group of staff. No mention of how to continue to support and develop those who could not apply for NUM posts as no vacancies. NO discussion about the challenges with 2 participants leaving the organisation.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Stoddart et al 2014 Scotland	To investigate the experiences and views of SCNs in relation to implementation of national clinical leadership policy	Concurrent mixed method study	Survey invited 93 SCN/Ms in 1 health board- 50 participants. Interviews 9 volunteer hospital based SCNs		Survey data and semi structured interviews	Descriptive statistics from survey. Constant comparative analysis after Glaser and Strauss for interview data.	SCNs reported mostly positive views of clinical leadership, team performance and improved patient care. Development needs for linking change management with wider strategic direction	Credible	How representative is the interview sample? Of the participants that completed the survey 9 agreed to be interviewed. Not possible to see from the findings reported if these are from all the SCN participants or just one. Are these findings generalisable within this organisation or wider? No consideration of the role of the researcher - could this have influenced interviews and findings? Self-report data only, nothing confirmatory.
Duffy and Carlin 2014 Scotland	To evaluate a clinical leadership programme for band 6 nurses midwives and allied health professionals	Multiple methods	Purposive sample of those completing the leadership programme [157], 137 completed questionnaire, 40 followed up for an update on progress, views from senior nurses gathered	Kirkpatrick's return on investment model	Short evaluation questionnaire, follow up contact	Descriptive data included	Participants valued the programme, for most it had impacted on their personal and professional development, 2 nurses managers identified improvements in practice	Credible	How were participants selected? Ongoing evaluation yet to be reported. Are the changes sustainable? Is progression to the band 7 role being supported? Limited manager feedback thus data primarily self-report

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Agnew and Flin 2014 Scotland	To identify leadership behaviours of SCNs that are typically used and relate to safety outcomes	Mixed method study	15 volunteers from 25SCNs in one hospital [Stage 1]. Stage 2 - 15 volunteer SCNs [10 from stage 1] rated by 82 staff nurses	Yukl's Hierarchical Leadership Taxonomy	Study 1 - semi structured interviews, Study 2 - self rating of leadership using Yukl's Managerial Practices Survey	Deductive approach, qualitative content analysis for stage 1. Stage 2 - aggregation analyses	Preliminary data on Yukl's leadership taxonomy. Several leadership behaviours relevant for ensuring safer ward environment	Credible	Variety of data presented - some unclear i.e. percentages associates with frequencies of leadership behaviours unclear. Volunteer sample and from one hospital so generalisability unclear
Russell and McGuire 2014 Scotland	To explore success of 2 different methods of supporting SCNs to enhance their leadership capacity	Methodology associated with the Scottish Patient Safety programme	9 wards from 3 general hospitals	None specified	Same data measures for both projects: Care Quality Indicators- Falls, pressure area care, food fluid and nutrition. SCN activity tracking from 6 hours observation each, minute by minute data collection. Discussion forum	Detail not given	Positive work environment and improvements to care noted in both project groups. Additional support role input needed to support SCNs to work effectively	Credible	Some findings presented but no information given about the means and processes for analysing this data. No detail of SCNs approaches before the project although some activity data was presented - this based on 6 hours observation. Whether this could be representative of their wider work is unknown. No control group - could these changes seen during the project be due to the project or a Hawthorne effect?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Carlin and Duffy 2013 Scotland	To develop an understanding of leadership as experienced by newly qualified staff nurses	Qualitative study using Interpretative phenomenological analysis.	Purposive sample of 5 staff nurses	None specified	In-depth unstructured interviews	IPA	SCNs are central to setting standards of care. SCN role is unattractive to newly qualified nurses - due to responsibility, lack of trust and negative feedback. Participants could identify tasks carried out by SCNs but did not identify leadership as such	Credible	How representative is the sample? Are these findings generalisable within this organisation or wider? No consideration of the role of the researcher - could this have influenced interviews and findings?
Fealy et al 2011 Ireland	To identify and describe clinical leadership development needs among nurses and midwives	Mixed methods approach	Random sample of 3000 nurses and midwives on the active register of nurses and midwives in Ireland	None specified	Postal national survey [911 respondents], 22 focus group interviews	Descriptive stats. Analysis of variance	Barriers to clinical leadership development perceived as lowered in relation to quality care as opposed to interdisciplinary relationships and influence and recognition	Credible	Focus group data not presented in this paper. Possible non-response bias with unknowable results. Reported findings from public sector employees only - thus not known if generalisable to private healthcare. Organisation and locality effect unreported. Classification of clinical manager not explained

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Boomer and McCormack 2010 Northern Ireland	How does a programme of WB and AL enable ward leaders to grow and develop practice? Do development processes used enable practice changes to occur	Programme evaluation methodology	48 Clinical leaders [F grade/band 6 or above] from 16 units in 2 hospital	Critical social science, work based learning and practice development	Workshops, action learning set data, evaluation from observations of practice (ward work method assessment questionnaire, patient handover audit, short quality of interaction schedule), interviews with participants, facilitators, managers, patients and nurses	Thematic analysis for observations of practice, participant and manager interviews, creative hermeneutic analysis for staff nurse and patient interviews	A cultural shift was noted with a strong sense of becoming, development of self-awareness. Evidence of increasing the effectiveness of patient centeredness in participating units	Credible	Were any participants lost to follow up? How were the 48 and their units selected? Was there bias in this selection? Can these changes in practice persist after the end of the practice development intervention?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
McCallin and Frankson 2010 New Zealand	To explore the charge nurse manager role	Descriptive exploratory study	Purposive sampling of charge nurse managers - 14 attended briefing [12 charge nurse managers from 1 hospital took part]	None specified	In-depth interviews	Thematic analysis after Davidson and Tolich	Role ambiguity, business management deficits and role overload emerged.	Credible	No detail of the number of charge nurse managers from whom the sample was taken. Interview questions included - no exploration of preparation for the role beforehand. Not possible to ascertain from the findings whether those in post for a short time responded differently from those in post for a longer time.
Porter et al 2006 Scotland	To evaluate the development and outcomes of a pilot to develop E and F grade nursing staff for management	Not specified	Purposive sample of 13 nurses on pilot development programme, 8 participants in the first iteration	None specified	Not specified	Descriptive and frequency statistics for the pilot evaluation	Generally objectives were not met for the pilot. Human resources content was most useful in the pilot programme. 84% stated knowledge was enhanced. On programme 1, objectives were met, 100% felt knowledge was enhanced. Human resources content was useful, clinical governance was not.	Credible	Data collection approaches unspecified. Difficult to interpret results in relation to this. All self-report data nothing confirmatory. Focus entirely on operational management. No evidence of how and if this learning is used in practice.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Stanley 2006 a England	To identify the differences between management and leadership	Grounded theory approach	Survey invited qualified nurses to participate [830]. No detail about number who responded. Stage 2 - random selection of staff in 4 areas, 42 interviews carries out. Stage 3 in-depth interviews with 8 clinical leaders	None specified	Interview data with 42 practitioners	Not discussed	Differences between management and leadership were identified; role conflict exists between leading and managing. Managers were seen as clinically remote and losing credibility. Leaders were identified across all grades	Credible	No detail given of the data collection other than by interview- no information about areas if discussion in the interview. No detail about the sample of 42 - how chosen, grades, length of service etc. Unclear from the findings whether participants conceptualisation includes ward sister/managers or not.
Bolton 2005 England	To investigate the effects of 'new' public management upon the working lives of nurses.	Longitudinal qualitative study stated	240 questionnaires distributed, 170 returned. No detail of interview sample	Goffman's concept of role analysis	Survey and interviews, shadowing	Not discussed	Nurses are firmly attached to their image of unstinting compassion and self-sacrifice. Ward sister/managers are involved in day-to-day nursing activity and never pass through the 'status' passage to become managers. The role of nurse and manager is in conflict	Credible	Interesting exploration of senior nurses' roles. No detail of the survey in terms of length and extent of focus. No detail of the data analysis in this paper. Percentage figures cited relating to qualifications unclear: appears that participants had to locate themselves in only one category thus not possible to identify accurately the educational background of participants. Not clear what data arises from the shadowing. Again nothing about the organisational context or responsibilities for

									the roles, roles considered in isolation from this.
STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Faugier and Woolnough 2003 UK	To evaluate the LEO programme	Survey	Purposive sample of 40,000 nurses and 8000 AHPs who had completed LEO	None specified	Evaluation questionnaire from 12000 participants [? Nurses]	Independent collation and analysis -no detail		Credible	Findings presented refer to thoughts, beliefs of participants about leadership, relationships, motivation, not about the programme itself or the value of the programme. Unclear if results presented are just from nurses or from wider range of LEO participants
Greenwood and Parsons 2002b	To evaluate the first clinical development unit leadership preparation programme		10 senior nurses from 2 area health services		2 Focus group interviews	Not discussed	Mentoring was not successful for all due to lack of mentor skills, lack of trust was highlighted. Tensions between clinical leadership and management noted. Time needed to learn new concepts	Credible	Findings interesting. Overall the reason for high staff turnover after completing the course is not explored. Not clear why this programme should be solely for preparation for clinical development units

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Greenwood and Parsons 2002a Australia	To evaluate a clinical unit leadership preparation programme	None specified	10 senior nurses from 2 area health services [from 14 applicants]	Clinical development unit approach	2 Focus group interviews	Not discussed	The course appeared to be successful in providing leaders with strategic skills. Increased understanding of trying to implement change	Credible	Findings rather limited but convey development and learning. Unclear whether this programme or the learning from it could be generalised to other areas.
Thomas and Bond 1990 England	To compare the differential contribution to nursing care of qualified nurses and nursing auxiliaries, and to determine the effect of 3 methods of care organisation on the work of qualified nurses and nursing auxiliaries.	Not specified	Purposive sample of 36 ward sisters	None specified	Questionnaire, interview, 21 questionnaires from 17 wards	Not discussed	Most ward sisters used some form of team nursing. In 11 areas team leaders allocated work to their team but only 1 ward sister devolved nursing accountability to the team leader. An absence of clearly planned ways of working noted.	Credible	MCQ format - this does not allow participants to give justification for their responses. Patient acuity not clear which might influence findings. Did age or years of experience of ward sister influence the nursing decisions? Data presented gives an outline of what the approach to nursing organisation is no insight to why this might be the case.
Lewis 1990 England	Exploration of the perceptions of ward sisters concerning their responsibilities.	Grounded theory approach	10 Ward sisters in 2 hospitals	None specified	In-depth interviews	Grounded theory approach	Ward sisters act as gate keepers for the professional function of nursing, through positional power and the power of expertise.	Credible	How were participants selected by the organisation? No details given of data collection and analysis. The primary gatekeeping theme unsupported by presentation of primary data. Self-report data only, nothing confirmatory.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Clarke and Marks-Maran 2014 England	To identify areas that would help sustain the productive ward programme following the disbanding of the PW team	Service evaluation case study	11 wards participating in the productive ward scheme	None specified	Clinical expertise related data: falls, acquisition of pressure sores or infections. Productivity data: staff annual leave, sickness, vacancies. Data related to progress and completion of productive ward programme		Change difficult to sustain. Appears to be a strong link between sustainability and the leadership skills and qualities of the WS	Partially credible	Very limited data presented to enable critique of the discussion. Sustainability evaluation completed at 4 time points - no detail of this evaluation. Reputed to include content about staff engagement - no detail of this. Findings suggest that the leadership skills of the WM were important - no data presented to support any assertions about the leadership of the WM.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Titzer et al 2013	To undertake a systematic review to identify and develop future nurse managers (succession planning)	Khan's 5 step systematic review method used	terms used (succession planning, succession management, leadership development, talent management, leadership continuity planning, mentoring, coaching, career planning, replacement planning, nurse managers, nursing leadership)	None specified	Databases included CINAHL, ProQuest, Business Source premier, Medline, Ovid, Inspie and Health Business, 2007-2012. 156 hits of which 13 met the inclusion criteria for the review	Review panel rated articles for inclusion. Scoring system detailed. No mention of data extraction	NM role is complex and those selected lack preparation and effective leadership skills. May take months to achieve competency and during the transition, productivity, nurse satisfaction and patient outcomes are adversely affected. Integrating succession planning strategies within the organisation's strategic vision and plan is needed. Core competencies that can be identified are needed. Varying methods were used to identify future leaders. Formal leadership education required. Mentoring and coaching future leaders is essential. Anticipated outcomes of succession planning initiatives are reducing recruitment and replacement costs. Only one study contained a cost-benefit analysis. Barriers to succession planning includes failure to see the need for SP. Resistance from current NMs to share	Partially credible	Although search terms given, no indication of how they were combined and whether searched as key phrases, subject areas. Unclear whether any other databases were searched. Research and anecdotal articles were appraised, provided that models, frameworks and evaluation methods were included. 13 out of 156 met the search criteria although of these, 5 were case studies and 7 anecdotal articles. Only 2 papers reviewed included a research design and only 5 included some form of outcomes - decision to include the 7 articles with neither research design or outcomes measures of any form questionable. Critique of the included material is lacking and primary findings are not included in any form. Individual papers suppositions are included in the discussion without critique or comment about their credibility. The paper's conclusion

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
							their knowledge and expertise.		includes references to material that was not part of the review.
Griffith 2012	To evaluate succession planning initiatives in nursing	No specified methodology	terms used ('effective succession planning', 'succession planning', 'leadership' and 'nursing' as key words, (succession planning and leadership) in Business source premier	None specified	Databases - CINAHL Plus with full text, Pub Med, Business Source Premier 1987-2011, 'the Internet'. 142 hits from the combined search. 24 papers 'selected' for the review	Not specified	3emerging themes: succession candidate leadership and managerial competencies, programmes for the identification and preparation of future nurse leaders, succession planning implementation processes	Partially credible	No detail of the search, sifting, I/E criteria, no definitions of SP or nurse leader, No detail as to what is included in the review and why those. Discussion includes assertions that may have relevance but no primary data included to support them, little if any detail of the nature of the included material or critique of the same
Bradshaw 2010 UK	To examine UK ward sister role in contemporary and historical context	Histographical analysis	Nursing text books 1877-1971, nursing/medical periodicals 1912-2010, official government reports 1960-2010, research studies on nursing 1960-2010		Interrogation of archival sources	Histographical analysis	Traditional authority of the ward sister for nursing standards, ward services and ward facilities is diminished. Motivation is from nursing rather than managerial values. Disparity in titles reflects values enshrined in the role.	Partially credible	Interesting review but no detail given of the quantity of material reviewed inclusion exclusion criteria. Very little primary data presented thus all the authors' summation and conclusion.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Jasper et al 2010 Wales	To discuss challenges in designing an All-Wales professional development programme to empower ward sisters/charge nurses, pilot programme evaluation	Collaborative staged approach	Target group of 936 ward sister/managers/charge nurses	Adult and work based learning	programme review from 33 participants in pilot area		Taught programme well received, examples of transformational change reported, participants appeared empowered	Partially credible	Very limited detail of findings from the pilot presented here. No detail of wider findings.
McEwen et al 2005 England	To investigate self-reported duties carried out by sisters and charge nurses on the wards and assess their attitude towards their management role	Not specified	Purposive sample of 93 ward sisters/charge nurses in 1 hospital, 45 responded	None specified	Questionnaire-34 item	Descriptive statistics	Ward sisters and charge nurses were allocated patients for half their shifts each week. Most did not have time to complete management duties. Most did not have time to attend clinical supervision.	Partially credible	48% response rate and of respondents 915 were G grades - how does that reflect the grades of the target sample? Can the findings from this sample be generalised to the whole population of G grades in the organisation? Survey Likert type responses may limit responses. Self-report data only.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Duffield 2005 Australia	To design provide (and evaluate) a Master Class leadership course for unit nursing managers	Not specified	Purposive sample of 24 unit managers (18 applied and selected)	(Experiential learning)	University evaluation tool 6/12 after the programme	Descriptive, not specified	Master class programme was positively evaluated. Participants valued choosing what they wanted to learn and networking and support from others.	Partially credible	Data collection 6/12 after the programme - maybe more useful to collect at the end and then at 6/12. All self-report data, nothing confirmatory. Difficult to evaluate discussion as very limited findings presented
Hancock et al 2005 England	To evaluate the impact and sustainability of the LEO programme on the role of G grade nurse managers and colleagues and patient care. Identify ongoing learning needs of G grades	Qualitative inductive methodology	Purposive sample of 4 G grades managers from each of the Trust's 4 clinical divisions		Interviews of participants, 5 of their colleagues, 3 colleagues each identified by their manager	Thematic analysis after Attride-Stirling		Partially credible	Not clear how the sample was specifically selected i.e. 4 from how many G grades. Could others have been selected? No primary data from interviews presented therefore difficult to judge the discussion of findings. Some ongoing learning needs were discussed but no primary data presented to illustrate this. Some of the study objectives were met. Did other professionals/nurses at other bands complete the LEO programme - interesting to compare findings if so?

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Bonner and McLaughlin 2014 England	To understand challenges of group members' roles, identify core cultures and values to support wards, identify areas for change to improve patient and staff experience,	Action learning	10 Inpatient mental health ward sister/managers	None specified	Through workshop activities	Detail not given	WM role in acute MH inpatient settings is unmanageable at times. WMs unprepared for administration tasks. Overall WMs felt they were supportive to staff and wards were recovery focussed.	Partially credible	Very little primary data presented. Work environment scale discussed - no primary data reported. No time frame given for this - was it at the start of the project or after 12 weeks. Are the findings discussed generalisable beyond mental health specialities? Self-report leadership styles evaluation referred to, nothing confirmatory.
Pitkänen et al 2004 Finland	To develop a project to develop the managerial skills of those nurses working as deputy ward sisters	Not specified	Purposive sample of 16 [? All of the deputy ward sister/managers in 1 hospital]	None specified	Survey at outset of programme to 16 deputy ward sisters, 16 ward sisters and 4 senior executives [75% response rate]	Descriptive and content analysis	Multiprofessional cooperation was good. Over half considered acting as a nursing expert with strong negotiation and information dissemination skills. Skills in monitoring measures, financial planning were poor. Learning needs identified for crisis management and conflict resolution	Partially credible	Very limited data presented from the initial survey. No evaluation data from the programme as the programme was ongoing. In underpinnings, links made to Finish literature but not to wider leader development literature

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Bolton 2003 England	To investigate the effects of 'new' public management upon the working lives of nurses.	Longitudinal qualitative study stated	Senior nurses in gynaecology wards and outpatients in one hospital [numbers not specified]	Goffman's concept of role analysis	Shadowing, observation and interview	Not discussed	Nurses can carry out multiple roles although management and caring may be seen as in conflict.	Partially credible	This is purported to be from a longitudinal study but that does not seem to have been explored. Narrative excerpts come from different years but no explanation or link to changing experience, context etc. WMs and Clinical nurse managers looking at their role. Changing role commented upon but no consideration of the organisation's role here in the changing roles.
Firth 2002 England	To investigate the experiences of ward sister/managers in an acute hospital trust.	Phenomenological study	Purposive sample of 55 ward sister/managers. 12 were recruited	None specified	Preliminary survey, interviews and observation, field notes	Colaizzi's procedural steps for analysis	Role ambiguity, a supervisory function to the role. Core skills and capabilities identified. Cognitive dissonance between clinical and managerial role demands	Partially credible	Ward sister/managers needed to have been in post for 4 years - no explanation as to why. Use of a survey to inform the interview strategy and an observational phase seem incongruent with phenomenology

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Koivula and Paunonen-Ilmonen 2001 Finland	To evaluate objectives, development strategies and problems of ward sisters in developing nursing	Programme evaluation	Purposive sample of all ward sisters in 2 hospitals	None specified	Questionnaire [37 ward sisters in 2 hospitals]	Qualitative data analysis after Knippendorff. Descriptive data analysis	Ward sisters wanted to develop the ward climate to be good, open, supportive and appreciative of others. Developing good care was important to all, encompassing ideas of care, quality and economy of care. Lack of time was a problem, ward sisters felt under great pressure, with too little time and too few staff. Increasing patient acuity and organisational factors complicate the care for some patient groups. Difficulties were noted with cooperation from doctors and hospital management.	Partially credible	Self-report data. Very little primary data included so difficult to evaluate the discussion. Ward sister participants ranged from 1.3 years' experience to 30, mean 13.6. If and how this influenced findings is not discussed. No discussion of what training/education they had experienced prior to this data collection

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Williams et al 2001 England	To examine senior nursing roles and their contribution to patient services in light of changes in local and national healthcare provisions and nursing roles	Not specified	Focus groups for ward sister/managers and specialist nurses - no detail. Survey to 47 ward sisters and senior nurses and 66 stakeholders.	None specified	Stage 1 - 2 focus groups, Stage 2- postal survey involving 2 questionnaires	Descriptive presentation of survey data. No detail of focus group analysis	Erratic grading profiles of senior nurses noted. Clinical expertise, leadership skills, communication skills and self-confidence were identified by all as key competencies. Senior nurses suggested the value of a buddying system to develop juniors. Clerical support and support for clinical supervision was lacking.	Partially credible	No clear definitions of what is meant here by senior nursing roles. Survey based on findings from focus group with 11 participants - do details given of primary focus group data Survey went to ward sister/managers and others who carried out specialist or advanced skills - no clear definition of what these are. Sequencing of data collection unclear. Response rate 70% - unclear whether this reflects 70% of sample of 70& of total population of ward sister/managers. Stakeholders' questionnaire asked about the WM role - unclear whether responses are based on what they consider it is or what it should be. No consideration of what the organisational constraints on roles might be.

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Dodwell and Lathlean 1987 England	To evaluate the outcomes of a ward sister training programme	None specified	194 participants selected by the chief nurse	None specified	Interviews at 3 intervals [before during and after the course] and questionnaire at the end of 6th month of the course completed by the participant and facilitator and manager.	Not discussed	Positive outcomes were noted in terms of improvements in individuals and noticeable effects for the hospital. Managers noted participants as more enthusiastic and motivated. Some participants still needed further help however	Partially credible	Not clear how participants were selected for the programme. Not clear how many of those participated in the evaluation. Not clear from the findings presented whether participants, managers and facilitator were in agreement.

Appendix 4 – Papers excluded following critical appraisal



Papers excluded following critical appraisal

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Phillips and Byrne 2013 England	To evaluate a leadership programme for ward sister/managers in one NHS Trust	Implied Case report	Purposive sample of 24 ward sisters	Not specified	Questionnaires , feedback on action learning sets	Not discussed	Reported increase in repertoire of leadership skills	Unsupported	Modules on the programme loosely based on Cunningham and Kitson, but no clear reference to why action learning sets. The learning organisation included in the intro and discussion but not clearly integrated into the programme itself. Only 12 of 24 participants completed the evaluation questionnaire - report bias? Self-report data - no confirmatory data
Tomlinson 2012 Scotland	To analyse the leadership styles of SCNs in acute clinical wards. Evaluate the impact of transformational and distributed leadership styles in clinical staff.	Interpretivist approach	20 Junior staff nurses	None specified	In-depth interviews	Data coding	No primary data provided. Inferred findings 4 themes, transformational leadership in some teams where clear vision existed. Staff were mainly engaged in the team. Patient centred care was a priority but difficult to achieve due to work pressures	Unsupported	No primary data presented here, cannot evaluate the discussion. What questions were asked at interview? The author interviewed, as an SCN how did she impact on the data? Was there any bias in interviewing or analysis? Participants were asked to comment on their SCNs leadership style - how likely is it that they might feel pressured to answer in certain ways?

STUDY AUTHORS	RESEARCH QUESTION	METHODOL OGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Paterson et al 2010 Australia	To describe and evaluate a leadership programme to build nurses' capacity to assist with the development of others	Implied Case report	Nurses within their graduate year or within 6/12 new in the organisation	Social learning theory after Bandura [loose link]	None provided	None	No findings presented here	Unsupported	Evaluation data not provided. No findings, all inferred, theoretical discussion
Wilson 2009 England	To explore the implementation of the productive ward - releasing time to care			Lean methodology	None really specified	Not discussed	Not really any findings	Unsupported	Evaluation referred to in the abstract but no evaluation data presented. In the conclusions data is referred to that appears to come from this implementation of the productive ward but this is unclear
Boomer et al 2008 Northern Ireland	To develop a shared vision in the context of a practice development programme for clinical leaders	Practice development project	9 wards in one Trust, 6 wards and 1 clinical from another trust	Practice development theory	None provided	None	No primary data presented.	Unsupported	Ward leaders and lead nurses undefined. PD Methodology outlined but no evaluation findings etc.
Platt and Foster 2008 England	To evaluate the genesis, contents and outcomes of a charge nurse development programme		Purposive sample of 95 nurses who have completed the development programme	None specified	Questionnaire	Qualitative analysis stated	No primary data presented. Evaluations were positive, 95% of respondents found the programme empowering. Networking was enhanced	Unsupported	How were the 95 participants selected, ? Selection bias, no primary data presented. Lead author was programme facilitator ? Researcher bias, no ethical consideration

STUDY AUTHORS	RESEARCH QUESTION	METHODOLOGY	SAMPLING	THEORETICAL FRAMEWORK	DATA COLLECTION METHODS	ANALYSIS	FINDINGS	CREDIBILITY OF FINDINGS	CRITIQUE/GAPS
Stanley 2006 b England	To identify who the clinical leaders are and analyse the experience of being a clinical leader	Grounded theory approach	Survey invited qualified nurses to participate [830]. 188 responded. Stage 2 - random selection of staff in 4 areas, 42 interviews carries out. Stage 3 in-depth interviews with two clinical leaders	None specified	Survey and interviews	Data was analysed with the use of Nvivo 2.0	No primary data provided. Inferred findings -clinical leaders demonstrated competence, clinical knowledge and being an expert. Other facets were identified which are attributed to a new configuration of leadership - congruent leadership	Unsupported	No primary data presented here so impossible to evaluate the discussion. What questions were asked at interview? Was the author the interviewer? Was there any bias in interviewing or analysis? No detail given of the approach to analysis
Cunningham and Kitson 2000a England	To evaluate whether the intervention of the RCN Clinical Leadership programme improved the clinical leadership skills of participants[phase 1 of the evaluation]	Pre and Post-test design incorporating action research	4 Senior nurses and 24 ward sisters from 4 acute hospitals	None specified	Pre-test using MLQ [given to participants and to 6 ward staff members], Organisation of care tool, Newcastle satisfaction with nursing scale and team roles effectiveness tool. Post-test readministered all the tools after the intervention.	Quantitative data analysed using ANOVA, thematic analysis [after Titchen and McIntyre] qualitative data collected from personal development profiles, workshops and action learning sets.	No findings presented here	N/A	

Appendix 5 - NRES approval letter





National Research Ethics Service

Central London REC 3

Room 4W/12, 4th Floor West
Charing Cross Hospital
Fulham Palace Road
London
W6 8RF

Telephone: 020 331 17287
Facsimile: 020 331 17280

22 March 2011

Mrs Judith Enterkin
London South Bank University
103 Borough Road
London
SE1 0AA

Dear Mrs Enterkin

Study Title: Navigating the transition from Staff Nurse to Ward Sister.
REC reference number: 11/H0716/1

Thank you for your letter of 02 March 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Response to Request for Further Information		02 March 2011
Participant Information Sheet: Key informant information sheet	4	07 February 2011
REC application	64431/170764/1/829	25 November 2010
Participant interview schedule	2	11 November 2010
Faith Gibson's CV		
Participant Information Sheet	4	07 February 2011
Protocol	3	22 November 2010
Evidence of insurance or indemnity		01 July 2010
Referees or other scientific critique report		
Investigator CV		22 November 2010
Participant Consent Form	4	07 March 2011
Covering Letter		07 December 2010
Summary/Synopsis	1	23 September 2010
Letter from Sponsor		01 November 2010
Key Informants Interview Schedule	2	11 November 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.


We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H0716/1

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely


Dr Yogi Amin
Chair

Email: adriana.fanigliulo@imperial.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Prof Nicola Crichton, Faculty of Health and Social Care*

Appendix 6 - R/D approval




NHS Management Approval Letter for Research

To: Judith Enterkin 

From: 

Date: 03/10/2011

Project Title: Navigating the transition from staff nurse to ward sister (RD11/033)

I understand that you have received a favourable ethics opinion for the above project, with the condition that you do not undertake research in an NHS organisation until relevant NHS Management Approval has been received. I am therefore writing on behalf of the  trust to inform you that the project has been approved by the Trust and may now proceed.

To maintain this approval, the following conditions must be met:

1. All staff involved in the running of this study must adhere to Trust and Research Governance Framework requirements (see www.nwlh.nhs.uk/research).
2. As Chief/Principal Investigator you are required to formally advise the R&D Office of **ANY** changes to the project including:
 - Any changes to the status of the project, e.g. abandoned, completed etc
 - Any changes to the protocol – however minor.
 - Any changes to the funding arrangements.
3. The Chief/Principal Investigator is also required to:
 - Notify the R&D, in a timely fashion, any Serious Adverse Events relating to the Research and the appropriate urgent safety measures taken in line with ICH GCP requirements.
 - Ensure that the R&D Office has copies of all annual and final progress reports.
 - Ensure all researchers involved in the project hold the necessary expertise required and have Honorary Contracts should they need to.
 - Ensure adequate and accurate reporting and monitoring of said project.
 - Co-operate with all internal Trust monitoring and auditing procedures.

4. This approval will automatically lapse if no annual report on this study is received at the R&D office, 14 months from the date of this letter. A guidance note on Annual reports is available at the R&D Office.

*Remarks- It is noted that the insurance details provided for this project expired on the 31st July 2011, a letter dated 01/011/2010 from Professor Crichton on behalf of the sponsor does confirm that Indemnity will be in place to cover this project. For file completion purposes please provide evidence of the renewed up to date insurance to the R&D Office.

Yours sincerely,



Approved Working Documents (For R&D Reference)

Document	Version	Date
Participant Information sheet: key Informants	4	07/02/2011
Participant Information sheet	4	07/02/2011
Participant Consent Form	4	07/02/2011
Protocol	3	22/11/2010



Appendix 7 - Participant information sheet



Participant information sheet

Navigating the transition from Staff Nurse to Ward Sister/Charge Nurse

I am a Doctoral research student and a Senior Lecturer from the Institute of Strategic Leadership and Service Improvement in Health Care at London South Bank University. I have been leading the Aspiring Ward Sisters Leadership Development Programme here at ██████████ Hospitals NHS Trust.

I would like to invite you to take part in a research study. Before you decide you need to take time to understand why the research is being done and what it would involve for you. Please take your time to read the following information carefully. Please feel free to discuss this with colleagues, friends if you wish to. Please contact me if anything is not clear or you need more information.

Please take time to decide whether or not you wish to take part in the research.

The purpose of the study

The purpose of this research study is to explore individual and organisational factors that influence the transition from Staff Nurse to Ward Sister in an outer London NHS General Hospital. This is research using a case study approach which allows me to use a range of methods such as interviewing key people, exploring Trust policies and documents to build up a picture of life for Band 6 nurses in transition to Ward sister within this organisation.

Exploring individuals' experience of this transition and related factors will enhance understanding of the challenges new and aspiring Ward Sisters face. It will in addition, provide information to the organisation as to how the organisation can facilitate a more effective transition process.

Why have I been invited?

You have been invited to take part in this study because you have recently undertaken the 'Aspiring Ward Sisters' leadership development programme.

The first part of this evolving case study will be an exploration of the experience of transition from staff nurse to Ward Sister through dialogue with staff nurses who are of have recently undertaken a leadership development programme.

Do I have to take part?

No.

It is up to you to decide if you wish to take part in the study. Should you decide to take part, you will be asked to sign a consent form to show that you have agreed. You are free however to withdraw at any time and without giving a reason. If you decide not to take part or to withdraw from the study you will have no detriment to your standing or employment within the Trust. If you wish to withdraw from the study at a later point, I will ask your permission to use the interview data already recorded. You may ask for any of your previous interview data to be discarded.

What will happen if I decide to take part?

You will be invited to an individual interview. I will then contact you to arrange a convenient time and location for the interview. I will carry out the interview myself and with your permission, I will tape record our interview discussion so that I can concentrate and do not have to take notes during the interview. The interview will last between one and one and a half an hours. I will be asking about your experiences as a Staff Nurse preparing for the Ward Sister/Charge Nurse role at some point in the future.

I would like to contact you again with your permission at two further time points. I will agree with you how you would like to be contacted. This is to enable me to look at your career progression over time. At the second and third time points which are likely to be six months to a year apart, I will ask to you sign a consent form again before inviting you to another individual interview.

What will I have to do?

I will ask a member of the Trust's Training and Development Department to make contact with you and ask if you agree to take part in the study. If you decide you would like to take part in the study, please complete the reply slip at the bottom of this information sheet and I will then make contact with you to arrange an interview.

If you do not wish to take part you need do nothing more.

Will my taking part in the study be kept confidential?

All information that you give during the study will be kept strictly confidential. All data that is collected will be stored in a safe and lockable place within the University. Only I will have access to it. The interviews will be transcribed either by myself or by a professional transcriber, under contract to the University. A pseudonym in place of your name will be used when writing up the findings. I will keep securely a list of participants' names, contact details and pseudonyms to enable me to contact you in the future. Key themes identified in this study will be fed back to the NHS Trust.

What will happen to the results of the study?

The results of this study will be written up in a thesis which will be submitted in fulfilment of my Doctoral Studies. I will send you a report about the study and its findings at the end of the research. The results will be presented in academic and professional journals and will be presented at conferences to share the work with other academic and clinical professionals.

Who has reviewed the study?

This study has been reviewed by the National Research Ethics Service, Central London REC 3.

Further information and contact details

If you would like to discuss this study in more detail, please contact

Judith Enterkin
Institute for Strategic Leadership and Service Improvement
London South Bank University
020-7815-8344
enterkij@lsbu.ac.uk

In the event that you wish to complain, please discuss it with me in the first instance.
If you are still unhappy once you have spoken to me about your dissatisfaction, you may contact :

Professor Faith Gibson
Faculty of Health and Social Care
London South Bank University
103 Borough Road
London, SE1 0AA

Appendix 8 - Key informant information sheet



Key informant information sheet

Navigating the transition from Staff Nurse to Ward Sister/Charge Nurse

I am a Doctoral research student and a Senior Lecturer from the Institute of Strategic Leadership and Service Improvement in Health Care at London South Bank University. I have been leading the [REDACTED] Leadership Development Programme here at [REDACTED] Hospitals NHS Trust.

I would like to invite you to take part in a research study. Before you decide you need to take time to understand why the research is being done and what it would involve for you. Please take your time to read the following information carefully. Please feel free to discuss this with colleagues, friends if you wish to. Please contact me if anything is not clear or you need more information.

Please take time to decide whether or not you wish to take part in the research.

The purpose of the study

The purpose of this research study is to explore individual and organisational factors that influence the transition from Staff Nurse to Ward Sister in an outer London NHS General Hospital. This is research using a case study approach which allows me to use a range of methods such as interviewing key people, exploring Trust policies and documents to build up a picture of life for Band 6 nurses in transition to Ward Sister within this organisation.

Exploring individuals' experience of this transition and related factors will enhance understanding of the challenges new and aspiring Ward Sisters face. It will in addition, provide information to the organisation as to how the organisation can facilitate a more effective transition process.

Why have I been invited?

You have been invited to take part in this study either because you hold a senior position within the Trust or because your name has been given to me by one of the Staff Nurses participating in the study as a valuable contact.

Do I have to take part?

No.

It is up to you to decide if you wish to take part in the study. Should you decide to take part, you will be asked to sign a consent form to show that you have agreed. You are free however to withdraw at any time and without giving a reason. If you decide not to take part or to withdraw from the study you will have no detriment to your standing or employment within the Trust. If you wish to withdraw from the study at a later point, I will ask your permission to use the interview data already recorded. You may ask for any of your previous interview data to be discarded.

What will happen if I decide to take part?

You will be invited to an individual interview which may be face-to-face or via the telephone. I will then contact you to arrange a convenient time and location for the interview. I will carry out the interview myself and with your permission, I will tape record our interview discussion so that I can concentrate and do not have to take notes during the interview.

The interview will last between one and one and a half an hours.

What will I have to do?

If you decide you would like to take part in the study, please complete the reply slip at the bottom of this information sheet and I will then make contact with you to arrange an interview. If you do not wish to take part you need do nothing more.

Will my taking part in the study be kept confidential?

All information that you give during the study will be kept strictly confidential. All data that is collected will be stored in a safe and lockable place within the University. Only I will have access to it. The interviews will be transcribed either by myself or by a professional transcriber, under contract to the University. A pseudonym in place of your name will be used when writing up the findings.

Key themes identified in this study will be fed back to the NHS Trust.

What will happen to the results of the study?

The results of this study will be written up in a thesis which will be submitted in fulfilment of my Doctoral Studies. I will send you a report outlining the research and results at the end of the research study. The results will be presented in academic and professional journals and will be presented at conferences to share the work with other academic and clinical professionals.

Who has reviewed the study?

This study has been reviewed by the National Research Ethics Service, Central London REC 3.

Further information and contact details

If you would like to discuss this study in more detail, please contact

Judith Enterkin
Institute for Strategic Leadership and Service Improvement
London South Bank University
020-7815-8344
enterkij@lsbu.ac.uk

In the event that you wish to complain, please discuss it with me in the first instance. If you are still unhappy once you have spoken to me about your dissatisfaction, you may contact

Professor Faith Gibson
Faculty of Health and Social Care
London South Bank University
103 Borough Road
London
SE1 0AA

Key information sheet/version 4: 7/2/11

Appendix 9 - Consent form



Appendix 10 – Participant Interview Topic Guide



Navigating the transition from Staff Nurse to Ward Sister/charge Nurse – Participant Interview Schedule

Introduction of self

Introduction of the interview process -

Reaffirmation of confidentiality, anonymity

Contact details for subsequent time points

- Tell me about your current role
- How long have you been qualified, worked in this Trust, in this area?
- How long have you been at the current Band?
- What do you think the role of the ward sister is all about?
- Have you plans to apply for a ward sister post? Tell me about your reasons.
- Have you planned your journey in your career to this point?
- What has influenced your career journey overall – friends or families, work location, speciality, life events, opportunity?
- Has anything at this Trust made an impact on your career decisions over the past few years?
- Are ward sisters important people in this Trust?
- Do they have a lot of responsibility?
- Are they respected?
- What could help you make the decision to go for a ward sisters post?
- What would help you be successful as a ward sister?
- What support do you think a junior nurse who wants to become a sister in the future needs?
- Is there anything else you think I should know about right now about becoming a successful ward sister in the Trust?
- I would like to talk to some other people in the Trust to help me gain a better understanding of the role of the ward sister and how staff nurses make the move to this post. Is there anyone that you think would be a good person to talk to about this?

Thank you for your time and participation. With your agreement I would like to talk to you again at two points in the future. I will contact you in 1 and 2 years from now and ask if you would be prepared to be interviewed by me again

JE

Version - Interview schedule/participants/version 2/ 11/11/10

Appendix 11 - Key informant Interview Topic Guide



Navigating the transition from Staff Nurse to Ward Sister/charge Nurse – Key Informant Interview Schedule

Introduction of self

Introduction of the interview process -

Reaffirmment of confidentiality, anonymity

- Tell me about your current role
- How long have you been qualified, worked in this Trust, in this area?
- Does the Trust have a philosophy or mission statement?
- What do you think the role of the ward sister is all about?
- Are ward sisters important people in this Trust?
- Do they have a lot of responsibility?
- Are they respected?
- When the Trust is recruiting for ward sisters, is it generally easy to select an appropriate candidate?
- Do applicants tend to come from within the organisation
- What does a successful ward sister look like?
- What support is in place to help junior staff nurses progress through their career to ward sister?
- Are there professional/academic courses that you think a prospective/new ward sister should participate in?
- Is there anything else you think I should know about right now about becoming a successful ward sister in the Trust?

Thank you for your time and participation.

JE

Appendix 12 - Participant Interview Topic Guide - repeated interviews



Interview topic guide for interviews over time

Intro – seek and gain consent, confidentiality and anonymity reassurances

Opener

- How are things at work? How are you?
- Has anything changed since the last time we met?

What have you done?

- What have you done in the last year? [Particularly development activities, courses, study days, shadowing, meetings, deputising]
- Is there anything you thought you would do but have not [and if so, why is that]
- Have there been any particular barriers to this?

What are you doing now?

- When we last talked, you were band ... in role, what are you doing now
- What is your role/remit [if not already covered]
- Where did you think you would be now?
- If you could sum up what work and your role entail now, what would it be.....

Collective narrative

- What do you think of the suggestion that there is a link between someone's personal work ethic, their motivation and whether or not they have a strong positive role model.
- How can you see that models of good practice [role modelling, team work and staff development] could be rolled out to other areas.
- What access do you have to a mentor, what do your staff have
- Who might you approach if you were seeking a mentor
- What do you know about the retitling of the WM – what impact has that had?

Also possibly

- What overall has influenced the path you have taken?
- What does a nurse leader look like to you [at band 7 or 8]
- How do you see yourself in relation to this view?

- Where are the nurse leaders for you in current role/organisation?
- How do we prepare the next generation of clinical leaders?
- Tell me about the responsibility for developing the next generation?
- What do you see as challenges for the future?

- Following on from the Francis report, what implications for clinical nurse leaders are there?

Appendix 13 - Full version of the thematic data matrix





Dimensions		Themes		Categories		Sub-categories	
Self fulfilment	1	Motivation	1	Personal attributes			
			2	Educational achievement			
			3	New post			
		2	Job Satisfaction	4	Expectations of the post		
		5		Approval-Trust	1	Direct	
					2	Lack of	
		3	Support mechanisms	6	Relationships with significant others	3	Supportive
						4	Lack of
				7	Formal/informal support networks		
		4	Role models				
Professional purpose	5	WM role	8	Knowledge and skills			
			9	Roles and responsibilities	5	Evolving role of WM	
					6	Clinical work gives satisfaction	
					7	Influence of WMs	
					8	Disincentives	
					9	Impact of titles	
					10	Willingness, readiness to take on to progress	
					11	Learning on the job	
					12	Falling into management roles	
					13	Too much work - is this the same as 'just do your job and go home'?	
		6	Work ethic	10	Nursing work essence	14	Knowing competence, limitations
						15	Passion, drive to lead a team, to do things better, incl nursing work ethic
					16	Negative connotations associated with 'just doing the job'	
				11	Supporting others		
				12	Taking roles, responsibilities	17	Willingness, readiness to take on to progress

Dimensions		Themes		Categories		Sub-categories
					18	Learning on the job
					19	Falling into management roles
					20	Too much work - is this the same as 'just do your job and go home'?
	7	Nature /essence of leadership	13	Self as leader		
			14	Others as leaders		
Departmental level work	8	Ward context	15	Philosophy of care/work	21	Nuts and bolts -how the ward ticks, including our team belonging
					22	Here for me or the patient
					23	Ward as a learning environment
			16	Value of ward work		
			17	The Team	24	Building the team, (supporting developing staff)
					25	
					26	Working with and in the MDT
	9	Developing people for the future, future roles at local level	18	Supporting, developing staff	27	Appraisal, feedback, development plans
					28	Transition from band 6 to 7
					29	Shadowing opportunities
					30	Supporting and developing band 7s in post
					31	Failure in provision, support of shadowing, appraisal, role modelling, training opportunities

Dimensions		Themes		Categories		Sub-categories
Organisation level of work	10	Trust remit for education and developing the workforce - better as Supporting and developing the WF?	19	Developing and supporting an organisation wide mentoring programme		
			20	Supporting the workforce through change and to manage change		
			21	Supporting, developing WM council		
			22	Developing valuable and appealing career pathways		
			23	Structured development programme		
	11	Nursing Leadership -vision and presence				
	12	Organisational context	24	Operational framework		
			25	Authority/responsibility [above WM]	32	Defined role, remit of matron
					33	Variation, lack of clarity, blurring of senior roles
			26	One Trust	34	One culture
					35	Two cultures