

LEADER IDENTITY CONSTRUCTION
AND ROLE MODELLING IN
NURSING - STUDY OF THREE
CASES

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Abstract

This study critically examined role modelling and leadership in nursing in the National Health Service (NHS) in the United Kingdom. Contemporary policy drivers call for inclusive, compassionate, collective and shared approaches to leadership in order to meet ongoing health service demands and reforms. Part of this could be achieved by harnessing and capitalising on the role modelling aspect of leadership, allowing all potential leaders to develop.

A constructivist case study methodology was used to explore this contemporary phenomenon in a naturalistic paradigm where there are multiple realities, shaped by individuals who in turn are influenced by their surroundings. This worldview corresponds to the intricacies in the concept of leadership. This translates epistemologically into undertaking research in the natural setting, directly exploring complexity, seeking understanding. A case study approach enabled role models and leaders to be identified, alongside individual perceptions, opinions, experiences and ideas associated with role modelling and leadership amid everyday practice. Data was collected across three acute nursing ward teams in a district general hospital through non-participant observation and semi structured interviews. Both inductive and deductive approaches were used in data analysis within and across the cases using a socially constructed lens. Rigour was assured through robust reflexive strategies and triangulation of methods, data sources and theory.

The two main findings which offer an original contribution to knowledge focus on leader location and co-construction of leader and role model identity. The fourfold leadership typology of Grint (2010), 'position, person, process' and results was utilised as a heuristic frame. The care context influenced how the Ward Managers enacted their roles and impacted on leader location: 'I am in front of you', 'I am beside you' and 'I am behind you'. Leader location formed the backdrop for the modelled content whether originating from the Ward Manager or other staff. It encompassed the clinical climate within which

leading and following occurred. Nurses were conversely viewed as role models regardless, and as a result, of their formal positions.

There are a number of implications for nursing and healthcare arising from this novel study which could contribute to personal and team development. It offers a means to explore a space in the leadership rhetoric, it exposes role modelling as a leadership behaviour and contributes to enhanced understanding of the interface between role modelling and leadership and the exchange of follower and leader roles. Essentially acting as a role model can be seen as leading in the sense of leading by example. This is the first connection to leadership. The second connection is when being a role model is expected as part of being a leader. In this study overarching factors have emerged: the act and impact of learning from a role model is evident in the nursing team; being seen as a role model is within the gift of anyone at any positional level, essentially constituting being 'followed'; and at some point in their developmental trajectory an individual begins to recognise themselves as a role model and this can happen when they become formal leaders.

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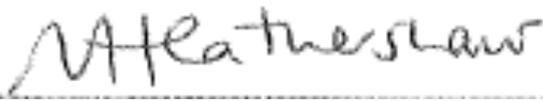
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Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material submitted for a degree.

Signed - 

Rachel Heathershaw

Date – 13th June 2022

Chapter 1 – Background

1.1 Introduction

Effective leadership is considered critical in healthcare and nursing leadership is one of the key determinants contributing to this. This research was undertaken with the purpose of exploring leadership and role modelling in nursing. This introductory chapter provides a general outline and background to the research, beginning with a discussion of my personal experience as a nurse and consideration of the notion of leadership as the underlying frame within which this study is situated. After this there is an introduction to current leadership practice within nursing and the National Health Service (NHS) in the United Kingdom (UK). The ensuing discussion demonstrates that leadership is problematised largely as a result of contemporary health care challenges and how this needs to change. This is followed by the rationale and justification for undertaking the research. The chapter concludes with an overview of the thesis.

1.2 Personal experience

This initial section charts the key factors that have influenced my development and thinking regarding being a leader and leadership. It introduces the notion of leadership as a definitional challenge (discussed further in section 1.3) inherent to everyday understanding and experience of leadership and its fluid and evolving nature.

I have been a registered nurse for over 35 years, being a nurse is part of my identity and cannot be detached from me as a person. I have worked in higher education for the last decade, prior to that I worked in the NHS. I was a staff nurse and junior sister; my career followed a standard traditional trajectory as I gained experience and seniority during the late 1980s and 1990s. For several years I was a Ward Sister, a role I aspired to become after qualification. This was extremely rewarding at the same time as being extremely challenging. As my experience grew, I increasingly recognised the crucial role that leaders and role models had.

My interest in leadership per se was piqued when I commenced an educational role as a Clinical Practice Facilitator¹ that required me to act as a leader but carried no direct managerial function. I needed to develop a different skill set in order to influence the practitioners I interacted with. I chose to study leadership and change at master's level; this was the origin of my formal interest. Consciously studying leadership opened my mind to ideas, concepts and knowledge previously hidden from me. Grint (2010) confesses that when he began to read about leadership, he thought that as he had been a leader, he understood everything but soon realised that this was built on spurious foundations. As he read more, his knowledge increased but understanding decreased, I have felt the same.

On completion of my Masters degree an opportunity arose to join higher education in a role that built on my existing experience and skills. My position in the University enabled me to remain close to practitioners through supporting practice learning and continuous professional development provision roles. My teaching role has predominantly been engaged in the field of leadership and change management.

Over the years I have benefitted from the opportunity to work for, and with, some great leaders and role models. This has given me the curiosity to discover more. In today's society, there appears to be an expectation for 'effective' leadership, with accompanying accountability and responsibility; abstinence is not tolerated, although criticism freely voiced. Using the word 'effective' infers a positive outcome, but this is context-specific and subjective. I have found that defining leadership is not straightforward. The sustaining challenge is that leadership means different things to different people. Northouse (2019 p.5). defines leadership as '*a process whereby an individual influences a group of individuals to achieve a common goal.*' This kind of influence is concerned with not '*simply about getting people to do things, it is about getting them to want to do things*' (Haslam et al. 2011 pp.xix). If these two statements broadly relate to leadership, then 'effective' leadership is

¹ The primary responsibility of the Clinical Practice Facilitator was to support learning in practice, helping pre-registration students and their mentors in clinical placement

about doing this well. Haslam et al. (2011) propose that leadership should not be about securing compliance, it should be about achieving influence: shaping beliefs, desires and priorities, it is about motivation. My experience in nursing supports this however, I acknowledge that this is my personal experience. I have seen a range of factors affect a leader's ability to influence others, these include the culture of the group and wider context, the nature of the organisation they belong to and the gender of the leader. Whilst this points to differences, one commonality is that leadership points toward mobility, moving people, in Ladkin's words (2010 p. 28) '*...collective mobilization towards an explicit or implicit determined purpose...*'.

My previous involvement with leadership tells me that whilst people have quite established ideas, a variety of factors can affect this. The choice of which approach to take can be determined by perceived efficacy of past experiences, the relationships within a team, as well as the level of current resource, both human and physical. Nevertheless, being a leader and engaging in leadership activities are not optional roles for nurses (Curtis et al. 2011). Nurses are expected to lead care for the patients at the point of qualification. Therefore, it is not unreasonable to expect that they be informed about what it means to be a leader, inclusive of the knowledge, attitude and practice of leadership. Taking on a leadership role in name only is not sufficient in itself (Curtis et al. 2011).

Current nursing leadership development is based on contemporary theory; however, this tends to stem from business and management domains which are simply superimposed onto nursing and clinical leadership and does not necessarily fit (Stanley 2008). I agree with Barr and Dowding (2016) who suggest that leadership as a concept has evolved and continues to change. Modern management evolved to cope with the need to ensure order and consistency in a complex environment, whereas the basis for leadership evolution has been change and hence has become important in healthcare because of this (Stanley 2006c). Whilst tools such as those devised by the NHS Leadership Academy (2021) offer an established framework for leadership development, a recent literature review by Cummings et al. (2021)

found that few conclusions can be drawn in regard to which nursing characteristics and organisational factors specifically contribute to nursing leadership.

In conclusion, personal experience of leadership, as a leader and follower, has helped me to attempt to develop the strategies required to face the challenges of clinical practice and higher education. This longstanding endeavour has raised a repetitious series of questions about leaders and leadership: Who influences who? Why do we act how we act? Why are some more influential? Why do we follow leaders? Do we need to know that person? To what extent do we recognise ourselves as leaders and so on. There are many possible answers within the leadership rhetoric and discourse, revealing a vast array of literature. The intention of subsequent sections in this chapter, therefore, is to frame leadership and nursing leadership in the context of this study: to attempt to illustrate the wider perspectives and issues with the aim of conceptualising 'effective' leadership within the NHS.

1.3 Defining leadership

This section elaborates on the previously mentioned definitional challenge. As propounded, leadership is a contestable concept; it is concerned with actions, behaviours, emotions, expectations and relationships. There are many different dimensions and definitions of leadership (Stanley 2006a, Daly et al. 2007, Curtis et al. 2011, Carragher and Gormley 2017, Northouse 2019) and a plethora of literature which at face value offers contradictory views on the meaning of leadership (Stanley 2006a). Leadership can be associated with traits, that is, qualities or skills that the leader possesses, or aligned to process, which reflects the interaction between leader and follower (Barr and Dowding 2016, Northouse 2019). It can also be linked with power as part of influence and how leadership can affect change. Leadership has similarities to management in regard to working with others and achieving a goal but is different in that leadership aspires to produce change and movement as well (Northouse 2019).

Ladkin (2010) talks about the lack of definitional clarity regarding leadership. She takes a philosophical standpoint and suggests that seeking to understand the nature of leadership, what it involves and encompasses, helps with trying to define it, but concurs that this may in itself, render trying to answer the 'What is leadership?' question inappropriate. Leadership can have an identity (for example be considered 'effective') but cannot exist without extension, that is, those who would enact it, the context from which it arises, as well as the socially constructed appreciation of its particular kind of interaction (Ladkin 2010). Thus, the multifactorial and complex nature of leading and leadership proffers an explanation for why there are so many existing theories and definitions. Even if there are similarities between for example, perceived leadership behaviours across contexts, there will be nuances and subtleties of expression which may be appropriate to one context but not the other.

Expanding on this, in essence the key ingredient in the concept of leadership is the presence of at least two individuals – one who leads and one who follows. Grint (2010 p.2) sees this as the simplest definition of leadership – '*having followers*'. Ladkin (2010) sees leadership as a collective process involving those known as leaders, and those known as followers. Leaders and followers could be the same people playing different roles at different times (Barr and Dowding 2016). Leadership is a socially constructed phenomenon and context dependent, therefore the 'lifeworld' that makes up the social construction of the people who live in this phenomenon make it leadership in itself (Ladkin 2010 p.21). Without the context and the people there would be no leadership. Haslam et al. (2011) also focus on leadership as a 'we' rather than an 'I' thing, they argue that leaders must be seen as 'one of us' doing 'it for us', they shape understanding of 'who we are' and 'make us matter' centring on social identity issues. Leadership is concerned with people, whether they are physically together or apart, whether they know each other or not. It is contingent on communication between leader and follower, verbal or otherwise.

1.4 Leadership practice in Nursing

This section explores leadership from a nursing perspective. Whilst day to day leadership of care delivery is expected from any nurse, it is useful to consider the pivotal role of the Ward Manager, the most visible nursing leader. In this study nursing leadership refers to nurses displaying leadership behaviours. In professional clinical roles such as nursing, clarity on meaning is important to ensure that the focus is clear. Leadership that is practiced by clinicians in the actual healthcare environment is referred to as 'Clinical leadership', it has been defined as the process of influencing and improving individual and organisational care practices to achieve safe, effective, high-quality care (Daly et al. 2007, Joseph and Huber 2015). It is fundamentally leadership that is provided by clinicians and has been utilised as an instrument for not only increasing engagement between clinicians but also across organisations (Daly et al. 2007). Some of these clinicians are nurses and this is the time where the skills of registered nurses are combined with general leadership skills.

From a nursing perspective, the role of the Ward Manager is crucial and remains the significant figure at the forefront of nursing leadership. Nursing leaders operate at the point of care where most frontline staff work and patient care is delivered (Sherman and Pross 2010). This symbolic position is also known as Ward Sister or Charge Nurse, the senior person from a nursing perspective (generally). The Ward Sister role has existed since the origins of modern nursing (Fenton and Phillips 2013) and has been considered an important role for many years and studied regularly throughout the last four decades. The name or title has been the subject of debate and discussion and reflects changes to the role during the last 40 years but nonetheless refers to the Ward Leader. For the purposes of this study, I will refer to this role as Ward Manager throughout this thesis.

It has been suggested that authority and 'permission' are required to lead and manage healthcare teams (Bradshaw 2010, Pegram et al. 2014). The role of the Ward Manager occupies a prominent position, but this is not without tension that has traversed time, albeit changing subtly. When exploring the

profound impact of the role, Pembrey (1980) suggested that although the Ward Sister represented the actual and symbolic continuity of care, having a direct managerial responsibility for nurses and patients, there was little authority to accompany the role. Whilst a strengthening of the role has been widely called for, Bradshaw (2010 p.3561), highlighted what she referred to as '*crucial paradoxes*', one debate related to conveyance of responsibilities to others which have previously been the sole remit of the Ward Manager. The maintenance of high nursing standards and teaching roles have now been devolved to that of the individual registrant through professional standards, higher education and mentor and expert practitioner roles. This means that these aspects are now outside of the Ward Manager's role and as such they have no authority for them. McWhirter's (2011) doctoral study found that whilst the role of the Ward Manager is complex and varied, it has been diminished by the development of modern matron and clinical nurse specialist roles. Similarly, Fenton and Phillips (2013) proposed that Ward Managers were the 'glue' of the health service, responsible 24-hours a day but often with little control. The advent of changes to the Ward Manager role responsibilities could indicate that other nurses take on leadership roles.

In addition to the issue of authority, there is a conflation between nursing management and nursing leadership (Cummings et al. 2021). Nurses can be required to make decisions that are at odds with their professional beliefs. The loyalty to the nursing profession has proved to be a strain for Ward Managers (Bradshaw 2010, Ericsson and Augustinsson 2015). It has been suggested most recently by Galura (2020) that frontline nurse managers face psychological challenges when implementing organisationally mandated actions which may be at odds with how they perceive the impact on staff to be. This is topical and was seen as high priority during the Covid-19 pandemic, the Kings Fund have produced a series of resources aiming at supporting leaders and their staff during this challenging time (Kings Fund 2021).

Nonetheless, the role of the Ward Manager continues to be recognised as complex and demanding (Royal College of Nursing [RCN] 2009, McWhirter

2011, Pegram et al. 2014). The empirical evidence points to the need for role clarity, adequate preparation and support for those in this position (RCN 2009, Bradshaw 2010, McWhirter 2011, Hewison 2013 and Pegram et al 2014). The call for action was unmistakable in the work of Hewison (2013) who examined the leadership role of the Ward Sister/Charge nurse in the NHS by critically reviewing relevant literature and policy. Evidence of nursing care provision was contextualised in the failures of care to establish the problem followed by analysis of research concerned with the ward sister/manager role. Hewison (2013) suggested that action was needed to place the Ward Manager at the heart of the health system; they need organisational and mutual support to ensure they realise their full potential. This reflects sustained attention on the Ward Manager role.

1.5 Leadership in the NHS today

This section recognises leadership in the NHS, and how healthcare is seen as important to all the population; it is an emotive subject and as such cannot escape from being a politicised entity. Even individuals not directly engaged as recipients or providers of the service are able to express an opinion. The NHS in the UK celebrated its 70th Birthday in 2018, its history is rooted in a liberal socialist ideology of health being a right for all, regardless of ability to pay, this gives a certain possessive leaning for the public (Barr and Dowding 2016). The needs of patients are changing and as health consumers, they are better informed and their demands changing (Powell 2016).

The complexity of healthcare is widely recognised and reflected globally; it includes issues such as interlinked priorities, different perspectives, competing objectives, finite resources and working collaboratively for the common purpose (Plsek and Greenhalgh 2001). The NHS is large and complex, attempts to summarise its history and approach to leadership can be risky as there are so many different factors to take into account (Hewison and Morrell 2013). This makes leadership in healthcare difficult to explain. Whether leadership is 'effective' or not infers an outcome. The way that Northouse (2019 p.1) describes it a '*highly sought-after and highly valued*

commodity' is value laden in that a commodity could be viewed as a product and theoretically be acquired and by default significant in impact. Over time, the demands on healthcare leadership have become more complex and the need for different forms of leadership more evident (Daly et al. 2007, Wong and Cummings 2009, Manley et al. 2011, Scully 2015, Joseph and Huber 2015). Powell (2016) argues that the role of the healthcare leader is '*extraordinary*' (p.5), to protect and shield people from the regulatory and political environment, at the same time making sense of what needs to be done and by whom. The leadership discourse in healthcare is associated with a cause/solution dichotomy without actually saying what leadership is.

1.5.1 Understanding the notion of effective leadership

In this section I explore the underlying terrain for leadership in the NHS. In order to consider where 'effective leadership' fits it is useful to describe the NHS in terms of four phases to get a sense of where it is now (Mannion et al. 2010). The four phases link broadly to political influences and their impact on the healthcare system. The beginning phase, 1948 – 1983, focused on administering the NHS service, largely to support healthcare professionals to deliver care. The next phase between 1984 and 1990, signified the advent of a general management and performance regime. This was followed by the advent of the internal market model of purchaser /provider from 1991 – 1997, which introduced clinical governance to raise quality (Hewison and Morrell 2013). The current position of the NHS, 1997 – to current day, is reflective of years of significant reform and investment.

A changing vista forms the backdrop for healthcare leadership. The campaign for improvement is relentless and remains a challenge in times of growing financial and workload pressures (Ham et al. 2016). Leadership continues to be important; additional modern reasons such as new health goals, changing expectations of service users and less deference for professional authority make it so (Hartley et al. 2008). This places 'effective' leadership at the heart of the transformation that needs to take place in the NHS, if the health,

financial, quality and reform challenges are to be met (Sobieraj 2012, Willcocks 2012).

Focusing on the notion of 'effectiveness' in relation to leadership helps to unpack the complexity of the concept. The importance of 'effective' leadership is framed against problems in healthcare leadership, this is a recalcitrant issue. Over ten years ago, the Healthcare Commission (HCC) found that continuity of leadership was vital. They identified recurrent cases of poor leadership in the NHS Trusts they investigated; citing a lack of strategic direction and a failure to deal with historical problems as significant (HCC 2008). There has been a number of high-profile system failures (Francis report 2013, Berwick report 2013) where patient care has been affected by and, in some cases, attributed to poor leadership (De Zulueta 2016, Barr and Dowding 2016). The Francis report (2013) highlighted the problem of leadership and culture in the NHS (Cunane and Warwick 2013). In response to this, the Government (DH 2013a) stressed that leadership must be encouraged at every level of the healthcare system; saying that it should be embedded throughout organisations rather than the responsibility of select persons. This places responsibility for leadership with staff throughout the whole organisation, in order to meet with the NHS core values (DH 2013b). The value of 'effective' leadership is unquestionable; however, it is sometimes only noted when it is absent (Carragher and Gormley 2016). Public confidence in the NHS is undermined by such reports and can waver in the aftermath. The loss of confidence gives rise to a 'chicken and egg' situation, paradoxically serving to increase anxiety and increase the requirement for the 'effective leadership' that it has found lacking.

The idea of 'effective' leadership has been associated with positive outcomes, including improved patient benefits as a result of high-quality nursing care, increased staff satisfaction and enhanced workplace cultures (Wong and Cummings 2009, Hewison and Morrell 2013, Paterson et al. 2015, Carragher and Gormley 2017). The changes within healthcare have been significant and far ranging. A series of white papers, reports, reviews and policy changes repeatedly emphasise the salience and impact of effective leadership. For

example, NHS England acknowledged that whilst the health service had improved, and there was a consensus on what the better future should be in the 'Five Year Forward View' (NHS England 2014a), this better future was dependent on local leadership, diverse solutions and a radical upgrade in prevention and public health. In addition, action area four of 'Compassion in Practice' (DOH 2014) called for a new way of leading in 'Building and Strengthening Leadership' (NHS England 2014b) – this new way being critical, the 'wicked'² (that is unsolvable) problem of the NHS requiring 'clumsy' solutions. Similarly, the Dalton review (DH 2014), which examined new options and opportunities for providers of NHS care, suggested that leadership capacity and capability was crucial. The expectation for effective leadership was made clear by Lord Rose in his review, 'Better Leadership for Tomorrow' (Department of Health and Social Care 2015 p.6) suggesting that *'Everyone should know what great leadership should look like...'*. Lord Rose argued for less management and more leadership, saying that attention should be aimed at how to lead change and uncertainty, rather than simply managing resources. 'Leading Change, Adding Value' (NHS England 2016), the Chief Nursing Officer's current nursing strategy was directly aligned to 'Five Year Forward View' (NHS England 2014a), it focuses on reducing unwarranted variation and proposes that increasing the visibility of nursing and midwifery leadership is vital for this. This repeated message continues to be topical post-study; following the recently launched NHS Long term plan (NHS England 2019) and NHS People plan (NHS England 2020) which recognise the impact of compassionate and inclusive leadership behaviours.

Thus, the challenge is enduring in novel and unforeseen ways. 'Effective' leadership ensures that stakeholder needs are met in a person-centred way, that staff demonstrate commitment, are empowered and meet their goals through evidenced-based practice (Manley et al. 2011). Identification and development of leaders is therefore required to ensure outcomes are achieved through effectively leading (Hewison and Morrell 2013, West et al. 2015, Akhtar et al. 2016).

² wicked problems are either new or recalcitrant for which there are no obvious answers (Grint 2010)

1.6 Approaches to leadership in the NHS

The way that approaches to leadership in healthcare have evolved is the centre of attention in this section. The transactional type of leadership which had been evident in the NHS of the 1980s was based on a plan, control and contracts model that was suited to the relative stability of the environment (Barr and Dowding 2016). Transformational leadership theory was subsequently offered as a solution to the problems in the NHS where change and creativity were needed (Thorp et al. 2007, Jarman 2007, Stanley 2008). This was because these types of leaders were proactive; they attempted to optimise development, not just performance (Bolden et al 2003). Attributes and behaviours of transformational leaders are associated with inspiring, motivating and developing behaviours – they are seen as charismatic leaders with a good deal of referent power. This style of leadership corresponds with the demand for improvement in recent years and has been dominant in nursing. Transformational leaders behave in ways that achieve superior results because they motivate and inspire, stimulate innovation and creativity and pay attention to individual follower's needs (Bass and Riggio 2006); they are strong role models (Northouse 2019).

As discussed in section 1.5 it is evident in the public high-profile reports, reviews and enquiries that the NHS discourse has been critical of the effectiveness of leadership, inferring that the approach and practice of leadership has not achieved the desired results. Hartley et al. (2008 p.6) suggested that new thinking about leadership was moving away from a '*one best way*' model and concentrating on a variety of approaches and methods. In order to meet the needs of a changing NHS, the focus has been on providing effective leadership and driving change, this needs to be strengthened and go beyond the remit of single positional leaders. Two strands of leadership practice are emerging as salient in regard to the aforementioned general NHS perspectives. Firstly, there is a need to focus on how leaders operate, that is, what kind of behaviours they display. Secondly, where they are structurally in an organisation, is becoming a pervasive argument. In a study seeking to identify who clinical leaders were in the practice setting, Stanley's (2008) participants, rather than identifying

transformational type leaders with visioning and creativity, chose those who displayed behaviours that reflected an awareness of where they stood and how they behaved when managing care. He found that clinical leaders were seen as being approachable, visible, adept in communication, clinically competent and viewed as role models. The Kings Fund set up a commission to investigate and report on management and leadership in the NHS in 2010; this was at the time that the NHS was entering the period of enormous challenge in regard to financial and quality outcomes. They recommended that leadership needed to extend '*from the board to the ward*' (2011 p. ix) clinicians needed to be engaged in leadership activity, old models of single leaders, the hero, needing to evolve into more shared strategies across both teams and organisations. This approach was considered by Willcocks (2012 p. 13) to be partly in response to the criticisms of transformational '*top-down, heroic leadership models*'. Transformational leaders have been criticised as they tend to focus on the bigger issues and because of their visibility do not concentrate on everyday leadership activities (Barr and Dowding 2016).

The argument for a more distributed style of leadership responds to the complexity found in organisations in order to deliver services within a multi-agency cross-network environment (Thorp et al. 2007, Bevan 2013). This approach to leadership appears to reflect the stance of concentrating on who the leaders are. Spillane (2006) reveals that distributed leadership means more than shared leadership; it is the collective interactions among leaders and followers in their own context. Distributed leadership has originated from the research, theory and practice that identifies the limitations of the leader-follower positionality that places responsibility primarily with the leader (Bolden 2007). A shared, distributed approach to leadership, has been described as moving away from authoritative hierarchical leadership, towards leadership that is based on influence within teams (Willcocks 2012). Vincent (2013) argues that in a complex multifaceted system such as the NHS, the right direction should come from collective leadership rather than a single individual.

The migration to a more shared approach aligns with 'Raising the Bar', Lord Willis's report (HEE 2015) sponsored by the Nursing and Midwifery Council and Health Education England (HEE). This identified that leadership should be a key skill at all levels, advocating for a collective approach to leadership – the power being devolved to where expertise, capability and motivation sits within an organisation. If leadership is thought of in terms of non-linear and reciprocal, this leans towards a more collective, shared or distributed approach where leaders and followers are mutually dependent (De Zulueta 2016). This further supports the change in leadership thinking of moving away from a 'command and control' approach reflecting disillusionment with the heroic leader style (Employers Network for Employability and Inclusion [ENEI] 2016). At the moment, the world is reeling in the aftershock of a global pandemic and 'crisis' leadership has been necessary, although providing a hiatus from the political NHS leadership critique.

Despite being the system's greatest asset, the people in the NHS are struggling and workplace challenges are considered the most significant issue facing the health service (Beech et al. 2019). The challenging circumstances and competing demands that exist in the NHS reflect the reality of leadership practice currently. This generates some of the most difficult challenges for leaders as the requests placed on staff delivering care are great and enduring. Whilst some NHS leaders view their roles as both a 'vocation' and a 'privilege', the substantial expectation and pressure they find themselves under as leaders makes these roles less attractive (Anandaciva et al. 2018). NHS staff are being asked to uphold the values of the NHS under challenging circumstances, in the face of growing media attention. What this means is that more often than not, people want to be led by leaders who are genuine and display their more human side (Sappal 2013). The affective element of leadership runs parallel with the demands of a modern health service.

This is important because Gerada (2013) suggests that leaders are trusted when they say what they think is right, those who act on their values and put honesty above popularity. This could reflect the need for authentic leaders who are inspirational and can restore confidence (Eagly 2005). In their

everyday operational roles, staff nurses and senior staff nurses deliver care to their patients, working with and leading their fellow team members: acting as role models for good practice. Luthans and Avolio (2003) describe authentic leadership as the type of positive leadership that is needed in contemporary times, where the best leaders have transparent links between their values, actions and behaviours when the environment and rules are changing rapidly.

Collective, compassionate, inclusive, authentic, approaches to leadership are becoming synonymous with effective leadership in the health service rhetoric. The 'Developing People – Improving Care framework (National Improvement and Leadership Development Board 2016) aimed to guide and equip NHS staff to deliver improved care; it suggested that leaders at every level should develop a set of critical capabilities including compassionate, inclusive, leadership skills. The significant leadership task in an inclusive approach to leadership centres on harnessing the leadership potential within, collective rather than individual 'heroic' leadership (Thorpe et al. 2007). NHS organisations are responsible for the delivery of continuously improving, high quality, safe and compassionate care. West et al. (2015) see that this requires growing a collective leadership culture, highlighting that the challenges in the NHS are too numerous and difficult to leave leadership to chance. Again, it is recognised that the covid-19 pandemic has placed individuals in command, even with specific roles having 'command' in the title. Some recent advice emphasises the importance of relationships, comradery and compassion as key to caring for staff during this time (West 2020).

1.7 Rationale for undertaking the study

The frequent reference to leadership, whether it be compassionate, inclusive, collective or distributed, reflects the value placed on it and the high profile of leadership in today's healthcare. This section identifies key issues which support the rationale for this study. There is a critical tone specific to nursing leadership, which matches some of the wider discourse in health leadership mentioned in section 1.4, particularly around clinical practice, where nursing leadership has been criticised. Willcocks (2012) argues that all nurses will

have a clinical leadership role that is important in driving change in clinical practice. However, there appears to be a lack of clarity about who the leaders should be and what these leadership actions entail, or how they can be evidenced in existing NHS leadership structures. Harkness-Hudson (2013) implied that a 'can't do' attitude had pervaded in the current culture in nursing, leading to disillusionment and lethargy, despite the NHS needing to change, leaders must evolve to match the needs of society. Reflections on the future of nursing, "Too Posh to Wash' (Beer 2013) implied continued failings in regard to leadership: Sturdy (2013) professing that the visibility and voice of nursing leadership had been lost, both nationally and at the bedside. Poor leadership resulting in unclear expectations and a lack of understanding in regard to roles and responsibilities, leading to poor team working and failings in care (Farenden 2013). Dixon-Woods et al. (2014) suggested that NHS staff have a desire to provide the best healthcare, but this is not without challenge and leadership at every level is needed.

Fundamentally, nurse leaders are essential for patient care (Scully 2015). The hospital nursing workforce is seen as the biggest asset of the NHS (Hockley and Boyle 2014) and around 70% of the recurring costs in NHS providers are staff related (Addicott et al. 2015). Nurses are an important sector of the workforce. The drivers for undertaking this study have stemmed from the clear evidence that nursing leadership is essential for delivering a high-quality service. Acting as a leader is widespread across nursing roles. For example, at the pinnacle of nursing leadership, a Chief Nurse will largely attempt to inspire, drive and align the strategic and operational efforts of the nursing workforce throughout an organisation, although Caplin (2013) considers that this role is becoming increasingly more difficult in a busy hospital. A senior nurse with the title 'Matron' will enact and share the nursing vision of the organisation, ensuring that care outcomes are delivered across teams. A Ward Manager will have a responsibility for harnessing the resources available to them, both physical and fiscal, to provide that care at ward level. A staff nurse will lead and direct the individuals in the team who contribute to that care on a daily basis.

In each of the nursing role examples above, the individual acts as a role model for high quality care through actively demonstrating leadership behaviours. In this sense 'lead' by example and in turn 'follow'. Bandura's (1977) Social Learning Theory suggests that the majority of human behaviour is learnt through behaviour modeled by others: it gives an idea of how new behaviours are performed and then coded for later use. A role model is '*a cognitive construction based on the attributes of people in social roles an individual perceives to be similar to him or herself to some extent and desires to increase perceived similarity by emulating those attributes.*' (Gibson 2004 p.136). Philpott and Corrigan (2006) describe the responsibilities and challenges associated with being a role model. Both were senior nurses and discussed how being a role model can be used to influence the environment and standard of care. This was achieved by acting in accordance with core values, being fair and honest, and trying to communicate effectively. They talked about how their own role models had affected them. Perry (2009 p. 36) clearly states that '*Nurses working in clinical settings are observed*' adding that knowingly or unknowingly, their behaviours become living lessons potentially influencing the words, actions and attitudes of others. This is pivotal, as nurses are role models whether they have given consent or not. Nevertheless Bandura (1977) says that the impact of modelled conduct varies, the engaging qualities of the model is one factor that contributes to this, as is the value attributed to the behaviour displayed; its salience and complexity. Nursing offers a range of situations in which, as role models, nurses lead high quality compassionate care. (Foster, 2013, Poll, 2013). As a challenging and changing profession, the next generation of nurses require great and inspirational leaders and role models to nurture and promote excellence in practice (Sines 2013, Scully 2015). This clearly links the role model to leadership.

The theme of 'modelling' behaviours is prevalent throughout the leadership dialogue: leaders behaving in ways that mirror their espoused values. Positive role modelling is the primary way that authentic leaders influence and develop followers (Avolio and Gardner 2005). The impact of a role model has a lasting effect and consequences within an organisation (Hiscock and Shuldham

2008). Being conscious of the actions that are taken and the decisions that are made is important as these are the signals that people use to decide on whether a leader is believable (Kouzes and Posner 2012). People will choose to follow a leader based on the leader's perceived credibility. Authentic leaders are leaders who are self-aware, they demonstrate openness and clarity regarding who they are through consistent behaviours which are in accordance with their personal beliefs, motives and sentiments (Walumbwa et al. 2008). High value is placed on the presence of role modelling in professional development, gaining insight into how behaviours are perceived and influence others. Kouzes and Posner (2012) suggest that leaders must model the behaviour they expect of others, aligning actions with shared values. In order to be able to enact this, leaders have to explore their inner self and clarify their values.

As such, the concept of role modelling as a practitioner, demonstrating good practice and conduct, appears to be a worthy pursuit, as role modelling is considered aspirational in its effect and subsequently influences others. Aston (2013) supports this, believing that it is imperative that leaders of nursing recognise the value of role modelling in developing excellence in nursing care. My interactions with practitioners suggest that current leadership and practice developments follow a more positional model and are not readily associated with role modelling. Although focused discussion exposes the presence of role models, this does not appear to correlate with how an individual views their personal leadership practice. Developing self-awareness and purposeful attention to role modelling and its associated behaviours in routine practice can be useful as a means of distinguishing areas for leadership development. Increasing self-awareness is an emerging process where an individual continually comes to understand their core values, beliefs, talents, strengths and sense of purpose (Avolio and Gardner 2005). Jarman (2007) considers the true value of leadership lies in the leader's skill when matching agendas with followers and the shared vision, being self-aware, knowing why, when and how to act is an essential aspect of leadership. A self-aware leader will be concerned with how values relate to their own behaviour and those around them.

If self-awareness and insight into the impact of behaviour is crucial from a leadership perspective, then it could be argued that social learning theory has some essential messages to give in order to develop this area of leadership practice throughout the nursing workforce. High value is placed on the presence of role modelling in professional development, gaining insight into how behaviours are perceived and influence others. If role modelling is an essential partner and part of leadership, it is pertinent to consider whether role modelling is intentional and how observing intentional, sustained, coherent positive practice influences the behaviour, values and attitudes of others.

As a nurse I was always conscious of setting an example, being watched, almost being on show. I never shied away from this and was happy to take a lead. Talking about role modelling as a conscious teaching strategy enabled me to discuss and gain an insight into the understanding and practice of individuals on the mentorship course I was facilitating. In addition to this, I received feedback from a range of students, particularly those in more junior work positions, in regard to developing leadership skills on the basis that these are within the remit of anyone as leadership is not solely reliant on positional status. My ontological and epistemological position is discussed in further detail in chapter three. Review of the literature exposes that the direct link between role modelling and leadership development has not been made in an explicit manner. There is a connection in education terms, but it is not as clear in the activity of leadership.

1.8 Research aims and objectives

The research aim was to explore role modelling as a leadership behaviour in nursing

The objectives were:

- *To explore how role modelling is displayed across clinically based nursing roles in a clinical division in an NHS Trust*

- *To investigate the association between role modelling and leadership*
- *To discover factors that assist an emergent understanding of self as role model*
- *To identify how role modelling could be utilised as a leadership behaviour for future practice.*

1.9 Thesis overview

This chapter has explored my personal experience of leadership and the definitional challenge inherent in understanding leaders and leading. Leadership in nursing and the NHS is explored as is the debate around effective leadership and diversity of interpretations. It has also considered the impact and application of theory, recognising that this is constantly evolving. A change in the approach to leadership is offered moving towards a more shared ethos. Role- modelling and leadership are considered of high value and discussed within nursing leadership positionality. Finally, it outlined role modelling within the general context of leadership and the research question that emerged.

The second chapter begins with a focused literature review on the social nature of leadership and leadership development in the context of nurses and nursing practice. It explores learning from others through self-comparison and social learning theory. This is followed by an examination of the research undertaken in relation to role modelling; how role models are identified and what behaviours they display. The notion of leader identity is explored, and challenges associated with this discussed. The close of the chapter culminates with a rationale for the development of theoretical lens and review of key points.

The third chapter is concerned with the methodology and methods. It begins by exploring my ontological and epistemological position and how this contributed to methodological decisions in the context of this study. This is followed by a discussion of the case study research design, the history of case study research and the challenges encountered therein. A detailed presentation of the methods follows and includes the study setting, access to the field and recruitment processes and an account of the ethical permissions sought. I then describe the methods used to collect data and provide a rationale for the analytic processes used in the research. This is supplemented by examples of the various stages. Rigour and triangulation within the context of the study is explored in respect of challenges associated with case study methodology. The chapter concludes with a discussion of strategies employed to manage the roles of nurse, educationalist and researcher.

The fourth chapter presents the ward cases in turn and introduces the hospital in further detail. Literature is interwoven with findings in keeping with case study methodology. Each of the ward cases: Acacia, Beech and Cedar, are presented from their unique perspective in order to provide the reader with a rich picture of each context. An overview of the themes in each area is presented and includes, but is not limited, to key aspects of teamworking, the position of the Ward Manager and how role modelling and leadership is encountered. The care setting and physical detail of each case are provided.

Chapter five presents the cross-case analysis: it examines how role modelling and leadership were associated and displayed in this study. Being a good nurse, doing a good job and delivering care were described by the participants as key motivators in all cases and offered without any hesitation. This gave a sense of constancy to the value placed on being a nurse in their teams and inferred a level of security in their roles. The participants worked together for a common goal and looked to each other for support, guidance, advice and practical assistance. In essence this occurred chiefly through

being influenced by a combination of leaders and role models. From the wealth and breadth of data two key findings are explored. Firstly, that leadership location of the Ward Managers stems from individual application of leadership and the nature of the care context. Secondly, that role model identity construction is co-constructed and within the remit of all nurses and not limited to formal leaders only.

The sixth and final chapter outlines the contribution that this study makes to professional nursing practice and leadership. It presents the key findings, implications for practice and contribution to knowledge. A critique of case study methodology in relation to this study is offered in combination with how the limitations of the study were addressed. A summary of key reflexive aspects is offered with reference to personal and researcher development. The chapter concludes by discussing the implications for nursing practice and proposes areas for further research.

Chapter 2 - Literature Review

2.1 Introduction

This chapter explores the literature concerned with the key concepts in this study: leadership and role modelling. This is important as researchers need to be able to demonstrate a familiarity with a body of knowledge, revealing the path of prior research and what is known (Muirhead 2007). Olsson et al. (2014) advocate for a broad overall review of the literature. The literature related to leadership research is expansive and diverse. Thus, the information and enquiry skills employed in searching are crucial and influence the development of the review (Warburton and Macauley 2014, Pretto and Curro 2017). Therefore, this review is limited to literature relevant to the research questions and as such, some logical decisions were taken toward literature included in the review. The study of all aspects of leadership has value, but the sheer breadth and depth of the topic can make it unmanageable without focus. The terms and meanings are conflated. In this study, for clarity, 'leadership' is described as a collective process, as it includes those who would be known as 'leaders' and those who would be known as 'followers' (Ladkin 2010).

The chapter begins with a focused literature review on the social nature of leadership and leadership development in the context of nurses and nursing practice. It examines the contribution of existing empirical evidence on role modelling, learning from others through self-comparison and the contribution of Goffman and Bandura's work in relation to nursing. This is followed by a theoretical appraisal of literature pertaining to leader identity construction. The chapter concludes with a presentation of the theoretical framework utilised during initial data collection.

The review followed an iterative or nexus approach advocated by Kwan (2008). It enabled ideas that emerged during data collection and analysis to be explored contemporaneously. In her study of how doctoral students determined the focus of their reading, Kwan (2008) concludes that reading

served different purposes at the different stages of the students' study journeys. Initially, reading for their study enabled the doctoral students to acquire preliminary knowledge, further reading then refined their study design, data collection and analysis. At the same time though, new learning of, and within, the research itself made students more critically aware (Kwan 2008). This organic evolving process revealed a dynamic growth. Kwan (2008) suggested that a nexus model captures the complexity and co-implication of reading, researching and writing. The work of Wisker (2015) supports this and concludes that the development of the literature view is iterative, whilst 'masquerading' as foundational, it facilitates transformative thinking and expression throughout the research process.

Therefore, I reviewed the literature in this study before the study commenced, during data collection and when completing the analysis. There is a large body of evidence in the literature relating to leadership, for this reason I had to be mindful of the specific areas of leadership theory I was exploring, consciously referring back to my research question and the aim and objectives of the study. As the focus of this study was leadership and role modelling, not one or the other but both, initial searching of the literature sought to keep this at the core but remained open to pursue lines of enquiry. A systematic search based on the terms 'role modelling/role model' and/or 'leadership/leading/leader' was initially utilised in order to access literature linked to the combination of both concepts. In addition to accessing electronic databases such as the Cumulative Index to Nursing and Allied Health literature and the British Nursing Index, similarly to Felstead (2013a) I used a backward chaining process to capture further sources and hand searched journals. Although healthcare is the space within which this study is framed, literature outside of healthcare was examined. Literature derived from international sources (for example, North America, Australia, Canada, Europe, Israel, Iran and Jordan) is included in this review demonstrating the breadth available. Consequently, the review encompasses an eclectic range of literatures, empirical and grey, that extends across these key areas.

2.2 Leadership

As discussed in chapter one, section 1.7, nursing practice in the UK offers a range of situations where nurses act as leaders. These have been inherently linked to traditional hierarchical impressions although more recently reflect political changes and modern thinking. This section explores the leadership literature and presents leadership as a social phenomenon rooted in relationships and evolving behaviours and identities. In correspondence with the political rhetoric and demand for inclusivity, compassion and a shared approach, the literature regarding authentic leadership is also presented for discussion. This very much underpins team working in a nurse's everyday experience.

The work of Grint (2010) provides a fourfold typology with which to navigate through the leadership rhetoric, he believes that leadership can be defined as position, person, result, or process. This typology is not hierarchical, universal or grounded in mutually exclusive foundations, however it offers a means to understand the phenomenon of leadership (Grint 2010). 'Position-based' leadership relates to the formal or informal context of leadership in an organisation associated to individual roles (Grint 2010). 'Person-centred' leadership refers to whether '*who you are*' determines whether you are a leader or not, it aligns with a traits approach (Grint 2010 p.7). 'Process' is concerned with leadership practices, that is what leaders do, rather than the competencies they possess, it is relational (Grint 2010). A 'results-based' view of leadership is connected to its purpose, fulfilling the potential of leadership. Grint (2010) suggests that the results-based view has two perspectives, firstly whether results can be attributed to a leader or not and secondly, whether the process by which they are achieved, matters. It is useful to use this typology as a lens for literary review. It serves as a reminder of the breadth and range of concepts associated with leadership. Whilst the conditions are not specifically discriminatory between each element, and some applications to leadership material can bridge across more than one aspect, it is helpful when constructing and appreciating a wider synthesis. Keeping the typology in mind as an aide memoire enables each piece of literature to be framed and the

layers unpacked through consideration of position, person, process and results perspectives.

Early theories of leadership considered the characteristics and behaviours of leaders, whereas later ones focus on the role of followers and the contextual nature of leadership (Bolden et al 2003). This reflects the transition from focusing on individual effective leaders (great man, trait theories) to an approach that recognizes the nature of the context and development of the follower (situational and contingency theories). The impact of the individual is concerned with personal agency: their attributes, behaviours, characteristics, and decisions in regard to personal development. These form the substance of 'influence', the skills and behaviours of persuasion, which Northouse (2019) believes is the essence of leadership. This is described by Grint (2010) as 'person'. In trait theories, the leader is a leader anywhere as a result of their skills and behaviours, the leader's role is key. Whereas, in contingency theories, an individual needs sufficient awareness of their own skills and the nature of the context so that these can be aligned to ensure effectiveness. In Grint's (2010) typology the context can be 'position' or 'process' specific. A situational approach demands certain styles of leadership for certain types of situation; this requires a flexible and versatile leader, the assessment skills of the leader and their understanding of the context being critical. Nonetheless fundamentally, the key ingredient in the concept of leadership is the presence of at least two individuals – one who leads and one who follows.

As stated above, the basis for this study is contextualised within the notion of nursing leadership as a social construct. In his social identity theory of leadership Hogg (2001) presents a set of interconnecting concepts in relation to leadership believing that leaders and followers exist because of each other making leadership a relational property within a group. Hogg sees leadership as a group process. Groups only exist in relation to other groups; they therefore derive their social meaning in relation to these other groups. Social identity is the knowledge that you belong to a social group which has some kind of emotional and value significance to you (Hogg 2001). A ward team forms a group, they work alongside other ward team groups. This is a pivotal

point and common to the contexts of this study. As leadership is a feature of groups, then leaders and followers are interdependent elements within that social system alongside associated social cognitive processes.

These social cognitive processes are comprised of the ability that an individual has to see and accept themselves in defining features of the ingroup, to incorporate these features as part of themselves and to see others through the lens of features that define ingroup or outgroup membership (Hogg 2001). Prototypes are the cognitive representations of the ingroup and outgroup social categorisations; group members conform to and are influenced by these prototypes. Hogg (2001) says that people are sensitive to prototypicality as it is the groundwork for perception of self and other group members. He also adds that depersonalisation is behind group phenomenon; things like attitudes, feelings and behaviours become stereotypical and normative. Within a group, people who are seen to occupy the most prototypical position are perceived to best reflect the behaviours to which others conform, they influence others, as this grows so does the perception of leadership. This person has the ability to actively influence others because they are socially attractive and able to secure compliance through their suggestions and recommendations, highly prototypical members may enhance this by behaving in a way that is more group like and thus group serving. A leader who behaves as 'one of us', is not only more socially attractive, but also afforded legitimacy (Hogg 2001). This person takes on a powerful position and leads by their example, arguably being a role model. The 'follow' aspect of leadership being related to influence and what is considered to be usual in that groups' everyday existence. How individuals go about their daily business, where leaders, followers and leadership co-exist and fits, dissects this social dimension. It is the source and space of Grint's 'position' where the 'person' acts out through 'process' and achieves 'results'. This forms the foundation for interplay of roles and leadership; following, leading, displaying behaviours and learning from each other.

How leaders behave captivates their followers and can be a source of inspiration and guidance. In relation to Grint's (2010) typology, the way that an

individual 'leads', stems from the 'person' they are and the 'position' they hold and can be both simple and unique to that individual. Leading with compassion, following beliefs and values, being inclusive as a leader, has been illustrated within the empirical literature (Stanley 2006a, 2006b, 2008, Prime and Salib 2014, Patterson et al. 2016 and Koya et al. 2017).

Stanley (2006b) proposed a new theory of congruent leadership, which he argued was best suited to clinical practice because it defined leadership in terms of a match between activities, actions and deeds of the leaders, and the leader's values, principles and beliefs. Stanley (2006a, 2006b, 2008) aimed to identify who the clinical leaders were in an NHS Trust and at the same time explore and analyse the experience of being a clinical nurse leader. He started by proposing an eclectic view of leadership, where leadership was seen in terms of a social world constructed around shared values and support for change. A grounded theory methodology was used with two principal methods of data collection (interview and questionnaire). Data was gathered over three phases: the first phase composed of a questionnaire to discover the qualities, characteristics, and identity of clinical leaders. During the second phase, registered nurses from four areas were interviewed and issues related to perceptions of clinical leadership and identified clinical leaders explored. Lastly in phase three, two clinical leaders from each of the areas in phase two were interviewed on their experience of being clinical leaders. Leaders were perceived at all staff grade levels and were not always the most senior staff.

The approach to clinical leadership was based on a foundation of care that was fundamental to the clinical leaders' beliefs and values. They were perceived as leaders based on previously identified characteristics and qualities like enthusiasm, motivation, knowledge and providing support and encouragement (Stanley 2006a). The type of clinical environment had an effect, there was a difference between the general and specialist area, specialist areas were more likely to see clinical leaders from junior sisters and

all 'G'³ grade staff, whereas general areas nominated junior sisters more frequently. This is of note, as the health rhetoric calls for shared leadership and steers away from a formal, position only perspective. Clinical leaders were considered to get the best out of people. Attributes of clinical leaders included clinical competence, clinical knowledge, effective communication, being able to make decisions, empower and motivate others. The clinical leaders needed to be approachable and visible. They were also perceived to be role models, being able to give effective care linked with role modelling. Stanley's leaders did not always recognise themselves as leaders, particularly if more junior but they all described their roles in terms of delivering '*hands on*' patient care (Stanley 2006a p. 34). When asked why they thought they had been nominated Stanley's leaders presumed it was because they had sound clinical knowledge, acted as role models, communicated well, were appropriate and visible.

He suggested that education aimed specifically at clinical leaders was required. This recognised that those clinical leaders were followed not for their vision or creativity (even if they demonstrate them) but because they translated their values and beliefs about care into action. Congruent leadership is based on the premise that leadership is concerned with where a leader 'stands' rather than where they are going. Where a leader stands in this instance is associated with values and how these are displayed in practice. This represents a key point as the 'leadership' displayed in Stanley's study was redolent of an operational need, situated in the 'here and now' and demands of practice at that juncture. Stanley's research reflects the difference between operational team leaders and formal positional leaders, followers are attracted to leaders because of the 'banner' they carry (p 140 Stanley 2006a). This can be aligned with Grint's a person/process perspectives, what qualities and attributes the leaders possess and how they enact them.

Within the NHS, working within a team and supporting individuals is crucial; Prime and Salib (2014) created the idea of altruistic leadership which enabled

³ G grade was the equivalent to a Band 7 Ward Manager in a previous iteration of NHS grading of NHS roles

people to develop and excel, appreciating the contribution of others and putting personal interests aside. They identified the notion of humility being at odds with common perceptions of leadership such as charisma, where the central focus is on the leader, instead of displaying humility by standing back. Prime and Salib (2014) sought to discover which leadership behaviours could promote inclusion and how they need to be adapted for different cultural contexts. They surveyed 1,512 employees from six countries. They found striking similarities in how people characterised inclusion, that was common to both men and women. Employees felt more included when they could see that they were viewed as both similar and different from their co-workers, there was a sense of belonging and as a result they were more engaged (Prime and Salib 2014). They found that in order to arouse feelings of uniqueness and belonging, leaders should display four behaviours: empowerment, humility, courage, and accountability. This focus on personal qualities leans towards the 'person' aspect of Grint's (2010) leadership typology and drives 'process' and subsequent 'results'.

The theme of relationships is evident in the work of Cardiff et al. (2018) who focused on a person-centred approach to leadership. Cardiff et al. (2018) studied the changes in clinical nurse leadership when approached from a person-centred perspective, as person-centred practice is a core element of nursing. This person focused model of leadership focused on the team, their well-being and person-centred cultures. Utilising an action research methodology, a set of attributes, relational processes and contextual factors that influenced the being and becoming of a person-centred leader were identified. Taking an action research approach in this study was of note as Cardiff et al. (2018) believed this type of approach was seldom used in leadership research. The research included four action research spirals and a six phased thematic analysis. It enabled the leaders in the study to reflect on their development as leaders as a shared benefit. In Cardiff et al.'s (2018) study, the leaders needed to want to become person-centred and should be authentically other centred (other centred meaning that others felt the leaders were authentic) and caring, this referred to the relational aspect particularly. In addition, these relationships occur in specific contexts and are influenced

therefore by different stakeholders and service delivery. Cardiff et al. (2018) concluded that person-centred leadership is a complex, dynamic, relational, and contextualised practice that aims to enable leaders and followers to achieve self-actualisation, empowerment and well-being. The study was concerned with 'being' a leader and 'becoming' a leader. Cardiff et al. (2018) described how the leader took a 'stance' which depended on helping their associates. One of the stances, which was called 'leading from the front' entailed offering directive support and being a role model. They distinguished person-centred leadership as being associate well-being focused, rather than being say, follower performance focused in a situational approach. How this type of leader behaves will rely on Grint's (2010) 'process' aspects, albeit conceived within the 'person'.

The connection between these approaches to leadership focuses on how the leaders interact with their followers and how this is underpinned by a genuine desire to be mindful of the others' position and need. It is suggestive of competing factors which have an impact, and pick out the different aspects of leading, following and leadership.

2.3 Authentic leadership

The compassionate, inclusive and collective approach to leadership as advocated by the political rhetoric around healthcare, draws on shared values and behaviours as (discussed in section 1.6). This section explores the empirical evidence supporting how an authentic approach to leadership offers a means to address the current demands and common desires of effective leadership.

Authentic leadership theory draws on positive psychology, positive organisational behaviours, transformational leadership and ethical and moral perspectives (Wong and Cummings 2009). It adheres to the tenet of 'being true to oneself' and as such requires self-awareness and actions which are in keeping with this (Avolio and Gardner 2005, Sparrowe 2005, Wong and Cummings 2009, Caza and Jackson 2011, Gardner et al. 2011, Anderson et

al. 2017). The relational, socially constructed, aspect of authentic leadership resonates with nursing, this type of leader also displays a positive moral perspective evident in transparent decision making (Wong and Cummings 2009). Gardner et al. (2005) proposes a model based on four aspects: self-awareness, internalised moral perspective, balanced processing and relational transparency. The latter three being self-regulatory. The value of authentic leadership can be seen by the close links between leader and follower, a concentration on positive psychological states, the positive moral and ethical components and its ability to reveal fresh connections between other theories through the concept of authenticity (this is explored further later in this section). Authenticity in this sense can be viewed as a positive attribute of behaviour, this refers to how someone acts in a literal capacity.

The notion of authenticity figures in the established leadership dialogue. Bill George, the former and successful chairman, and CEO of Medtronic (2003) argued for new leadership, leaders who were committed, of the highest integrity and true to their core values. He called for authenticity and likened this to leaders having the desire to serve others through leadership, using their natural abilities to create enduring relationships with people. Leaders need to be their own people, accepting their faults as well as using their strengths (George 2003). George's five dimensions of authentic leadership are acquired on an incremental evolutionary basis, pivotal to this is knowing oneself, denoted as the search for an individual's '*true north*' (George 2003 p.20). George (2003) asserts that being an authentic leader is not connected with leadership style but rather is in relation to being the person that you are meant to be. Kouzes and Posner (2012) echo this inward facing aspect, affirming for the discovery of personal values and beliefs and a set of guiding principles. Leaders need to discover who they are and find their voice, standing up for their beliefs and living their values (Kouzes and Posner 2012). Kouzes and Posner's (2012 p. 42) leaders '*show by their actions that they live by the values they possess*', this forms the groundwork for 'modelling the way' one of five of their core leadership practices and suggestive of authentic behaviour.

On an everyday level, being authentic is linked with honesty and integrity. Being seen as authentic is not simply an 'either/ or' condition, it is rather a case of 'more' or 'less' (Gardner et al. 2005). The common experiences faced by nurses are situated within an arena of persistent change, in the midst of delivering care and as such are potent (Shamir and Eilam 2005, Michie and Gooty 2005). This means that the background of change is unsettling, an individual's response to change is subjective and personally context specific. At these times, followers look to their leaders for guidance. Authentic leaders need to repair trust in response to ethical and moral dilemmas in the current workplace, they need to focus on openness and consistency in communication (Wong and Cummings 2009). This is crucial given the current challenges in the NHS. The moral and ethical component is pivotal to authentic leaders, ethical work climates are important, people need to feel safe and feel able to raise issues in the face of ordinary work challenges (Walumbwa et al. 2008).

Shamir and Eilam (2005) examined the concept of authentic leaders and authentic leadership. Their definition of authentic leadership was based on the leader's self-concept: their self-knowledge, self-concept clarity, self-concordance and person-role merger. In keeping with other definitions of leadership (general and clinical) they felt there was actually no single definition but saw the above aspects as common to all. They urge that if authentic leadership is to be seen as distinct in its own right, it should illuminate aspects of leadership which had not been emphasised strongly by other theories. According to them a clarification of terms offers a means to discriminate between authentic and other types of leadership or leaders (Shamir and Eilam 2005). They considered the defining characteristics of authentic leaders to be that they are not 'fakes', they lead from conviction and are true to themselves. These leaders are unique on the basis of their personal experiences, their actions are based on their values and convictions. Being a leader is central to them and they have a good idea of their values and beliefs and are motivated by goals that represent these (Shamir and Eilam 2005). According to Shamir and Eilam, being an authentic leader is not without challenge, it requires effort and energy and the ability to draw on inner

strength. Authentic leadership includes authentic followership, people who follow the leader for authentic reasons and have an authentic relationship with them, they share values and beliefs and in effect authenticate the leader. This links to the notion of role modelling: leading by example and learning from others specifically.

Being seen as authentic will affect the delivery of care and leaders model this explicitly, although this occurs in the group context (Eagly 2005, Sparrowe 2005). Eagly (2005) presented a relational view of leader authenticity, saying that this was derived from firstly endorsing group and wider community values, and secondly that followers could personally identify with those values. The leader's role is concerned with processes that connect those two components, namely communication of values through behaviour of the leader and followers' attitudes toward their leader and their values. The latter being afforded some level of legitimacy based on the perceived right to express and convey values (Eagly 2005). This may be concerned with belonging to a profession for example and has parallels with the attractiveness of the 'model' in social learning theory which is discussed further in section 2.4.1. Critical to legitimacy are challenges such as followers trusting that the espoused values are tangible and will benefit the group, rather than simply hearing about those values without action (Eagly 2005). Authenticity of the leader materialises through transactions between them and followers. Role incongruity and value inconsistency can provide a rationale for why individuals from outsider groups encounter resistance (Eagly 2005). The message here for contemporary authentic leadership is not to forget the strength of the group and the shared impact that their beliefs and social norms hold.

This aspect is evident in the work of Sparrowe (2005) who proposes a perspective on authenticity drawn from hermeneutic philosophy, he believes that authenticity is not achieved by self-awareness of one's inner values or purpose and being absent from others – it is derived in relation to interactions with others. Self-regulation is central to authentic leadership (Sparrowe 2005), consistency, both in terms of intra and inter that is, behaving

consistently in line with values and beliefs, is essential. This can create a strain for the leader however, as there is an intentional self-regulatory element and decisions on behaviour are made deliberately (Ladkin and Taylor 2010, Nyberg and Sveningsson 2014). This infers effort on the part of the leader. Nevertheless, Ladkin and Taylor (2010) propose that whilst authentic leadership may be rooted in the notion of the true self, it is through embodiment of that true self that leaders are perceived as authentic or not (Ladkin and Taylor 2010). Using Stanislavski's technique of method acting, Ladkin and Taylor (2010) discuss the potential of an individual's ability to create an authentic performance and use it for leadership in reference to how one portrays oneself. This literally means the physical actions, how the leader uses their body: the symbols that are given, language, dress, gestures, facial expressions and so on. They talk of Goffman's (1959) impression management (which is explored further in section 2.4.1 and relevant to leadership and self-awareness). Physical actions should encompass the emotional and intellectual artefacts associated with them to be perceived as truly authentic. They conclude by suggesting that creating an embodied authentic leader involves being attentive to somatic clues of their bodies as they encounter experiences, then choosing how to reveal them. This refers to the self-regulatory aspect of authentic leadership and requires achieving a balance between managing internal reactions and external actions in a way that represents being a leader.

2.3.1 Impact of Authentic leadership

Authentic leadership has been found to have an impact on nurses as individuals, their psychological well-being, work performance and creativity. (Rego et al. 2011, Laschinger et al. 2012, Nelson et al. 2014, Laschinger et al. 2015). This section explores how authentic leadership affects the commonplace working of individuals.

Authentic leadership and the mitigating role of psychological capital have been found to predict an individual's creativity (Rego et al. 2011). In Rego et al.'s research, psychological capital was made up of the four positive

psychological states of Luthans and Avolio (2003), self-efficacy (confidence), optimism, hope and resilience. This research was important as a means to find out how creativity can be fostered in organisations so that innovation and change can prosper. 201 employees across 33 companies reported on their senior's authentic leadership and psychological capital. Supervisors rated employee creativity at work. Authentic leaders were seen to promote employee's creativity by supporting employee psychological capital growth (Rego et al. 2011). This is a foundation of authentic leadership: authentic leadership for authentic followership, one driving the other (Rego et al. 2011).

Laschinger has investigated the effect of authentic leadership extensively. In a study testing a model linking authentic leadership to new graduate nurses' experiences of workplace bullying, burnout and subsequent job satisfaction and intention to leave jobs, Laschinger et al. (2012) demonstrated the importance of authentic leadership in creating supportive work environments. 342 nurses returned the survey representing a response rate of 38%. The results of the study support the proposition that nursing leaders' authentic leadership behaviours are associated with the new graduate nurses' experiences, although the nature of the study prevents any statement of cause and effect. Bullying was linked to higher levels of burnout, and authentic leadership influenced nurse retention by reducing the likelihood of bullying. In a later study which tested a model linking authentic leadership, areas of work-life, (workload, control, reward, a sense of community, fairness and values congruence) occupational coping self-efficacy, (belief in coping), burnout and emotional well-being amongst new graduate nurses, Laschinger et al. (2015) found that authentic leadership had a positive effect on areas of work-life. This in turn had an effect on occupational coping self-efficacy, resulting in lower burnout, which was associated with poor mental health. This study employed a cross sectional approach using validated tools. Although the survey only included 1109 out of 3743 new graduate nurses from across Canada, the response rate being 27%, this was acknowledged as a limitation. Notwithstanding, this adds to the body of literature that suggests that authentic leadership has a positive outcome for new graduate nurses (Laschinger et al. 2015). In keeping with a positive impact, Nelson et al (2014)

aimed to deepen understanding of psychological well-being among nurses by assessing the role of both authentic leadership and work climate. They employed a time lagged study using two self-reporting questionnaires (n=406). Authentic leadership was found to impact on the work climate in a positive way increasing levels of psychological well-being (Nelson et al. 2014) although limitations in terms of response rate and generalisability were expressed.

The literature presented in the preceding paragraphs was formed from a more quantitative position drawing on fewer qualitative papers. There are areas for development regarding future research approaches as suggested by Gardner et al. (2011) who aimed to clarify the type of knowledge in this field and analysed 91 papers drawn from theoretical, empirical and practitioner literature. The 25 empirical papers covered the period between pre 2003 to 2011. They offered five recommendations for future research based on their content analysis. They suggested that there should be more attention to authentic followership and a focus on effective authentic leadership development, the latter being crucial for further dissemination of the construct (Gardner et al. 2011). Gardner et al. (2011) advocated for greater attention to the basic components of the theory in combination to theory testing and a shift towards qualitative research denoting more development of theory. They also recommend more rigorous and diverse methods in response to the over reliance on surveys, cross sectional designs and single source data. In a later systematic review of the antecedents, mediators and outcomes of authentic leadership in healthcare, while finding support for authentic leadership, Alilyyani et al. (2018) also recommended further research in more varied healthcare teams and settings. Studies revealed that authentic leadership mediated trust and psychological capital, they also showed direct and indirect relationships between authentic leadership and staff outcomes, including a positive workplace environment. Findings supported the four dimensions of authentic leadership (balanced processing, relational transparency, internalized moral perspective and self-awareness). Alilyyani et al. (2018) suggest that future studies include longitudinal experimental designs to examine causal relationships and extend to more diverse samples of

healthcare professionals which links to the previous point of Gardner et al. (2011).

However, the key messages, which extol on the positive influence of authentic leadership in regard to empowerment; increase in job satisfaction and decrease in associated workplace challenges such as burnout, are evident. The basic tenant that being that an authentic leader is grounded in acting in a way that reflects values and convictions is situated in the social context. Authentic leaders are seen to have a positive effect on work life balance and support follower psychological growth enabling creativity.

2.4 Learning from others

In the sense of leadership and the leader/follower interface, relational working has influence and impact. Being a role model is cited from a theoretical perspective and acting as an exemplar, whether intentional or otherwise is a key focus of this study. Therefore, this section explores the theoretical foundations of modelled behaviour from that of the model and observer. From a professional nursing perspective this is influenced by the performance and presentation of the individual; Goffman's (1959) work on the presentation of self is insightful in regard to factors that influence this exchange. Additionally, one way to make sense of and understand how a leader acts as a role model is through Bandura's (1977) social learning theory. The leader as the model displays behaviours to others. As described in the next section this is affected by factors such as frequency and nature of the context.

2.4.1 Goffman and Bandura

In his seminal work on the analysis of the structures of social encounters, Goffman (1959) says that individuals have the capacity to give an impression; this is distinguished between that which he firstly 'gives' and secondly, that which he 'gives off'. The first refers to verbal symbols that convey information attached to those symbols and the second is attributed to a wide range of actions associated with expectations that were executed for reasons other than the information conveyed (Goffman 1959). The difference here can be

affiliated with intent, 'gives', infers deliberation. Goffman (1959) uses the term 'performance' to describe the activity of an individual situated within a particular context. This performance is viewed by a set of observers and can involve a 'setting', an 'appearance' or a 'manner'. This extends to that of the whole team. In this study, the 'settings' were the ward areas; the uniforms were part of the 'appearance' and nursing routines and tasks part of the 'manner'. As discussed in section 1.5 expectations of the health service extends to that of nurses and nursing. As an individual, each nurse in this sense has a part to play and 'gives off' an impression because of where they are for example, and the uniform they are wearing, as well as what impression they 'give' by their actual communication. There is the potential for discord if expectations of the 'audience', that is the public or patients, do not coincide with the reality of what they see.

This impression can extend to interrelational working environments wherein leaders and followers co-exist. Goffman (1959) advises that the term 'performance', can actually serve to convey the characteristics of the task not so much the performer. In teams, the purpose of this is to give off a favourable definition of their service. Each team member is expected to play their part towards this. This is an extension of the impression given by an individual or even two individuals who appear to have an 'understanding'. Goffman (1959) suggests that when this demonstrates similarities, it becomes a reference point and therefore prototypical. This becomes the team's reality and performers have the power to sabotage the 'show'. There is therefore an element of dependency which transcends any formal rank (Goffman 1959). The team needs to cooperate to continue the performance however this infers that the players know the script and will '*maintain the party line*' (Goffman 1959 p. 88). The prototypical performance represents the background reference frames in this study.

The origins of the performance can partly be attributed to learning in the team. In Bandura's (1977) Social Learning Theory, it is suggested that the majority of human behaviour is learnt through the observation of behaviour modelled by others: it gives an idea of how new behaviours are performed and then

coded for later use. Bandura (1977) describes four component processes that govern observational learning: the attentional, retention, motor reproduction and motivational processes. The first of his processes, the attentional process, determines what is selectively observed amongst the plethora of influences. This can be affected by such factors as the model themselves, the features of the activities and structural human interaction (Bandura 1977). This is multifactorial, the impact of the model themselves is relative to the observer, whether they are engaging and personable, how frequently they are observed and whether the behaviours are salient and/or complex. The frequency of contact and observation of the model partly underpins Bandura's (1977) second process, that of retention. This is concerned with how observers remember the modelled behaviour. For the behaviour to become embedded the observer needs to develop a memory in symbolic form, the relevance of this is influenced by the needs of the individual related to their personal and professional development. However, even transient experiences can be retained in memory and as a result of repeated exposure, create retrievable images. From a nursing perspective the model could be someone they see frequently, another practitioner, a peer or their manager for example, the desired behaviour, part of their role. They need a mechanism for retaining this observation and the opportunity to practice it with feedback.

Bandura's (1977) third and fourth processes, that of motor reproduction and motivation, involve converting those symbolic codes into actions and whether modelled behaviour is adopted based on perception of an outcome being considered rewarding or not, if it has positive or negative consequences. Motor reproduction depends on the availability of the component skills, this means that in order for an individual to enact the observed behaviour accurately they need to possess the skills. If this is not the case the skills will need to be broken down, observed and practiced. If, however, they do have possession of the required components, individuals should be able to integrate them into their behaviour. Corrective adjustments linked with feedback and repeated demonstrations of missing elements may be required. (Bandura 1977). The notion of model is linked to a role and becomes 'role model'.

2.5 Role modelling

In healthcare much of the literature concerning role models and role modelling centres on the effect that role models have on pre-registration learners or novices (Wiseman 1994, Landridge and Hauck 1998, Wright and Carrese 2002, Donaldson and Carter 2005, Bluff and Holloway 2008, Cruess et al. 2008, Perry, 2009, Felstead 2013a, Baldwin et al. 2014, Burgess et al. 2015, Bahman-Bijari et al. 2016, Jack et al 2017, Horsburgh and Ippolito 2018 and Lindberg 2020). Role modelling is a commonly used teaching strategy in clinical practice, it offers a wide range of opportunities and aims to make the learning meaningful (Armstrong 2008). However, this can extend beyond teaching solely, Cruess et al. (2008) locate role modelling in medical education within three curricula; the formal (course structure outcomes and so on), the informal (unscripted and unplanned learning opportunities), and the hidden (organisational culture and institutional structure), role models function in all three. The following sections explore this literature, inclusive of the work of Gibson (2003, 2004), it encompasses the source of role models, what their behaviours consist of and the perceived impact of role modelling.

2.5.1. The source of the role model

The identity, location and source of the role model has been explored in the literature. The rationale for this choice being reflected in attributes associated with the 'salience' aspect of Bandura's attentional phase. This means that people choose their role models for reasons important to that particular individual, in that role, at that particular time. In a study by Wright and Carrese (2002), staff were asked to identify their role models from the medical team. 29 out of 30 role models identified participated in their study. Those physician role models described role modelling consciousness: in that they specifically thought about being role models when interacting with learners, they were aware that they were perceived as role models and being watched, particularly in difficult or stressful situations (Wright and Carrese 2002). Characteristics relating to role modelling were identified and subcategorised under the domain of personal qualities and teaching. Although there was

some overlap, role modelling was more encompassing than being a mentor and included more affective moral and ethical aspects. Being a strong clinician was necessary but not sufficient for being a role model – perceived barriers included aspects such as being impatient, although these were balanced by positive attributes and higher order clinical skills and personal qualities. Having multiple role models to draw on was perceived as important.

The multiple role model aspect resonates with the work of Gibson (2003). Gibson (2003) explained that role modelling combines the concept of 'role', that is, behaviours and activities associated with specific positions, with the concept of modelling. According to Gibson (2003) this draws on social learning theory and identification theory, in explicating how people define their role models, both theories concur with selection of the model and making sense of how a role model can help through observation. Using an inductive qualitative approach Gibson (2003) analysed 43 sets of interview data seeking to question two implicit beliefs: firstly, how individuals select and interpret the attributes of their role models and secondly, at what point they occur in life. He found that role models were depicted as cognitive constructions, based on an individual's needs, wants and ambitions. In regard to when they occur, Gibson (2003, 2004) concluded that role models could be construed along two cognitive dimensions (positive/negative, global/specific) and two structural dimensions (close/distant, up/across-down). These were considered on bipolar continua representing the different ways that individuals view their role models. The positive and negative dimension was linked to similarity, outcome and relevance; whether participants wanted to be like positive models, or not, because of negative results and belonging to an out-group. The global versus specific dimensions, related to the amount or type of skills and traits that the model was perceived to possess, a large range or a specific selection. The close/distant and up/across-down dimensions were concerned with the availability and whereabouts of models. This refers to the frequency of possible observations, notwithstanding the previously mentioned 'similarity' connotations. It is also linked to whether the model was considered a peer or expert.

Dimensions were mapped to career stages as well. Gibson (2003, 2004) discovered that while participants adopt role models throughout their careers, the relative importance changes. For example, early career individuals were more likely to construe their models as having global attributes whereas middle and late career individuals tended to focus on specific attributes in role models. Gibson (2003) referred to this trajectory as, early career – acquiring, middle career – refining and late career – affirming. Conceiving of role models in terms of these dimensions, could focus further study away from looking at one role model to an individual's set of role models (Gibson 2004).

Whilst the context of this study was located outside of a healthcare environment the overall message is significant in terms of career progression and the nature of evolving needs and growing role identity. The manner in which role models are identified and for what reason is multifactorial. This is important to acknowledge in relation to nursing, because while Baldwin et al. (2014) concluded that nurse clinicians were considered role models they also recognised that student nurses can be exposed to a range of influences during their course. They acknowledged that there was little reference to other health care professionals and their impact, or that of the organisation in their systematic review of research on role modelling in undergraduate education though. Baldwin et al. (2014) shared that all of the papers they reviewed discussed role modelling in nursing education in relation to registered nurses role modelling for nurses, this having been widely investigated. 33 papers were identified, 26 relating to role modelling during clinical placement and seven related to the academic setting.

The nature of individual attributes influenced the choice of role model for other health care student participants in Bahman-Bijari et al.'s (2016) study. This study used quantitative data from self-administered questionnaires to determine which professional and humanistic attributes were demonstrated by teachers in the health disciplines that caused them to be perceived by students as positive or negative role models. This cross-sectional study yielded an impressive 83% response rate from 3 cohorts of medical, dentistry and pharmacy graduates. They identified the personal attributes of positive

and negative role models, this included being distinguished and admired, being a good manager, being a good teacher, as well as being respectful of colleagues, students, and patients, serious, cooperative, knowledgeable and kind. Humanistic and professional qualities were considered important, and if present, assigned to positive role models and conversely if not present assigned to negative role models. Bahman-Bijari et al. (2016) suggest that different role models and typologies can emerge in different cultural settings, thus offering transferable learning. This continues to support the multiple role model element.

Using theoretical guidance from a practice-theory perspective where role models can be viewed as embodied ideals, Lindberg (2020) found an issue with gender when she examined how gendered ways of thinking relate to role models in medical education. She used an exploratory, qualitative, cross-sectional design and carried out 57 interviews with 28 medical students and 29 faculty members. The most common favourable aspects (for example being good with patients and being knowledgeable) were seen in both males and females. However, personal non-work-related attributes were described positively for males and male role models were generally viewed more admirably than female role models. Lindberg (2020) felt this pointed to gendered ways of thinking and potential disadvantages for female doctors, careers and opportunities. She recommended using the results as a basis for discussion and the importance of gender in role modelling and in medical education in general. Although Lindberg acknowledged that the gender of the participants was not clear so potentially skewed, this is nonetheless of interest to note in nursing where the population is predominantly female and of value to note in relation to the health leadership rhetoric, with widely recognised gender challenges. These challenges, whilst improving, remain significant. Northouse (2019) locates these differences with human capital issues, that is things like education; or prejudices such as gender stereotyping and gender differences aligned with self-promotion, style, effectiveness, commitment, motivation and negotiation aspects.

2.5.2 Behaviours displayed by role models

Role models are considered to display a range of behaviours, positive and negative. How these are enacted or approached is also influential and can form the basis for subsequent behaviour in the observer, this section examines literature exploring this perspective. The purpose of Wiseman's (1994) study was to identify the behaviours of nursing faculty clinical members role modelling behaviours that nursing students considered important. Wiseman (1994) was interested to expose any difference in perceptions between junior and senior students. She used Bandura's (1977) social learning theory as a theoretical framework and highlighted the role modelling behaviours in the phases of this model. Using a Likert scale based on three sections, it was found that students look to faculty members as role models and identified a range of behaviours which they associated with being a role model. The role model behaviours encompass activities associated with nursing such as demonstrating a caring attitude, keeping confidential information to oneself, being flexible, listening to others' points of view and respecting the patients' integrity. They made judgements about which behaviours they considered important, which they choose to practice and those they perceived were recognised and rewarded by faculty members. No difference was discovered between junior and senior students in regard to perceived importance and frequency of role model behaviours however, there were some inconsistencies in relation to perception of rewards for things they saw as important. This could relate to perceived feedback and reflect individual position or progress. This study included only students (n=208), the researcher suggested exploring the findings with faculty members and staff nurses.

The students in Landridge and Hauck's (1998) study also looked at faculty members as role models. In this phenomenological study, final year students discussed their experiences of role modelling and experiential learning. Landridge and Hauck (1998) used Burnard's conceptual framework of experiential learning as a guide where experiential knowledge is gained through direct contact with a person, place or thing. They categorised the essence of role modelling into six sub themes: valuing teaching and learning,

being committed to nursing, being knowledgeable and skilled, an effective communicator, valuing individuals and being open and approachable. Learning in the field was linked to the role modelling of their clinical educators and other practitioners. Students were able to describe the attitudes and behaviours of role models and how their learning benefitted them, they were also able to discuss the negative effects of poor role modelling. Landridge and Hauck's (1998) conclusion inferred accessing more than one model – the role model was seen as different to each other but similar, united by role.

In a Jordanian study using critical incident technique, Hayajneh (2011) developed 10 categories that reflected the motivating behaviours of role model clinical instructors. Participants thought that clinical instructors should be able to communicate clearly, be prepared and be available and accessible. They were expected to act as advocates for the students, support their learning as well as be tolerant of mistakes. Hayajneh (2011) suggested that there was a relationship between the categories, for example, role modelling professionalism and teaching at the same time. Medical students in Australia identified the positive and negative characteristics and behaviour displayed by their clinical role models (Burgess et al. 2015). Burgess et al.'s (2015) study drew on an inductive analysis grounded in the data. Role model attributes that the students would like to observe and emulate included clinical, teaching and personal qualities. For example, they were impressed by knowledge and expertise but bothered when communication and empathetic skills were lacking. Excellence in role modelling demonstrates these qualities and reinforces the importance function of clinical bedside tutors as role models being cognisant that role models can influence the student's choice of behaviour type to engage in next (Burgess et al. 2015). The students in this study were in their first year, the relevance of this can be connected to early-stage role identity and development.

In addition to what behaviours role models display, the approach they take, that is 'how' this behaviour works has also been studied. The work of Morgenroth et al. (2015) offered a motivational framework for role modelling based on expectancy value theories. They felt that the literature on role modelling was fragmented and lacked reference to motivational literature, this they considered to be key in understanding how role models work. By integrating different definitions of role modelling into a new conceptualisation, Morgenroth et al. (2015) describe how role models were considered to motivate the behaviour of individuals and inspire them to set ambitions and goals. Three distinct functions of a role model were highlighted: acting as a behavioural model; representing the possible; and being inspirational. Role models were positive sources of social influence although there was no firm consensus on what constitutes this influence. They add that role models can represent the possible by evoking a shared social identity, this is dependent on goal embodiment and attainability. Seeing someone reach a goal (goal embodiment) and believing that they can be like that person (attainability), helps a role aspirant to imagine themselves in the position of the role model and believe they can achieve the goal. Being part of a shared group affects attainability, but is mitigated by whether this is perceived to be similar, important or meaningful. Someone can be inspired 'by' something or inspired 'to' do something (Morgenroth et al. 2015). Role models can function as inspirations, their actions and behaviour need to be perceived as desirable though, in order to be identified, internalised and admired.

The two main motivational factors in Morgenroth et al.'s (2015) framework are the expectation of success and the perceived value, or desirability of success. Expectation refers to the perceived subjective likelihood of success, this could be different to the actual likelihood of success. Values refers to the individuals perceived subjective desirability of said success, that is, the results and whether they want them. In this context, expectancy can refer to short- or long-term goals, factors internal or external to the individual (Morgenroth et al. 2015). According to Morgenroth et al. (2015), perceived value is influenced by a number of factors, for example, attributes of the goal, whether it is enjoyable or not, or the effect of reaching that goal. Role model attributes (who they

are, what they can do) and role aspirant attributes (goals), interact and contribute to role aspirant achievement, this prompts vicarious learning, that is, learning through the observation of a role model. Fundamentally, potential role models need to embody a role aspirant's already existing goals: These are concerned with whether the possible is attainable; and whether membership in a shared group is desirable and attainable, or beyond reach.

2.5.3 Impact of role modelling

The outcome and result of accessing a role model is described in terms of value, purpose and impact. Learning from a role model appears to be generally considered beneficial when positive in nature as discussed in the following section. Davies (1993) sought to determine whether the observation of role models enabled students to discover knowledge embedded in clinical practice. She used a grounded theory methodology conducting interviews with six students. Although the rationale of selection of students was not clear the findings are similar with later research, in that students identified good and bad role models and the impact that this had on the care delivered was evident in the data gathered. The student participants were able to recognise creativity and flexibility in practitioners and relate this to the provision of individualised care, thus reflecting knowledge discovery. In Donaldson and Carter's grounded theory study (2005) the value of role modelling in teaching and learning within the clinical area was explored. The students in this study expected to be able to identify a role model whom they considered to be 'good' Nursing students provided examples of good and poor role models. The good models acting as sources of aspiration and poor role models being identified as those who did not offer feedback, as giving feedback was depended on by the students. Confidence and competence seemed to improve if the student was supervised appropriately by a good role model. Donaldson and Carter (2005) recommended including discussions on the value of role modelling in mentor preparation courses as access to a role model was important in order to observe and practice skills/behaviour.

Bluff and Holloway (2008) discovered that the impact of role modelling extended from the everyday nature of practice to professional development, sometimes this included how not to act. They explored the influence of midwifery role models on the role that midwives learn. They also used a grounded theory methodology (20 student midwives and 17 midwives) and discovered that students learn the role of the midwife in a changing culture, some midwives clearly practicing flexibly and autonomously, whereas others were more prescriptive and followed rules blindly. Students emulate the role of the midwives with whom they work suggesting that all midwives are effective role models. However, this is limited by the quality of the specific midwife's practice (Bluff and Holloway 2008). In this study students chose to emulate their midwifery supervisors when in their presence to ensure that they achieved on placement, as not doing so was risky, conforming to their mentors' ways of practicing enabled them to access the learning opportunities that they needed in order to pass their placements. Fundamentally, autonomous midwives are influential role models, and they are the ones who the students want to follow and be like when they qualify.

Building on the impact of role modelling from a broader perspective, Perry (2009) felt that role modelling could tap into hidden craft knowledge making it more accessible to learners, she explored how role modelling by exemplary nurses could be used to teach nursing. This could start to infer role models as leaders. Perry (2009) believes that practitioner or craft knowledge is inherently difficult to pass on for the same reasons it is important; it is context specific and hard to share beyond the immediate context. Her phenomenological study collected a substantial amount of data. Nurses, in a large tertiary care hospital, were asked to identify nurses who they would like to be looked after by, arguably exemplary nurses. Eight were chosen at random and data collected by interviews, conversations and observations. The single major finding was that the exemplary nurses in this study were found to be outstanding role models. They attended to the 'little things', made connections, modelled effective actions and interventions in a facilitative way and affirmed others. This demonstrated a willingness and recognition that they were role models, they were also open to learning from role models

themselves (Perry 2009). Being a role model was seen as mutually beneficial, Perry used the term 'transpersonal learning' to describe one who teaches becoming the one who learns.

In essence, these role models were self-aware and insightful, the epitome of leaders, seeking a common connection was important. This notion of being conscious and purposefully acting as a role model, has attracted comment and builds on the quest for further exploration around leadership and role modelling. As mentioned earlier, Wright and Carrese's (2002) physician role models described role modelling consciousness: this notion is evident in the work of Felstead (2013a, 2013b). Felstead's doctoral study (2013b) used an interpretive phenomenological analysis approach to explore the impact of role modelling on student nurse's professional development, he interviewed 12 students. Students were influenced by senior nurses, particularly those who 'lead by example', they also learned how not to behave, which in itself was considered a good learning experience. The development of student nurses therefore is influenced by clinical role models (Felstead and Springett 2016). Felstead (2013a) discussed the effect of conscious role modelling and said this could be considered contentious because it makes acting in a certain way as a role model purposeful. He argues that 'playing a role' could be false and be concerned with giving an impression, rather than being an embodiment of a behaviour which happens naturally. This creates a potential tension for leadership, the connotation of recognition as role model and notion of being self-aware as fundamental requisites for a leader.

This point is elaborated further in Jack et al.'s (2017) descriptive narrative study of the influence of role models on undergraduate nurse education. Student nurses viewed role models as valuable, they described how negative role models made them consider what type of nurses they wanted to become; however, at the same time this also created a risk that poor behaviour was emulated. The findings support the use of role models in nurse education and propose that further research of conscious role modelling of practice is required. They suggest that the act of identification makes someone a role model, rather than someone being perceived as a role model simply because

of the position they occupy. The importance of interrelationships is also discussed in regard to the ways that professional identity is constructed through social processes of comparison, learning from role models being an aspect of this. This latter thread also adding an identity development suggestion.

The awareness of being a role model is also present in the work of Horsburgh and Ippolito (2018) who used Bandura's model of social learning theory to explain role modelling as an active process. This was predicated on two parts of the role model construct: firstly that people have a tendency to identify those who they hold in an aspirational social position and secondly that they attend to those who possess the skills and ways of working they want to learn. They used a qualitative interpretative methodology to interview 6 final year medical students and 5 clinical teachers. The students described how they learnt from role models, this was selective, they consciously paid attention, used retention strategies and copied behaviour but acknowledged that this was complex. It was suggested by Horsburgh and Ippolito (2018) that students should be introduced to Bandura's model, and then use it to develop the teacher's understanding of how learning from observation occurs and their ability to maximise opportunities and create the conditions which enable students to observe their role models frequently and closely. There was reference to peer support but not general awareness of being a role model.

In summary, the review of the literature pertaining to role modelling reveals that individuals potentially access multiple role models, for subjective reasons which can change over time. Role models possess a range of positive skills and attributes which are considered worthy of emulation, although negative role models also can be a source of learning too. There is some inconsistency in the conscious element and perception of self as role model although role modelling is widely recognised as a teaching strategy. This can create a tension around embodiment of role and the notion of 'playing a role' and self-awareness inherent to leadership.

2.6 Leader identity construction

Leadership, the impact and activity associated with it, is more than hierarchy, position and status, although historically this has influenced nursing. How people see themselves is at the core of leadership identity. Whether this originates from an innate belief, a constructed belief, through self-comparison or via feedback from a social interaction, it can be considered dynamic.

2.6.1 Future selves

This section explores the idea of how an individual conceives of themselves in regard to identity development in a social group. As described earlier in section 2.5, the individual who is observing another, whatever the situation or role they play, will learn from the other. The complexity of social groups is the essence of the interactions and responses to expectations inherent with concepts such as 'prototypicality' and 'performance'. Individuals may undertake a self-comparison and reflect on their future behaviour and develop a 'possible' self. Markus and Nurius (1986) examined the theoretical features of possible selves.

They tell us that possible selves are concerned with an individual's idea of what they might become, what they would like to become and what they are afraid of becoming. Markus and Nurius (1986) stress that these possible selves are important because they can motivate future behaviour and also provide an evaluative basis for current view of the self. This self-knowledge enables taking an interpretive view when making sense of the past. This means that the self- concept is seen as a set of affective cognitive structures about the self, that give form and integrity to the individuals self-relevant experiences. Possible selves are derived from past representations; they include representations of the future self but are different from current selves. Many possible selves are the outcome of previous social comparisons where thoughts, feelings and behaviours have been measured against those of others (Markus and Nurius 1986).

Therefore, the idea of the possible self is based on the contextual experience and understanding of the individual, whether it be role or profession orientated. Ibarra (1999) argued that people adapt to new professional roles by experimenting with images that serve as 'trials' for possible, but not yet fully elaborated professional identities, identity changes can often accompany career changes. Ibarra's (1999) perspective derived from two grounded theory type studies of business roles going through career transition. Role models were seen to display desirable identities, from observation of these, participants learned tacit rules and ways of signalling important professional traits (these constituted role prototypes). They then compared themselves to those role models. Variation on the number and type of role models observed generated a repertoire of models with which to experiment as provisional selves (Ibarra 1999). Guided by internal (role and expectation congruence) and external (feedback from others) evaluation, individuals modify their personal store of possible selves. These ideas can be used to explain the basis for how individuals might comprehend future selves through accessing a role model. Expectations from a professional perspective exist through professional role frameworks, progression and promotion.

2.6.2 Leadership identity development

This section focuses on leadership identity development from two socially situated viewpoints initially: cognitive and co-constructed models. This is conveyed in terms of deep level skills, self-identity and awareness of the social structure that the leaders function in and their individual subjective understandings.

Lord and Hall (2005) propose that leadership skill development is organised in terms of progression from a novice to intermediate to expert, the individual's capability growing through identity work, values and mental representations. They indicate that an adequate model of leadership development needs to go beyond the traditional discussion of training or self-directed learning, which tended to focus on acquisition of surface level skills. Instead, the model needs

to go deeper to principled aspects which help to understand long term development (Lord and Hall 2005).

Lord and Hall (2005) describe a novice as someone who is learning to be a leader; these individuals concentrate on their personal identity and are beginning to be accepted as leaders. Social processes help to validate their view of themselves as a leader; this is surface level in that they are focused on what leaders do when they lead. An intermediate leader has a level of meta- monitoring skill, they have context specific knowledge and their focus shifts from self to others, they are concerned with the group. Intermediates have experience and are knowledge rich and can manage unfamiliar situations, whereas expert leaders demonstrate more of a principled and contingent perspective, this is based on extensive experience and represents a deeper structural shift (Lord and Hall 2005). Lord and Hall (2005) suggest that the leader's identity moves to a value-based identity grounded in abstract principles at the expert level. For an expert leader, this principled level of knowledge and understanding is often in terms of values, emotions and identities: identities shift in focus. Thus, this theory is also situated within a social milieu: the leadership skill development being related to the particular praxis context and behaviours. However, the evolutionary nature of leader development which does not occur in a vacuum is acknowledged, again there is a connection with learning from those around.

Progression as a leader is considered to be reflective of a cognitive bootstrapping process whereby micro level skills are first learned through problem related experiences or observational learning. Access to a role model is critical for observational learning. This is a key point as the skills are then organised into higher-level systems that guide knowledge, behaviours and social understanding (Lord and Hall 2005). According to Lord and Hall (2005), individual identities emphasise the uniqueness of the self, relational identities define the self in terms of roles or relations, collective identities define the self in terms of groups or organisations. As the leader's goals, knowledge and understanding changes (leader identity) it in turn affects that of followers. This development follows a structured trajectory which appeals to the practical

nature of nursing work and is resonant of the work of Benner (2001) and her seminal work on 'Novice to Expert'.

DeRue and Ashford (2010) believe that leadership identity is co-constructed in organisations when individuals claim and grant leader and follower identities, an alternative way for leader identity development. Their fundamental question is, if leadership is not simply prescribed because of someone's position in an institutional hierarchy, then how do leadership and leader-follower relationships develop in an organisation. They focus on the interplay between leader and follower identities and the social exchanges in the development of a leader relationship. The relationship is considered dynamic and leader-follower identities can shift over time and across situations (DeRue and Ashford 2010). This happens through social construction processes. The leadership identity construction is composed of three parts: individual internalisation; relational recognition and collective endorsement.

Individual internalisation occurs when someone incorporates the identity of leader or follower as part of their self-conceptualisation (DeRue and Ashford 2010). The leader identity is stronger in comparison to the follower identity, and as a consequence, is relationally recognised when others respond by taking on a follower identity, sometimes, but not always evident in a hierarchical organisation. Collective endorsement refers to being seen as part of a social group from a broader social environment. DeRue and Ashford (2010) describe identity work processes of claiming and granting a leader identity. These are formed through social actions and reciprocation. 'Claims' are actions that people take to assert their identity, whereas 'grants' are actions that people take to bestow an identity on another (DeRue and Ashford 2010). These are generally recognised through direct or indirect means, verbally or non-verbally. They should be of 'sufficient quality' to be perceived, but nevertheless vary in clarity and visibility and are impacted by prior history. The reciprocal nature of receiving grants in support of leadership claims drives further leadership claims, a negative spiral occurs when claiming or granting behaviours are not positively reinforced. DeRue and Ashford (2010).

advise that this can be influenced by an individual's leadership schema and whether this aligns with a hierarchical or shared leadership structure.

Using prepared videos, Marchiondo et al. (2015) invited observers to respond to questions around leader and follower claims and grants in a meeting situation. These were rated and tests of statistical significance reported on. Marchiondo et al. (2015) tested leadership identity construction and attempted to understand how the interaction between leader claiming/granting and follower acceptance/rejection influenced observers' perceptions of the leader and follower. They discuss issues such as how leadership claiming in itself is leader like and contributes towards an observer's leadership schema. They propose for example, that a leader's claim in isolation does not provide sufficient information in regard to that leader's claim, it needs to be accepted to make it appear appropriate or warranted for an observer. For example, an individual may offer to take a lead on a project, unless anyone objects to this either indirectly, through not carrying out a task perhaps, or directly by disagreeing, that claim is upheld. Therefore, multiple parties contribute to the strength of the leader identity (Marchiondo et al. 2015). Overall leadership claiming heightened the observer perceptions of the leadership claim when a responding team member accepted, rather than rejected, this claim. Granting a leadership claim was also seen to be beneficial as it could be seen as empowering and in itself a leadership behaviour. Inherently any such endorsements have value and an impact that is spatial, temporal and contextual.

Marchiondo et al. (2015) acknowledged that the videos they used in their study were reflective of 'overt' leadership scenarios rather than implicit situations. Nonetheless, these could be reflective of expectations associated with a positional type of leader role and transferable to this study. The relationship between leaders and followers can be seen as complex overall. This situates leader identity development within the clinical context with multiple opportunities for change and validation which are context and time specific. Moreover, this could be considered redolent of Hogg's depersonalisation and prototypicality in social groups and therefore influential.

2.6.3 Challenges in leader identity development

Shamir and Eilam (2005) propose that the traditional approach to leader development uses leader's stories to illustrate events and experiences that have been critical for leadership development, these being connected to the acquisition of particular skills or traits. The literature associated with the trajectory of leader identity is located within the personal position. How this identity is constructed in relation to other identities and beliefs concerning identity strength and motivation is the source of challenges and discussed in this section.

From a professional perspective, nurses and other clinicians have been seen to hold their professional identities in high esteem. Against a leader identity this can prove problematic as patient care, clinical tasks and meanings take priority (Croft et al. 2015, Koskiniemi et al 2017). Nurses in Croft et al.'s (2015) study of emotional attachment to professional group identity, were passionate and positive about nursing but less so about their leader identity. They talked about three kinds of identity work: distancing from their managerial leader identity demands; retaining a professional influence by talking about their leadership identity in nursing rather than managerial terms and moving from a nurse identity to a leader identity without emotional attachment. Thirty-two Nurse Managers, who had taken part in a leadership development programme, participated in the narrative research. Croft et al. (2015) argued that the biggest challenge for nurses was managing the tension between building a leader identity and that of their professional identity - the feeling that they were losing their identity as a nurse and no longer able to influence the group.

The tension between professional and leader identity is explored further in Koskiniemi et al.'s (2017) study set in Finland, which took an existential-phenomenological perspective to understand and describe the experienced leader identity development of healthcare leaders working in dual roles. Data was gathered through interviews with 24 nurse and doctor leaders. They also found that individuals had an emotional attachment to their profession. Leader identity development was linked to clinical work and relationships. The

meaningfulness and reward derived from helping patients gave both reason and meaning to leadership. Helping patients was the core mission and took priority over leadership duties. Relationships within the working team and working environment were important (Koskiniemi et al. 2017). Solutions are proposed by Gjerde and Ladegard (2018) who offer four strategies for crafting a leader role when entering a new position. They used an inductive research design and interviewed 28 senior leaders from four different contexts in Norway. The contexts provided a range of leadership contexts in terms of preparation time for the role. The four strategies are 'Present – informing and demonstrating', 'Adapt: complying to and moderating behaviour', 'Challenge: persuading and challenging expectations; and 'Experimenting with old and new ways'. Each of the strategies were used by the participants, depending on the situation at hand, but they acknowledge that crafting the leader role is complex. Nonetheless, adopting these could help with navigating the tension between leader role expectations and leader role identities when entering a new position, depending on the context. Drawing on role models is specifically noted in the 'experimenting with new ways' theme and links to the work of Ibarra (1999) on provisional selves.

The motivation to lead and belief in self as leader, is influenced by leadership development and is particularly associated with self-reflection and self-comparison (Paterson et al. 2015, Guillen et al. 2015, Yeager and Callahan 2016 and Miscenko et al. 2017). Paterson et al. (2015) evaluated a local leadership programme. They used surveys to evaluate self-perceived leadership capability over a 9-month period: at the start of the programme, at the third workshop and six months after. The programme was locally designed and consisted of three workshops which were composed of self-directed reflection and application activities. It was designed for entry level and relatively junior registered nurses. The results suggested that the programme was successful in assisting the participants to manage complex care issues, they reported enhanced communication skills and collaborative working, which contributed to this. Perceived leadership capability significantly improved throughout the programme and participants also indicated a willingness to enact leadership behaviours through reported activities.

From a self-comparison perspective, Guillen et al. (2015) conducted surveys of nearly 400 people to test their hypotheses of leader self-comparisons. Their research demonstrated that self- to- exemplar comparisons with specific leaders, were positively related to motivation to lead, as were comparisons with more abstract general representations (prototypes). Motivation to lead refers to an individuals' willingness to engage in training activities and assume leadership roles (Guillen et al. 2015). Personal leadership standards also influence this through comparisons with perceived attributes from personal encounters with leaders. Guillen et al. (2015) adduce that concrete role models would offer an example of a behavioural script that would boost the confidence of prospective leaders to succeed as a leader, whereas more general abstractions, would only reinforce a positive effect toward the act of leading.

Learning from role models is apparent in the work of Yeager and Callahan (2016) in their study that explored the early experiences of young leaders' identity development. Young leaders talked about learning to lead from example, that is role models, developing relationships, authenticity and motivation to lead. Authenticity as a leadership attribute emerged as participants reflected on experiences of integrity, trust and accountability. Relationships that affirmed and validated leaders were seen as effective, in addition to how the motivation to lead originated from internal and socially constructed perspectives. Leadership identity was perceived to change in line with changes in leadership skills (Miscenko et al. 2017). Attendees of a leadership development programme participated in the study. The study employed latent growth curve modelling and latent change score analyses across seven measurement points. These strategies are appropriate to use when aiming to estimate growth over a period of time. The strength of leadership meaning was defined as the extent to which the individual identifies as a leader. Although individuals held strong beliefs in personal leadership, this tended to weaken at the start of the programme as their insight into the leader role increased. The leader identity plateaued and then strengthened again toward the end of the programme. This is due to the

nature of the development interventions that trigger self-reflection and self-comparisons which caused individuals to question their efficacy.

Strength of leader identity also impacted on Kragt and Guenter's (2018) integrative model of leader identity, which they had constructed and tested to explain why reactions to leadership training were associated with leader effectiveness. They proposed that this was conditional on leader experience. They found that leader identity mediated the relationship between reactions to leadership training and leadership effectiveness – the stronger the leader identity the more enhanced leader effectiveness was, but only for less experienced leaders. Data was collected through online questionnaires; respondents had received some leadership training in the preceding six months. There was a differentiation between the needs of less experienced leaders and more experienced leaders: this was distinguished as leadership training and leadership development respectively. The former focusing on solutions to day-to-day problems and the latter focusing on the leader's ability to respond to unknown issues (Kragt and Guenter 2018). This could represent the difference in leadership efficacy and skill acquisition based on experience.

Individuals who saw themselves as leaders, were more likely to be seen as leaders by others in Peters and Haslam's (2018) longitudinal study of leader and follower identity and leadership in the marines. Participants rated their identification with leader and follower roles. Leadership qualities and potential to become leaders were evaluated by commanders, and leader embodiment assessed by peers. In addition, it is of interest to note that those who considered themselves followers and were seen as followers, were considered leaders by peers. The latter being associated with the possibility of motivating individuals to act as one, with, and on behalf of the group. These findings suggest that follower and leader identities underpin various aspects of leadership and that these are differently recognised by others. Differences between raters were noted and attributed to involvement in the leadership process, sensitivity to impression management and notions of leadership potential (Peters and Haslam 2018). This is related to a rate knowing the individual's usual performance, acting differently with more senior others and

seeing leadership in others based on different experiences themselves. They surmise that there is a nuanced relationship between leadership emergence and leader and follower identities, the question being 'when' and to 'whom' these relationships are important (p.718 Peters and Haslam 2018).

The main points of this section reveal how self-belief as leader, the motivation to lead, improves with access to leadership development activities and perception of efficacy as part of self-comparisons with specific or prototypical leaders. The specific comparison related to actual role models being particularly helpful for confidence building. For those in healthcare, leader identity can affect how they are perceived as professionals – connotations for the social positioning incumbent in the clinical context and emotional attachment afforded to it.

2.7 Theoretical lens

In this study the intent was to explore the nature of leadership free of the constraints of seeking a new or best theory of leadership. To enable a nuanced lens through which to explore role modelling in leadership and for reasons explained in chapter one, authentic leadership was posited as the leadership theoretical frame. Following the review of contemporary health and social policy and pertinent literature, social learning theory provided a further lens through which the cases could be studied. The aim was not to look for convergence of these but rather to illuminate potential elements of the case in relation to role modelling and leadership. The particular aspects of the theories were applied to the practical elements of nursing. For example, what behaviours might be displayed in relation to the 'balanced processing' component of authentic leadership and what aspects of this could be observable in the phases of Bandura's (1995) social learning theory model (Appendix 1). This is discussed further in the next chapter section 3.13.

2.8 Key points

Leadership has been contextualised as a social phenomenon in this study: it is rooted in relationships, evolving behaviours and identities. This review

illuminates key points which are present in the discourse. The preferred approach to leadership aligned with an authentic approach, where leadership offered a means to address the current demands and common desires of 'effective leadership' in the NHS. Authentic leaders are grounded in acting in ways that reflect values and convictions, this was considered positive although how the role model aspect could be capitalised on, was not clear. From a leadership and leader/follower interchange perspective, relational working has influence and impact. Each individual nurse in this sense has a part to play and gives off an impression. This can be aligned with a leader or role model identity. One area that connects identity development and role modelling, centres on how self-comparisons can be made when involved in personal development and whether this is from a more general, that is professional role perspective or leader role perspective. In healthcare much of the literature concerning role models and role modelling centres on the effect that role models have on pre-registration learners or novices. This is widely considered to be positive if the role model 'good', and conversely not emulated if 'poor'. The basic premiss of learning from a role model is not restricted to pre-registration learners however. A tension is exposed around whether acting as a role model should be purposeful or embodied. Therein lies a challenge, leaders are described as leading by example, but this is not always recognised as a conscious effort, despite acting as models for future behaviour. These key points contribute toward the background issues (which are explored further in the methodology and methods chapter, section 3.4) and frame for this study.

2.9 Summary

This review followed an iterative nexus approach thus capturing the broad and complex literature base of the study. It included both national and international literature on leadership, authentic leadership, leader identity construction and role modelling. The main argument developed in this review is that leadership is multifaceted and complex. The chapter began with a focused literature review on the social nature of leadership and authentic leadership in the context of nurses and nursing practice, the balance of lead and follow. It

explored learning from others through self-comparison and social learning theory. This was followed by an examination of the research undertaken in relation to role modelling; how role models are identified and what behaviours they display. The notion of leader identity is explored and challenges associated with this discussed. The close of the chapter culminates with a rationale for the development of theoretical lens and review of key points.

Chapter 3 – Methodology and Methods

3.1 Introduction

This study proposed a new way to explore role modelling. It sought to investigate the association between role modelling and leadership and any factors that assist an emergent understanding of self as role model. This chapter begins by exploring my ontological and epistemological position and how this contributed to methodological decisions in the context of this study. This is followed by a discussion of the case study research design, the history of case study research and the setting and application of the methodology. In the second half of the chapter, the study setting, access to the field and recruitment processes are described alongside an account of the ethical permissions sought. A discussion of the methods used to collect data follows and then the rationale for the analytic processes used in the research. This is supplemented by examples at the various stages. Rigour and triangulation, within the context of the study, are then explored in respect of challenges associated with case study methodology. Reflexivity is an essential part of this process, and the chapter concludes with a discussion of strategies employed to manage the roles of nurse, educationalist and researcher.

3.2 Ontological and epistemological perspective

This section looks at how paradigms or ‘world views’ dictate and influence what should be studied, how research should be done and how results should be interpreted; they sharpen the researchers focus (Bryman 2012, Polit and Beck, 2018). The questions that nurse researchers ask and methods they chose are predicated by their view of how the world ‘works’ (Polit and Beck 2018). A paradigm is often described in regard to the way that it answers basic philosophical questions: ontologically, asking what the nature of reality is; epistemologically, what the relationship between the inquirer and that being studied is; and methodologically, how should the inquirer obtain knowledge (Lincoln and Guba 2013, Polit and Beck, 2018, Denzin and Lincoln 2018).

Being a role model and role modelling as well as leading and leadership are inherently socially situated and involve people: their experiences, feelings, meanings, actions and behaviour. Naturalistic methods of human inquiry explore the issue of human complexity directly, being cognisant of the way that humans shape and create their own experiences (Polit and Beck 2018). In ontological terms, the naturalistic inquirer believes that reality is not a fixed entity, instead, reality is a construction of the inquirer; many constructions are possible and these are relative to the context. Epistemologically, the naturalistic paradigm considers that knowledge is maximised when the distance between inquirer and participants being studied is minimised (Polit and Beck 2018). The relationship between the inquirer and those studied is person and context specific (Lincoln and Guba 2013).

In nursing there are multiple, context specific realities. In this study, I believe that exploring role modelling and leadership in nursing needed to happen close to the context, so that the research could encompass those perspectives first-hand. Interaction between the inquirer and the person being studied is subjective and mediated by the inquirer's prior experience and interpretation of the context; epistemologically knowledge is created within this time/space schema (Lincoln and Guba 2013). As a nurse myself, I appreciate that how individuals encounter leadership and role modelling can be interpreted in different ways by different people and represents a complex set of experiences and constructs which are relative and not easy to extrapolate from each other.

The next sections provide an overview of the underpinning rationale for taking a holistic view and constructivist approach, which enabled leadership and role modelling to be explored as a dynamic social exchange between individuals and within nursing teams, as nurses went about the everydayness of being at work.

3.2.1 Holistic and complete

This study proposed a holistic approach. Thomas (2011) asserts that fundamental beliefs about the basic purpose of inquiry, that is, whether we are scientifically developing laws or theories for explanation and prediction or trying to understand subjective things of the social world; make the assumptions of viewing the world as 'divisible and reducible' or 'indivisibly complete' complex. He proposes that the argument about reductionism and holism, has been ongoing for 2,500 years, with the natural sciences favouring the former. Thomas (2011) describes how the thinking of Windelband on idiographic approaches; Gestalt psychology and the human tendency to invest meaning in and make sense of seemingly unrelated things have contributed to the discourse on reductionism and holism.

Windelband conceived the term 'idiograph' to distinguish between 'idiographic' and 'nomothetic' in social inquiry; the former describing an approach that studied individual phenomena in detail whereas the nomothetic approach generalises from many and formulates laws (Thomas 2011). Gestalt psychology is based on the idea that things should be seen in their totality and that human minds make connections and do not look at things in isolation (Thomas 2011). Both of these perspectives point towards an approach that values detail and connections. In this study, role modelling and leadership are complex and multifactorial, the empirical evidence associated with both concepts shows a connection. Leadership can be subtle and nuanced or overt and direct, it is evident in everyday life and not always connected to formal or informal structures. People 'follow' other people for different reasons, sometimes not because they have to, but because they want to. How or why an individual sees themselves as a role model or leader is not clear. Polit and Beck (2018) argue that reducing phenomena to their composite parts is considered of less value in the social world and inherently is seen as a major limitation by naturalistic researchers. They suggest that naturalistic researchers reject the traditional 'scientific' method, because composite parts are defined in advance by the researcher, rather than being allowed to emerge from the experiences of those under study. To only study role modelling as a leadership behaviour from one perspective, would risk missing

a key concept in the pursuit of further understanding, therefore a holistic inquiry was sought.

3.2.2 Constructivism

Constructivist thinking asserts that social phenomena and their meanings are continually enacted, that is constructed, by social actors and as a result are in a constant state of revision (Schwandt 1994, Bryman 2012). Leadership and role modelling are inherently social constructs, this is indisputable in the literature. Relational properties of groups are comprised of leaders and followers as interdependent elements (Hogg 2001), with social processes validating self-views (Lord and Hall 2005) and the co-creation of identities (DeRue and Ashford 2010). In combination with this, learning can occur in social situations through the observation of a role model (Bandura 1977). Constructivists start with the belief that social reality is relative to the individual and context in which they find themselves (Lincoln and Guba 2013), therefore this type of study can produce rich, in-depth information which may clarify the different aspects of a complex phenomenon (Polit and Beck 2018).

Nurses experience role modelling and leadership from different positions and perspectives which can be separate from specific theoretical origins, taking a constructivist approach allowed the data to be analysed and represented through a socially constructed lens. Leaders enthral their followers and can be a source of inspiration through being a role model. Leaders and Leadership has been examined and explored from a variety of angles as revealed in chapter two. I wanted to explore role modelling as a leadership behaviour holistically and meaningfully within the context of nursing practice, and to understand this from a number of perspectives.

3.3 Research design

The next sections discuss research design and case study research in further detail. This includes case study history, definition, type and boundaries in support of rationales for design choices in this study. This study called for a research plan that enabled the exploration of role modelling and leadership

with a holistic intent, Merriam (2009) suggests that the choice of design relates to what the researcher wants to know. In this instance the design needed to be cognisant of contrasting perspectives: diversity of form, individuality; culture; and impact in the 'real-life' setting for those experiencing it. Qualitative research is an overarching concept covering several forms of inquiry that help understand and explain the meaning of social phenomena (Merriam 2009). Stake (1995 p. 37) distinguishes between quantitative and qualitative research as the difference between '*searching for causes versus searching for happenings*', the latter seeking to understand complex interrelationships. As stated, the foundations of effective leadership are intricate; role modelling in this context potentially could have been subsumed within the leadership role. Role modelling and leadership are associated with subjective social relationships, meanings, values and influence. Taking a qualitative approach was chosen as this research was concerned with meanings that people have constructed, how they make sense of things and the experiences they have (Merriam 2009, Denzin and Lincoln 2018). This coincides with the behavioural element of role modelling and leadership, that is, how individuals interacted with each other within that particular context, it translated into undertaking research in the natural setting and aimed to directly explore this complex phenomenon.

3.3.1 Case study

The study's broad aim and objectives reflected an absence of knowledge about this phenomenon (Swanborn 2010). A case study design was chosen as Merriam (2009) believes that it offers the opportunity to obtain a rich, holistic account of the phenomenon when investigating complex social units consisting of multiple variables anchored in real-life situations. Two of these features made a case study design particularly appropriate, its ability to offer a holistic approach whilst capturing the complexity of a case. This is rooted in the idea that case study is the kind of research that concentrates on one thing; looking at it in depth; it is about the particular rather than the general (Thomas 2011). In a case study, the starting point is that certain phenomena are more than the sum of their parts and need to be understood as a whole

(Thomas 2011). In an integrative review of qualitative case study research, Anthony and Jack (2009) found that case study research was used to meet objectives that sought to describe, explore, understand and evaluate phenomena. The goal of the case study is to describe the case as accurately and fully as possible, investigating each aspect (Cronin 2014, Zucker 2001). Sangster-Gormley (2013) sees case study as the 'ideal' methodology for nursing as it takes place where the phenomena can be studied.

In this study, the use of case study methodology allowed for the inclusion of multiple perspectives, complex contexts and different wards. As discussed in chapters one and two the concept of leading and leadership in the NHS is multifactorial and context specific. This point is important to acknowledge, as a case study gathers and describes the experience, perceptions and opinions of participants (Atchen et al. 2015). The ability of the case study to encompass and acknowledge the complexity of a social situation has also been endorsed in the literature (Walshe et al. 2004, Hellstrom et al. 2005, Anthony and Jack 2009, Casey and Houghton 2010 and Sangster-Gormley 2013). Case study strategy fits with the requirements of a constructivist ontology; it affirms the holistic nature of realities and the credence of studying phenomena in their natural uncontrolled settings (Appleton 2002).

Other methodological approaches were considered, Yin (2009) advises that that there are circumstances where other research methodologies might be relevant. In this study for example, an ethnography, which can utilise similar methods over an extended period of time may have been appropriate. In broad terms, ethnography refers to the study of groups of individuals, their understandings and beliefs, placing importance on the point of view of those involved (Denzin and Lincoln 2018). It involves the social world or culture, often with the researcher being immersed within the field (Ormston et al. (2014). In this particular context however, at a basic level, the phenomenon, role modelling as a leadership behaviour, was not necessarily limited to a particular group of individuals (that is nurses) in their specific culture. The intent of the study was to remain open to multiple explanations, therefore a

case study was more appropriate. Alternatively, a grounded theory approach, seeking to discover a new theory in relation to leadership could have been used. The breadth of extant literature on leadership offers a plethora of information and evidence to navigate through already, despite Ormston et al. (2014) informing us that there are several different versions of the grounded theory approach. The case study strategy in this instance offered distinct advantages (Yin 2009) as described in the preceding sections.

A qualitative approach using a case study methodology was taken as this study sought to achieve a greater understanding of how role modelling as a leadership behaviour in nursing existed in an NHS Trust

It enabled:

1. Role models to be identified, alongside individual perceptions, opinions, experiences and ideas associated with role modelling in the complexity of everyday practice.
2. The examination of behaviours associated with role modelling in the context of different nursing roles within a nursing team.
3. The discovery of any factors contributing to the recognition of self as role model
4. The identification of any association between role modelling and leadership enabling application of learning to future leadership development.

3.3.2 Case study history

Reviewing the history of case study research is helpful for the researcher, to understand what has shaped and influenced the evolution of case study methodology (Simons 2009). Case study emerged during the 20th century with the purpose of understanding phenomena as interconnected, rather than disconnected parts (Thomas 2011). The emerging dominance of positivism in science in the late 1940s and 1950s made quantitative methods popular in social sciences, and this dominance continued throughout the 1960s and 1970s where empirical results were considered to be the gold standard

(Harrison et al 2017). At this time, case studies were generally used as a mechanism for description within quantitative studies (Flyvbjerg 2011, Harrison et al 2017). In natural science, case study was used as the principal method when experimentation was not possible, for example, astrology (Thomas 2011).

Issues arose in early educational evaluation where previous models had failed to capture the complexity of the programmes and only demonstrated 'what' was achieved rather than 'how' and 'why' (Simons 2009). These previous models were largely experimental or survey in nature, they used quantitative outcome measures for evaluating social and educational programmes to determine the effect and inform decision making (Simons 2009). However, in the late 1960s and early 1970s, on both sides of the Atlantic, development on alternative methods of educational evaluation were taking place, the key authors were Stake in the USA and MacDonald in the UK. In 1967, Stake suggested that evaluators needed to tell the story of the programme; this needed to include data on antecedents, transactions, judgements and outcomes. Thus, the case study approach to research was developed to capture complexity which took into account the variability of human action: the different influences; interrelationships; acts and consequences; and judgments of those within the context (Simons 2009). This resonated with the complex nature of leadership, people with their multiple realities in unique contexts, and helped to validate the choice of case study methodology in relation to this study.

3.3.3 Definition of Case study research

A definitive definition of case study research is not easy to locate. Case study means different things to different people and there is no single understanding (Simons 2009, Schwandt and Gates 2018). Therefore, there are significant variations in definitions across the methodological discourse, some broader than others (Swanborn 2010). For example: Merriam (2009 p.40) defines case study as '*an in-depth description and analysis of a bounded system*', with defining special features in that it is particularistic, descriptive and heuristic in

nature. Case study can also be viewed as an intensive analysis in which there is an attempt to understand the dynamic nature of a situation, plus the key variables therein, in order to provide a comprehensive insight into a phenomenon of interest (Appleton 2002). According to Thomas (2011), the case study is a focus, and the focus is on one thing, whereas Simons (2009 p. 21) defines case study research as *'an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy institution, programme or system in a real life' context.* Flyvbjerg (2011) is critical of definitions of case study, finding some more useful than others. Nevertheless, common to most definitions is the desire to study a phenomenon in its real-life context, to study complexity and to define case study research in ways that are not limited to its methods (Simons 2009).

3.4 Choice of case study approach

The two most prominent commentators of case study who influenced my thinking were Robert Stake and Robert Yin. Their views on case study research contributed to my understanding and influenced methodological decisions (see table 1 for comparative purposes). I aligned with the work of Stake to inform the execution of this case study.

	Stake (1995, 2004, 2005)	Yin (2009, 2014)
Definition	Choice of object rather than a choice of methodology	<p>Twofold definition: A case study is an empirical inquiry that:</p> <ul style="list-style-type: none"> • Investigates a contemporary phenomenon (the 'case') in depth and within its real-world context, especially when • The boundaries between phenomenon and context may be clearly evident <p>A case study inquiry:</p> <ul style="list-style-type: none"> • Copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result. • Relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result • Benefits from the prior development of theoretical propositions to guide data collection and analysis
Rationale	Optimise understanding, interest in the case rather than the methods used. Asking, what can be learned here that a reader needs to know?	Classifying the type of research question is the first and most important condition for differentiating among research methods
Use of previous knowledge	Case researchers seek both the common and the particular, they focus on 'issues' that are complex, situated and problematic, relationships	Initial study propositions and rival explanations should form part of study design to ensure that examination of these would inform any potential analysis of data,
View on generalisation	Supports naturalistic generalisations that stem from the reader's conclusions and personal engagement or their vicarious experience which makes people feel that it has happened to them	Supports analytic generalisation, this is achieved by either a) 'corroborating, modifying, rejecting, or otherwise advancing theoretical concepts that supported the design of the study or b) identifying new concepts that arose as a result of the study.

Table 1 – Comparison of Stake and Yin perspectives on case study

Reflecting on each approach helped to unpack the applicability for this study. Yin's definition of case study research is focused on the research process whereas Stake's definition is focused on the case (Merriam 2009). In Yin's (2014) two-fold definition, the first part focuses on the scope of the study. This helps distinguish case study research from other methods, for example an experiment would separate the phenomenon from the context. The second part of Yin's definition refers to the fact that many variables and aspects can be included and therefore other features become relevant. Stake (2005) sees case study as the choice of what is to be studied, whatever the method. Yin (2009) states that case study is the preferred method for examining contemporary events particularly when the relevant behaviours cannot be manipulated. He adds that some situations exist in which all methods might be relevant, but you should also be able to identify some situations in which a specific method has a distinct advantage (Yin 2009). For a case study this is when a 'how' or 'why' questions is being asked about a contemporary set of events over which the investigator has little or no control. Stake (2005) seeks to find out what can be learned in the single case from an optimal perspective. Whilst both of these ways to view case study by definition, have appropriate elements, Stake's primary focus on learning fits best with leadership and role modelling because of the breadth of knowledge already in existence and desire to stay open minded.

Yin and Stake approach the contextualisation of case study differently. Yin (2009) suggests that the inclusion of propositions and rival explanations assist with clarity of purpose in case study. Stake (2005) sees the selection of issues as crucial; case studies being organised around issues. Stake suggests that issues evolve throughout the study and continue to the end. The topical concern in this study is role modelling as a leadership behaviour in nursing. The researcher then poses fore-shadowed problems; in this study, role modelling was not explicitly linked to leadership. Concentration on issue-related observations then follows; described in this study as the unknown association between leadership and role modelling. Lastly patterns of data are interpreted, and the issues reformed to assertions; in this study role model and leadership identity development (Stake 2005).

The other significant area of difference is concerned with their respective positions on generalisation. Yin (2009, 2014) talks about generalising the lessons learned in a case study as analytic generalisation. He bases his analysis either on comparative approaches to existing theoretical advancement or new concepts. In comparison, Stake (1995, 2005) advocates for naturalistic generalisations which come from conveying the experiences of the participants in addition to those of the researcher. He acknowledges that there needs to be a choice made between balancing the researcher's intent for generalisations and contributing to those of the reader. This is the space between the researcher's experiential knowledge of the case and that of the reader. Naturalistic generalisation assists the reader to maximise learning from within the case and their own experience.

Adhering to the approach advocated by Stake corresponds with this study, largely from two perspectives. Firstly, the notion of issue utilisation connected with a constructivist approach and aligned with the research questions and focus of the study. Stake's case study seeks multiple perspectives of those involved and diverse notions of what occurred (Lauckner et al. 2012). Secondly the nature of leadership is diverse and expansive, aligning with an analytic generalisation would have risked limiting or obscuring new knowledge. Therefore, reviewing the methodological literature confirmed the choice of a case study methodology in alignment with the approach of Stake, as this provided a more cogent fit with a constructivist ontology and epistemology in relation to the subsequent design choices and nature of generalisation associated with his work.

3.5 Type of Case study

Case studies are categorised into different types, this relates to the underlying philosophy, research purpose and research questions. Merriam (2009) indicates that case studies can also be differentiated according to function and whether they are single or multisite. Whereas Schwandt and Gates (2018) categorise case studies as; descriptive, hypothesis generating and theory development, hypothesis and theory testing and cross-case analysis.

Stake (2005) takes a view that centres on the interest in the case. He calls a study that has an interest in the case itself 'intrinsic', it has a particular focus. When the researcher wants to provide insight into an issue or to redraw a generalisation, the case is secondary and takes a supportive role, it facilitates understanding of something else, Stake (1995, 2004) then calls the case study, 'instrumental'.

An instrumental design was chosen for this case study as it aimed to increase understanding regarding how role modelling in nursing, as a leadership behaviour, was displayed. Readers examining an instrumental case study are shown how the phenomenon exists within the case, which is often looked at in depth: its contexts examined, its ordinary activities detailed, because it helps the researcher pursue the external interest (Stake 2005). A case in this study, being a clinical ward space where nurses interacted and carried out their everyday activities

A collective case study extends the desire of the instrumental study to that of several cases, whether they are similar or dissimilar. The aim is still for understanding of the issue. In this study, accessing more than one case, that is taking a collective approach, meant that the cases were instrumental in seeking to understand how role modelling as a leadership behaviour occurred in nursing. As advocated by Baxter and Jack (2008), this approach allowed me as the researcher to explore the phenomenon within and across settings, in order to understand the similarities and differences. When conducting an instrumental case study, any number of cases can be chosen to be explored: the final decision can relate to the inclusion of a vital element, geography and willingness of the organisation and people to be involved (Simons 2009). In order to maximise learning from the case study, three cases were included in this study (this is discussed further later in the chapter). In a multiple case study, the focus is firmly on the phenomenon of which each case is an example, the focus is on the object, because there is more than one case, each individual case is less important than the comparison that each offers to the other (Thomas 2011). Two issues particularly impacted on case study type selection. Firstly, leadership can be seen to occur temporally and socially

in discrete contexts, these are particular and would not necessarily be considered leadership in a different situation (Ladkin 2010). Secondly, I acknowledge that the roles of leader or follower are not static and can be interchangeable given the situation (Ladkin 2010). If the research investigated only a single ward or registered nursing role there was a risk of only revealing a narrow perspective in such a complex concept. In repeated case studies there may be the opportunity to explore the significance of different social and physical contexts and consequently, their impact on the social process (Swanborn 2010).

3.6 Case Boundaries

In addition to deciding on the type of case study to use, the actual nature of the case needed to be clear. The choice of cases was based around advancing understanding. Stake (2005) reminds us that cases can be simple or complex, but they should be specific, features should be easily recognisable as inside or outside; they are bounded by specificity. This is because if a phenomenon of interest is not intrinsically bounded, then it is not a case (Merriam 2009). The main feature of the choice of case stemmed from an interest in the subject of the study, that is role modelling in nursing leadership. A variety of factors can contribute to deciding on the boundaries of a case, these include but are not limited to the physical setting, people, policies, ethics, economies and history, whilst some can be identified early on in the planning phases of the study, some are confirmed toward the end of the study (Stake 1995, Simons 2009). Thomas (2011) describes the case both as a container, akin to a suitcase or wrapper, and as a situation or event. The case as container is likened to the physical sense, being able to lock it, bounded by the case and studied from within. Whereas the second description is a particular instance, an event, and concerned more with the conditions or circumstances in their completeness. In this study, each case consisted of a nursing team, attached to a ward area, within a clinical directorate, which was part of the organisational structure. The staff within each ward area were within the case, senior nurses assigned to that ward were included, as were student nurses on placement. This set the boundary,

nurses outside of the specific wards and incumbent nursing teams were excluded from the study.

A case has its own uniqueness and is distinct from others (Stake 1995), Baxter and Jack (2008) suggest that case boundaries indicate what will and will not be studied. They add that this relates not only to the sample but also the breadth and depth of the study too. Therefore, whilst nurses are the focus of this study, the case extends to their context, team and environment. In the context of this study the primary units of analysis were nurses. The nurses needed to be in groups, as although theoretically any nurse could be a role model or leader, for role modelling and leadership to be explored fully there needed to be more than one nurse, because of the social nature of the phenomena. In order to explore the notion of role modelling as a leadership behaviour in nursing, the cases needed to contain registered nurses (RNs). To investigate the influence of position and a variety of experiences and perceptions on this, it also should contain nurses of different positions and seniority (including assistant practitioners at Band 4 level⁴, healthcare assistants of varying positions and student nurses on placement). This aimed to give maximum opportunity for learning, in contexts where interaction with each other was frequent and accessible. Role modelling and leadership are relational and socially constructed, therefore any interaction in the team could have had an impact on behaviour. Doctors and professionals allied to health are acknowledged as part of the multidisciplinary team, however in this case study the intent was to focus on nursing.

There is a discourse around whether a case should be chosen for its typicality or difference to others. Stake (1995) cautions that it may be useful to select cases which are typical or representative of other cases, but often unusual or atypical aspects helps things overlooked in typical cases. This is echoed by Simons (2009) who believes it is not necessary to seek the typical as each case is unique, although concedes that sometimes there may be

⁴ 'Band' refers to the grade or position on the national 'Agenda for Change' national pay system for all NHS staff and can be used as an indication of terms and conditions, job role and basis for the job description (NHS Employers 2020)

commonalities. In that instance seeking different cases will help to explain differences rather than ensure representativeness. Fundamentally the case needs to be the best it can be to enable exploration of the phenomenon, (Simons 2009) this aligns with Stake's guidance (2005). Stake (2004) advises that a case should be chosen in which the learning will be maximised, this could mean the one that is most accessible or the one that the most time can be spent with. He believes that the potential for learning may take priority over representativeness, there can be much to learn from the atypical case. This study focused on nursing leadership and role modelling and as such did not specifically relate to other professions or a typical situation. Therefore, the focus on the issue was contextualised with different nursing teams which were similar in structure and nursing role but different in service provision in order to encapsulate more than one context.

3.7 Challenges of using case study

The rhetoric on the challenges of utilising case study research started from debates about understanding of the methodology. The challenges that have been identified in relation to case study research stem from the terminology within case study literature and the different methods that can be used. This lack of consistent use of terminology and the concept of case study has been considered to impede the use of this methodology (Anthony and Jack 2009). The phrase or label 'case study', is not necessarily restricted to a research context, it has been used as a component of professional education in addition to the practice of, for example, medicine and law (Gomm et al. 2004, Swanborn 2010). The term 'case study' has been used to refer to the methodology and study as a whole or conversely, as 'case study' for a single example. There has also been a claim that case study can be considered confusing (Appleton 2002) and difficult to grasp because of sharing methods with other forms of inquiry (Walshe et al. 2004). This is because as case study is compatible with a range of methods it is difficult to position in a system of approaches (Swanborn 2010).

As discussed in section 3.3.3 definitive definitions are evasive and dependent on discipline and underlying paradigm. The special features that can influence the decision to take a case study approach can also be challenging, the rich, thick description of a particularistic study takes resource and time (Merriam 2009), documenting the unusual also needs time to plan, gain access, gather data and write up (Stake 2005). Even though case study is being more widely used, it is still held in low regard, on the basis of areas of misunderstanding (Flyvberg 2011). These misunderstandings are concerned with the value of case study knowledge, the usefulness of case study for generating and testing theory, the presence of bias toward falsification rather than verification and difficulty summarising case studies (Flyvberg 2011). In addition, the inability to generalise from single cases attracts much attention (Stake, 1994, 2005, Simons 2009, Flyvberg 2011, Schwandt and Gates 2018).

In qualitative research, the researcher is the primary instrument of data collection and analysis (Merriam 2009, Simons 2009). Therein lies both strengths and limitations when using case study methodology: the researcher can be responsive to maximise opportunities but at the same time can also miss opportunities and be restricted by personal bias (Merriam 2009). The sensitivity and integrity of the researcher is integral to material selection for reporting purposes (Merriam 2009). How these issues were addressed and mitigated for is discussed in further depth in sections 3.18.

3.8 Study setting

The setting for this case study was a District General Hospital within an acute NHS Trust. The study was undertaken in three individual clinical areas within the medical service division. Each of these were considered as individual 'cases'. The hospital served a predominantly rural population: it provided a wide range of emergency, medical, surgical and maternity services to its users. During the study the Trust underwent a significant re-design of services which resulted in a major re-configuration. The site was chosen as it was known to me through existing relationships and on initial enquiry amenable to

being part of the study. All organisational names, location and people were given pseudonyms to protect identity (please see section 3.10.1).

3.9 Access

A series of steps were undertaken to gain access to the field, in alignment with research and NHS protocols (Health Research Authority 2019). Conducting research in a healthcare location necessitated securing access through gatekeepers (Coyne 2009) as these have the key role in granting or denying access (Bailey 2007). Initially, I sought permission from the Director of Nursing (DON) as gatekeeper. I provided her with a brief overview of the proposed study, as I needed to explain who I was and why I wished to conduct the research (Bailey 2007). Advice and guidance from the local research and development committee to manage this stage of the research process was essential as there are regulations to protect human subjects (Stake 1995). Gatekeeping in this way at an organisational level ensures that all research activity can be monitored, gatekeeping at a professional level ensures that the research is honest and plausible and the researcher competent (Lee 2005). After I obtained permission from the DON, I was advised to meet the medical division nurse lead who invited me to attend a senior nurse meeting to share information about the study across the clinical division via the Ward Managers. This was crucial in order to provide suitable information to the prospective senior nurses, as health care professionals must be protected when being asked to participate in research (Lee 2005). Seeking access to people's lives, work area, emotions or experiences as part of research activity made it necessary to provide some information about the study for them to consider and allow entry, although Lofland and Lofland (1995) recommend that it should be brief, straightforward and appropriate to the audience. Three Ward Managers came forward and expressed an interest to join the study.

3.10 Ethical approval

Ethical approval through research governance processes was sought and gained from the University of Brighton and the Health Research Authority

(HRA), the latter being through application via the integrated research application system (IRAS). The HRA's core purpose is to protect and promote the interests of patients and the public by ensuring that any research is ethically reviewed and approved (HRA 2020). Codes of ethics in different disciplines provide guidance for making ethical decisions (Bailey 2007). In addition to this, approval to undertake the study at Meadow Court hospital⁵ via the local NHS Trust research and development committee was gained. This included the construction of a research passport and written confirmation of the granting of access⁶. The Trust was reassured that every effort would be made not to impact in any way on patient care, both regarding my presence in the clinical environment or access to staff delivering care. In addition, as a nurse registrant I am also held to account by the Nursing and Midwifery council (NMC) and adhere to the Code (NMC 2018a), I made it clear in the participant information sheet (Appendix 2) that any observation or disclosure of professional misconduct would be passed on to the Trust (and University in the case of a student nurse) as per policy and duty of care. Ethical approval was also gained from the local University as student nurses were potentially available to participant if on placement in the clinical area. General principles of research ethics focus on voluntary participation and the right to withdraw, protection of research participants, identification of risk and benefits to participants, obtaining informed consent and respecting privacy and avoiding harm were adhered to (Silverman 2017).

3.10.1 Managing risk to participants

To protect participants interests, the researcher should anticipate any possible risks and take steps to avoid them (Denscombe 2017). I remained cognisant that careful attention to ethical aspects must be given throughout the whole research process, a central tenet being that of 'doing no harm'. Participants needed to know that they were being treated fairly, with clear processes in place should any difficulty have arisen during the research (Simons 2009). A clear explanation of the study and what it involved was provided to any

⁵ This is a pseudonym as described in section 3.8

⁶ The research passport and letter of access form part of the health research good practice guide and assist non- NHS staff when they carry out research in the NHS (HRA 2020)

potential participants, this included the future utilisation and reporting of the research (Appendix 2, participant information sheet). The participant information sheet was provided to the three areas via the Ward Managers, this was available to any potential participant prior to data collection, giving them the opportunity to make decisions about whether or not to become involved. The participant information sheet was carefully constructed and described the research in a way that potential participants could understand it (Silverman 2017). Potential participants were given the opportunity to contact me if they had any questions prior to the study.

As with much qualitative work, case study research shares an intense interest in personal views and circumstances, consequentially there is risk to the participant in regard to exposure, embarrassment, loss of standing, employment and self-esteem (Denzin and Lincoln 1998). There is also a power relationship between researcher and participant: the researcher seeking knowledge that the participant holds but equally the researcher having the power to decide what the final outcomes are (McDermid et al. 2014). In this study a potential risk to participants derived from having their personal practice observed, being judged, or by sharing personal feelings and events that may have caused them some concern or anxiety.

It was advisable to think through the ethical implications of the methodology, for example, the piloting of any tools (Simons 2009) such as the interview guide, to ensure readability and appropriateness of the questions regarding invasion of privacy and sensitivity. During the observations I explained to participants that I was not judging the quality of the nursing care they provided, my aim was to observe how they behaved and interacted with each other. At the start of the interviews, I assured participants that I was not looking for a 'right or wrong' answer, I was interested in what they had to say. I was also cognisant of the possibility that consent given by participants may not be static, it could be withdrawn at any time (Bailey 2007), therefore ongoing consent was sought throughout the study (discussed further in the next section).

Concern may also have originated from being identified in the study. This is an important ethical issue in field research and protection of privacy paramount in research ethics (Bailey 2007, Morse and Coulehan 2015). This was addressed by ensuring that confidentiality was always maintained: firstly, by anonymising data (name of the Trust and study setting); numbers and pseudonyms were allocated to all participants and cases; and secondly by the secure storage of data as per University of Brighton and the Health Research Authority (HRA) guidance. Any perceived risk to participants was monitored and support offered through me and Trust support services. Throughout the study I continued to check for any queries from participants.

3.11 Sampling and recruitment

Merriam (2009) asserts that the case is selected as it is an instance of the issue. A purposeful sampling approach was taken based on the assumption that a researcher wants to discover, understand, and gain insight and therefore must select a sample from which the learning can be maximised (Stake 1995, Merriam 2009, Silverman 2017). It should also aim to meet the purpose and goals of the research (Bailey 2007). Detailing the dimensional range of a case can be problematic though when the researcher is faced with a complex issue, however clarification of how the case will inform data collection and lead to further understanding of the phenomenon is important (Appleton 2002). In the acute hospital setting site for this study, the Medical Services division, as an organisational unit, provided a self-contained entity to initially recruit from several different wards. The medical service setting was approached as this type of clinical area was accessible and willing. The three cases (wards) in the division self-selected through volunteering at the senior nurse meeting. These three cases reflected different care disciplines in terms of organisation of care, skill mix and environmental design and are discussed in further detail in chapter four.

The invitation to participate in the study was offered to all nursing staff within each ward: Ward Managers, junior sisters, staff nurses, assistant practitioners, healthcare assistants and student nurses (where available on

placement). In a single division there would be one senior nurse and two or three Matrons, each ward had one Ward Manager and approximately fifteen to twenty registered nurses.

Consent to participate was not sought until ethical approval was granted. Assurances to participants were offered through the opportunity to ask questions, they were made aware of the purpose and procedures of the research, risks and benefits and the voluntary nature of the research (Bailey 2007). Seeking informed consent was vital, as potential participants should understand what they are agreeing to (Pick et al. 2013) and consent should be gained based on 'opt in' rather than assumed or implied. Consent was sought for data collection methods on an ongoing basis and participants reassured that they could withdraw at any point during the research process without consequence (example in appendix 3). In practice the observations were arranged through the Ward Manager, the nature of staff rostering meant that not all staff were present on each shift, therefore consent was sought and provided at the commencement of individual observations.

3.12 Data collection

The primary sources of data in a naturalistic inquiry, such as this case study, were the words and actions of the people, these words and actions were encountered through a combination of looking, listening and asking (Lofland and Lofland 1995, Merriam 2009). Thus, from a naturalistic perspective the field is constructed throughout the different phases of the study (Helleso et al. 2015). In order to explore role modelling and leadership from a variety of different perspectives, I collected data using two methods: non-participant observation; and interview. Each of the methods used in this case study enabled the extraction of different perspectives of the phenomenon and were salient in seeking to understand this complex issue, the case study methodology allows for different sources of data (see table 2 below). The sections thereafter explore each data collection method in further detail.

Data Collection method	Aim	Research Objective to be met
<p>Non -participant observation</p> <p>Observation in the natural setting of a clinical area over an extended period of time – to include handover, ward meetings, shift changes.</p> <p>Shadow individual nurses and matrons as they fulfil their duties</p>	<p>To observe everyday practice, behaviours, events and experience the culture of the case from the inside:</p> <p>‘Leadership’ behaviours modelled through interactions within the team, delivering care on a day-to-day basis.</p> <p>Observe interactions of verbal and non-verbal communication - directing staff, guiding actions, giving feedback and confirming decisions which are aligned to aspects of ‘role modelling and leadership’ behaviour</p>	<p>To explore how role modelling is displayed across clinically based nursing roles in a clinical division in an NHS Trust</p> <p>To investigate the association between role modelling and leadership</p> <p>To discover factors that assist an emergent understanding of self as role model</p>
<p>Interviews</p> <p>Semi structured interviews with RNs from clinical areas</p> <p>Interviews with individual senior nurses and matrons</p>	<p>To explore and gain insight into people’s feelings, emotions, experiences and opinions</p> <p>To explore, attitudes, perceptions, feelings and ideas drawn from previous analysis about specific topics from the collective</p>	<p>To investigate the association between role modelling and leadership</p> <p>To discover factors that assist an emergent understanding of self as role model</p> <p>To identify how role modelling could be utilised as a leadership behaviour for future practice.</p>

Table 2 – Data collection methods

3.13 Non-participant observation

The first method of the data collection comprised non-participant observation in the field. Participation as observer is when the researcher is openly recognised: this takes the form of shadowing a person or group through normal life, witnessing first-hand and in intimate detail the culture/events of interest (Denscombe 2017). This was the mode of observation used in this study. The point of field observation is to observe things as they actually happen in the field whilst trying to avoid disrupting this naturalness (Denscombe 2017). In this study, observations focused on aspects of practice that included interactions between individuals aiming to uncover the cultural and behavioural aspects of role modelling and leadership. Activities such as the planning of service delivery, the sharing of organisational and divisional goals, handover, directing and supervising staff, making decisions and giving feedback were included.

Observations needed to be pertinent to the issues, this was with a view to expanding understanding, therefore opportunities were chosen which would increase this (Stake 1995, 2005). The foundation and direction of theoretical framework development was based on connections in the literature between role modelling and leadership (discussed in chapter two). In this sense the theoretical framework was the scaffolding or structure of the study; it stemmed from the disciplinary lens, the concepts, terms, definitions models and theories (Merriam 2009). In this study, this framework was reflective of the current rhetoric around leadership, cognisant of nursing leadership practice and the need for change. It was also concerned with how role modelling was demonstrated by nurses.

The use of an observation guide aimed to ensure that previously identified 'issues' helped to tease out the problems of the case (Stake 1995). As discussed in section 2.8, issues noted from the literature review revealed a connection between self-awareness, identity development, leadership and

role modelling, these concepts were acknowledged and were in my thoughts during the non-participant observations (Appendix 1). Baxter and Jack (2008) conjecture that researchers should maintain a journal of their thoughts and decisions for discussion to ensure that any framework does not inhibit inductive thinking (see section 3.18 on reflexivity). The observation guide provided a broad lens through which to focus and view my observations, not as a constraint but rather as a reminder. The purpose of this was to highlight how everyday nursing practice could be construed as 'leaderful' and form the basis for modelled behaviour.

When undertaking observations in the field Simons (2009) suggests that suspending any previous knowledge and judgment is integral in order to record what is actually happening to enable concentration on the factual and descriptive. Using observation is at risk of bias as a method in that the researcher selects what is significant and what is not. The risk being that focusing on recognisable features that fit known concepts can hide what is really happening (Simons 2009). To mitigate against bias, I maintained a reflexive stance throughout the research process being mindful that I was the main instrument in data collection. I used reflexive memos in the form of a journal at each stage of the research process, in field notes and at the analytic stages. This initially focused on how I felt but began to take on a more critical tone as the research progressed (this is discussed further in 3.17). It was crucial to recognise my world view, beliefs and values, declare these and consider how these impacted on the research (Simons 2009) this is discussed further in section 3.19.

I discussed preparing for the observations with my supervisors. They suggested thinking about this when I was in a public place, such as a coffee shop, to hone my senses regarding the environment, trying to see interactions between people, general activities and ambience. This was very helpful as it enabled me to gain some insight into observing people and the possibilities of what data could be captured, as data from observations should include not only what happened, but also how it happened (Denscombe 2017). Doing this

helped considerably with preparing how I was going to manage myself in thinking about what I was observing and utilising available time. Making preliminary observations of activities is seen to assist with the preparation of data collection (Stake 1995).

In addition to this I had previously undertaken some extensive observations as part of a staffing project although this was more quantitative in nature. I had recorded what people were doing and how frequently they did it, rather than why. My personal learning from this had a practical focus which also helped with thinking about how I would sustain my attention and develop a field method for notes recording. This was essential to enable a comprehensive record to be constructed.

The non-participant observation activity encompassed observation of all consented nurses in the clinical context, it was anticipated that I would observe participants as they enacted their roles. In the ward environment the intent was not to focus on individuals, rather the phenomenon as a whole, that is behaviours associated with role modelling and leadership primarily. Deciding on the focus of observations was important. As a result of the initial reflections, I decided to record as many aspects of the observations as possible to ensure that I had a rich data set. Helleso et al. (2015) explain that taking field notes raises questions in regard to what the researcher chooses to record: sometimes events are in the foreground, at other times they are at the back. For example, I noted where I was standing and the physical environment as the physical surroundings carry social implications.

The application of authentic leadership and social learning theory into an observation field guide offered a baseline guide for data collection and informed the non-participant observation prior to my first encounter in the field. I used the guide to sharpen my focus and sensitise myself to what I was seeing, I took it in my notebook and re-read it between observations. There was a balance between directing observation based on the theoretical framework and feeling assured that this did not constrain any analysis and findings. The clinical environments were very busy, and the guide acted more

as a reminder, helping me to look for and extrapolate meaning in what I was seeing.

The next stages of observation periods became more strategic, as the study progressed, I employed a variety of strategies to enhance this method of data collection. As the number of observations increase and build, field notes can contain analytic ideas and inferences and patterns are seen to emerge (Lofland and Lofland 1995). Bailey (2007) suggests developing a system whereby you can differentiate different items in your notes, for example, verbatim quotes and general information. The sessions also became more focused as important issues materialised (Bluff and Holloway 2008) for example how participants interacted with each in each ward. Stake (1995) indicated that qualitative case study researchers try to see what would have happened as if they had not been there. This means that the researcher being in the field should not impact on the context (this is discussed in section 3.18). I hoped to capture the everydayness of practice uncontaminated by my presence.

As I watched and listened to the participants, I continually made extensive notes. I did not make a note directly after a particular interaction, as looking at someone and writing about them immediately seemed to heighten the invasive nature of the observation and felt inappropriate. Lofland and Lofland (1995 p. 90) refer to this as '*jotting inconspicuously*', writing notes, when shielded or withdrawing from the immediate vicinity, can reduce anxiety at being openly watched. This was a deliberate intent on my part to reduce the impact on the staff of being watched. When undertaking the observations staff initially looked at me in return, but this appeared to dissipate through ensuring that introductions were swiftly made and by undertaking the observations in each setting relatively close together. As staff tended to work shifts over two- or three-day periods this meant that staff recognised my face. Staff were generally busy delivering care, so once my reason for being there was known they carried on with their duties. I carried a large notepad in which I recorded field notes, I also had spare participant information sheets and consent forms. I had thought about what I would wear and where I might stand prior to

arriving on the wards. Denscombe (2017) suggests that the presence of the researcher is likely to be noticed, so attempts to make this short lived to assist with reducing the initial disruption, will help things settle down. I wore smart casual clothes, flat shoes and no jewellery, in keeping with working in a clinical environment. This aligns with the advice of Stake (1995) who believes that during fieldwork, qualitative researchers should try to remain unobtrusive. As I became more adept and comfortable in the field I relaxed more and tried to blend into the background. Although I had my letter of access with me at all times and university identity badge, I did not have a visitors' badge and was challenged by a consultant during the last phase of observations.

More than once, there was direct engagement between those observed and myself. The staff conversed with me in a humorous way and said, '*did you see that/write that down?*'. If something was referred to that I did not recognise or understand, when appropriate, I sought clarification. This was generally in regard to local language and acronyms associated with a person or activity. I also kept moving. This was chiefly to enable a wider opportunity to observe interactions between participants; the sheer number of people present in the cases necessitated this in order to track individuals, however I did not enter any bays or clinical areas. I walked up and down the main open areas of the wards and consciously kept my eye contact and other non-verbal cues open and neutral. I tried to capture what I saw and heard, Lofland and Lofland (1995) call this capturing raw behaviour, rather than making any judgment about what the participant's state of mind might be. Stake (1995 p. 62) asserts that during the observation the case study researcher needs to keep an accurate record of the case which provides a '*relatively incontestable description*' for further analysis.

Observation, as a method of data collection, enabled a comprehensive picture of the case that could not be revealed by speaking to people alone, it aimed to explore the culture of the environment and also contributed to a detailed 'rich' description as a basis for further analysis and interpretation (Thomas 2011). This was apt when seeking to explore role modelling and leadership behaviour, as perceptions were based on interpretations of perceived actions,

how individuals communicated with each other, how they delivered nursing practice and directed others: the influence of the role model and leader rooted in practical experience. The observations took place over an extended period (11 observations across the three cases lasting 3-4 hours on each occasion). The field notes from the non-participant observation were typed up and examined directly after the observation to ensure they were fresh in my mind as the time between undertaking observation and writing up notes should be minimised (Lofland and Lofland 1995). My field notes were detailed and contained literal data in the form of physical spaces, activities and interactions between participants as well as reflective notes and thoughts to myself for later consideration. Field notes serve as a repository for important and not so important data of field research (Bailey 2007). They follow a trajectory that is not necessarily linear: mental notes; jotted notes and full field notes which incrementally increase through the process of constructing a log of observations (Lofland and Lofland 1995). Each observation experience has its own rhythm and flow (Merriam 2009). In each case the observations preceded the interviews although data collection on more than one case was in progress at any one time.

3.14 Interviews

The second method of data collection involved inviting participants to be interviewed about their experiences and opinions. The interviews provided the opportunity to supplement the non-participant observations and yielded a wealth of data (triangulation processes are discussed in section 3.17). According to Denscombe (2017), when the researcher wants to gain insights into things like people's opinions, feelings, emotions and experiences, then interviews will almost certainly provide a suitable method. Deciding on a semi-structured approach to interviewing offered the opportunity to prepare specific questions that were organised by topic (Bailey 2007). The key quality criteria for an interview are described as: evidence of spontaneous, rich, specific and relevant answers; the extent to which responses are followed up to clarify meanings; interpretation present throughout the interview; interviewer verification during the interview; and the interview being self-reliant

(Brinkmann and Kvale 2015). I developed an interview schedule guide (Appendix 4) for the purpose of providing a list of issues that I intended to cover and potential questions which could be probed further (Thomas 2011). I thought about the perspective of the people I was interviewing, developing the guide after thinking through the topics of interest (Lofland and Lofland 1995), Stake (1995) sees this as a special art. Topics and probing questions included: how the participants experienced, understood and defined role modelling and leadership, their feelings and opinions alongside examples. Using semi-structured interviews enabled me to be flexible in terms of the order in which topics were considered. This lets the interviewee develop ideas and speak more widely on the issues raised by the researcher (Denscombe 2017). In this study, topics revealed from the observation were expanded on and explored in more depth, for example seeking to explore how an individual or team had learned to behave in a certain way that had been noted during an observation period.

The challenges with seeking participant's views from interviews, centre around issues such as the interviewer effect and the fact that what people say they do, what people say they prefer to do and what people say they think, cannot necessarily be assumed to be the truth (Denscombe 2017). I attempted to mitigate for this, by building rapport with the participants during the interviews, focusing on the participant and putting them at ease. An aspect that assisted this was that I was already known by several participants, having undertaken observations in the ward environments. This was important, as the interview is an interactive engagement in which consideration must be given to the relationship between the interviewer and researcher (Simons 2009). The interviews were undertaken close to the clinical environment, this was a pragmatic decision and cognisant of the perceived challenges of reducing impact on care delivery. The interviews were relatively short and supplemented the observational data. Brinkman and Kvale (2015) believe that research interviews can be too long, they advise that if the researcher knows what, why and how to ask a question, they can conduct short interviews that are rich in meaning. I prepared for the interviews to ensure that the most productive questions were asked in relation to the

research topic and that the best response was elicited from the participant (Denscombe 2017). Ten interviews were undertaken across the three cases, a range of roles were represented in the interviews. Also, in advance of these, I tested the digital recorder for volume and use as advocated by Denscombe (2017). As a novice interviewer this was important as I wanted to be assured that I was able to capture data without anxiety about the equipment, as time was limited. In busy environments with busy people events can be beyond the control of the researcher (Denscombe 2017). In each case I negotiated attending the wards to undertake the interviews, a space to undertake these being identified by the participants on the day.

All interviews were transcribed verbatim, this necessitated listening to the interviews repeatedly and assisted with becoming 'close' to the data. I had intended to make notes during the interviews to ensure the recording of aspects that would not be obtained from audio transcripts alone such as non-verbal cues. In reality I made short notes on the interview prompt which assisted with subsequent interviews, for example, *'remember to ask when they first recognised themselves as a role model'*. I was very conscious of asking leading questions, this presents a challenge in that on one hand the wording of a question can influence the answer but in contrast can be used to check the reliability of an answer (Brinkmann and Kvale 2015). The critical issue being *'not whether to lead or not to lead but where the interview questions lead to'* (Brinkmann and Kvale 2015 p. 201).

3.15 Data management

The combined data collection methods generated a large amount of data to be managed. Field notes from the observation were recorded as soon as possible during, and after the sessions, to ensure timely recollection, they included margins for initial notes and memos. Interviews were transcribed verbatim. Systematic ways to manage the recording of chronology and data flow were utilised to ensure that all data was included in analysis and contextualisation. Mapping the data from multiple sources was an important task (Zucker (2001), it required consistent and careful attention. In case study,

data from each source converges in the analysis process, each source was a 'piece of the puzzle' (Baxter and Jack 2008 p. 554).

The data from each case was sorted with the aim of constructing narratives according to each individual ward area. Following the tenets of Miles and Huberman (1994), the analysis consisted of three concurrent flows of activity: data reduction, data display and conclusion drawing/verification. This involved affixing codes to field notes and interview transcriptions for naming and reporting purposes; then examining these materials to identify similar phrases from participants, relationships between data, patterns, themes, distinct differences and commonalities as they emerged. In this study assigning codes fundamentally meant giving some sort of shorthand to the different aspects of data for later retrieval purposes (Merriam 2009). Bailey (2007 p.125) calls this a 'multipronged process' which involved breaking it down, studying the components and investigating and interpreting meanings.

Initially, all data was transferred onto individual word documents. For the non-participant observations, I used a four-column table with the first column entitled further exploration: these were factors associated with the wider context (Figure 1).

Further exploration	Questions	Observations	Reflections
Workforce demand and priorities Increasing acuity Staffing Patient safety	What is busy? What is calm? Is this quantifiable? Why does it need to be calm? How is this linked to a high quality service?	5.6.17 – 1440 – 1545 First impressions- the ward is obviously busy, no empty beds but feels calm	It feels busy but calm, lots of activity... makes me remember when I use to work on a ward like this...
		There are several doctors around and some visitors.	I'm not sure who is who... or what the ward routine is... is

Figure 1. Original method of recording field notes

Focusing on initial thoughts enabled me to extrapolate some of these into the broader contextual issues that were important, but slightly disconnected from my research aim and objectives at that moment. The original second column entitled 'questions', became more like analytic memos (Figure 2). I started to separate the ideas in order to seek verification.

Is good communication consistent? Is it about being clear in relationships? Is everyone equal? Where does respect come from?	WM1 and HCA 1 discussing a patient who wanted a drink	A quick exchange, about giving a patient fluids, I feel there's equity and respect...each get the opportunity to speak and listen to each other. Band 7 to band 2
Does each staff member expect to direct each other?	HCA 1 telling HCA2 about when obs are due and passing information on to a patient	HCA2 was from another area HCA1 directing her to ward routine...
The ward is busy, but time is given to	HCA2 listening to a patient, giving time, looks	Good non-verbal cues, sat down next to the

Figure 2. Example of evolving recording of field notes

I then transferred the text of the word documents onto excel spreadsheets for ease of use and the ability to create new worksheets for separate concepts and ideas, adding a second reflection column. Silverman (2017) calls this expanding field notes, this was important for developing a sense of what was happening. Each field record note was assigned one row (Figure 3).

	Observations by number	Behaviour	Why	Perception	Reflections	2nd reflection
1.1.1	5.6.17 - 1440 - 1545 First impressions- the ward is obviously busy, no empty beds but feels calm.		Busy because people are moving quickly, they look focused and as if they are carrying out tasks, nobody is 'standing around'. It also feels calm though because non-verbal cues aren't indicating any kind of anxiety, facial expressions balanced and noise level acceptable	Busy Calm	It feels busy but calm, lots of activity... makes me remember when I use to work on a ward like this...	Ward full can equal stability, none in an out, patient flow can increase workload
1.1.2	There are several doctors around and some visitors.			Noted several people around.	I'm not sure who is who... or what the ward routine is... is that important? Or because I know that I used to like being organized on the ward....	People around can be challenging to see doing what, visitor well, who can they
1.1.3	There are several nurses around The WM 1 introduces me to a couple of staff in the office (AP 1 plus another) tells them what I am	Introduces, tells,	I'm introduced in a neutral way, not here to judge or scrutinise but because of something I'm doing...			Role of the ward m to filter informatio

Figure 3. Example of spreadsheet data set

Each case had one excel spreadsheet containing all data. The interview transcripts were also transferred from word documents to the same excel spreadsheet. The interview responses were grouped according to phrases against key areas and colour coded for each participant. In each case the interview data was spliced together by response. This enabled an iterative, 'all at once' scrutiny of the data (Appendix 5 – example of colour coded data). Full data sets were extremely valuable in the analysis stage, this aided comparability across data and enabled patterns to be seen (Huberman and Miles 1994). The construction of a data database enabled swift access to data, and the ability to track and organise data sources thereby enhancing reliability (Baxter and Jack 2008).

3.16 Data analysis

The data collection from non-participant observation and interviews took place simultaneously across the three cases, but the capture of observational data preceded the interview data within each case. Early data analysis commenced with notes in the field, Stake (1995) proposes that analysis involves taking something apart, it is concerned with giving meaning to first impressions alongside the final compilation, there being no definitive starting point. This overlapping of data collection and analysis, was viewed as useful and opportunistic and gave an element of flexibility (Merriam 2009, Cronin 2014); concurrent data collection and analysis being a feature of case study (Walshe 2011).

One of the early choices to make, was whether to make use of codes or interpret directly from observational data (Stake 1995). According to Stake (1995) there are two prominent methods when seeking to make new meanings about cases: the first is categorical aggregation, looking for individual instances; and the second direct interpretation of the individual instance. The former is particularly pertinent for an instrumental study where understanding of a phenomenon is being sought, however, ultimately the nature of the study and focus of the study combine with researcher curiosity to guide the analytic strategy (Stake 1995). Brinkmann and Kvale (2015) describe an eclectic approach to analysis of interviews that involves the use of adhoc methods and conceptual approaches. This can include reading through the interviews to get an overall impression, going back to specific passages, using metaphors to capture key understandings and visualising findings in diagrams in the pursuit of connections.

In an attempt to make sense and give meaning to the data, I started to look for instances and group these, some instances were particularly meaningful and indicative of a particular aspect of role modelling or leadership behaviour, the initial 'issues' prevailing. The data from the observations and subsequent interviews was analysed iteratively to enable further development of the research questions and interview guide. Stake (1995) claims that the 'story' of the case study starts to take shape during observations. The key being to

draw rich, interconnected information from observational data and then derive unique insights during the analysis that follows (Appendix 6 for example of instances in raw data extract).

3.16.1 Inductive and deductive reasoning

It was useful in the earlier stages of data collection to frequently revisit and explore thoughts of data analysis in order to engage in reflexive activity. Induction is the process of identifying a general idea on the basis of several observations of data (Merriam 2009, Thomas 2011). Utilising an inductive process aided me to integrate information from the specific to the general (Polit and Beck (2018). In qualitative research, iterative data collection and analysis is comprised of inductive and deductive reasoning, when a theme or pattern is identified inductively, the researcher moves onto verification, trying to confirm or qualify the findings by deduction, this then starts the inductive process again (Huberman and Miles 1994). I listened to and read all data, noting my thoughts in my research journal or on the transcript as mentioned previously. I revisited the data multiple times and advanced my thinking from what I saw and heard, to why it was interesting, and then to why a study on role modelling in leadership benefits from the interesting *thing*. Subsumed within the analysis were key reflective questions that enabled a critical, constant and constructive approach, these enabled me to get beyond these initial thoughts and attempt to 'push' them into a more objective position (Figure 4 below). At latter stages of the analysis, these were almost simultaneous and demonstrate the cyclic nature of inductive and deductive reasoning. The flexible integration of theoretical perspectives in this work contributes to the rigour of case study methodology (discussed further in section 3.17). Using these theoretical lenses allowed the processes during data analysis to be both inductive and deductive.

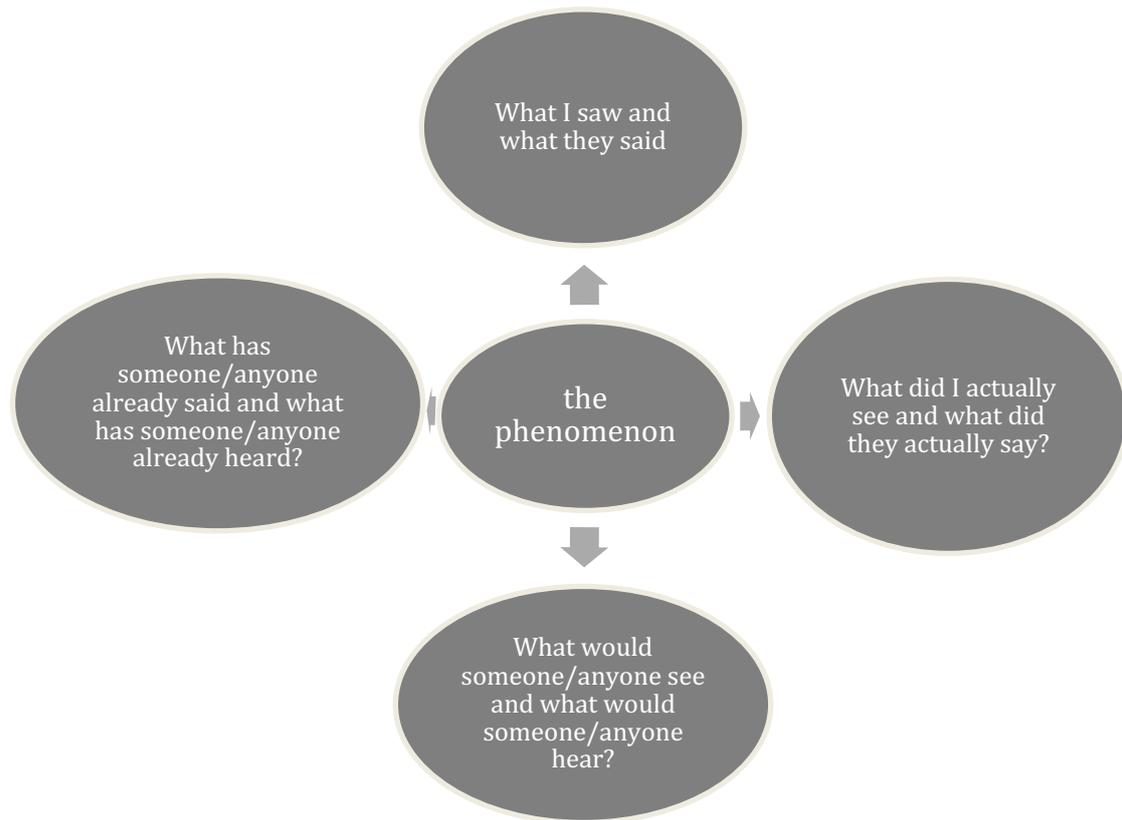


Figure 4. Relationship between key analytical questions – inductive and deductive reasoning

Stake (1995) suggests that readers expect researchers to engage in the interpretation of observations and find meaning where others do not. For example, on initial reflection the wards were both similar and different to each other, three distinct areas; however, one commonality was the general pervading ‘busyness’ reflected in work activity. This ‘busyness’ was common to each case but not the same in each case. I attempted to distinguish this between the cases.

On Acacia, ‘busyness’ was based on workload and an increase in pace. This was demonstrated through a slightly more urgent focus, there were fewer smiles and a little more noise, but the intent remained purposeful and controlled. Whereas, although Beech ward had a reduced investigation and treatment schedule during one observation, and as a result decreased workload, this was managed by the re-allocation of staff to other areas. The remaining staff were still busy but there were fewer staff and less to do,

meaning that although the workload was reduced there were fewer staff functioning at the same pace as previously. Cedar ward on the other hand, was persistently fast paced with many staff and patients coming and going, they were busy. However, this appeared to be 'normal' and did not cause too much anxiety, that may have otherwise been revealed in the non-verbal cues of the staff.

3.16.2 Early pattern development

Stake (1995 p. 78) puts forward the suggestion that there is an art and intuitive processing to searching for meaning, and often '*the search for meaning is a search for patterns*'. Categorical aggregation and direct interpretation depend on patterns, these can be known in advance and provide guidance through identification of the research questions or alternatively emerge from the data analysis (Stake 1995). According to Silverman (2017), questions to be asked of data include: identifying the main units in data and how they relate to one another; finding which categories are used by the participants and what are the context and consequences of their use of categories. An iterative, reflexive type of activity enabled me to start to scrutinise the data and explore how I might analyse, make sense and find meaning in the individual cases and across the three cases. This purposeful reflection helped to raise my confidence levels and contributed to the iterative nature of the data analysis and further data collection.

Initial patterns from the non-participant observation were aligned with 'Working together' and 'Getting the job done'. 'Working together' was concerned with the way that people treated each other; how they listened to each other, demonstrated respect and appreciation and responded to concerns. It was also related to how people sustained relationships, motivated each other and revealed 'happiness at work'. It evolved further into ideas that demonstrated actions and behaviours that reflected the worth and contribution of individuals. The 'Getting the job done' behaviours linked more to action: adhering to and demonstrating good practice; giving direction and guidance; offering advice and help; keeping busy and demonstrating expertise.

(Appendix 7 – Example of raw data extract, ‘Working together’ and ‘Getting the job done’ early pattern development) Each set of behaviours contribute to being leaderful and are worthy of emulation. Positive behaviour was mirrored in the cases and included activities associated with role modelling and leadership such as communicating effectively, providing support, being available. There was also clear reference to how individuals perceived themselves as leaders and role models which followed a developmental trajectory. The response to negative and less positive behaviour was also redolent of role modelling and leadership: how individuals ‘dealt’ with situations utilising similar behaviours to those noted above. These initial patterns were used to supplement the interview guides and contributed to the individual and overall case themes discussed in chapter 4 and 5.

3.16.3 Cross-case analysis

As discussed in section 3.5, more than one instrumental case is described as collective case study, an instrumental case study extended to several cases, chosen because it was believed to lead to greater understanding (Stake 1995). Comparisons across the cases retained the uniqueness of each case, because what I was doing was comparing ‘these’ particular cases with each other (Thomas 2011).

This cross-case analysis, as highlighted by Stake (2006) did not have a definitive starting point, however full attention to cross-case patterns was given when the individual case analysis was complete using a deductive/inductive method. Stake (2006) offers guidance in the form of tracks for cross-case analysis but urges that individual cases are not merged too quickly to ensure scrutiny of each situation. Finding a common feature orientated to the phenomenon was important (Swanborn 2010). I was seeking to build a substantive abstraction of concepts across the cases rather than a longer description of three cases (Merriam 2009). Stake (2006 p. 6) argues that for multicase study, there is a word to describe the collective target, he coins this term ‘*quintain*’. Remaining focused on the phenomenon as a quintain, enabled a concentrated analysis of the single cases in order to

achieve greater understanding. Going back to the literature throughout data analysis enabled me to check concepts and findings and look for alternative explanations, similarities and differences in the cases.

3.17 Rigour and triangulation

There is growing realisation that validity and reliability should be built into the process of inquiry (Morse 2018). Stake (2005) argued that we should choose to study the case, whether simple or complex, and do so in a scholarly manner, gaining credibility by triangulating the interpretations systematically throughout the study. This 'scholarly manner' refers to whether the reader can rely on the process, conduct and outcome of the study. Triangulation is a procedure that is used to ensure that the research is valid, the point being that in a study, an assertion can be explored and analysed from more than one perspective (Schwandt 2001). The different types of triangulation, originating from Denzin, include data source triangulation; investigator triangulation; theory triangulation; and methodological triangulation (Janesick 1994, Stake 1995, Flick 2018). These types of triangulation refer to the use of different data sources; the use of different investigators; the use of multiple theories to interpret a dataset; and the use of multiple methods to study a phenomenon respectively (Janesick 1994, Flick 2018). Janesick (1994) also includes interdisciplinary triangulation to include other disciplines to inform the research process and broaden understanding of method and substance. Essentially the concept of triangulation means that the research is constituted from at least two perspectives (Flick 2018).

Being able to trust research is important, especially in professional fields if the knowledge is to be applied (Merriam 2009). This is salient, as a failure to address issues of rigour can undermine the methodological quality of a case study (Anthony and Jack 2009). The applied nature of the health field means that there should be a confidence that the study has been conceptualised, conducted and reported appropriately (Merriam 2009). This is achieved through careful consideration at each stage of the research process, drawing on tools that would otherwise be used for judging the quality of the finished

project, they become tools for self-examination (Morse 2018). There are different methods for ensuring rigour in qualitative research; validity checks being one of them (Morse 2018). External validity refers to the extent that the results of a study can be applied to other situations; whereas internal validity specifically refers to the congruence between the research and reality; whether researchers are measuring what they think they are measuring (Merriam 2009). Concerns of validity and reliability should also be congruent with the philosophical approach (Merriam 2009). Ritchie and Ormston (2014) feel that there has been an ongoing debate in regard to the function of triangulation and its validating purpose: this is underpinned by two challenges, that of the ontological view, there being no single reality of the world and that of an epistemological view, that each data source yields specific types of data; In this study the measures to assure validity were concerned with the ontological and epistemological approach, triangulation of methods and analysis.

The nature of a constructivist inquiry relies on multiple perspectives which are subjective to the participants in the study, however researchers desire some validity to both their measurements and interpretations of meaning (Stake 1994, 1995). This means that ways to capture those multiple perspectives should be fit for purpose, for example in this study different people, with different realities, were invited to participate rather than one person, with one reality; and different methods for capturing 'any' reality were undertaken. Trying to amalgamate understanding should be based more on revealing different perspectives rather than the same perspective in different ways (Ritchie and Ormston 2014). Between methods triangulation refers to the use of two methods or 'within methods' triangulation (Flick 2018), in this study observation and interviews. In this study the tenuous nature of role modelling and leadership seen through non-participant observation is based on behaviour, it is tacit in that whilst indicative of how leaders and role models behave, it is not declared overtly, the participants did not articulate that they were role modelling or leading per se. Asking the participants about their understandings and experiences offered an alternative view of the same reality. Engaging in data collection sufficiently enhances closeness to the

field, Merriam (2009) advises that this can be difficult to decide on but essentially there should be a feeling of data saturation, seeing or hearing the same things over and over. Fusch and Ness (2015) believe there is no one-size fits all regarding data saturation and suggest that is better to think of data in terms of richness and thickness. This is when rich means high quality, that is, multi-layered, detailed and intricate data, and thick, is in relation to high quantity. In this sense, presentation of the cases, the cross-case analysis and unique findings, are crucial.

Observing and interviewing some of the same participants allowed for comparison, thereby enhancing rigour (Casey and Houghton (2010). It was also through asking questions following on from non-participant observation that a deeper understanding of experiences, motives and meaning was sought and could be considered member checking (Merriam 2009). The analysis of the interview data was also integrated with the observational data, looking for shared meaning, supporting evidence and conclusions. Utilising different sociological theories to interpret results allowed multiple perspectives to be considered. So, whilst there was triangulation of methods, data sources and theory, this was flexible and focused on interpretation.

Stake (1995, 2005) offers a list of activities which can assist with validating naturalistic generalisation: these include describing the methods of the case study in ordinary language; providing raw data prior to the interpretation so that readers can formulate their interpretations; and providing information about the researcher and other inputs. In this study, each aspect of the research has been presented alongside commensurate insights and supporting literature, as including sufficient detail in the report can help readers assess the validity or credibility of the work (Baxter and Jack 2008). This detail will enable the reader to make their own comparisons and explore issues further themselves (Stake 2005). It is not considered possible to generalise in the same way from a case study as with other research designs, nevertheless people can learn much that is general from single cases (Stake 1995, 2005). To mitigate for this therefore, the case should be described in a such a way that it would provide anyone reading it with information required to

picture the case with sufficient clarity to be meaningful to the reader (Stake 1995). Extracts of raw data and observational field notes and interview data are used liberally to enable the reader to gain insight into the cases and form their own subjective meanings. As interpretations began to emerge these were detailed in accordance with the nature or impact of the issue (Stake 1995), for example how the participants talked about their role models, who their role models were specifically and so on. Stake (p.112 1995) discusses how this can be delineated by deciding whether something is '*central to making the case*'. The challenges to case study research discussed in section 3.7, are addressed largely through the strategies discussed above in combination with taking a reflexive approach to self as researcher. This is particularly crucial in a constructivist case study, as the researcher is the primary instrument.

3.18 Researcher positionality and reflexivity

Reflexivity is a key analytical tool where the researcher examines their world view, beliefs and values on an ongoing basis (Simons 2009). Hertz (1997, p.viii) considers '*it essential to understand the researcher's location of self*'. Therefore, adopting a reflexive stance was beneficial as a novice researcher. It was essential to preserve researcher integrity, and being open and reflexive throughout the research process, allowed me to understand and demonstrate how methodological and analytic decisions were achieved (Merriam 2009) and guard against personal bias (Polit and Beck 2018). The purpose of a reflexive stance is to consider how and in what ways the self may influence understanding and analysis of the potential scope and meaning of data in the field, to reduce the likelihood of biased observation and reporting (Polit and Beck 2018). Being aware of this and how it could influence the research through either, for example, access to participants or data collection, was essential, as conducting research involving colleagues or peers can present challenges, particularly in relation to boundaries (McDermid et al. 2014). The following sections consider my personal transition to researcher and the impact on research conduct and process during this study.

3.18.1 Transition to researcher role

I have not found the transition to becoming a nurse researcher straightforward. De Laine (2000) suggests that being able to make ethical decisions, includes being aware of personal values and principles within a context that is characterised by professional and power relationships. For example, I was concerned about accessing the field and recruiting to the study, as well as whether my data capture, documentation and analysis would be accurate and 'good enough'. I therefore attempted to maintain a reflexive stance throughout the research process as presented in the remainder of this chapter. The aim of this is to demonstrate how I not only acknowledged, but mitigated, for any impact or influence that my personal experiences and bias as a nurse could potentially have had. This was fundamental to support the research and my ongoing development.

3.18.2 Approaching the study

From the abstract theoretical beginnings of the inception of this study, I considered how my own experience and personal values may have influenced the research. Although my interest in leadership for example, is longstanding and of high value to me, I recognise that this is not the same for others. I had taught students from a variety of different programmes about leadership and role modelling as a conscious teaching strategy on a mentorship course previously and explored these topics extensively. Any contact I had in respect of leadership has been in relation to illuminating the possibilities within their own personal sphere of influence, either in my educational role or previously as a Ward Manager myself. I needed to forget what I already thought I knew about leadership and role modelling and stay focused on the issues from a contemporary and empirical perspective.

Prior to the start of the study at the time of its inception, my role as associate professor included project work, a strategic pre-registration student placement lead role and coordination of continuing professional development provision. Whilst there was interaction with NHS staff, this was limited to those in specific roles, it was not operational or generally with nurses who were

working clinically. In addition, my role, whilst having a strategic placement and faculty role, did not directly engage on a day-to-day basis with pre-registration student nurses. There were post-registration students from the organisation enrolled on CPD modules, predominantly the leadership course.

Initial thoughts that came to mind focused around the fact that my everyday role may have presented a power dynamic in respect of my responsibilities in regard to day-to-day activities associated with course provision and partnership working. Whilst it was unlikely that individuals at ward level would be aware of this, more senior individuals who were involved in affording permission to access the field were. Student nurses from my institution could have been involved in the research and awareness of the ethical impact when approaching these individuals was essential. I ensured that I approached all communication with the Trust from a neutral stance, making requests, offering information and assurances as clearly as possible, the focus being on the study and my position as researcher. This enabled an open and positive dialogue and confirmation of the study parameters and expectations.

3.18.3 Approaching data collection and analysis

Approaching the wards to undertake data collection through participant-observation and interviewing caused some anxiety to me as a novice researcher for practical and intellectual reasons. As discussed, I had been advised by my supervisors to prepare for the data collection, I had had the opportunity to undertake clinical observation in a previous project so had some experience of being in the field, which I perceived to be of benefit to this study. However, the emotive flood of reflections that the initial actual observations evoked was almost overwhelming. This is represented in my field notes:

It feels busy but calm, lots of activity... makes me remember when I use to work on a ward like this... (Field note 1.1.1) and also *'I'm not sure who is who... or what the ward routine is....* (Field note 1.1.2).

I have not practiced clinically as a nurse for many years and having been a Ward Manager on a busy acute medical ward I had existing beliefs and

values, which I subsequently recognised had lain dormant. I reflected on these, initially this was affective: in that the standards and expectations that I had adhered to, channelled my feelings and thoughts around my observations. These were concerned with 'being a nurse'; how I felt nurses should conduct themselves, what behaviours I held in high regard, and the value I place on the relationship between nurse and patient; and nurse and nurse. I wondered how long it would take me to become a 'real' nurse again. This was value laden in that it revealed a perception and questioned whether I think I am a 'real' nurse now. For me these originated from a deep-seated belief that patients should be placed at the centre of nursing work and as nurses we hold a privileged position. This is noted in the field notes below:

'Are Ward Managers efficient? Where does this come from? Me? My personal beliefs and values? The key person on a ward...everything to everybody? 24-hour accountability?' (Field Note 1.1.8)

'When I was a Ward Manager people generally did as I asked, I had an awareness of power associated with the role...but I was nice to people too as found this was the person I wanted to be and it gave more rewards.' (Field Note 1.2.10)

I realised that personally, this was associated with being part of a nursing team and the emotion that this generated. Unluer (2012) discusses the advantages and disadvantages of being an insider-researcher in his case study on the integration of information and communication technologies in the teaching-learning process. He opted for a preventative approach in order to meet things like overlooking routine behaviours, making assumptions about the meaning of events and people assuming you know what they know. As a nurse and previous Ward Manager this understanding was critical, whilst I was an outsider organisationally, I felt I was an insider from a professional, albeit previous role perspective. I recognised that this meant that I was seeing through the eyes of a nurse, which although affecting me initially, also resulted in the desire to make my observations and data collection explicit and meaningful for others. I wanted to acknowledge this part of me but 'step out' of this role.

Conversely, I was also afforded some status being introduced as a PhD student. I found myself telling people I was a nurse and reflected on whether I was trying to be 'nice' and wanted to fit in.

It feels odd not to be involved, the staff don't ignore me though they smile, and some make eye contact – not all though. (Field Note 1.3.6)

Lofland and Lofland (1995) offer two complementary methods of self-presentation which are beneficial and appropriate in the research situation. Acting in a non-threatening manner was important, being respectful, interested and courteous to all participants and people encountered during the fieldwork ensured that my presence was not incongruent with the role of researcher (Lofland and Lofland 1995). I tried to be neutral and fade into the background in order not to overtly influence the day-to-day comings and goings of the ward teams. As a previous medical nurse, the environment felt safe and familiar, so it was relatively straight forward to do this. I was still acknowledged but my position had changed.

I was very conscious to be impartial in any communication and restrain any kind of interaction that could be construed as coercive. In addition to this, taking what Lofland and Lofland (1995 p. 56) called the '*socially acceptable incompetent*' or learner stance, assisted with becoming accepted, although the bond of being a nurse as well, engendered familiarity. Lofland and Lofland (1995) advise that the recording of emotions and feelings in field notes provide a means to be honest with yourself and therefore appreciate that others, that is, the study participants, may share such emotions. They also highlight that these feelings can influence analytic leads in terms of understanding your worldview in relation to those being studied, and how when reviewing them later, away from the field, obvious biases can be seen. I found this particularly useful and noting these at the time was helpful and enabled me to make sense of what I was feeling against what I was seeing and hearing.

These conscious reflections, through the use of reflective memos, helped me to develop and refine my skills as a researcher:

'I am conscious again about seeking consent. I feel that it would be disingenuous not to say that I am a lecturer in case they see me again at some point and it comes to light.

I feel less awkward today though, people recognise me and say hello, smile

I feel more organised and have thought about what I am observing

I have decided to capture as much as I can through these observations, I have re-visited the authentic leadership framework....

this is in case I inadvertently miss something as I go along' (Field Note 1.2.1)

The staff on all the wards engaged me during observations. They asked me questions, referred to me when I was in earshot, often in a humorous way and were courteous to me:

RN2.2's toe trodden on by another...called over 'Rachel, did you see that?'... they all laughed (Field note 2.3.128)

This may have reduced their anxiety at being 'watched', as well as my own watching them. This could also be reflective of the fact that staff were under frequent scrutiny from a range of stakeholders on a regular basis. This was often as part of a governance mechanism, for example, an audit or a Care Quality Commission inspection.

Undertaking the non-participant observation made me reflect on my previous roles and what they meant in regard to undertaking this study. Whilst I felt I had considered this from the outset, it generated a host of self-reflective thoughts that helped me to make sense of what I was seeing, taking the reflexive stance a stage further (Appendix 8, example of questioning stance in raw data extract).

I found undertaking the interviews challenging and discussed this with my supervisors. Some participants were more comfortable in the interview situation than others, and I was concerned to put them at ease. Initially, I was also very aware of making the best use of time. I also felt that my interview technique was lacking. Each participant was given the opportunity to ask questions and signed a consent form immediately before the interview commenced which enabled a welfare check as well. Some participants needed to be assured that they were not being 'tested' and others found the

interview quite straightforward. According to Brinkmann and Kvale (2015), some interviewees are cooperative and eloquent, they give concise answers and are truthful and consistent, however they caution that the ideal interview subject does not exist; it is the task of the interviewer to motivate and facilitate such exchanges and to obtain data rich in knowledge. I was particularly conscious of not asking leading questions during the interviews and finding the balance between letting interviewees tell their story and not wanting to influence their line of thought. I deliberately did not offer any direction for the leadership and role modelling questions in order to remain as open as possible.

Consciously taking a reflexive stance, enabled me to contemporaneously review and build an understanding of what I was seeing and hearing by helping me to recognise my sense of self as both nurse, lecturer, researcher, leader and role model. When engaging in professional dialogues around role modelling and leadership my normal default mechanism is to 'teach'. I was very aware of this and whilst undertaking the data collection I restrained this aspect of my behaviour.

To mitigate against my personal bias and prior knowledge as I began to analyse the data I 'pushed' the questions that the data generated away from what I thought, into what anyone else might think. In essence finding my position enabled me to distinguish between, and focus on, what I was seeing rather than what I felt. I stayed focused on the cases and the data generated from them, remaining true to them and not seeing something I wanted to see, based on my preconceived ideas. I engaged in critical and regular dialogue through supervision. Attempting to adopt an objective and interpretive stance around helped me to illuminate the cases throughout the research process and build a solid foundation for the interpretation required.

3.18.4. Construction of thesis

Baxter and Jack (p. 555 2008) describe how the '*goal of the report is to describe the study in such a comprehensive manner as to enable the reader to feel as if they had been an active participant in the research...*'. This forms the basis for Stake's (1995) naturalistic generalisation and was crucial in the formulation of this thesis. Being reflexive is more than reflecting on the process. The thesis should be accessible and clear to the reader. Each stage of the research process has required a reflexive posture to be taken; from initial development of the issue, approaching the field, recruitment of participants, collecting and analysing data to producing the report. This has been the cornerstone for reducing bias, establishing my position and ultimately feeling more confident in the process. Engaging in reflexive practice has been beneficial and contributed to my personal development as a nurse, educationalist and researcher.

3.19 Summary

Given the complexity and breadth of literature available on leadership, this study aimed to focus holistically on role modelling and leadership in nursing and chose to take a constructivist approach using case study methodology. The first half of this chapter offered an exploration of my ontological and epistemological position and how this contributed to methodological decisions in the context of this study. It then provided a discussion of the case study research design, the history of case study research and the challenges encountered therein. This chapter has also discussed the methods used to collect data and provided a rationale for the analytic processes used in this case study. There is a discussion of the ethical permissions sought and strategies to address any issues of rigour. It presents an account of my experience as a developing researcher, how my sense of the 'self' as a nurse and researcher shaped my collection and interpretation of the data.

Chapter 4 –Presentation of Cases

4.1 Introduction

This chapter is the first of two chapters that present the findings of this study. This first chapter looks at the cases individually and draws on the literature and driving leadership ambitions of the NHS. The second chapter offers a cross-case analysis and picks out some key and unique points using Grint's fourfold typology and Hogg's (2001) notion of leaders and followers co-existence making leadership a relational property applied by DeRue and Ashford (2010) in the co-construction of leader and role model identities.

Chapter four begins by introducing the hospital in further detail. Literature is interwoven with findings in keeping with case study methodology. Each of the ward cases: Acacia, Beech and Cedar, are presented from their unique perspective in order to provide the reader with a rich picture of each context, the care setting, what the ward looked like, how the staff worked together and how they behaved. These include introductions to service settings and the nature of patient care in each ward. Reflective vignettes aim to share reflexive researcher insights into each area. An overview of the themes in each area is presented in the diagram below (Figure 5) which include, but are not limited to key aspects of teamworking, the position of the Ward Manager and how role modelling and leadership is encountered.

Presenting the themes in this way is important within this case study as it demonstrates the social context within which each team functions. It acts as a backdrop and basic terrain for the enactment of activities associated with leadership and role modelling therein. This phenomenon is subsumed within, not separate, to everyday practice. The unique themes presented in the next cross-case analysis chapter: leader location and the co-construction of leader and role model identities are rooted thus. Rich and thick description tells the story of each case and enables the reader to experience this vicariously and formulate their own naturalistic generalisations.

As discussed in section 2.2, Grint’s typology talks about leadership in terms of position, person, result and process. The role of the Ward Manager in each case remains an enduring and significant player in leading nursing work. They are the focal point for service delivery, but in different ways as can be seen in the cases. Their organisational ‘position’ affords them a recognised leadership status, their individual traits and personalities are reflected in ‘person’, impact on the manner that they enact their roles, in the ‘process’, which in turn influences outcomes or ‘results’.

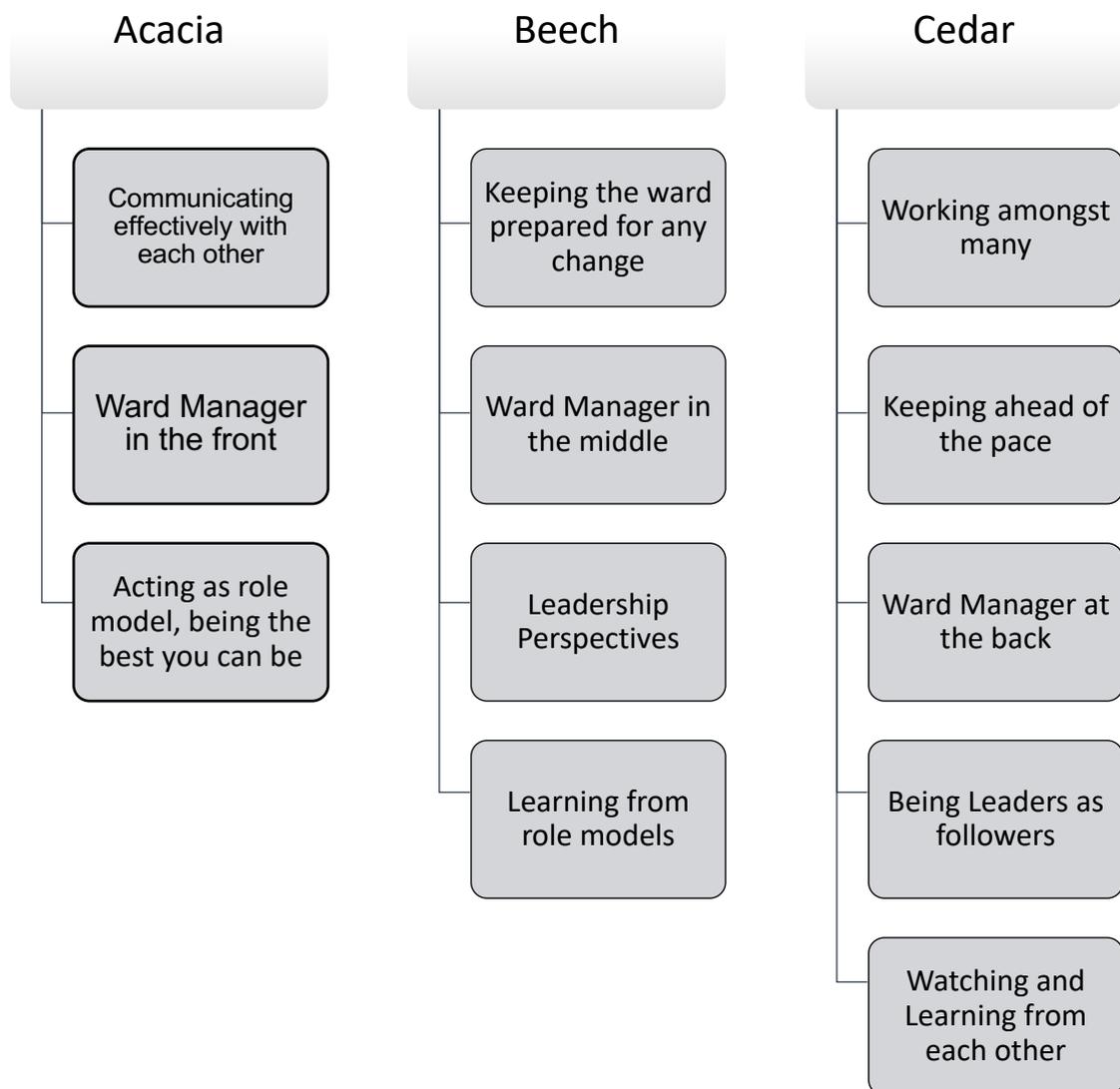


Figure 5. Overview of themes within cases

This research study was set within a large district general hospital – Meadow Court hospital ⁷. The hospital served a predominantly rural population: it provided a wide range of emergency, medical, surgical and maternity services to its users. The Trust strives for excellence and believes that it belongs to the community. The most recent Care Quality Commission rating was ‘good’ overall. It has clear values, placing service users at the centre of the care provided, as evidenced in organisational aims that align with the NHS constitution. The three cases were situated within an organisational group of wards that constituted a service department within the hospital. Data was collected from three ward areas: Acacia, Beech and Cedar.

Acacia ward was an acute medical ward that specialised in dementia care, patients in this environment were in acute medical crisis requiring specialist treatment. Beech ward was a day ward specialising in cardiac treatment. Cedar ward was a short stay medical ward that was part of the emergency assessment service.

4.2 Introduction to Acacia Ward

Acacia ward provided care for patients requiring acute specialist medical interventions, this included frail patients and those living with a dementia diagnosis. Whatever the reason and route of their admission, patients with acute medical illness requiring specialist ongoing care are streamed to specialist beds (Royal College of Physicians [RCP] 2007). Whilst people in the UK are living longer, they often cope with one or more long-term conditions, which poses a complex problem (Cornwell 2012). This is compounded for someone with dementia who can become confused and agitated in unfamiliar surroundings such as a ward environment, distracted by over stimulation that adds to heightened anxiety (Waller et al. 2013). This was evident in Acacia, where patients with diversely presenting co-morbidities were cared for by the multidisciplinary team. Dementia is a growing challenge globally and sometimes people are in hospitals for conditions that would not require admission if they did not have dementia (DoH 2015). This group of patients particularly, should be managed holistically and proactively to ensure

⁷ All names are pseudonyms

that they are transferred back to the community as soon as possible when well, so that they do not lose the ability to self-care (NHS England and NHS Improvement 2019). Therefore, enhancing care for patients living with dementia had been the focus of service improvement and development on Acacia ward; both in terms of the physical environment and staff training. Activities aiming to provide high quality care, adhering to standards and maintaining patient safety were observed on Acacia ward. For example, one bay could not be left unattended as the patients within it were deemed at high risk of falls or harm.

4.2.1 Service setting

From the first impression Acacia ward presented as a busy clinical environment

'Busy because people are moving quickly, they look focused and as if they are carrying out tasks, nobody is 'standing around'. It also feels calm though because non-verbal cues aren't indicating any kind of anxiety, facial expressions balanced and noise level acceptable' (Field Note 1.1.1)

It had 27 beds, four bays of six patients and three side rooms. The layout of the ward was constructed around a central reception area with bays and side rooms making a broad horseshoe shape around the open desk area and the ward entrance. The Ward Manager's office, clinic room, bathroom, toilet and sluice were opposite to the reception area. The dependence⁸ of the patients meant that workload activity was high and reflected in the focused and purposeful manner in which staff carried out their roles. Patient throughput⁹ was low and steady, this means that admissions and discharges had a relatively low impact on the ward's workload. This case reveals how providing care in this busy clinical environment was constant and that all staff engaged in this shared goal. Due to the nature and specialty of the ward, nurses often needed to work directly together to meet the needs of the patients in their care (Appendix 9 - Example of extract raw data extract Acacia 'Helping each

⁸ Dependence refers to the level of care need, a high dependency being given to patients who need an increased level of nurse input to meet their care needs. This is influenced by biopsychosocial needs, diagnosis and treatment plan

⁹ Patient throughput refers to the number of admissions and discharges occurring on the ward, this can have an impact on the workload for that shift for example through discharge/transfer planning and admitting patients

other’). This impacted on interrelational team working and everyday role modelling and leadership, with the Ward Manager as figurehead as demonstrated in the presentation of themes in sections 4.3, 4.4, and 4.5 (Figure 6).

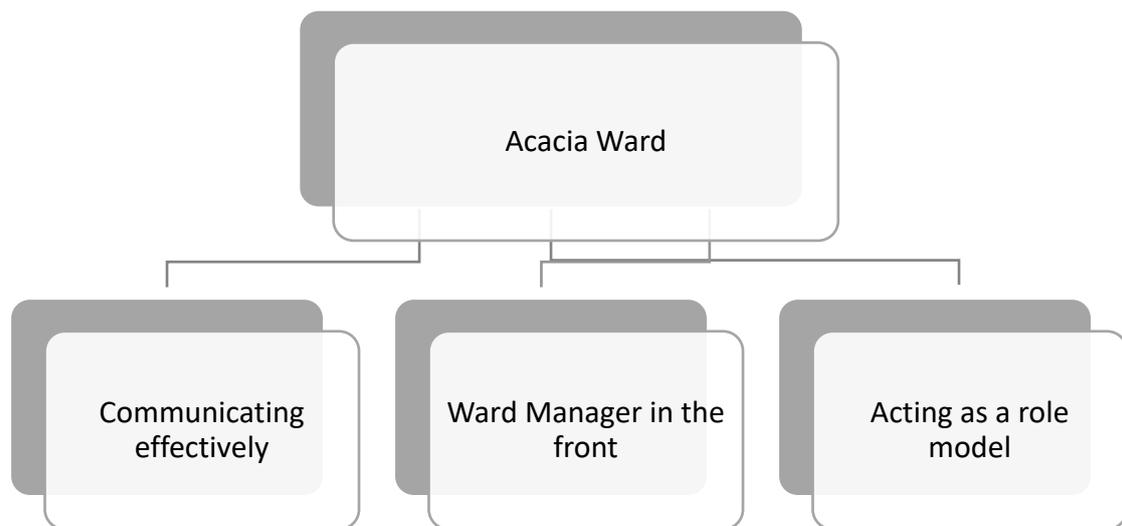


Figure 6. Themes on Acacia ward

Entry to the ward, revealed a reception desk that was low, unlike a higher, more traditional, ‘Nurses Station’. There was a round table and armchairs beside it for patients to sit at. At times, it was a very busy space, and in line with Gum et al.’s (2012) study, it was an area where several healthcare professionals sat, paused to write notes and exchange dialogue around patient care and their everyday lives. The environment aligned with a dementia friendly ethos (Waller et al. 2013) the ward décor was bright and decorated in primary colours:

‘...lines on the floor leading to toilets, big wall painting of a sunny cornfield opposite to the table. Yellow, orange and red doors, big

images on signs... It looks bright and cheery, easy to find things and clean A good therapeutic environment' (Field note 1.1.8)

Acacia had a single Band 7 Ward Manager, Alison, who had overall responsibility for the ward team. The rest of the team was composed of two Band 6 junior sisters and a range of Band 5 staff nurses, assistant practitioners, trainee assistant practitioners and healthcare assistants (interview participants in table 3 below). The ward was a placement area for student nurses throughout the undergraduate programme.

Name	Band	Role
Alison	7	Ward Manager
Jane	6	Junior Sister
Paul	5	Staff Nurse

Table 3 - Names and banding of participants on Acacia ward

The key motivator for staff on Acacia was to do *'a good job'* (Paul, Staff Nurse, Acacia) and ensure good outcomes for patients. These desires were seen as inspirational by them, *'... we all work together to the same end...'*. (Alison, c) Satisfaction was derived from being able to see patients *'getting home as safely as possible'*, (Paul, Staff Nurse, Acacia) planning a discharge and being able to *'see it through to the finish'* (Jane, Junior Sister, Acacia) They were inspired by colleagues, particularly those who *'go that little bit further'* (Alison, Ward Manager, Acacia) those that *'jolly others along'* (Jane, Junior Sister, Acacia) and colleagues who demonstrated that they were *'dedicated'* (Paul, Staff Nurse, Acacia). In contrast, staff who did not *'pull their weight'* (Jane, Junior Sister, Acacia) or *'whinged'* (Jane, Junior Sister, Acacia) and displayed negative feelings, were considered to de-motivate. In addition to the ward-based nursing team there were often several other hospital staff present on the ward involved in service delivery. This included medical staff of varying grades, professions allied to health: physiotherapists and occupational therapists, as well as social workers, specialist nurses, bed flow managers and a range of ancillary support roles. The general ambience of the ward

recorded in the field notes provided a welcoming ethos congruent with the care philosophy of the organisation (box 1 reflexive vignette¹⁰).

Acacia

The ward feels harmonious – people look focused and purposeful, not smiling but not frowning either. I am being shown around the ward, different bays and side rooms... all the staff are wearing different uniforms – new in the Trust... apparently ‘the darker the blue the higher the rank’.... There is a low hum of activity, sounds of people getting on, chatting, no one crying out, no raised voices, trolleys and equipment moving, general ‘noise’... it feels like a busy calm – an easy atmosphere people making good eye contact, looking focused and directed but not ‘stressy’... it feels in control, there is not a palpable urgency...not emotionally charged ...the staff make time to talk to each other and relatives... one bay has a patio area, the aspect looking onto a playing field...it is a warm and bright sunny morning, the doors open into a courtyard, there is a sculpture on the patio and a light breeze coming through the doors into the bay... the ward feels nice, whilst obviously clinical, the atmosphere is calm, it is a pleasant place to be.... (Field notes 1.1.17, 19, 1.2.13,16,31, 1.3.3, 1.4.16)

Box 1. Vignette Acacia ward

The atmosphere and care delivery model on the ward, were driven by the nature of the care. There was no delineation between the staff when undertaking direct care¹¹ activities, they overtly helped each other, and more than providing physical assistance, small gestures and interactions between them gave an added unsaid connection below the surface. The way that they supported and interacted with each other was pronounced and clearly impacted on the emotional atmosphere and output of the ward. Alison captured the cohesion of the team ‘*we’re all in it together aren’t we*’. The focus was on holistically achieving patient outcomes and all activity revolved around this. The following example outlines how staff addressed psychological as well as physical needs during a very busy shift where numerous, direct and

¹⁰ The reflective vignette gives a brief vivid description (Soanes 2001) of immediate reflection

¹¹ Direct care activities involve being with the patient at the bedside, for example, assisting with physical tasks, interacting with them, administering medicines and so on. Whereas indirect care activities concern patient care but are undertaken away from the bedside, for example making telephone calls, referrals or preparing treatments.

indirect patient tasks were required, with each given equal attention, *'B62 sitting with [patient and visitors], talking to them and listening, looks relaxed and not in a hurry, giving time...'* (Field note 1.4.29). The staff member's non-verbal cues in this exchange were congruent with active listening, making eye contact, adopting an attentive posture through relaxing shoulders and facing the subject (Hargie 2016). This was modelled by other staff who had made the time to sit down and share time with patients as seen in this field note

'this was during a period of much activity, demonstrates the ethos of the ward, their priorities, human contact, putting the patient's needs first...' (Field note 1.2.14)

4.3 Communicating effectively with each other

The nature of interrelational working and effective communication contributed to team effectiveness and the care environment on Acacia. This theme reveals how both verbal and non-verbal communication, was an essential part of delivering care and working in the team. Communication was open and timely; all staff were informed of any change and able to feedback to each other: There was a connection between staff on the ward that reflected mutual respect and common goals that transcended positional roles. This was evident in the way that people chatted as they got on with tasks, for example: *'N1 and Alison catching up with paperwork, helping each other, talked about satisfaction of ticking jobs on the list off.'* (Field note 1.2.33). This approach to communication demonstrated value and respect for each other's contribution, enabling staff to plan their work and consequently work as a team. Shamir and Eilam (2005) believe that authentic leadership includes authentic followership, this means that authentic behaviour is seen in actions that reflect shared values and beliefs, being true to themselves and not 'fakes'.

Staff sought help and advice from each other; they asked and answered questions (Appendix 10 - Example of extract raw data extract Acacia 'communicating'). All staff stopped what they were doing to help each other regardless of their positional role and felt able to ask for help. Modelled behaviour was demonstrated by Alison at the front, *'Alison helping in bay – talking to patients'* (Field note 1.3.41) and congruent with her expressed

intentions. Small physical gestures demonstrated kindness and concern toward each other, for example tying someone's apron when they were going to work together. This type of touch demonstrated friendship and warmth (Hargie 2016). There was a thank you in the smile, with eye contact and a nod in return, chivvying each other along. This was important, as the action was not required physically; the staff member could tie the apron herself, so it appeared that the helper was being kind and wanting to make a connection.

Generally, the body language of the ward staff was relaxed, their non-verbal cues indicated that they were happy in their work and to work with each other. I noted *'The staff joke with each, use humour, appear to enjoy their work. They are friendly toward each other...'* (Field note 1.2.16). The staff smiled frequently (Appendix 11 - Example of raw data extract Acacia 'smile'). According to Hargie (2016), a smile is one of the most easily recognised facial expressions: spontaneous, as opposed to contrived smiles, can be recognised by involvement of the eyes and mouth. A smile or smiling indicated familiarity and interest on a human level by; greeting a co-worker, signalling approachability, giving affirmation and reassurance, demonstrating understanding, being willing to help, giving assurance that someone was coping, showing a general interest in another as well as simply displaying pleasure.

The participants placed importance on working as a team in a supportive inclusive environment, they were quick to help each, for example *'Someone trying to sort out discharge – organise TTOs. Alison offered to fetch them, found in clinic room.'* (Field note 1.3.5) They viewed feeling valued, being treated kindly, being able to show concern and appreciation for others, using humour and banter to motivate; as fundamental. This could be seen in a variety of ways from general chitchat to the board round¹² as in these examples.

'N1 big welcoming 'hello!' to night staff' (Field note 1.2.43)

¹² A board round is when the multidisciplinary team come together and discuss the patients' progress and treatment by going through each patient at the desk, looking at the patient names board.

'N2 and NA1 banter over chocolates in the office, share out...'chocolate makes everyone happy'...the mood is lighter (Field note 1.3.57)

'Board round – questions across the team, B62 good eye contact – made a comment – humour used, they all laughed' (Field note 1.3.65)

They said that it was about getting on, being part of a team and important for morale, inter relational working being key. When asked about whether she saw this type of behaviour occurring on the ward Alison agreed and said:

'All the time, all the time, all the time... a) how you can possibly get by working somewhere like this to a degree and b) it makes your job and what you are doing more enjoyable...' (Alison, Ward Manager, Acacia)

This is endorsed by Cope et al. (2014 p.90), who found that staying positive and seeing the humour in everyday nursing *'enhanced feelings of teamwork and humanised the health care environment.'* The participants on Acacia suggested that the team worked better in this way creating a sense of ease and in essence, a degree of trust and reliability. The manner in which teams engage and function with each other are fundamental aspects of team working (Bach and Ellis 2011). Relationships appeared to be secure, teasing and banter reinforced and supported camaraderie, when checking staffing levels and referring to another member of staff someone said, *'got that [name] with us...'* (Field note 1.4.28). This example reflected an easy familiarity; it was said with rolling of eyes within earshot of the other member of staff, but with pleasure and a smile.

4.4 Ward Manager in the front

This theme concentrates on how Alison led from the front. In her role as Ward Manager, she noticeably contributed to care as part of the team, providing guidance, direction and support to others. In alignment with Grint (2010), her positional role carried expectations in regard to day-to-day actions as Ward Manager, these were enacted as 'process', with a spirit of awareness and intent from a 'person' perspective. Alison presented as a confident and knowledgeable nurse. She impacted on the emotional environment and how others enacted a leadership role. Alison expressed and demonstrated her key values, the things she believed in, in her everyday working. She started by

introducing her ward, highlighting key aspects of practice that reflected a desire to ensure that care was of a high quality and safe. For example, Alison said that protected mealtimes were in place and there had been some organisational effort to support changing the therapeutic environment, one of the changes included adjusting the artificial lighting to reflect a more natural day.

In this hierarchical leadership position, Alison recognised herself as the formal leader in line with her nursing role, she had insight into her performance, demonstrating a level of self-awareness about how others might perceive her.

'...I know I am a bit fast and frenetic because I've got a lot to do and can come across as being a bit abrupt and I know that people who don't know me very well think that but once they get to know me know I'm not But initially, and I try really hard not to come over like that although sometimes I do a little bit, but those I have worked with for a reasonable amount of time know I'm not like that at all...everyone has got their faults laughs... I [suppose]... it's about awareness.... yeah yeah I am aware of it ...' (Alison, Ward Manager, Acacia)

This is redolent of the work of Shamir and Eilam (2005), who propose that identifying with the role of the leader should be central to a leader's self-concept. The leader's self-concept clarity (coherent and consistent values and convictions) should also be strong enough to drive the motivation to lead. Alison demonstrated a clear intent to influence her team and as a result deliver high quality care. In striving to be a good leader Alison said that the *'Biggest thing would be to look after my staff...treat them well and hope they respect me and in return they will do the same for patients'*. This is supported by Hiscock and Shuldham (2008) who argued that focusing on patients' well-being and experience is at the core of patient centred leadership which should be evident throughout an organisation. Alison's frontal role in the team was observed by others. She also recognised the importance of the leader's role in regard to impact on others, expressing this directly in terms of positive and negative:

Generally, ... I think leaders can make people feel ... lots of different ways.... laughs.... valued and supported and encouraged ...can actually make them feel... scared and frightened and worthless it's quite an important role isn't it? ...' (Alison, Ward Manager, Acacia).

“Taking a stance’ figured in the work of Cardiff et al. (2018), who explored a person-centred approach to leadership. In their person-centred leadership model, Cardiff et al (2018) discuss being authentically other centred, this means that a leader actually wants to be caring toward others which is reflective of relational working. ‘Person centredness’ has been proposed as a means to value staff and patients and a core value for effective cultures (Manley et al 2011). One of Cardiff et al.’s (2018) stances was leading from the front and being a role model which matches some of the factors that influenced Alison’s performance as described above and in the next section.

4.4.1 Managing the emotional environment

Alison played an explicit and influential role in managing the emotional environment during service delivery, whether acknowledging and supporting staff or providing a means to give feedback as seen in the examples below.

‘Alison said everyone could go home, thanked everyone, letting people go a bit early, they were pleased’ (Field note 1.2.53)

‘N1 and Alison catching up with paperwork, helping each other, talked about satisfaction of ticking jobs on the list off.’ (Field note 1.2.33)

Alison’s demeanour affected the rest of the team, she was visible on the ward and lead from the front. Goleman et al. (2002) suggest that leaders need to ensure that they regularly display a level of optimism, authenticity and energy, remembering that through these actions their team will feel the same too. Alison displayed this through verbal interactions and modeled behaviour:

‘The ward manager smiles as she goes around, ‘efficient’, her voice carries and is loud, but not too loud. She moves quickly and looks in ‘charge’... industrious, getting on...’ (Field note 1.1.11)

As stated, Alison was a focal point in the busy care environment. Her tone of voice was unfaltering, it could be heard and distinguished from others, carrying out tasks as she moved: answering questions, making a note, talking to a patient, staff member or greeting people. Her nonverbal cues, open demeanour and smile made it acceptable to approach her and seek advice/answers/help as seen in the field note. *‘Alison doing IVs – asked for some fluids to be written up, said with a smile and easy assurance.’ (Field note 1.2.15).*

Her office was just inside the ward entrance, so she was very accessible even when she was not out in the ward. Alison's mood diffused across the team. This resonates with the work of Goleman et al. (2001) where the leader's mood was seen to have an effect on the team and literally considered contagious. Fredrickson (2004) proposed that positive emotions should be cultivated as they are short-lived feelings that contribute to longer-term psychological and physical well-being. This is largely due to the complimentary effect they have on actions and thoughts that can enhance personal resources over a longer period of time.

A change in Alison's tone of voice signalled specific attention to care delivery and elicited a deferential response: breakdowns in communication between staff and less than optimal care was challenged by her. The work of Hargie, (2016) on skilled interpersonal communication, describes how when the speaker puts greater emphasis on certain words, inserts pauses or changes tone, the importance of said words are fixed in the mind of the listener. For example, in the following field note, the '*Alison asked for pyjamas to be put on a patient being walked to the toilet in a gown quite assertively.... [staff] looked a little sheepish...*' (Field note 1.2.7). The staff concerned appeared to respond to this tone and were apologetic in manner, made reduced eye contact and displayed passive non-verbal cues, trying to say that although not great, the patient's dignity was maintained. Alison's tone of voice was clipped and more directive, signifying that this was not the most appropriate action to take. The staff appeared to recognise this, Druskart and Wolff (2001) suggest that establishing group norms around caring and confrontation are the most effective way to regulate group emotions.

The amount of communication, mood and emotional atmosphere changed across the team when the environmental conditions differed. It was noticeable that when the workload activity was particularly high, staff talked to each other less in order to complete care tasks, there was less overt support of each other. During these times they worked more quickly, prioritised tasks and omitted non-essential dialogue. Wiggins (2006) suggests that there are different strategies available to cope with time pressure: these include

acceleration; filtering; prioritizing; omitting or avoiding and using decision rules. I noted on separate observations: *'Mainly talking to patients, not each other'* (Field note 1.2.32) and *'All staff occupied, look purposeful, swift working to task'* (Field note 1.4.41). Reduced verbal communication also indicated a reduction in energy and enthusiasm at the end of a busy shift; or when resources were not available. This was seen in a staff member *'...on the back of the desk doing paperwork, looks tired...looks physically and mentally tired, bit pale, yawns, not much of a smile'* (Field note 1.3.54). The competing demands of a busy clinical environment had an impact; the challenges of meeting those demands were evident at times, sometimes masked, *'Looking tired, looking frustrated as can't get on... shoulders low, forcing a smile'* (Field note 1.3.4).

Similarly, although the staff were heard to laugh freely, possibly indicating that they were generally happy in their work, the absence of laughter signified a change in mood. During one observation I noted: *'the ward is obviously busy, 4 empty beds. There is a bit more noise and a few fraught faces.'* (Field note 1.3.1). Having four empty beds indicated that patients had left the ward, this involved increased activity as well as the anticipation of new admissions. The ward atmosphere felt hectic and noisy, the different sounds and absence of laughter made it appear less calm. A sense of heightened anxiety was revealed by more serious facial expressions; fewer smiles, less eye contact and an increase in rushing around. Overall, this level of activity indicated a consistent focus on getting through the shift.

It was during these times particularly that Alison attended to the affective needs of her team. Hard work was recognised and rewarded by Alison in a consistent way; during one observation, she allowed staff to go home early as a reward, thanking everyone, *'...staff smiled, indicating pleasure at going, being kind, this is mirrored in the way that staff assist each other.'* (Field note 1.2.53). Alison thanked some medical staff with chocolates as they left the ward; this had been the subject of some amusement and laughter; it demonstrated appreciation and sharing, seeing everyone as part of the team. Alison's kind behaviour lightened the mood at the end of a busy shift. This

could be construed as acknowledging and valuing the contribution and feelings of others. Nelson et al.'s (2014) findings support the consideration of integrating authentic leadership practices in the health domain to improve the work climate and psychological well-being at work of nurses. Authentic leaders are seen to value their staff, authentic leadership practiced by participants in Laschinger et al.'s (2015) study reported a positive effect on areas of work life such as workload, control, rewards, community, fairness and value congruence, thus improving self-efficacy and reducing burnout.

Emotion management can also be seen in the way that non-activity and good work was acknowledged. Alison was aware of this and appeared supportive as she displayed empathy by smiling and saying that staff were having a rest in the bay as their '*work*' was done, she appeared happy with this and did not intervene, saying '*they have done two long days...tired.*' (Field note 1.2.35) as an explanation. Staff were commended for recognising and reporting a change in a patient's condition, praise was given, and appreciation displayed to a junior member for responding to patient need, they were told '*well done for spotting that*' (Field note 1.3.32). This is reflective of an authentic leadership approach, these leaders listen to their staff through 'balanced processing', they are also seen to be 'real' in their relationships through 'relational transparency', and they are sensitive to the needs of their teams (Northouse 2019). It also demonstrates compassion in leadership which is a cornerstone of contemporary leadership as described in chapter 1, section 1.6.

4.4.2 Personal perceptions of leadership across the ward team

This theme explores personal perceptions of leadership, on Acacia where all staff were involved in care delivery across the nursing roles, expectations of leadership associated with Grint's 'position' were evident (Appendix 12 - Example of raw data extract Acacia 'leaders'). Describing leadership did not come easily to the participants initially though as seen below in table 4.

Alison, Ward Manager	<i>'Ok ... laughs.... Probably similar to my definition of a role model...no... I think leadership isoh it's really hard put on the spot'</i> (Ward Manager, Acacia)
Jane, Junior Sister	<i>'someone who is good at getting other people to do what needs to be done um without them hating it too much (laughs) um'</i> (Junior Sister, Acacia)
Paul, Staff Nurse	<i>'Umm someone who sort of takes charge really and be, well knowledge of the ward and that sort of stuff I would think'</i> (Staff Nurse, Acacia)

Table 4- Participant definitions of leadership

Alison, in her formal role as the Band 7 Ward Manager, articulated leadership in regard to its outcome and effect on others, saying

'... I think a leader brings out the best in ppl...that's what I'd would like to think... by some way or another I just think that's the most important thing... so you might be able to celebrate someone's strengths but also to constructively look at their weaknesses with a view to improving them, so that you're getting the best out of somebody... and they're confidently growing and learning and developing themselves because that's what most ppl would want to do wouldn't they in life... in a career...those are the things I can talk about...um that's probably the narrowest definition what being a leader means ... so that's yeah kind of my description.' (Alison, Ward Manager, Acacia)

Alison recognised the impact on service and process, how sustaining and developing staff was essential in order to help people in her team improve and function more effectively.

The Band 6 Junior Sister Jane, focused on the skills and attributes of the person: the leader being persuasive, influential and inspirational. Jane felt that it helped if leaders had charisma, being naturally likeable and able to get on with colleagues. She described charisma as *'a certain something about them that draws people to listen to them.'* (Jane, Junior Sister, Acacia). Being charismatic as a leader is seen as an attribute that enables leaders to appear competent, it communicates an ideological perspective and high expectations of followers (Northouse 2019). Charisma has been associated with transformational leadership. Hogg (2001p.189) suggests that leaders who are highly prototypical and socially attractive are likely to be viewed as possessing

intrinsic leadership capabilities or 'charisma', they stand out in this respect, they act as *'one of us'*. As everyday working and operational roles for more senior nurses necessitate leading care operationally, Jane also recognised leadership associated with her role, but with a caveat:

'To a certain extent, I have to be because of the position I am so I'm leading a team when I'm here every day so yeah I am a leader...'
(Jane, Junior Sister, Acacia)

The notion of 'leading' was not limited to a positional formal leader. The Band 5 Staff Nurse, Paul, viewed a leader as, someone who took not only took charge and was proactive, they were also calm (Grint's (2010) 'process' and 'person' perspectives). He did not consider himself a leader overtly and appeared to lack confidence in this respect. He nevertheless acknowledged that others might view him as such by virtue of his experience, it being the source of his advice and influence:

'...a lot of new qualified staff ask me for advice, and I say yes you can do this or this is how you make antibiotics up like this and things like that....' (Paul, Staff Nurse, Acacia)

The growing experience and knowledge of nurses as they progress through job roles aligned with expectations of leadership and increasing responsibility. This mirrors Lord and Hall (2005) who suggest that leader identities shift from the individual to the collective with growing experience. An individual's sphere of influence gets wider as their role changes. Individuals were more likely to be seen as leaders, if they saw themselves as leaders in Peters and Haslam's (2018) study of leader and follower identities. Their research concluded that the different relationships between leadership emergence and leader and follower identities was subtle depending on, with whom and when, experiences and interactions occurred.

4.5 Acting as a role model - Being the best you can be

In this theme role modelling is seen as a collective pursuit and influential in regard to how the team worked together and how everyone learned to contribute to care:

'By role modelling (laughs) I would say, I don't think we, we don't, that's certainly not something that's verbally said to them, it's not written down it's just... yeah... watch us' (Jane, Junior Sister, Acacia).

On an individual basis a role model was considered to lead by example and display positive skills worthy of emulation. Alison (Ward Manager, Acacia) saw this as: *'Be the best you can be so that others will want to be the same'*. Pegram et al (2015) found that 87% of their participants strongly agreed that leading by example was an aspect of being a ward manager. On Acacia it was implied that role models were key for service delivery, integration into the team and practice development.

Acting as a role model or role modelling was broadly considered to be behaving in an aspirational way. Paul elaborated saying that:

'Role modelling, that's, well my understanding of it is... it's sort of like leading by example, showing others this is what you should be doing as a nurse and teaching students and trying to make as positive a role for them as you can, or getting as much information as you can to them.' (Paul, Staff Nurse, Acacia)

In this context 'lead' from a 'person/process' perspective rather than a 'position' perspective, seeing someone who they considered a 'good nurse' setting an example for others to follow. Jane said that it depended on your definition of leadership:

'...well I pose a role model is going to lead even if they're not in that job role, you still lead even if you're not in that leadership role or whatever... I mean I did sort of say oh yeah a band 6 I'm a leader and I mean the band 5s are still certain types of leaders yeah, it does depend how you are defining leader as well doesn't it.' (Jane, Junior Sister, Acacia)

Intimating that even without the power of position an individual could still lead by example, they could still attract followers and act as a role model and influence the behaviour of others through vicarious learning.

It was suggested that role models facilitate others, are cognisant of how others should be treated and demonstrate good practice. Perry (2009) found that exemplary role models attended to the little things; they made connections, affirmed others and modeled purposively. This case

corroborates with Perry, there was a sense of a role model recognising their potential, being capable and worthy of emulation. Being a role model was associated with an affective element, being self-aware, recognising personal strengths and weaknesses, illustrated by Jane as:

'mostly for me it's how they well behave towards other people how they treat other people who are below them, well I say below but you know what I mean, job structure um... how as well they get the job done I mean if I feel they do a good job and get it done without upsetting everybody as well I think that's a good role model' (Jane, Junior Sister, Acacia)

Gibson's (2003) participants distinguished between those whom they wished to emulate and those they did not. On Acacia, the way that people interacted with each other was worthy of modelling and regularly observable as in the examples below:

'The nurses smile and chat to each other, they appear relaxed, they answer each other's questions and are helpful.' (Field note 1.1.10)

'RN1 asks the ward clerk to print two wristbands for her... nicely, not in a hurry with a smile'. (Field note 1.4.20)

'N2 and TN1 smiley and helping each other' (Field note 1.2.34)

'B62 apron on, getting pads and sheets to go behind curtains... 'big wave' both hands, smile and hello to ward clerk.' (Field note 1.4.10)

'N3 answering the telephone in a bright manner, going on to help another.' (Field note 1.3.11)

However, *'people who were quite unnecessarily sharp with other people, don't give explanations for what they're doing'* (Jane Int 7.1.12) was offered as an example of not being a good role model.

Jane and Paul could cite role models easily; they identified Alison, as well as another experienced member of staff. Ladkin and Taylor (2010) propose that how the leader uses their body, inclusive of language, dress, gestures, facial expressions and so on, embody the true self and demonstrate authenticity. As a nurse leading from the front this was visible and therefore the aspirational content of modelled behaviour. It is that which captures the attention of the observer in keeping with Bandura's 'attentional phase' (1977). It links to the attractiveness of the model and the salience of the content, that is, being a nurse. Alison, on the other hand could not identify a current role model, however she said:

'... not one specific person really, no not really, no one springs to mind immediately... I might have done several years ago or at certain points in my career but not at this precise time ...' (Alison, Ward Manager, Acacia)

Whilst respecting, feeling supported and seeing the 'good' in her leaders, Alison did not see them as role models, she felt that *'it's almost like a kind of association with the role model being perfect and because I know that nobody's perfect'*. Gibson (2003) sought to answer two questions in relation to role modelling: the first centred on the selection and attributes of role models and the second was in regard to when role models occur. He discovered that whilst his participants construed, that is, encountered or drew on, role models throughout their careers, the relative importance changed. According to Gibson (2003), the emphasis on the different dimensions changes, for example, early career individuals are more likely to look for positive, close role models and source a variety of attributes, whereas mid to late career individuals draw on the more particular attributes of their role models whilst being more cognisant of negative aspects. At this stage in her established career Alison may not have to encounter very many new or unknown experiences.

4.5.1 Seeing themselves as role models

The staff's perceptions of themselves as role models were congruent with expectations of their everyday work role, in a similar way to how they perceived themselves as leaders: Ward Manager, Junior Sister, Staff Nurse. Their perceptions linked explicitly to impressions and past experience and were reflective of a sense of growing self-awareness and confidence (Table 5 below).

Researcher: Do you consider yourself to be a role model?		
<i>Alison, Ward Manager</i>	<i>Jane, Junior Sister</i>	<i>Paul, Staff Nurse</i>
<i>Umm probably not until we started to talk about it... but well no that's not true, cos a lot is mentioned before so it's probably in my job description truth be told ...so yeah I do to a degree</i>	<i>Ummm I know I have to try and be a role model I hope, I hope over the years I have people that have looked at me and thought that at times that I do a good enough job that they would like to do something like that um and I try to bear in mind that I am a.. (laughs) but you know people are looking at me and seeing how I behave so...</i>	<i>Umm not all the time no... sometimes I doubt myself quite a lot ... oh yeah even though I say to myself this is definitely right, it's definitely right, is it?.. (laughs) even though it is...</i>

Table 5 – Perception of self as role model

Perspectives were influenced by how they learned from their role models and became role models themselves. The abstract notion of role modelling moving from an external to an internal focus as cognition of self as role model evolved. Alison, whilst admitting that she had not really considered it, recognised that being a role model was a part of her role (as a Ward Manager) and ‘*probably*’ for all staff she interacted with. She reported ‘*I don’t want them to think I’m afraid to get my hands dirty because I’m not, so I do role model in that way a lot yeah*’ (Alison, Ward Manager, Acacia) fortifying her position of being in the front. Jane’s view (as Band 6 Sister) reflected a temporal and experiential perspective. She felt that her behaviour was observed, having become a role model as soon as she was not the newest member of staff as a Band 5. She progressed from being a role model as a mentor specifically when supporting students, to becoming someone who was generally more conscious of being a role model. She recalled her own experiences and modified her behaviour in response to this.

Paul's perception was linked more to the mentorship aspect rather than his operational role, he saw himself as a role model in this respect:

'...oh hugely when there's students, before I was a mentor, students would say, ooh you would make a really good mentor, you've got us doing lots of things, you let us do as much as we want to do as safely as possible... I was like really? Oh ok, so then I went off and [did] my mentorship, but until then I didn't really think, I just focused on the job and made sure the patients were ok...' (Paul, Staff Nurse, Acacia)

The nature of the mentor/student relationship being explicitly linked to learning through observing a role model. This has been studied extensively in pre-registration education and as a conscious teaching strategy frequently encountered. The nature of the individual attributes influenced Bahman-Bijari et al.'s (2016) students when choosing role models. Morgenroth et al. (2015) propose that role models motivate the behaviour of individuals and inspire them to set goals. The commonality between role modelling and leadership was seen in terms of inspiration by Jane (Band 6) and Paul (Band 5), they viewed role models and leaders as sources of influence across the range of roles within their team and couldn't easily distinguish between the roles:

'...people who are above me and people who I'm in charge of you know as well ... I think there is definitely people in the team that kind of seem to jolly everyone to give the best of themselves ...' (Jane, Junior Sister, Acacia)

Alison identified similarities in role modelling and leadership from an aspirational perspective, saying that a role model and leader would want to be the best and act accordingly, however she discriminated between these by virtue of intent. She said that a leader would facilitate people toward ways of working whereas a role model would try to be that person. Perry's (2009) exemplary nurses were outstanding role models, these self-aware individuals attracted followership and were in essence leaders. They weren't necessarily positional leaders, however the impact on followers was similar. Alison's comment linked to intent of the leader rather than conscious embodiment of the role.

4.6 Introduction to Beech Ward

Beech ward was a day ward specialising in cardiac treatment. The ward formed part of the Trust cardiology services and included an outpatient department. It provided a service for in-patients and elective admissions. Generally, there was one theatre list in the morning and one theatre list in the afternoon. The ward undertook cardiac investigations such as angiograms¹³, as well as treatments such as cardioversions¹⁴ and pacemaker fittings¹⁵. The ward was open Monday to Friday, closing at 8pm. Patients were consciously sedated and generally only an in-patient for the day.

The last four decades has seen much progress in technology and applicability to the treatment of obstructive coronary heart disease (Banning et al. 2015). A redesign of services, corresponded with the national efforts to address the challenge of cardiovascular disease as the leading cause of death worldwide and continues to be high on the agenda (Public Health England 2019). The number of people being referred for elective consultant led treatment is around 1.7 million with significant development of pathway design to reduce avoidable demand and ensure patients are being cared for in the most appropriate setting first time (NHS England 2019). Cardiology services are increasingly provided on a network basis (Royal College of Physicians [RCP] 2019) and it is essential that these services are appropriately equipped, the staff competent and the cases appropriately selected (Banning et al. 2015). The team on Beech ward were multi-professional and as advocated by the RCP (2019) included roles for specialist nurses, physiologists, medical staff and radiographers.

4.6.1 Service setting

Beech ward had 12 beds, two bays of four beds and four side rooms, these were divided mid-way by a wide corridor type space with an entrance to the

¹³ An angiogram is part of a procedure that provides information about the structure and function of the heart (NHS 2020)

¹⁴ Cardioversion is a treatment that uses electricity to shock the heart back into a normal rhythm (NHS 2020)

¹⁵ A pacemaker is a small electrical device that can be surgically implanted to send electrical impulses to the heart to keep it beating regularly (NHS 2020).

operating theatres on one side and entrance from the waiting room on the other. This case focuses on how being prepared and ready to care for patients in the ward was based on core and technical skills. The themes reflect how the Ward Manager was an integral part of the operational team and acted as a role model and professional leader in the middle of the team (Figure 7).

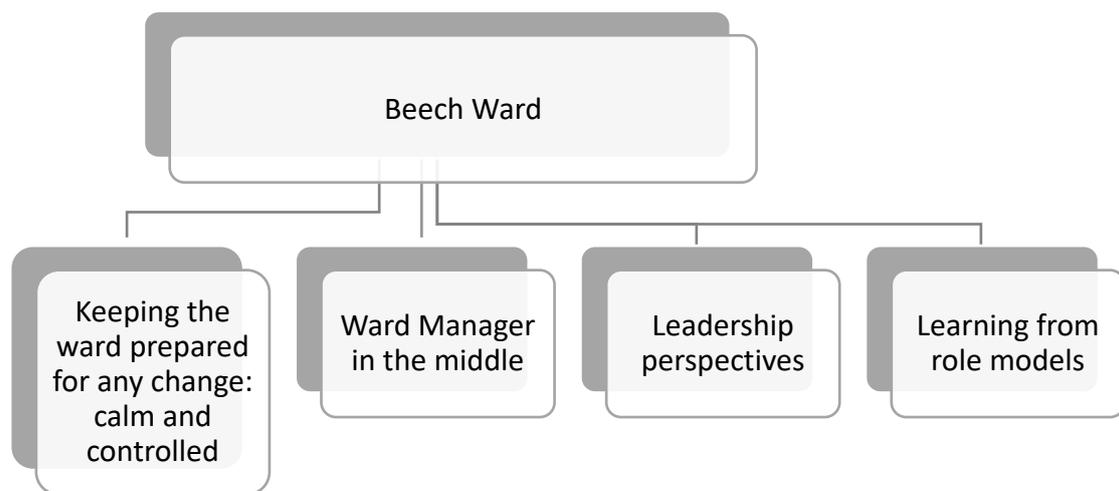


Figure 7. Themes on Beech ward

Access to Beech ward was protected. The ward was not open entry, the entry doors were locked centrally by reception and ward staff. Staff were able to gain access via a staff ID card reader, whereas patients and relatives were given permission to enter the ward via a call buzzer system operated by staff. On entering the ward, on each side was an open 4 -bedded area. This was split by a wide corridor type space to theatres. There was a big notice board in the desk area at the back to one side of the theatre entrance, this was out of general public sight. This space had two chairs and two computers and screens. To the right side of this on the wall there was a shelf with folders on. On the opposite wall a white board was marked with bed spaces. The white board had squares marked for recording names and information. In the

doorway to the waiting room corridor there was information for patients and a 'staff on duty' board saying who the shift coordinator for that day was. There was also a display of how the Chief Nursing Officer commitments to support nursing, midwifery and care were applied locally to the division. Other than this the walls were plain; the ward was open plan and it looked new and clean.

The ward was managed by a Band 7 Ward Manager, Jill, who also had responsibility for cardiology (inclusive of outpatient clinics) and the recovery area. There were three Band 6 nurses, a range of staff nurses at Band 5 and healthcare assistants who made up the ward nursing team (Table 6 below for interview participants).

Name	Band	Role
Jill	7	Ward Manager
Claire	6	Junior Sister
Teresa	5	Staff Nurse
Laura	5	Staff Nurse

Table 6 - Names and banding of participants on Beech ward

Being part of the original inception of the ward and ward as a whole had enabled Jill to think about her role in the service's development. Taking a step back and being open to new ways of working and fresh perspectives had created an ethos of improvement:

'...we're all for doing that constantly reviewing what we're doing, why we're doing it that way, is it best for the patient, is there another way of doing it... and that's really helpful what we want to avoid is people becoming sort of task orientated, do this do that... it's about interacting with the patient ... is this new diagnosis, do they need to know about angina, how to use the GTN spray ... do they want info or much more, it's sort of gauging what the patient needs from you...' (Jill, Ward Manager, Beech)

The staff came on shift at different times in order to meet service demand, some at 0700, some at 0800 and some at 0830. There were busy periods: at the start of the day admitting patients, preparing patients for their treatments, taking patients to and fro from theatres, monitoring patients during recovery

following treatment and then discharging those patients. This was repeated from late morning for the afternoon theatre list. During peak activity periods, there was little verbal communication until direct care tasks were achieved, the atmosphere was one of *'industrious quiet'* (Field note 2.7.43) and *'quiet efficiency'* (Field note 2.7.45) all staff were occupied, and no chit-chat was heard. Reflexive field notes describe the overall atmosphere (Box 2 – reflective vignette).

Beech

I stand near the entrance, I can see the desk but not the patients...there are staff at a small desk, all wearing scrubs (I don't know who is who) ... the ward manager said they have fought to keep them [scrubs], the Trust wants nurses in uniforms...there is a quiet beep of a monitor in the background and occasionally the whooshing sound of the echocardiogram.... when the nurse call buzzer goes it's loud and makes me jump ... it's quiet, at least half of the staff are waiting...the atmosphere is different to a ward on here, there are no windows, it's ok though... those delivering patient care are purposeful – others willing to help when asked and offer the same.... maybe a peaks and troughs kind of place.... staff must know what to do when they need to... a relaxed atmosphere – calm.... like 'efficiency in the background' – getting on with work quietly.... not much general noise from patients ...odd laughter from staff...I realise the shoes make it quiet! They were nearly silent...only that squeaky noise on the clean floor.... up and down... (Field notes 2.5.1, 13, 23, 25, 45, 2.6.6, 41, 2.7.22)

Box 2. Vignette Beech ward

Participants were motivated by the nursing care they delivered. This was contextualised within the service model and how patients needed to be prepared for their investigations and recovered after their treatment. Nursing and care activities, direct and indirect, were carried out seamlessly, two or three nurses to each patient. Each participant offered a contribution to this common desire. They described *'spending time with my patients making them happy'* (Laura, Staff Nurse, Beech) and *'looking after the patients and making them better'* (Claire, Junior Sister, Beech) as incentives. Teresa adding:

'One of the biggest things that motivates me is seeing the difference between patients who are very anxious and patients who have been

carefully prepared for their procedure and therefore not so anxious ... and good sort of old-fashioned nursing care.' (Teresa, Staff Nurse, Beech).

The participants were motivated by receiving positive feedback from patients as well as perceiving that they provided a smooth efficient service. The episodes of care were brief and time for patients in the ward short, so swift engagement was necessary. This temporal aspect influenced the activity of the team and enabled them to see '*... the difference between patients who are very anxious and patients who have been carefully prepared for their procedure and therefore not so anxious*' (Teresa, Staff Nurse, Beech). Occasionally a patient was admitted to another ward for further treatment. Jill revealed that this often came as a surprise to a patient who thought they were going home after their treatment, having been relatively well and maybe at work the previous day.

4.7 Keeping the ward prepared for any change

Activity in the background ensured that the team and ward were ready for care delivery. This theme demonstrates how this activity set the flow and pace of the clinical environment and was instrumental for everyday team working and the calm, controlled clinical climate as revealed by Claire:

'...I try to be working, be always thinking ahead of things... like this morning I'm working, we're doing pacemakers but I'm very aware we've also got PCIs which need to be done as well so I'm thinking ahead, thinking you know... the staff in the xxx can also do PCIs, all the staff and we've got more PCIs than pacemakers so they're going to flip this list over so I was all ready I had the trolleys out ready, you know you're forward thinking it ... there's no delay we can get the patients through.' (Claire, Junior Sister, Beech).

The ward needed to have beds and equipment available in order to prepare the patients for their investigation or treatment in a timely way, this reflected an efficient approach. The expertise of the staff was tacit and reassuring, from the way that they interacted with one another, to helping each other out as seen in this field note example '*Smiling and helping each other....'where are you up to?*' (Field note 2.5.45). The staff on Beech completed care delivery as a team, overlapping with each other without verbal requests.

Edmonds' (2017) research aimed to explore the stories of patients, carers and nurses surrounding their experiences of Primary percutaneous coronary intervention (PPCI)¹⁶. She presented these experiences as voices based on emotional states aligned with feeling ill and feeling well. Edmonds' (2017) literature review identified six voices that reflected different emotional responses, reactions and behaviours. Some of the concepts resonated with the context of my study, the rationale for why and how participants responded to patients and behaved with each other. For example, Edmonds (2017) discussed voices from a patient's perspective, one was the 'quiet' voice. This was a patient who is struggling to come to terms with what is happening to them as they feel relatively well but are waiting for treatment. Participants in my study referred to preparing patients for their treatment and soothing their anxiety:

'One of the biggest things that motivates me is seeing the difference between patients who are very anxious and patients who have been carefully prepared for their procedure and therefore not so anxious ... and good sort of old-fashioned nursing care' (Teresa, Staff Nurse, Beech).

According to Edmonds (2017) the 'knowing' voice represents the way that patients and carers felt managed by healthcare professionals who knew what they were doing. The technical skill of the nurses on Beech represented 'knowing' and acted as a motivator, as seen in the example above.

4.7.1 Being ready for anything

The staff on Beech ward moved in and out of the ward, to theatres, for breaks, to other departments and into the office often. This sub-theme explores the impact of this way of working. The filtered access to the ward meant that although at times there were several different professionals present, this was not as high as in a general ward context. The ratio between qualified and non-qualified staff was high, although as previously mentioned it was not clear from a distance who was in what role. I noted that the ward had *'that industrious feel, high ratio of trained staff – 2 or 3 get a patient ready for*

¹⁶ Primary percutaneous coronary intervention is a procedure that widens the coronary artery (NHS 2020)

theatre it appears... slick' (Field note 2.6.42). The core activity centred around quick responses to care needs which enabled staff to be available and ready for the next task. Whilst no urgent or emergency situations were observed, the prevailing atmosphere was that of an organised, efficient environment. The ways in which the staff enacted their roles contributed to the controlled ambience of the ward. The staff moved swiftly with purpose and although they frequently assisted each other this was undertaken without obvious interruption:

'...sometimes when you're doing a patient's vital signs you know.... it's time to get a jug, everyone knows each other, so you'll see someone doing a blood pressure and someone will go up regardless of grade and say do you want me to get that tea and you'll sort of help.' (Jill, Ward Manager, Beech).

On Beech ward, staff ensured that the ward, bed spaces and equipment were all ready for admissions, undertaking known and necessary tasks in order to prepare and be ready for any change, simple activities like those illustrated below performed without prompts:

'All behind curtains – admitting patients' (Field note 2.6.9)

'NA1 tidying notes trolley' (Field note 2.7.6)

'RN5 general tidying, up to the room at the top' (Field note 2.7.18)

Claire summed this up:

'I think it's the ethos certainly out in recovery, it's all much of a muchness, the emphasis is on getting the patients ready to get them through for their procedure so we don't want any hang up... you know more or less we can all do the same jobs and it's just a matter of in the morning just get in there, get the patients ready, do you need a hand to have it done, I don't care if I admit, cannulate or shave it's,... everyone is everyone, some people can't cannulate so you go in and cannulate for them... you just do it don't you. You get the patients ready.' (Claire, Junior Sister, Beech)

Indirect care activities were attended to without delay and the ward kept tidy and clean. This also supports the research of Edmonds (2017) who extracted 'routes' for nurses– these included 'getting the job done' and 'taking a familiar route'. In Edmonds' work, part of 'getting the job done' was about being ready, which meant that activities such as packing the trolleys were completed in order to mitigate for not knowing the condition of their patients. This was also linked to recognition of possible complications and anticipating problems.

On Beech ward the white board in the desk area, informed activity and allowed all staff to see at a glance direct care needs. Direct care needs were based around monitoring and recovery following sedation. When patients returned from their procedure they were observed very closely. Prior to this there was a feeling of waiting, standing around, staff busying themselves with low key tasks, tidying, re-stocking, keeping ahead, I was told *'when people come back from theatre they will be on half hourly obs. Another group of patients will be coming in later this morning as well'* (Field note 2.5.33). However, as soon as a patient arrived, they congregated in the bed space together, *'3 staff straight over plus doctor'* (Field note 2. 5. 40). The protected environment provided a relatively uninterrupted, predictable way of working which was cogent with the rhythm and flow of theatres. Fluidity was achieved by ensuring that staff knew what was expected and when it was expected, irrespective of role:

4.7.2 Managed calm to reduce potential anxiety

The prevailing light mood is the focus of this sub-theme, it was calm and balanced by attention to the technical nature of the specialist service. There was time to complete tasks at the start of the shift and prepare for the expected patients. The overriding environment felt relaxed and calm as noted in separate observational sessions: *'general atmosphere feels calm and relaxed'* (Field note 2.5.27), *'– calm – efficiency in the background.'* (Field note 2.6.41) *'The pace and ambience is calm'* (Field note 2.7.80).

The staff relationships appeared to be a constant in this closed environment. Getting to know each other as people as well as colleagues reflected a different aspect of team working aside from providing a professional service. The calm environment was evident in the easy familiarity between staff, this was considered by Jill to be part of getting to know someone, she said:

'Yes we've got quite a few with a dry sense of humour, you have to get to know the person but know where to draw the line... we have that with not only nurses, but doctors as well it's nice, helps to release, just relax the moment... it makes you work better as team if it's not just... I don't know you appreciate them as a person, not only their role as a

nurse but acknowledging them as a person, a different relationship going on as well (Jill, Ward Manager, Beech)

There was a sense of this being formed in relationships and part of group development, about getting to know personalities, Teresa felt that:

'When you are a valued member of the team and you feel appreciated, I think it doesn't necessarily matter what your role is, you're part of the whole, that's a happy place to be ... especially if the work you're doing is having a positive effect on your patients, relatives and so on' (Teresa, Staff Nurse, Beech)

This synergistic working was rooted in confident easy exchanges which ensured that staff knew what was expected of them and when:

'When not undertaking a task or specifically delivering care the staff chit chat about anything.... but as soon as they need to they get back on, almost like a switch...there in the background' (Field note 2.6.59)

Thus, the staff switched seamlessly between interacting with each other socially and delivering care. Although they chatted this was at a relatively low noise level and ceased whenever staff were engaged with direct care activities. Staff would stop almost mid-sentence, carry out patient care and then resume their conversations where they left off as illustrated here: *'General chitchat interspersed with a clinical comment....'has bed 3 gone down yet?* (Field note 2.5.47). The staff good-naturedly teased each other when waiting for patients to come back from theatre. This was extended to the me as the researcher, *'.... toe trodden on by another.... called over Rachel, did you see that? The other said 'I barely touched you' they all laughed...'* (Field note 2.7.67). They showed interest in each other's lives and chatted freely and easily with each other. This contributed to a feeling of value and security which in turn generated a positive effect on the patient. In the midst of this 'preparedness' social engagement between staff was perceived as a means to release the moment and relax, the tone being set from senior staff. This mirrors the work of Cope et al (2014) who found that social support provided by colleagues, families and friends contributes toward being resilient.

Staff articulated a confidence in each other and were always available to support each other if necessary. Knowing what to do and when to do it provided a means to exert control and created a sense of comfort and

confidence, familiarity means that nurses perform tasks known to them (Edmonds 2017). Teresa felt that the '*person at the top set the tone*' (Int 5.2.21) for service delivery. As well generating trust and commitment, teamwork plays an important role in the provision of a safety culture, leadership having a critical role (Jarrett 2017). Feedback from patients was seen to reflect the '*pleasant, happy team*' by Claire. Using humour and laughter was considered not only as a means to manage stress in staff but important for the care also. It was used to enhance the mood and atmosphere therapeutically for patients who may have been quite anxious and in doing so created a controlled clinical environment. When approaching a patient with a colleague to take an extra blood pressure, the staff said, '*we are here to attack you*' (Field note 2.7.12) this was said with very open nonverbal cues, smiling and the tone was light, jokey and soothing, with the implicit intent to alleviate anxiety. Throughout the patient interactions the technical know-how was in the background waiting, with staff presenting their interactions in an informal manner but ready to adjust in response to the immediate clinical situation.

4.8 Ward Manager in the middle

This theme focuses on Jill, the way she interacted with her team and contributed to care delivery. On a specialist type environment such as Beech ward, the 'person' aspect of Grint's (2010) typology plays an important part as the expertise required is essential. As a Ward Manager, this was combined with 'position' and from a flatter, rather than hierarchical, expert context 'process'. When not in the office for brief periods of administrative work, Jill maintained direct patient contact and worked in the middle of the team. Jill was a technical expert delivering care similarly to the experienced registered nurses (RNs), in addition to having a managerial function that was carried out away from the ward in her office. As a leader, Jill, felt that she had a duty to perform to a certain standard and that staff were reliant on her, reflecting recognition of her role expectation and position. In their investigation of the ward sister and charge nurse role; the Royal College of Nursing ([RCN]2009) found that their participants described leading nursing in order to deliver safe,

high-quality care as an expert clinical practitioner, as the main purpose of the role. Jill felt that offering guidance and support was part of her role. The RCN (2009) found that the role was not without challenge, the sheer breadth of it, which included leadership and management, clinical practice, education and teaching, resulting in significant pressure to be successful.

Jill's perception of professional leadership effectiveness was linked to maintaining a patient focus. She needed to have the courage to uphold this and be an advocate, although this could potentially result in unpopularity at times. When describing leaders, Jill felt that:

'...they shouldn't be judgmental, they should be good listeners, they should be up to date they should know what they're talking about, I also feel, I don't know, you shouldn't ask somebody to do something you're not prepared to or can't do yourself.. [...]... ah it still should be patient first focused. But sometimes your priorities change...but I always try to put the patient first, that is my priority and sometimes I become unpopular... but I'm not here to be popular.' (Jill, Ward Manager, Beech)

This illustrates the interface between Grint's (2010) 'person', who you are, 'position', your positional role and 'process', how you do things. There was a delicate balance between upholding beliefs and values and having to take courses of action which did not meet these. Pegram et al.'s (2015) study, exploring the aspects of working life and views of a ward manager, provided an insight into their job satisfaction, occupational stress, professional identity and organisational commitment. They found that whilst the multifaceted nature of the ward manager's role can be a source of satisfaction it is also a source of occupational pressure suggesting a complex relationship between both. Clinical leaders in Stanley's (2008) study, were identified as those who, when faced with challenges, remained true to their values and beliefs about care. This was a significant factor for Stanley's participants when identifying clinical leaders and can reflect contemporary challenges for clinical leaders.

Jill wanted to remain involved clinically, not only to contribute to care but also to retain her skills, she said that she urged her staff to do this and lead by example. Jill's clinical role demonstrated a technical know-how which was also displayed by other RNs, there was a level of equity associated with the

nature of care required, which meant that formal position was not easily distinguishable between RNs. Coupled with this, the staff on Beech wore theatre scrubs instead of uniforms. Their lanyards indicated what role they were, for example, 'nurse', 'doctor', other staff in attendance included radiographers, physiologists and theatre staff. This meant that visibly there was no overt explicit delineation between Jill and the other staff either. In relation to wearing scrubs Jill said that the ward:

'... managed to keep them... 'fight for it' because of having to go to theatre. Trust would prefer nurses to wear uniforms... By way of compromise, if there is a clinic they wear uniforms.' (Field note 2.6.6)

The Trust had invested some resources into uniforms and enhancing the profile of all nurses across the bands in the organisation. Not wearing a uniform masked the difference between nursing bands and other health care professionals which was usually apparent when wearing different uniforms. This meant that Jill looked the same as the other nurses on the ward. Staying involved in patient care and modelling good practice was considered an important part of being a ward manager and effective nurse to Jill, this could be construed as the core of her professional identity. The divide between being a manager and nurse can be difficult to navigate, it can be considered two different jobs and take the nurse away from the patient. Croft et al. (2015) suggest that one of the challenges for nurses when constructing a leader identity, is addressing the differences between the leadership identity and their professional identity. Jill also reflected that her ideas of leadership had changed:

'I've changed my idea of leadership...when I came into this post I was ok, I was a Band 6 and I was clinical, not managerial, I found the shift very difficult, still do...it took me a long time to realise that it was ok to say I don't know how to do that as I've stopped doing that ... it's not my role anymore and my role has changed, I've found that quite difficult to accept, I still make sure that I'm clinical because, one, I have to because of the numbers but also it's a skill I don't want to lose...' (Jill, Ward Manager, Beech).

As the formal leader with overall responsibility for the ward, Jill recognised the duality in her role. The nurses in Croft et al.'s (2015) study associated positive emotions with their professional group identity, they experienced identity

conflict around the loss of this and the feeling that they were no longer able to formulate a nurse identity in the same way. This resonates with Jill's description.

4.9 Leadership perspectives - Qualities and skills

On Beech, the participants expressed their understanding of leadership largely in terms of behaviour and impact, which was not obviously aligned with Grint's (2010) formal 'position' (Appendix 13 - Example of raw data extract Beech – 'leadership'). This theme examines how a good leader was considered to be a role model on Beech ward, leading by example and worthy of emulation. Claire suggested that being professional and knowledgeable was important as well as being able to see outside of the current situation into the bigger picture:

'...it is the foresight, seeing the bigger picture umm just juggling everything together you know they've got their eyes everywhere and they can see, they can think outside the box ...' (Claire, Junior Sister, Beech)

Claire also felt that *'Leadership is where you are going to take ownership of something and you're going to take it forward'*. Leadership was considered to be concerned with supportive, guiding behaviours, being able to listen, being non-judgmental; being unafraid of talking to people, making difficult decisions, acting assertively and sometimes being slightly aloof. Laura felt that leadership included:

'Strength, assertiveness, delegation skills, somebody who is not afraid of talking to people, not controlling them but just organising and having some kind of order' (Laura, Staff Nurse, Beech)

Teresa considered leadership as a privileged position:

'...there's quite a lot of responsibility that comes with that and a bad leader would be somebody who is using their status and power perhaps for selfish ends rather than for the good of the whole.' (Teresa, Staff Nurse, Beech)

Claire felt that some people were *'natural born leaders'* in that they appeared to be able to function well and could cope with several competing demands, she stated:

'...the really good ones think outside the box but not just about one problem but about several problems and sometimes it's boggling me because I'm not a natural and I have to sometimes just step back and think right what have we got to do here and it's you know ticking away in my brain and you can see a natural leader and they just go bosh and do it and you think why didn't I think of that.' (Claire, Junior Sister, Beech)

In this instance the notion of a 'natural born' leader appears to be in reference to the ease with which an individual was able to act as a leader, Claire said. *'...it just oozes from them everything just seems to be streamless, they don't have to think about it they just do it.'* Shamir et al. (2005) found that one of their major themes centred around leadership as a natural process and offer two perspectives. The first being the story of the 'born' leader who acts as a leader from an early age, and the second, being those who come to leadership later in life but possess the inherent talents and tendencies that surfaced at the appropriate time. Both of these examples of leadership were considered to be part of a natural process, inferring little effort or struggle and similar to Claire's remark. This could be aligned to personality. In keeping with trait theory some individuals may inherently possess qualities, attributes and skills, which are associated with leadership behaviour, whereas others have to develop these consciously. The link being that qualities and attributes are displayed through behaviour. The leadership literature supplies a set of leadership qualities, attributes and skills that arguably any individual can learn. Northouse (2016) questioned whether trait theory research has ultimately provided an extended list of traits that individuals aim to display, develop or possess. They are not restricted to those in a leadership position, hence the premise that anyone, at any level, can behave like a leader. Northouse (2016) suggests that some individuals see leadership in this way which is indicative of thinking that aligns with a trait approach to leadership.

Participant's perceptions of self as leader were related to the possession of experience, knowledge and position. Claire was relatively new to her role but could see that others followed her:

'Well I know that because they will come to me with problems cause I've only recently become a band 6 on here anyway, so it's a little bit difficult, because I have been a band 5 here and then been given the

band 6 and I know that people are already thinking of me as that leader type role, I've got my own team and they're coming to me with problems and things for me to sort out, advice and I know the other staff nurses as well and health care assistants are using me as well so I'm thinking yeah they're actually seeing me in that role now so...
(Claire, Junior Sister, Beech)

Neither staff nurses on Beech, Teresa or Laura, saw themselves as leaders with any conviction, however Laura felt that knowledge and confidence enabled her to lead in a specific clinical environment where she had expertise. In contrast, Teresa described how recognising herself as a leader was affected by the tensions of a hierarchical culture:

Researcher Do you see yourself as a leader?

'... yes, but perhaps with a small 'I' (laughs)... I think there are skills and abilities and experience that I've got, gleaned over the years that I think are useful and valuable but ... (Teresa, Staff Nurse, Beech)

Researcher – Do your colleagues see you as a leader?

'...some of them may do but I think we're still a bit trapped in the sort of... I can't think of the word really... sort of hierarchy set up where some people are very conscious of what band or grade they are and don't always treat lower grades with the respect that perhaps would be helpful ... (Teresa, Staff Nurse, Beech)

Despite this, Teresa utilised skills and attributes that she had developed, to support, advise and encourage others on a more informal basis. Informal leaders have power and influence, this is gained through performance and behaviour rather than position, they contribute to team norms and values and coordinate effort (Downey et al. 2011). The impact of a leader was seen directly in terms of positive and negative. Claire felt that:

'...a good leader would make you feel quite happy umm you know that you could try things if it's not going to work, it's not a failure, you've not done it wrong, you've tried something and it's just not worked at that particular time therefore they will give you the positive encouragement that you would like to try something differently to see if that would work.' (Claire, Junior Sister, Beech)

In addition, having the ability to either make staff feel like they were '*doing a good job*' (Laura, Staff Nurse, Beech) '*important and valued*' (Teresa, Staff Nurse, Beech) or conversely '*demoralised*' (Claire, Junior Sister, Beech) and '*demotivated*' (Teresa, Staff Nurse, Beech) depending on whether good or poor. Stanley's (2006a) study talked of an approach to leadership based on a foundation of care that reflected beliefs and values. Leaders were identified at

all grades of staff and reflected an operational perspective, followers being attracted to leaders because of the 'banner' they carry. Leaders were seen to have a 'hands on' role and be approachable and visible. This may have impacted leader perceptions as in specialist areas leaders were identified in both junior staff and 'G' grade nurses, whereas general areas saw leaders more in junior roles.

4.10 Learning from role models to being a role model

This theme explores the space between learning from a role model to being a role model: the dynamic trajectory between the two. Seeing a colleague as a role model made participants feel proud to be working in the same team and confident in the effectiveness of their care. Jill suggested that attention to personal role modelling meant showing others what you expected to happen, she describes this as:

'... ummm role modelling I would say is leading by example, showing others what you expect to happen....people look at another individual and that's how they learn, they may learn how not to do something or, it might be positive or negative but it's just by observing other people's behaviour.... The way they behave the skills...' (Jill, Ward Manager, Beech)

Conversely, role models also made participants feel inferior, Claire suggesting

'...sometimes very inadequate (laughs)... I think because we all have those days when you know you come into work or you're at home and you just not 100% and you're not completely on it...' (Claire, Junior Sister, Beech)

A variety of concepts not unique to a position or person were revealed. Jill, as Ward Manager, saw the potential in all, *'everyone is a role model... it doesn't have to be to junior staff it can be to for everyone up or down'*. Teresa felt that role models were self-aware and recognized their own strengths and weaknesses, she recognised this in herself as a role model:

'I wouldn't say I'm perfect, but I've been around for quite a long time (laughs) and I think one of the things that I feel I'm quite good at which may be partly a personality type thing is an awareness of how other people are Just sensing somebody is having a good day or not... whether that's a patient or a colleague and ... sort of helping to ease things along' (Teresa, Staff Nurse, Beech)

Being a role model was seen as leading by example and being inspirational. All participants were able to identify role models who they drew on and gave examples from their past and current situations (Table 7 below).

<p><i>Jill, Ward Manager</i></p>	<p>– several yes...yeah – one of the doctors well, several of the doctors, one of the doctors particularly, he can doing a complicated case in theatre and I can see by my eyes that it's not going well... but if you didn't know what he was looking at you would never know, he keeps very calm he is very aware that if he gets panicky it will affect or impact on the whole team and it won't be very productive...so his calmness I think is brilliant, one of my band 6's is never a problem she's never defeated, she will always look for an answer... senior people um, to be honest quite a few I look at and think I won't do that or I would have done that differently... another senior manager I had I, now whenever I do something think would she have done that... she was very very professional, some areas she wasn't 100% in but she always respected confidentiality which I hope I do I do think would she have done that</p>
<p><i>Claire, Junior Sister</i></p>	<p>– yes I can.... - Probably more than one, certainly I have my work role model and my home role model</p>
<p><i>Laura, Staff Nurse</i></p>	<p>– yeah yeah I can - several of my best friends are role models, I look up to them, my parents, there's colleagues here obviously doctors, yes there's more than 1... I look up to a lot of people because I always feel that I'm slightly beneath them (laughs) – there's one doctor in particular, it's the way he talks to patients, it's almost like they were mates basis, he makes them feel really relaxed to begin with umm it's the way he talks to them uses their language he doesn't use all the technical terms and if he does he asks them if they understand and breaks it down for them , he just puts them at ease</p>
<p><i>Teresa, Staff Nurse</i></p>	<p>– yes... somebody who is experienced as a nurse, been here quite a long time, always manages somehow even if things are stressful, manages to keep her sense of humour , who when things are not quite so hectic will offer a cup of tea or just a bit of chit chat over lunch or whatever ... and yeah somebody that I feel I'm confident in how they treat their patients and other members of staff</p>

Table 7 - Participants' role models on Beech

The multiple role model aspect is reflected in the work of Gibson (2003) and his dimensions: the structural dimension referring to 'close/distant' to indicate

availability of models. Role models from within the case team would be considered 'close', these were those most frequently observed, whereas friends, parents and early educationalists would be 'distant' as not observed as often on a day-to-day basis (Gibson 2003). Claire and Laura cited friends who they considered role models; because they were able to manage and 'juggle' home life effectively as well as confident and experienced colleagues who demonstrated key behaviours to be modeled, for example, managing to retain a sense of humour and display tenacity and commitment. Jill admired colleagues who managed emotional environments through skilled communication, picking out one doctor in particular:

'...one of the doctors... I can see by my eyes that it's not going well... but if you didn't know what he was looking at you would never know, he keeps very calm he is very aware that if he gets panicky it will affect or impact on the whole team and it won't be very productive...so his calmness I think is brilliant...' (Jill, Ward Manager, Beech)

Leaders were viewed as role models by virtue of their behaviour. Bandura's (1977) salience aspect in the attentional phase aligns with the notion that people choose their role models for subjective, context specific reasons. Those reasons being meaningful to them at that time. The conditions within which each participant viewed their leaders as role models could be attributed to frequency of engagement with the leader, the nature of the relationship, impact on their everyday role and perceived worth. This was influenced by personal definition of leadership and perception of who the leaders were. Claire suggested that leading as a role model was intentional: '*lead everyone into how you want to work*'. Teresa discussed leaders who she viewed as role models from within the team on the basis of their qualities and skills:

'...I would put things like courtesy and respect as being desirable aspects of a good role model ...willing to work hard but willing to kind of give a bit of slack, a bit of give and take Mmm somebody that would support me and others in their role' (Teresa, Staff Nurse, Beech)

Claire acknowledged that the nature of the care environment made the ward isolated from the wider division, she viewed external leaders as role models in an abstract way:

'...yes certainly from the managers you see outside of [ward name], yeah they have their fingers in a lot of pies don't they and how they keep it all level headed is beyond me' (Claire, Junior Sister, Beech)

The perceived connection between role modelling and leadership was ascribed to the positive aspects of being a role model and a leader and difficult to separate by the participants. Claire and Teresa saw being a good role model as part of being a good leader. Jill, whilst acknowledging that they were connected also felt a difference could exist.

'...a stranger could come in here and become a very good manager but not have the clinical knowledge because ideally she wouldn't need the clinical knowledge it should run on its own.... I think a good leader needs to have an awareness of what's going on out there so that you can empathize with your staff...' (Jill, Ward Manager, Beech)

She contrasted leadership with management, a good manager not necessarily having the clinical knowledge or empathy of a professional leader. Jill's perspective illuminated the affective element of empathy as an important leadership attribute. The positive aspects of leadership, such as having empathy, being supportive and caring having been associated with good role modelling. Perry's (2009) exemplary nurses demonstrated a willingness and recognition that they were role models, they were also open to learning from role models themselves.

4.10.1 Anchors for behaviour

This sub-theme illustrates how role models acted as anchors for behaviour and aspirations; they were recalled as those who should or should not be emulated and as a point of reference both positive and negative. This was derived from how the perceived models behaved; from being efficient and effective, using experience positively, possessing effective, balanced interpersonal skills, to being emotionally intelligent. In formal roles, such as, mother, team leader and mentor, being a role model was identified as an expectation of that role. Jill remembered a senior manager *'.....whenever I do something, I think would she have done that...'*. Claire described how this could have a positive impact if the learned behaviour had been achieved *'... if that person was here and they saw me they would think yeah you're on it...'*

Each participant acknowledged that they themselves were a role model to someone, this however varied according to when and where. Jill admitted that she did not recognise herself as a role model until she gained some experience and seniority as a nurse:

'Probably not until I became a Band 6 senior nurse and I think only then because I was working with another Band 6 and the next person was a HCA...the manager then went off sick so it was my colleague and I who were also overseeing Band 5s...but I never saw it as a Band 5, as a Band 5 I just got on and did my job...' (Jill, Ward Manager, Beech)

This may be reflective of a growing self-awareness. It can be compared with Benner's (2001) work on excellence in nursing practice, the trajectory of a nurse from novice to expert. At the proficient stage (more senior staff nurse level) the nurse is able to see the 'whole' and see practice in terms of long-term goals.

Claire's wistful tone suggested that the perfect role model was out of reach:

'...oh it's just really efficient, effective...it's you know people just get on and do things don't they and they're just really efficient and effective, and the people just get on and do things, people just get on and do things, they're chirpy all the time you know and they're that ideal person that you want to be...' (Claire, Junior Sister, Beech)

Although a new team leader, she recognised that she was a role model to other members of the team, and as a result had tried to work in a broader, more anticipatory way.

'I think you have to be aware of that all the time really don't you , because you need to be giving the best care and I always think what care would I like to be given and that's how I know what care I'm giving, because if [that's] what I would like to be receiving and that's what I always say to students , always give the care that you would want to receive ...' (Claire, Junior Sister, Beech)

Laura said, *'I try to be a role model for my children for example, I want them to see me work hard and go to work every day and study and just to try and be a good person all the time'* (Laura, Staff Nurse, Beech). Conversely from a work perspective Laura did not see herself as a role model explicitly, indicating a positional tension, she said:

'No not really... I try not to have any ideas above my station really, I hope that I am for example for students, yeah I like to think I am for students I know what I'm doing here and I like giving that information to students and I like to make them feel comfortable because I can remember what it was like when I was a student and had some good experiences and some really bad ones so I always try to explain everything.' (Laura, Staff Nurse, Beech)

Teresa remembered being on show early on in her career:

'...ummm I think probably just coming into nursing which is many years ago but as a student nurse it was quite clear that we had quite a lot of responsibility even though we weren't top of the authority tree (laughs).' (Teresa, Staff Nurse, Beech)

When recalling when she first recognised herself as a role model, Claire stated that:

'Ooh I think it's got to be years ago, I think something probably I realised when I was mentoring students way back and they are copying you, they are literally following you round doing what you're doing and you're thinking if I do anything that I shouldn't be doing, if I'm doing anything wrong they potentially could be copying that.' (Claire, Junior Sister, Beech)

As novices, students are sensitive to those that guide them and can initially be unaware of variances in effective practice. Role models play a critical role in influencing students' motivations and choices of behaviour (Burgess et al. 2015) and thus this relationship is consequently very influential. In Bluff and Holloway's (2008) study, student midwives shared with each other the negative ramifications of not conforming to their role model's expectations of how to perform. The student midwives identified not doing so was risky, as conforming to their mentors' ways of practicing enabled them to access the learning opportunities, they needed in order to pass their placements. Nevertheless, Donaldson and Carter (2005) had previously discovered that students expected to be able to identify a good role model advocating that this must be the subject of any role preparation that supports practice learning.

4.11 Introduction to Cedar Ward

Cedar was a short stay medical ward; it was a busy care environment. The service parameters dictated that patients should only be in the ward

environment between 48 and 72 hours. Short stay medical wards were introduced in acute hospitals in an attempt to improve patient flow (Powter et al. 2014) and reduce the length of stay (Cameron 2013, Damiani et al 2011) without compromising quality. Cedar ward worked very closely with the Emergency Admission Unit and was supported by 'on call' medical teams which rotated weekly. Streaming patients early ensured they received specialist nursing and medical care in the appropriate setting (Cameron 2013). The dependency of the patients on the ward was relatively low, but activity was high, patients generally went home directly from the ward but were occasionally transferred to a different specialty. This was a fundamental aim of the ward, as admission to a short stay medical ward ensures that the patient with an anticipated short length of stay receives rapid attention without unnecessary transfer to another ward (Downing et al. 2008). This type of facility is crucial in response to increased medical admissions and the resultant pressure on beds in the NHS (Downing et al. 2008). The number of available NHS beds in England has halved in the last 30 years, with concerted efforts being made to avoid re-admission, reducing variations in length of stay and improving discharge (Ewbank et al. 2017). Reducing the length of stay offers a range of potential benefits: there is a reduced risk of developing a hospital acquired infection, an improvement in patient satisfaction, an increase in efficiency (Damiani et al 2011) and reduced complications without increasing re-admissions (Powter et al. 2014).

4.12 Service setting

Cedar ward had 27 beds: three six bedded bays, one five bedded bay and four single rooms. The layout was of the same design as Acacia with a central desk and bays and side-room around. On entering Cedar ward, the nurses' station was situated in front of the Ward Manager's office, the clinic room and the sluice. The desk looked like a traditional Nurses station. It had a high front housing computers and telephone; on the inside, there were shelved sections for filing folders and paperwork. The ward clerk sat behind this desk. Beside the desk were computers on wheels, a printer and additional chairs acting as an extra space for staff to gather at, in order to carry out their duties when not

involved with direct patient care. The clinic room behind, where drug trolleys, medicines and controlled drugs were stored, could only be accessed by certain staff via a proximity card reader on their ID badges.

The themes (Figure 8) centre around how the nature of the care environment necessitated keeping abreast of any changes and ensuring that the focus of individual nurses concentrated on preparing patients for their anticipated discharge whilst providing appropriate care. The context of care influenced the Ward Manager to take a facilitative, supportive role in the background.

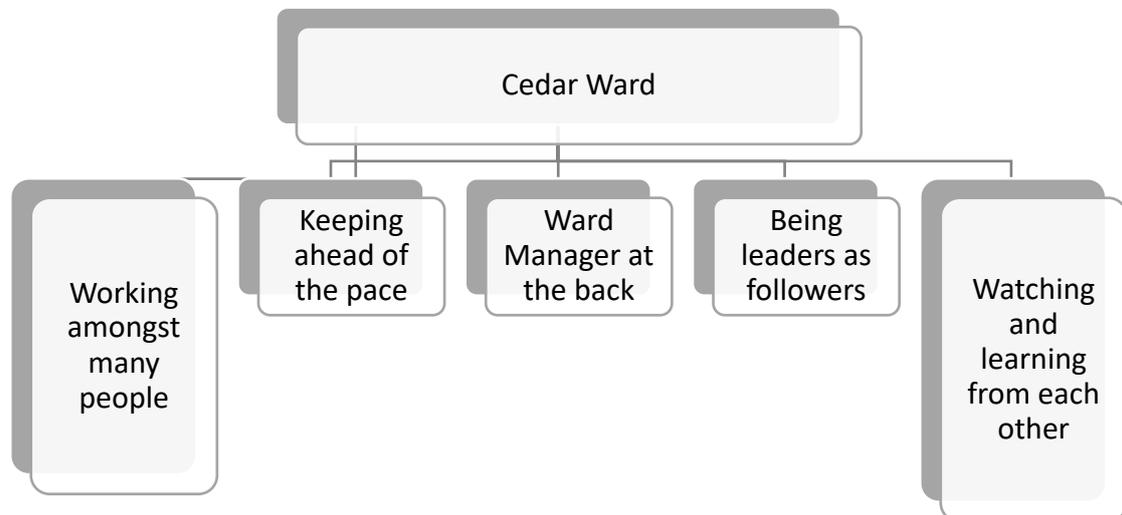


Figure 8. Themes on Cedar ward

On the wall in front of the clinic room was a metal board; a ‘flow board’ that housed index cards with handwritten information on them. There were enough rows for each bed space and enough columns to display extra cards that had details like referrals, discharges, transfers and so on. It was not dissimilar to a clock-in type board, only an inch or so of each card showed in each slot and the cards could be moved from space to space. The board showed the bed flow of the day before, and planned transfers or discharges in and out of the

ward for that day. This was an established mechanism for keeping the patient flow information current; a digital display opposite the desk theoretically performed a similar function but only had a 'real-time' display.

The ward team was led by Heather, the Band 7 Ward Manager, there were three Band 6 junior sisters, a range of registered nurses at Band 5, some of whom had been on the ward for several years and some newly qualified staff nurses (table 8 below for interview participant names).

Name	Band	Role
Heather	7	Ward Manager
Adrian	6	Junior Charge Nurse
Vicki	5	Staff Nurse

Table 8 - Names and banding of participants on Cedar ward

The team was supported by health care assistants, a ward clerk and housekeeping staff in various roles. One registered nurse was nominated coordinator for each shift. The activity rate on the ward was high. This was largely in the form of indirect care as most of the patients did not require significant assistance with meeting their personal needs. Staff moved in and out of the bays, interacting within the wider multidisciplinary team to cater for individual needs. Nurses needed to be able to coordinate the care, alongside planning and executing safe discharges for the patients in their charge. Working in this setting required a dedicated, specific skills base; inclusive of emergency care and solving a wide range of clinical and social issues (Cameron 2013, Bradas et al. 2016). The relatively short length of stay necessitated a constant flow of communication which centred on continued progression toward patients leaving the ward. Frequent multidisciplinary meetings were essential to facilitate planned and early discharge (Royal College of Physicians 2019). Providing a service for patients was identified as a key motivator, this was expressed as doing '*the best*' (Heather, Ward Manager and Adrian, Junior Charge Nurse) for patients and seeing patients go home. The care environment was very busy, but not chaotic; this is reflected in the reflexive vignette box 3 below derived from field notes.

Cedar

It was dark when I first arrived, slowly the lights go on and the day starts... it feels friendly enough, the staff seem like they are already 'en pointe' though and focused, they exchange pleasantries at handover as well as asking 'any sickies?'... everyone starts to go about their business.... It feels like a time lapse film.... the background is in blurred soft focus, lots of activity, some laughter and smiles, many people, from various disciplines, coming and going, talking to each other and to patients, picking things up, putting them down, answering the phone, moving beds... but the sharp focus is the nurses, the constant, they keep moving all the time, they don't chat much, they concentrate, weaving in and out of everything.... Separate, but fluid. (Field notes 3.8.1, 4, 53 3.9.48, 3.10.15)

Box 3. Vignette Cedar ward

4.13 Working amongst many people

The nature of the service parameters mean that environment was not inert. This section aims to illustrate the impact that the volume of people; staff and visitors entering the ward had on service delivery. In keeping with the high bed flow of patients, many were involved in delivering the service.

'The environment is not static, this matches the movement of patients, so lots of people involved, they need to ask for updates, move paperwork and so on...' (Field note 3.9.43)

The primary focus was on discharging patients, which necessitated high levels of activity and an intense focus. For example, the RNs often held documentation in their hands as they walked, this gave off an increased sense of purpose and direction to their movement. Vicki revealed that:

'...every where's a mess so when we're doing our paperwork usually we've got it all in front of us, that's why we're so focused, because the minute we leave that area someone will move our stuff. ...laughs... the ward clerk will tidy it up or the doctors will need the notes and then we can't do it ... so that's why we focus, get it done really quickly.' (Vicki, Staff Nurse, Cedar)

There were many additional staff from across the hospital present on the ward sometimes, resulting in chatter and encroachment on physical space around the nurses' station. This meant that the RNs had to move around more, illustrated in this field note *'Little cluster of people and their trolley almost*

obscure the space and people have to walk around' (Field note 3.1.52). The work of Gum et al. (2012) describe how nurses' stations are 'contact places' for staff and patients. They studied how physical design could promote interprofessional collaboration; finding that space had an impact on patterns of communication; generating barriers and challenges.

On Cedar ward space was restricted, I noted '*1840 – all at the desk again!*' (Field note 3.9.45). Although being seen as an organised environment was espoused as an admirable aspect of the ward, the heavy footfall and constant flow meant that this was not obvious to an outsider. Similarly, one of the wards in Gum et al.'s (2012) study had a lack of space around the nurses' station, conversations were held in doorways or corridors which was not ideal, however, when staff did sit down to write in notes and so on, a social and professional discourse took place. On Cedar, the nurses were not always able to stay at the nurses' station when there were too many people there, as space was limited. Nevertheless, working alongside fellow colleagues motivated staff, as did the pace of the care environment. The short length of stay made patient outcomes observable to all staff within their working week. Vicki, the Band 5 staff nurse, expressed her motivators as:

'the people I work with, this team on here I really like... the fast pace ... so we can see patients for a day or two, get to know them and then discharge them happily, they're more [or] less much better than they were before.... So just knowing and seeing their journey is what motivates me.' (Vicki, Staff Nurse, Cedar)

The diversity of people in the team inspired participants. Although working largely independently, each member of the team contributed to service delivery and relied on each other to do this; this was succinctly stated by Heather (Ward Manager) as '*...none of us could work without the other...*'. Bach and Ellis (2011) endorse this, saying that teams are organised to function cooperatively.

4.14 Keeping ahead of the pace

The nature of the service parameters necessitated maintaining a proactive continual focus, this was achieved by frequent updates between staff. This

theme explores strategies in support of this. These centred on consistent attention and frequent effective communication. Although there were moments for pausing, nurses worked swiftly to task, they moved quickly around the clinical environment, Heather's presence as Ward Manager always in the background.

4.14.1 Maintaining a consistent focus and communicating effectively

When considering the previously mentioned purposeful way that staff on the ward worked Heather suggested that:

'...you know from the minute you start handover normally what sort of day you are going to have... and you think oh my word we've got some really sick patients or some really dependent patients...' (Heather, Ward Manager, Cedar)

This set the tone and pace of the shift and was replicated in observations and modelled by RNs. The high level of activities and outputs of service necessitated a consistent focus as there were multiple needs to be met. Staff displayed the ability to engage in a variety of tasks at the same time. *'Adrian appeared on the ward, answered the telephone, smiled as he walked past. Talking to RN1 who was on the telephone still.'* (Field note 3.10.16). If the content of handover indicated that the shift looked like it was going to be busy, Heather said this necessitated getting a *'game face'* on. This was congruent with observational data, nonverbal cues were aligned generally with looks of concentration: although relatively relaxed as indicated by neutral faces, lowered shoulders and congenial albeit focused, expressions. I noted during one observation:

'Conversations are brief... some look more 'stressed' but that is not the right word.' (Field note 3.8.48)

'Nurses and doctors look like they are in a hurry... others go about their business with a smile.' (Field note 3.8.49)

Reduced eye contact and the increased pace precluded significant interruptions. This fast pace was reflected in physical movement on the ward as well, nurses literally walked very quickly, weaving in and out (Appendix 14 - Example of raw data extract Cedar 'move'). This is consistent with Wiggins (2006) who asserts that completing predictable tasks swiftly enables time to be available for unplanned or urgent issues. The nurses on Cedar moved to

and from the desk, up and down the ward, in and out of the bays, the sluice, the clinic room, off the ward and back on the ward. I recorded in my field notes that an RN '*flashed*' into the clinic room (Field note 3.11.28) the use of this word was not intentional at the time but gave a flavour of the pace when reviewing field notes.

Face-to-face communication formed the basis for staff interactions, it ensured staff were kept up to date with service provision; the staff talked to each other about care delivery, progress toward goals and bed flow activity. They communicated across the multidisciplinary team, asking and answering questions throughout the many changes:

'0845 – more people on the ward – 'busier' curtains around various beds, trolleys out, linen, skips. [...] answered phone several times. Heather answering phone too. Another [...] came onto ward as bleep holder, quick hello. Heather's voice is calm and soothing.' (Field note 3.8.24)

The pace of care delivery set the background tone on the ward, where staff did not always need to engage with each other directly. The one-on-one conversations between nurses were brief and often part of other activities, they stopped walking to answer a question, looked away from a screen to give information, updated the flow board behind the desk whilst talking or asked a question when completing documentation (Appendix 15 - Example of raw data extract Cedar - 'talk'). This was recorded as part of the flow of working; *'RN1 walking back with folder into bay and out again, smiled at something someone said, "Student in there too".'* (Field note 3.9.18). This seamless, uninterrupted way of working appeared to be underpinned by an awareness of what was required by everyone in regard to routine tasks in order to prepare for and take on the unpredictable elements. Heather ascribed this to recruiting the '*right*' people to fit in the team as it aided overall achievement. This is endorsed by the Chartered Institute of Personnel Development (CIPD 2018) who say that finding the right people with the appropriate skills knowledge and qualifications is crucial. Adrian reported that new staff were supported to fit into the team and become familiar with the routine whilst learning the ward's systems, saying: *'...we are there to support all the time...they will get used to the role and the ward and you know how the system works.'* (Adrian, Junior

Charge Nurse, Cedar). A planned approach to localised induction helped new staff to settle in and supported them to contribute to the team (CIPD 2018). New staff on Cedar were supported by the regular team to learn normal routines and processes.

In contrast to the informal and more adhoc means of communicating with each other, frequent handovers and ward rounds featured as prominent methods of information exchange. These methods were indicative of the both the nature of the care environment, frequent changes and emotional demands of the forthcoming shift. The time assigned to these was considerable. Aspects of service were likely to change in a short space of time necessitating effective communication strategies. The need for a contextually responsive structured handover is recognised in the work of (Bruton et al. 2016) who suggests that there is a lack of consensus around the format of nursing handover, concluding that although their sample was very small, different wards have different needs. In the fast-paced environment of Cedar ward, with a high patient throughput, there could be many changes; therefore, handovers by necessity were more detailed and longer. They were attended by all staff and then repeated as necessary to others, for example by the Ward Manager to the physiotherapist and occupational therapist who attended the ward later in the shift. The format of the handover routinely contained name, age, diagnosis, date of admission, expected date of discharge or transfer, as well as a treatment plan. Reference was also given to bio-psycho-social needs supporting a holistic overview. This information enabled the staff to plan the shift and prioritise what they needed to do.

4.14.2 Finding spaces for pausing

This theme acknowledges that whilst advice and information were freely offered and received, assistance with direct care tasks was not obvious. The nurses did not chatter or stand unoccupied for any length of time. This meant that they appeared to work independently of each other, although overall as a team. The direct care tasks associated with personal care were not required in the same way on this ward as most of the patients were relatively

independent. They were continuously engaged as recorded in field notes, '*RN1 at computer doing documentation, walking purposefully with a drug chart into the clinic room and back out...*' (Field note 3.10.11) There appeared to be little opportunity to discuss anything other than work when in the open areas of the ward.

However, two areas on Cedar ward were regular spaces for a pause, these were at the flow board and in the clinic room. Nurses hovered by the flow board to check progress to task and changes to bed flow as well as adjusting priorities. The salience of this was revealed when it was reported as needing to be part of new staff and student induction. It was an established and trusted means of communication – the effectiveness of it was recognised:

'...other wards have lost theirs and they've gone to the [digital] board, we work too fast in my opinion to keep that up to date. I very rarely touch it or look at it and is it because we're afraid of change, I don't know but in my mind, the [flow board]...because you can just move the cards, you can just write on the cards, you can yeah.... If we could get all that information really simply on the electronic board I think we would use it.' (Heather, Ward Manager, Cedar)

Vicki (Staff Nurse) elaborated that the flow board was only within the control of one or two individuals; '*...really only the coordinator touches the board ... laughs ... it's too important ...*'. This was expressed in a good-humoured way. Access to the flow board therefore emphasised the importance of this and embodied the authority of the coordinating nurse and ward clerk as those who had control of information in regard to patient flow, albeit with the accompanying responsibility that this held.

The clinic room, with its protected access, provided a space that was not shared with most staff or any patients. Laughter was heard coming from the clinic room behind the closed door. It was not too loud or obvious but nevertheless heard at different times. This laughter could reflect the 'off-stage' areas described in the work of Brown (2009). Although looking at mental health services, Brown (2009) suggests that healthcare environments should strike a balance where openness is crucial, but staff needs are met as well.

He describes an 'on-stage area' which has nurse – patient interaction and an 'off-stage area' which can be used for treatment planning. On Cedar, staff were together away from the rest of the ward for only short periods of time. When asked about the clinic room, Vicki explained how nurses generally carried out tasks independently, therefore opportunities to engage with others were limited except when tasks coincided, for example preparing intravenous medicines in the clinic room,

'I've never really thought about it but I can see, I understand it because we will do our paperwork, and then those jobs we do on our own individually so we'll do everything like that and then we'll go and do some IVs, someone else might be in there ... I think most of us get on.'
(Vicki, Staff Nurse, Cedar).

Thus, the clinic room with its protected access provided a social workspace where staff came together away from the gaze of other visiting staff and the public. The nature of the care environment, good organisation and the focus around discharging patients were seen as key influences when establishing the daily service delivery model.

4.15 Ward Manager at the back

This section explores how Heather acted as leader and role model, she led from behind and was articulate and humble. From a Grint (2010) 'position' role perspective as formal leader, in this she displayed an empathetic and supportive approach to leadership on Cedar, this represents Grint's 'person' aspect. She was able to express clearly how shared decision making and supporting others to develop, contributed to her style of leadership. The whole team were a source of inspiration for her as seen below:

Researcher – Are there people in your team who inspire you?

'Oh yeah, all of them, none of us could work without the others we've got HCAs that are fantastic they know their jobs inside out and are so good to the patients, but then again we have newly qualified or inexperienced members of staff that are just so kind and want to learn and are so eager and just listening to them speak with the patients and how they interact um everybody brings their own thing to the team. I've got two new band 6s, just started and they're already members of the ward, they worked for me as band 5s but now they've been promoted to band 6s and again the things they bring, their skills with people, with their colleagues with other patients and yeah I try to take something from everybody if somebody's done something well I don't care if it's an

HCA or an RN, if they've done it well, yeah let's do it that way.'
(Heather, Ward Manager, Cedar)

She acted in a facilitative manner and capitalised on her compassionate skills in the management and delivery of services on Cedar ward (this is Grint's (2010) 'process'). In this ward, with the relatively short length of stay and fast patient flow, there were large numbers of staff from many different teams, as well as patients and their relatives or carers, present at times. A Ward Manager would be expected to be available and accessible in order to respond to queries, requests and questions from a range of people (Royal College Nursing [RCN] 2009).

Heather considered herself to be calm and *'laid back'*, she provided a constant presence in the background. She said that a leader:

'... involves everybody I think um they give clear instructions or clear guidance to what is expected from everybody and then evaluate all the while, go back and revisit, be willing to make changes in how we do things for a better outcome but I think keeping the finger on the pulse all the time.' (Heather, Ward Manager, Cedar)

She projected a composed persona, which permeated throughout the team from behind. This was significant and twofold: Strickland (2000) argued that in the face of calmness, people are more willing to be candid. This encourages staff to talk openly and frankly with their managers about difficulties, seeking support and solutions from a leader. In addition, Heather's espoused style of leadership was inclusive; inclusive leaders empower others to lead; this is reflective of Goleman et al. (2001) who suggest that the leader's emotional intelligence and style creates climates within which positive feelings of trust, sharing, healthy risk taking, and learning are abundant.

Heather was approachable, her office was just behind the nurses' station, easily accessible and door open. Goleman et al. (2001) suggests that the behaviour and mood of the most effective leaders match the situation; they respect how people are feeling but also model a hopeful way. Heather occupied a background role, she made herself available to help when needed and assisted in tasks as required.

'It is very fast paced so we have to be organised. Yeah, we don't know what's coming, emergency admissions, the patients are acutely unwell but there still are the routine jobs that have to be done.... And everybody's aware of exactly what those routine jobs are... how it happens is because I think everybody has the same pride in this ward. Everybody wants to be seen ... we do we think we're the best ward in the hospital and nobody wants that to change so everybody pushes and pushes themselves...' (Heather, Ward Manager, Cedar)

The nature of the care context required engagement with other members of the team on a one-to-one basis. This concurs with the Hay Group's (2006) high performing ward managers who foster an environment where staff are proud to belong to the ward. It is also evident in Cope et al.'s (2014) work on resilience where participants discussed their sense of professional pride and value in their chosen career of nursing.

Whilst Heather appeared to have established views on leading and managing her ward and team, she was cognisant of how this was influenced by her evolving personal leadership role. She expressed the desire to ensure that all members of staff did their best by, *'following my plan and vision...'* (Heather, Ward Manager, Cedar). She aimed to make this part of a collective goal. Being the ward leader was concerned with setting care standards, observing, supporting, assessing and supervising ward staff (RCN 2009). When talking about her own vision for the Cedar ward, Heather, referred to the importance of taking other people's points of view though, which formed the basis for decision making where possible:

'...what I try to do on here with the management team, the Band 6s and myself is we speak together very, very regularly about how we're dealing with different issues and in that team there will be different people leading on different things ... whatever it may be, but that person will lead on it and then come to me with ok I've done that and this is the outcome and that's all fantastic.' (Heather, Ward Manager, Cedar)

This concurred with aspects of different leadership theories: authentic leadership and servant leadership particularly. It demonstrated a facilitative approach underpinned by Heather's leadership behaviours in the background. Involving the whole team, engaging with staff, is congruent with the skills of an authentic leader who listens to others, they are not biased and consider

information objectively before making a decision (Northouse 2019). This notion also links with a servant leader ideology, leaders who serve from a developmental perspective. Greenleaf (1977) says that the servant leader wants to serve first, this is founded on principles such as making sure that other people's needs are prioritised and being able to articulate a clear goal.

Heather recognised that:

'When I first started you know I would delegate tasks but then I'd be checking them really closely and saying ooh how've they done that, why have they done that.... No! these are people that you've appointed to Band 6 for a reason or if you're a manager I've got my Band 7 who has been appointed for a reason, they can do their jobs and I think that was a huge step for me realising I don't have to do everything and sometimes I do need telling' (Heather, Ward Manager, Cedar)

Heather displayed a degree of insight recognising how a leadership course had contributed to her personal development. A literature review of the Ward Manager role undertaken by Pegram et al. (2014) supports the benefits of development programmes, reporting an increase in self-esteem. In Heather's case, personal growth was balanced by receiving and responding to feedback:

'I need the criticism, I never take anything personally because it's not personal against me it's against my management style of this thing, I think ok yeah I need to change that then. I do have faith in my abilities, but I do like telling when maybe I'm not doing something quite right or need a bit of guidance.' (Heather, Ward Manager, Cedar)

Miscenko et al. (2017) suggest that undertaking a leadership programme provides a new set of identity meanings and a change in the strength of leader identity can emerge. This change in leader identity strength happens as a result of self-reflection and increasing awareness through being exposed to new leadership identities which may be retained, discarded or revised in line with their personal leadership development and leader identity (Miscenko et al. 2017). Heather's self-reflection is congruent with this point, illustrating personal growth:

'I think it was recognising that you're not alone, that every hospital is going through the same things, that all new managers are feeling the same, same worries, same concerns... but that you can do it. Teaching a few techniques of how you can do it and like I said making sure you

have got the right team behind you and that you can trust them to do things.' (Heather, Ward Manager, Cedar)

Kragt and Guenter (2018) found that leader identity was mediated by the relationship between reactions to leadership training and leader experience. Less experienced leaders, requiring a more 'training' day to day solutions approach and more experienced leaders, focusing on development and a response to unknown issues. Heather's self-identity as a leader was evident.

4.16 Being leaders as followers

How participants' views of leadership varied according to their occupational role, is linked to Grint's (2010) 'position' and 'process' categories and discussed in this theme. Heather, as Ward Manager, expressed leadership in terms of vision and personal expectations in alignment with a positional role, whereas Adrian and Vicki, as junior sister and staff nurse, described leadership in regard to a more day to day 'process' team-leading role, the latter from an 'in charge' perspective. Participants' personal perceptions of self as leader were divided between expectations of formal role and the possession of advice, knowledge and experience. However, regardless of the position that the leader held they were viewed as needing to be approachable, good at listening, clear in communication, calm and have experience to draw on.

Recognition of self as leader had a temporal aspect associated with the acquisition of skills and knowledge, '*years of experience*' (Adrian, Junior Charge Nurse and Vicki, Staff Nurse) being included in the rationale for being seen as a leader by others in the team. An expansive range of factors feed into the shared understanding of the leader role, subjective definitions and external expectations contribute to this complexity (Gjerde and Ladegard 2018). Leadership development as a nurse, mirrored growing experience and knowledge as a registrant, other members of staff either saw or assumed this by virtue of traditional nursing structures and perceived competence. This reflects a dynamic transition from being a follower to leader and vice versa. As

a nurse becomes more experienced, they are expected to lead care for more patients and teach and support junior members of staff.

Adrian was new in post and was at the onset of his more senior role as a junior charge nurse and formal nurse leader. He had previously been a staff nurse on Cedar, he said:

'...they come to me... they ask advice from me and I help them out, they are recognising something in me or they won't come to me. Most of the problems, from head to foot, they will come to me and I do the best I can for them because I have been here for 14 or 15 years' (Adrian, Junior Charge Nurse, Cedar)

He accepted that he and colleagues with similar lengths of service were approached for help and support on a range of issues, advice was freely given, and assistance offered. This was displayed by being available and helpful as in the examples below.

'RN1 asked a doctor to change some medication under the direction of Adrian' (Field note 3.10.50)

'Adrian sought assurance that RN1 happy to tell the patient about meds change,...Adrian made RN1 smile.' (Field note 3.10.52)

'RN1 into sluice... asked Adrian to give someone an update, asked with a smile.' (Field note 3.10.61)

On a daily basis, activity associated with leading a team, was seen as necessary in order to take control or be 'in charge' of a situation or shift. As discussed in section 2.2, Grint (2010) describes how 'position' orientated leadership generally refers to a 'spatial' position in an organisation. This is often understood as a vertical hierarchy, there being people 'above us' and leadership-in-charge e.g. Ward Manager, Junior Sister, Staff Nurse in decreasing hierarchical order. This is linked to positional control but can be a restrictive way to look at leadership. Grint (2010) said that leadership-in-front reflects a more horizontal approach where leadership is viewed as a heterarchy – a more fluid and flexible network. Where this merges with leadership-in-charge it can be seen in an individual who is lower down in the hierarchy but has some formal authority. On Cedar, this can be demonstrated through the way that a Staff nurse who is relatively lower down in the nursing hierarchy nonetheless could be 'in-charge' for a shift by virtue of their competence as an RN and experience. Staff nurses are expected to 'take

charge' and lead care for groups of patients, this increases with experience and seniority. Vicki, as a more junior registered nurse, did not see herself as a leader routinely though, although she did acknowledge that she could operationally lead, that is, be 'in charge' in certain circumstances:

'...on nights I can coordinate...but I don't think I would be able to do it effectively on a day not as well as other people would ... so in that sense no, maybe a smaller group of people I could do not the whole ward' (Vicki, Staff Nurse, Cedar)

A reduced number of staff on a night shift offered more opportunity whereas day shifts proved challenging due to the volume of people and workload. She did realise that others must see leadership qualities in her though, as she was also approached for help by newer colleagues.

Adrian felt that there was an increased risk of the shift '*falling to bits and pieces*' if there were too many leaders or an absence of a clear leader on a shift, as this would result in a lack of focus and direction. Adrian's example associated advice and help, that is Grint's (2010) 'process', with knowledge and experience whereas Vicki's being in charge on nights inferred more of a 'position' view linked to RN job roles. The expectation that experience underpins knowledge was strong and seeking direct assistance from seniors prevalent. Leadership, when carried out well, was considered to not only have an emotional impact on the team, but by default on the patient care as well. Vicki (Staff Nurse) described this as making her think that a good leader '*...really impacts on the day you're having and also overall patient care*'. How leaders made individuals feel was congruent with the leadership style and how it affected the mood of the team.

4.17 Watching and learning from each other as role models and leaders

Participants learned how to nurse and function within their teams, and how to interact with each other through following role models and leaders. They observed individuals who they considered a role model and acknowledged in turn how they themselves were watched by their colleagues and others (Appendix 16 - Example of raw data extract Cedar – 'Role models'). This resonates with the work of Wright and Carrese (2002) and Perry (2009), both

of these studies looked at the perspectives of models who had been previously identified as outstanding, that is, a role model. Wright and Carrese (2002), found that most of their informants recognised that they were being watched. Perry (2009 p.36) also asserted that every nurse is observed: by patients, families, staff and students, *'their words and actions become living lessons'*. This supports the basic premise of observational learning: learning from watching others and being observed. Morgenroth et al. (2015) suggest that individuals are 'inspired by' and 'inspired to' by role models referring to motivations for behaviours and setting of goals and ambitions respectively. Expectations of success and perceived value or desirability of success act as key motivators in this.

Being considered as a role model was primarily focused around how the model delivered care, the overt behaviours aligned with effectiveness as a nurse. Heather felt that it was important to be seen as engaged in direct care tasks and was confident in her ability to do this. She saw herself as a role model in her position as senior nurse aiming to demonstrate that *'basic good nursing care'* (Heather, Ward Manager, Cedar) was the remit of all. The participants on Cedar observed each other going about their daily tasks, they drew on their own role models for exemplars of behaviours which would help them to function well in their roles. Outside of their formal positions each nurse was clinically competent and fulfilled a similar role in regard to patient care delivery. Individuals were seen to possess desirable skills and could be viewed as the embodiment of a nurse.

In some aspects of their roles the participants talked about being a role model and being watched, Adrian said:

'...you know when you're working with a student or your colleagues, they're watching you and they are looking [at] how good you are as a nurse... people probably think I want to be like that person... the best I can ...' (Adrian, Junior Charge Nurse, Cedar)

Predominantly, observing a role model was considered to be connected with learning: aspiring towards and wanting to be like that person; and being able to act like them in a variety of different ways. Heather reflected: *'... I think it's*

learning from how other people do things, how you've seen them act with people um yeah and interact with people.' . Each participant could identify role models; Heather viewed the previous Ward Manager as a role model, using her behaviour as a benchmark for actions and development.

'I suppose my best role model for me would be the ward sister that I took over from, who is now my matron... I do think how would she have dealt with that and yes some things I deal with completely differently [because] I might have seen her deal with and think yeah that's not me, so I think as a role model you don't have to follow exactly what that person did because this is my ward now and I had to make it my ward. So I will deal with things differently but it's ... yeah I suppose admiration does come into it, you admire how somebody works...'
(Heather, Ward Manager, Cedar)

This was similar to Adrian, who picked out the positive aspects of his colleagues. He explained that he learned different aspects from different people, trying to build on the strengths and areas that would be most beneficial to him. This concurs with Gibson's (2003) global/specific aspect, which refers to whether role models are observed for a range or specific aspects of their behaviour. Role models are considered to display a range of behaviours as seen in the examples in the table 9 below. As discussed previously the content of the modelled behaviour acts as a trigger for emulation or avoidance.

Role model attributes and behaviours
Positive attributes such as compassion, caring, patience, confidence, gentleness, calmness, flexibility and acceptance which impact on care provision, nurse/client interaction (Davies 1993)
Demonstrating a caring attitude, keeping confidential information to oneself, being flexible, listening to other points of view and respecting others (Wiseman 1994)
Personal qualities – interpersonal skills, positive outlook, commitment to excellence and growth, integrity, leadership. Teaching skills – establishing rapport, develop specific teaching methods, committed to learner growth. (Wright and Carresse 2005)
Being a good nurse – skills demonstration, consistent supervision, timely and constructive feedback (Donaldson and Carter 2005)
Exemplary role models attend to the little things, Exemplary role models model, Exemplary role models affirm others (Perry 2009)
Ten categories of motivating behaviours – orientates the student, available when needed, acts as advocate, supportive, tolerant, respectful of opinions, confidence in learner, teaches skills when required, genuine interest in patients, provides feedback (Hayajneh 2011)
Clinical attributes: a good knowledge base; Teaching skills; rapport, empathy, respect; Personal qualities: respectful, prepared, demonstrative. (Burgess et al. 2015)
Individuals who influence role aspirants' achievements, motivation and goals by acting as behavioural models. Representations of the possible, and/or inspirations (Morgenroth et al. 2015 p.4)
Role models seen as distinguished and admired. Good managers and teachers. Respects colleagues and students Active at work, Serious, cooperative, kind, good tempered, exact, knowledgeable, organised (Bahman-Bijari et al. 2016)

Table 9 - Examples of role model behaviours

Vicki drew on role models from an alternative service environment who had displayed a positive outlook which aligned with her personal motivators. She also gave an example of wanting to be calm and organised:

'So maybe like their attitude, if they are quite calm, again it's quite busy on here so we can have days where we're discharging so many people and some people go into a little bit of a panic, other people will be so calm, they will have a plan they'll know what they are doing, be so organised about it, makes it so much easier, you just want to be like them.' (Vicki, Staff Nurse, Cedar)

The broad range of behaviours ascribed to a role model, were affiliated to everyday role expectations. Vicki reflected on role modelling

'I think it brings certain people to mind and what they are like, you want to act and be like them and be able to do jobs like them as easy as they do.' (Vicki, Staff Nurse, Cedar)

These jobs included activities and skills such as managing the ward, being calm, carrying out a plan, being organised, displaying compassion, dealing with difficult situations, competency issues or patient complaints. Experience was associated with being a role model, Vicki remembered that she began to consider herself as a role model when the ward was short staffed and she suddenly found herself to be the most experienced person.

'...I think probably when you're newly qualified and you're having those moments when maybe you're short staffed and then you're realising that you're the most experienced person on the ward and people are coming to you to ask questions... that's when I realised that you're probably ... like more of a role model than you were before...' (Vicki, Staff Nurse, Cedar)

Being a good leader was firmly associated with being a good role model on Cedar, linked to expectations and aspirations:

'...why would somebody aspire to become a leader if the leader they are watching or is looking after them or in their team is not a good role model....' (Heather, Ward Manager, Cedar)

This was echoed by Adrian and Vicki with being a role model expressed as a requirement for leadership.

4.18 Summary

In this chapter I have presented each individual case. On Acacia ward, activity to meet care need was constant and all staff engaged in this shared goal, often working directly together. Communication between the team members was frequent and positive and concerned with all aspects of care: direction and updating, support and advice. The Ward Manager at the front, impacted on day to day working through providing a visible example, contributing to care and giving feedback and praise to staff. The positive nature of relationships on Beech underpinned care providing a positive clinical environment. The fluidity of interactions allowed the staff to switch seamlessly between tasks and conversations, there was an intuitive implicit way of working that was pervasive across the care environment reflecting easy confidence in each other. The Ward Sister functioned in the midst of this as a registered nurse with activities associated with management carried out away from the care context. In contrast, Cedar was a fast-paced ward and busy care environment where staff were supported to function as individuals within the wider team. The focus in the care context was continuous and purposeful with a clear remit for supporting planned patient flow. The Ward Manager in the background underpinned this goal by taking a facilitative, collaborative approach, enabling her to keep up to date with activity, sharing decisions and providing assistance when needed.

The uniqueness of each ward area and how the team functioned together and as individuals has been explored. The social situatedness of each ward team had an impact on care delivery model, leadership and team working. Their perspectives on role modelling and leadership have been discussed in each specific context demonstrating a level of association between the two concepts. A picture of each Ward Manager's approach to leadership, particular to each environment, has been revealed. In the following chapter I present the cross-case analysis which explores two of the key findings of this study.

Chapter 5 – Cross - case analysis

5.1 Introduction

This chapter presents the cross-case analysis: it examines how role modelling and leadership were associated and displayed in this study. The notions of role modelling and leadership were contextually, spatially and temporally situated. Being a good nurse, doing a good job and delivering care were described by the participants as key motivators in all cases and offered without any hesitation. This gave a sense of consistency to the value placed on being a nurse and inferred a level of security in their roles. The participants worked together for a common goal and looked to each other for support, guidance, advice and practical assistance. In essence, this occurred chiefly through being influenced by a combination of leaders and role models. From the wealth and breadth of data, two key findings are explored. Firstly, that leadership location of the Ward Managers stems from their individual application of leadership and the nature of the care context. Secondly, that a conscious role model identity is not limited to formal leaders only, it is co-constructed and within the remit of all nurses. Leadership location is contextualised within Grint's (2010) fourfold typology and viewed through Goffman's presentation of self-lens. The co-construction of leader and role model identities are considered through social identity theory and the work of Hogg (2001), Lord and Hall (2005) and DeRue and Ashford (2010).

5.2 Leadership location of the Ward Manager

In this section the first key finding focuses on the 'leadership location' of each Ward Manager. The 'leadership location' originates from differing aspects. As discussed in chapter four, observable leadership behaviours were unique to each case, they stemmed from the care context and overriding presence and practice of the Ward Managers. This means that as the health needs of the patients directly impacted and influenced the service delivery model, it also affected how the Ward Manager acted and how leadership behaviours were displayed. This, in turn, guided the utilisation of resources: human and otherwise.

As highlighted in sections 2.2 and 4.1, Grint's (2010) fourfold typology can be utilised to understand the nature of leadership by contemplating position, person, results and process. This is also a useful way to unpack the notion of leadership location. 'Position' relates to the formal context of leadership (Grint 2010). The role of the Ward Manager is a formal nursing leadership 'position' in line with professional and organisational structures, this was singularly common across the cases. Grint (2010) suggests that 'person' in leadership, refers to 'who you are', it can link to unique individual characters and determines whether you are a leader or not. The personalities, qualities and skills of the Ward Managers in the cases were diverse and discernible to others. From a healthcare perspective, as explored in section 1.5.1, effective leadership has a common aim that focuses on delivering high quality care, this is the 'results' of Grint's (2010) typology: leadership in the broadest sense having a product. The character of teamworking and way that the Ward Managers supported staff was concerned with 'results', that is patient outcome, through enacting 'process'. 'Process' is composed of leadership practices, that is what leaders do, rather than the competencies they possess (Grint 2010). This was evident in processes, systems and mechanisms in each case, for example, team communication. This study offers an additional category for nursing leadership to Grint's (2010) typology: that of 'care context'.

5.2.1 The care context

As described above 'Leadership location' is linked to the Ward Manager's behaviour and how this was driven by the nature of the care. The Ward Managers expressed the desire to contribute to care delivery as nurses in the clinical environment. This section explores the concept of 'care context' in nursing leadership and how it underpinned and drove behaviour. It was based on the way that leaders acted, what they did, when they did it and why they did it.

The significance of the care context and role of the Ward Manager can be understood through Goffman's (1959) seminal work on the analysis of social

encounters. As highlighted in section 2.4.1 individuals have the capacity to give an impression; that which they 'give' and that which they 'give off', they perform. Within a given context, the team enact a performance. Goffman (1959) states that the term 'performance' actually serves to convey the characteristics of the task, not just those of the performers. The characteristics of the task are unique to that performance and therefore care context. The purpose of the performance for the team, is to give off a favourable picture of their service, each team member playing their part. Therefore, team performance is an extension of the impression given by individuals (Goffman 1959). The context of care was constructed from the physical and service background of each case (the physical sense being environmental and human). Whilst sharing basic tenets, the diverse nature of service users, clinical environments, teams, and practice made this dynamic, individual and adaptable. Goffman (1959) suggests that a consistent and similar performance becomes a reference point and thus prototypical. This 'performance', therefore in each case became the team's reality and the 'way things are done' (Figure 9 below). Individuals within each team were dependent on each other in this performance and needed to cooperate to continue the performance, inferring that the players, that is the ward staff, knew the script and '*maintained the party line*' (Goffman 1959 p. 88).

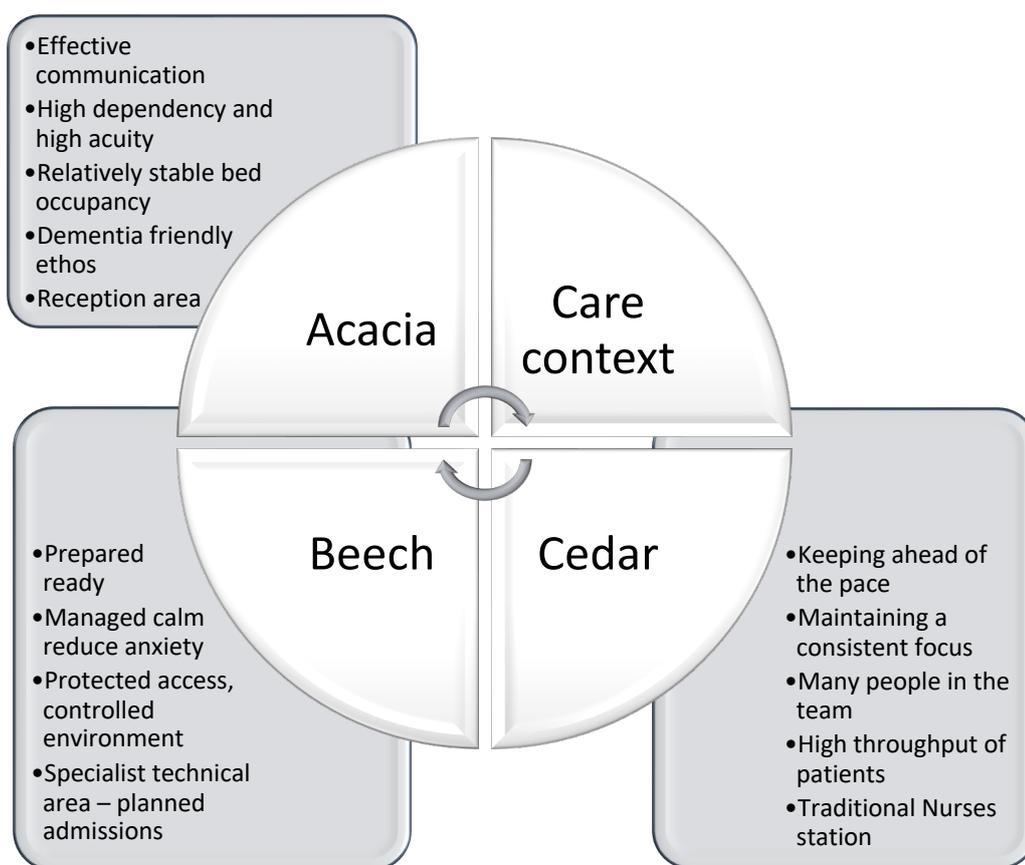


Figure 9. Factors impacting on the notion of team ‘performance’

The individual wards in the cases were very different environments. The overriding impression from Acacia was of cheerful busyness, working together, staff relying on each other to look after their patients (section 4.2, 4.2.1. 4.3). Beech was a specialist, technical environment, calm and controlled with a seamless team approach (sections 4.7, 4.7.1, 4.7.2,). Keeping up with the pace in a consistent way, to manage the high turnover on Cedar, meant that staff moved quickly and largely worked independently (sections 4.12, 4.13. 4.14. 4.14.1, 4.14.2). Each team clearly worked together to its common aim, this was endorsed and accepted by all participants. They were motivated in their roles and inspired by each other as captured in the responses below, this formed the basis for a shared understanding of ‘performance’:

'...most of my colleagues inspire me towards it because we all work together to the same end because it's teamwork and we all want the same thing for the patients' (Alison, Ward Manager, Acacia)

'I think everyone does in their own little way' (Jill, Ward Manager, Beech)

'...pretty much most people that I work with inspires' (Laura, Staff Nurse, Beech)

'Oh yeah, all of them, none of us could work without the others we've got HCAs that are fantastic they know their jobs inside out and are so good to the patients, but then again we have newly qualified or inexperienced members of staff that are just so kind and want to learn and are so eager and just listening to them speak with the patients and how they interact um everybody brings their own thing to the team' (Heather, Ward Manager, Cedar)

'...they care in a passionate way' (Adrian, Junior Charge Nurse, Cedar)

Goffman (1959) talks about the role of a 'director' who brings people back in line and allocates parts – in this study, this was equivalent to the Ward Manager's role. The Ward Manager set the tone, motivated and guided staff, acting as a connection between the wards internal and external environment. Where and how the Ward Managers literally worked, 'gave off' different impressions, this spatial inference is explored in more detail in the next section. Anecdotal common sense assumes that nurses wear uniforms; they have professional titles, work in healthcare settings with other healthcare professionals and are expected to act in a certain way. This impression is influenced by multiple sources which include the audience, or observer's, personal experience, professional expectations in the public domain, and how nurses are portrayed in the media. Opinion on the role of the Ward Manager can be narrower, with a focus on a managerial position that is based on the observers first, second or third-hand experience and consequently is highly subjective.

The way that care was delivered and actions that the Ward Manager engaged in, affected communication strategies used throughout the team and reflected the leadership location. The Ward Managers expressed the desire to communicate and listen to others, they wanted to be supportive and constructive. This included being able to

'...celebrate someone's strengths but also to constructively look at their weaknesses with a view to improving them, so that you're getting the

best out of somebody...patients and patient safety comes first... but you can't have happy well cared for comfortable patients if you haven't got happy well cared comfortable for staff ... so that goes without saying... my biggest thing would be to look after my staff...treat them well and hope they respect me and in return they will do the same for patients.' (Alison, Ward Manager, Acacia)

Leaders were required to:

'offer support, guidance, sometimes making difficult decisions, ensuring that quality is adhered to... taking the buck and ensuring that policies and procedures, everything is done properly, yes overall managing... but you know support perhaps stepping in where need be, perhaps having awkward conversations delegating...' (Jill, Ward Manager, Beech)

Leaders also needed to know:

'...what you want to achieve or you want you and your team to achieve and getting that message across, that this is what we are working towards, this is how we are going to do it but taking other people's points of view on board...They involve everybody I think ...they give clear instructions or clear guidance to what is expected from everybody and then evaluate all the while, go back and revisit , be willing to make changes in how we do things for a better outcome but I think keeping the finger on the pulse all the time.' (Heather, Ward Manager, Cedar).

This was intrinsic to each case and considered a priority. In congruence with authentic leadership, this could be considered part of the balanced processing and relational transparency components. This had an impact on the team and was seen in the way that the nurses in this study worked together in harmony. Laschinger et al. (2012), found that authentic leadership positively influenced staff nurses' perceptions of access to workplace empowerment structures and enhanced performance. The Ward Managers in this case study demonstrated a positive intent toward their teams in alignment with their formal role. This links to the work of Prime and Salib (2014), who found that when employees observed altruistic or self-less behaviour in their managers, they were more likely to report feeling included in their work teams. The Ward Managers modelled positive communication which was reinforced and supported by interrelational working within their teams, although this was enacted differently in each ward area in response to leadership location as a consequence of care context.

Essentially, the Ward Manager's 'direction' influenced the team's 'performance' thus providing the content to be modelled. Learning from a role model has an impact on an individual in two ways; firstly, through direct learning and emulation and secondly through the observed reactions of others (Horsburgh and Ippolito 2018). This is called vicarious learning (Bandura 1977). The constitution of the ward teams and social character was the backdrop for the care context and influential in team relationships.

5.3 I am in front of you, I am beside you, I am behind you – different leadership locations

This section is concerned with the leadership space that the Ward Manager occupied: their observable place, how they embodied the role of a senior registered nurse. It was related to Stanley's (2006a) 'banner', that is how leaders display their values (section 2.2) and Cardiff et al.'s (2018) display of core values in person centredness and taking a 'stance' (section 2.2). As highlighted, the influences on service delivery and everyday nursing workforce activity and organisation were multifactorial. The diagnosis of the patient informs treatment, this means that nurses are engaged in direct care activities such as the administration of medicines, recording physiological observations, for example, blood pressures, plus attending to tasks associated with helping patients maintain their activities of daily living such as washing themselves and going to the toilet. This is in combination with indirect care activities such as making referrals, multidisciplinary collaborative working and engagement across the wider team. The nature of the care was context specific. Therefore, the number and grade of staff required to meet these requirements differed from case to case. These fundamental components of care delivery are strategically planned and operationally monitored through well-established delivery and governance processes. How nursing teams are structured, and the number of registered nurses on shift have an impact on everyday allocation to workload and service delivery model, and fundamentally, the input of the Ward Manager to nursing care. This study exposed how physical factors such as office location and the wearing of uniforms for example, also influenced and shaped the actual day to day enactment of the Ward Manager

role. The visibility, accessibility and physical presence of the Ward Managers contributed to the concept of leadership location. In this study, this emerged as new understanding expressed as 'I am in front of you', 'I am beside you' and 'I am behind you'.

The way in which the Ward Managers were involved in direct nursing care was one of the distinguishing features that discriminated between each leadership location. This activity was aligned with primary motivations and prioritising patient care. Across the cases, the Ward Managers were involved in delivering nursing care based on individual ward need. Koskiniemi et al. (2017), found that the emotional importance of professional identity and related clinical work, was the most meaningful element in a nurse's professional work, despite their position. Being seen as a nursing role model, carrying out operational nursing tasks, enabled the focus on nursing to be constant for the Ward Managers in this study as they acted as role models.

Clinical leaders in Stanley's (2008) congruent leadership study, were identified as those who, when faced with challenges, remained true to their values and beliefs about care. They were followed because of this, not the vision and creativity that aligned more with leadership theories of a management paradigm. Gjerde and Ladegrad (2018) explored the deep-seated tension between leader role expectations and leader role identity. They suggest that when these diverge, leaders are faced with a quandary; should they meet role expectations or behave in line with their role identity. In this study, the Ward Managers chose to remain visible within the working team, albeit displaying this differently.

5.3.1 I am in front of you

On Acacia, where the acuity and dependency of the patients was high, two nurses were often needed to care for a patient. This meant that more than one staff member may be needed to meet their needs, for example, two nurses may have been required to assist a patient move in the bed. On Acacia, the overall level of acuity required all nurses on shift to be engaged in

delivering direct patient care, this generally was a healthcare assistant and another member of the team, registered nurse or otherwise, and due to staffing levels included the Ward Manager. Decisions and feedback were free flowing and the emotional environment influenced by the Ward Manager at the front. In the highly technical specialist environment of Beech, the ratio of nurses was heavily weighted to registered nurses with associated technical skills. At times the Ward Manager acted as a nurse on shift for a specialist treatment list in theatres in the same way as the other registered nurses did, thus working alongside them. On Cedar, the registered nurses largely worked alone, as the focus of care was related to discharging patients and acuity relatively low, the Ward Manager facilitated others and contributed to direct patient care as needed. Therefore, the Ward Manager on Acacia was literally leading care delivery, visible and involved, the range of staff roles placed her positionally in the front. Perry's (2009) exemplary role models were willing to purposely be role models and facilitated the opportunity for novices to view them in those roles. 'I am in front' fits with this notion. The Ward Manager on Acacia displaying this with intent:

' I often think to myself god I've got loads to do but a) I don't want to be stuck in that office on my own doing stuff on the computer as it's boring but I want them to know I have to set an example so yes, I do want to be a role model, it's funny I have never thought of the word... but I need to lead by example... we're all in it together aren't we...I don't want them to think I'm afraid to get my hands dirty because I'm not so, I do RM in that way a lot' (Alison, Ward Manager, Acacia)

5.3.2 I am beside you

The Ward Manager on Beech was away from the ward team sometimes at planned meetings, although for a significant proportion of her time she contributed directly to service delivery in the midst of the team. The type of treatments undertaken on Beech were carried out in controlled and sterile conditions and the staff wore theatre scrubs. These are cotton tops and trousers that are plain and block coloured and worn by every member of staff in the operating theatre type of environment for safety. The visibility of the Ward Managers as they engaged in direct care, was affected by their uniforms, as a means to distinguish them from other staff. On Beech, the nurses did not wear uniforms unless in a clinic setting, so it was not overtly

obvious who was in charge or who was who, until close enough to read the lanyard or identity badge, the Ward Manager looked the same as the other staff. On Beech it was difficult to 'see' the Ward Manager, therefore the notion of 'I am beside you' was the overriding presentation. The way of working was fluid and seamless, with staff contributing to care in a cohesive collaborative manner as revealed in section 4.7. In contrast, on Acacia and Cedar wards the Ward Managers wore a dark blue uniform and as the only staff doing so were recognizable as someone different to the other staff members and stood out from other nurses. These perspectives reflect the everyday visibility of the Ward Manager in the literal sense.

5.3.3 I am behind you

The accessibility of the Ward Manager supplemented leadership location and enhanced or limited the visibility of the Ward Managers. For example, on Acacia, the Ward Manager's office was nearly the first door into the ward opposite the reception area. This meant that when in the office the Ward Manager was visible to those standing at the reception desk straight away. Whereas on Cedar, although the office was near the ward entrance it was masked by the nurses' station. As mentioned in section 4.12, the nurses station on Cedar ward was of a traditional design and dominated the space, it was more difficult to see what was behind and who was in the office. The Ward Manager on Cedar engaged with direct care activity on a regular basis at the request of other team members. On Cedar, the Ward Manager played a facilitative role, which involved orchestrating relational working in the background position. She recognised this:

'...as a leader you need the ability to recognise the skills you've got in your team and to use those ...to their best advantage... what I try to do on here with the management team, the band 6s and myself is we speak together very very regularly about how we're dealing with different issues and in that team there will be different people leading on different things ... [] so I think it's communication, you've got to be approachable, you do have to be a good role model or you won't get the buy in from the rest of your team' (Heather, Ward Manager, Cedar)

With a patient demographic of a lower dependence, the nurses delivering direct patient care were able to do this more independently. The Ward Manager advocated for collaborative working and was accessible to the team.

Gjerde and Ladegard (2018), reported that leaders used the strategy of experimenting with old and new ways in order to match leader expectations with those of followers. They experimented with behaviours from their own experiences and drew on role models themselves when looking to improve their own leadership behaviour, this aligned with the facilitative approach of “I am behind you”, supporting and guiding the team.

The Ward Managers were viewed as role models, the leadership location within each case was static, and directed by the care context as it was during the study. This largely unfluctuating care context driving how these Ward Managers enacted their roles. This finding contributes to original knowledge and describes how each of the factors discussed in preceding sections culminated in a perception of care context and the effect on ‘leadership location’. The Ward Manager on Acacia, ‘I am in front of you’, seen working alongside the rest of the team who were hierarchically structured due to the nature of roles required for service delivery. ‘I am beside you’ in the case of the Ward Manager on Beech as generally working in the team in the same way as other registered nurses and ‘I am behind you’ reflecting how the Ward Manager on Cedar supported her team of nurses working independently.

5.4 Co-creation of leader and role model identities

The second finding focuses on leader and role model identity co-construction. Drawing on Lord and Hall’s (2005) work on leadership development, at the same time as application to DeRue and Ashford’s (2010) claims and grants work is original as a means to increase understanding of how role modelling and leadership in nursing is associated. The evidence in this study demonstrated that formal leaders were role models by virtue of expectations and behaviours. However, whilst role models ‘lead’ they were not always formal positional leaders. The practice of leadership and leader identity development in the cases, was particularly associated with clinical effectiveness that sprang from experience, knowledge, skills and formal position which had been gained over time. These perspectives represent what Hogg (2001) calls ‘implicit leadership’ theories which are composed of

people's preconceptions about how leaders should behave. Generally, the participants considered a good leader to be a role model, leading by example and worthy of emulation and followership. Role modelling and leadership were considered to be intertwined but not necessarily dependent on each other. The connection was described as 'intermingled' (Claire, Junior Sister, Beech) and expected in a purposeful, conscious way, leading and behaving as a model encompassing how you would want to be seen, '*why would somebody aspire to become a leader if the leader they are watching or is looking after them or in their team is not a good role model*' (Heather, Ward Manager, Beech). This was more nuanced on further deliberation and began to reveal subtle differences between the two concepts relating to intent:

' I think if you see yourself as a role model you want to be the best... and you want to do the best by everybody and a leader I think is kind of the same... although I spose a leader would perhaps facilitate more than a role model would... does that make sense... so a leader would facilitate people to um ...in the ways of working, develop and encourage them ...like bring it all together whereas a role model is somebody who would just try to be this person...like in the way that would act and behave...' (Alison, Ward Manager, Acacia)

As discussed in the cases (sections 4.4, 4.4.2, 4.8, 4.9, 4.15, 4.16), the participants understanding of leadership was expressed in terms of behaviour and impact: that is, what leadership is, what a leader does, who a leader is, how a leader makes people feel; and what the outcome or affect was. Words in the responses to describe being a leader, leadership and being a role model and role modelling were congruent and sometimes used interchangeably (Appendix 17 - Example of raw data extract, leadership and role modelling descriptors).

The data reflects a direct exchange for some descriptors, for example, leader as role model and role models leading by example. Other descriptors reveal a focus on Grint's (2010) 'person' aspect: for example, knowledge, efficiency and compassion, in both leader and role model. 'Process' and 'position', how leaders and role models behave, are described in relation to how they communicate and interact. This is expressed in practical (for example, giving advice, guidance) and emotional (providing support, being respectful) terms.

(Summarised in table 10 below). In table 10, the interview responses that were given regarding leadership are in an embolded font and the interview responses given regarding role modelling are left in regular font to identify the source. This aspect of the cross-case analysis demonstrates the association between leadership and role modelling in the cases. Further discussion of identity development in the next sections explores this in more detail.

'Person' (Grint 2010)	
knowing what you want to achieve or your team to achieve non- judgmental, good listeners, professional, knowledgeable, good at getting other people to do what needs to be done, up to date, be willing to make changes, foresight, seeing the bigger picture, think outside the box ... not just about one problem but about several problems, assertive, honest good manners, outgoing, calm	professional, aware of strengths and weaknesses, efficient, effective chirpy, compassionate to patients, polite, calm, organised
'Process' (Grint 2010)	
keeping the finger on the pulse all the time, offer support, guidance, ensuring that quality is adhered to, give clear instructions or clear guidance, getting that message across, ensuring that quality is adhered to following policies and procedures, juggling everything together, good communication, good interpersonal relationships, think about answers good decision makers, proactive, evaluates	facilitates others, showing others what you expect to happen, behave well towards other people get the job done well without upsetting everybody, deal with situations well, showing others this is what you should be doing as a nurse teaching students, treat other people, staff, patients with courtesy and respect, willing to work hard but willing to kind of give a bit of slack, a bit of give and take, support others in their role, effective in role, have a plan
'Position' (Grint 2010)	
making difficult decisions, taking the buck, takes charge	

Table 10 – Common descriptors - Leader and leadership - role models and role modelling (All participants contributed)

The participants in this study report being effective in their roles, *'doing a good job'* (Paul, Staff Nurse, Acacia), as a shared desire, this was offered unanimously, they expressed this as:

'doing the best for the patients and making sure every member of staff on the ward is doing their best for the patients' (Heather, Ward Manager, Cedar)... *'you manage to do something to help that person as a nurse'* (Adrian, Junior Charge Nurse, Cedar)... *'what brings me in to work is the people I work with, this team on here... the fast pace ...we can see patients for a day or two, get to know them and then discharge them happily'* (Vicki, Staff Nurse, Cedar)... *'making sure the patients are well looked after and getting home as safely as possible'* (Paul, Staff Nurse, Acacia)... *'to make a difference'* (Alison, Ward Manager, Acacia) *'to make them better'* (Alison, Ward Manager, Acacia, Claire, Junior Sister, Beech) ...*'to actually see it through to the finish'* (Jane, Junior Sister, Acacia)... *'spending time with my patients making them happy'* (Laura, Staff Nurse, Beech)... *'good sort of old fashioned nursing care'* (Teresa, Staff Nurse, Beech)... *'perform to a certain standard'* (Jill, Ward Manager, Beech)

The value that participants expressed through their clinical practice motivators places being a 'good' nurse as a 'worthy' end. Mok (2007) discussed Charles Taylor's notion of identity, saying that for something to be part of our identity it must be seen as intrinsically worthy by us. He refers to properties that a person cherishes, things that have a high importance. In their self-based model of authentic leader and follower development. Gardner et al. (2005 p. 344) draws on the positive psychology literature of Harter to say that *'authenticity involves both owning one's experiences and acting in accordance with one's true self'* – in reality this means saying and doing what you really think and believe. The participants enacted their roles as nurses in the social situatedness of their ward teams. Bandura (1977) states that as learning purely from their own actions would be potentially risky, individuals learn how to behave from the observation of others, from a role model. These ideas of how to behave are then symbolically coded and subsequently serve as guides for action. Role identities provide the motivation required to develop in a role and succeed at it (Peters and Haslam 2018). These identities, professional and otherwise, were created in the social context of the wards and are important as they help to explain how leadership and role modelling occur. They offer a means to unpack these concepts in nursing and strengthen the

positive aspects of learning from leaders and role models by conscious attention to these roles.

5.5 Claiming and granting leader and role model identities

Leader and role model identity construction can be demonstrated in this study as a series of claims and grants within the context of the social groups. This section helps to explain how the nurses in this study saw themselves as leaders and role models and offers a new perspective on the work of DeRue and Ashford (2010). DeRue and Ashford (2010) describe a dynamic process of reciprocal claims and grants which reveal how leadership identities can be co-constructed in a social milieu: individuals 'claim' an identity and others 'grant' an identity. These claims and grants then form the basis of leader and follower relationships; they promote individual internalisation of identities and their relationship in groups (DeRue and Ashford 2010). Given the social nature of observational learning, and the interplay between the roles of nurse, leader and role model, application of these processes can illuminate that an identity as a role model is also achieved through 'claiming and granting'. This presents a fresh way to understand the association between role modelling and leadership, as whilst agreeing a connection, some participants found it difficult to express the difference between the two constructs (section 5.4).

5.6 Claims and grants by role

In this study, claims and grants of leadership and role modelling occurred in the medium of the ward cases, they were linked to formal roles, expectations, knowledge, experience and perceptions. Claims and grants of an identity can be overt and obvious, or much more subtle. For example, claiming by direct verbalizing, using phrases such as 'As leader I will...' to indirectly granting an identity by leaving the 'leaders' seat vacant for the leader at the head of the table in a meeting (DeRue and Ashford 2010). In this study the way that claims were made reflected self-awareness and role recognition. Therefore, the manner in which the claims were made were categorised to reflect the magnitude and assurance with which they were given, ranging from 'tentative' or 'firm'. A 'tentative' claim reflected that it was made without confidence and limited by perceived lack of competence or experience. Ascribing a claim as

'firm' inferred certainty, this was measured by the manner of the response and confidence within which it was given. The language changed from 'not really' and 'hopefully' to 'yes'.

Across the cases the registered nurses claimed and granted identities as leaders and role models that were rooted in professional, public and organisational expectations and structures. Expectations were diverse and context specific. For example, all participants in the wards, apart from one specifically, viewed and granted their formal leaders (both internal and external to the team) role model identities to lesser or greater degrees. As discussed in sections 4.5, 4.5.1, 4.10, 4.10.1, 4.17, this was based on their personal context, relationships and frequency of engagement.

Professional expectations were associated with knowledge, skills and experience demonstrated through competence and everyday working. The NMC Code (2018a) clearly states that in promoting professionalism, nurses should be models of integrity and leadership, and act as a role model for professional behaviour. This is a core foundation in nursing. Each participant acknowledged that they were a role model to someone, this varied according to when and where. The participants perceptions of themselves as conscious, that is purposeful, role models were congruent with and matched the expectations of their everyday work role: Ward Manager, Junior Sister, Staff Nurse, Mentor and their life outside of work. Public expectations derived from generally held traditional 'common sense' perceptions of what nurses do and how they should behave, but also contributed to the group prototype and collective endorsement. This had been present in one participant since the start of her career:

'I think probably just coming into nursing, which is many years ago but as a student nurse it was quite clear that we had quite a lot of responsibility even though we weren't top of the authority tree (laughs)...[]...even as a student nurse I felt that I was sort of on show, part of putting on the uniform and performing the role ... sort of learning to be a professional um and there was quite a lot at stake so there's a public persona that's important to, not be big headed, but to be aware of , public service sort of role' (Teresa, Staff Nurse, Beech)

Organisational expectations and structures set out the framework of job roles albeit with an element of historical legacy, for example expectations association with the Ward Manager role construct as discussed in section 1.4.

DeRue and Ashford (2010) propose three levels of self-construal for identity construction. The first is on the individual level where the identity is part of the self-concept. The second is at the relational level, tied to the recognition of roles, and the third is focused on collective endorsement and being part of a particular social group. From an individual and relational perspective across the cases, the staff clearly functioned together, they interacted with each other, valued and supported each other. The ward areas were well established social groups. There was recognition of the impact of leadership and team working on service delivery, and how sustaining and developing staff was essential. This was a fundamental part of everyday working. In this study participants talked about the self and others in relation to the group behaviour of their ward teams, redolent of their 'performance' according to Goffman (1959). Hogg (2001) says that depersonalization is behind group phenomenon; things like attitudes, feelings and behaviours become stereotypical and normative. He adds that people are sensitive to prototypicality, as it is the groundwork for perception of self and other group members. From a collective perspective, there is a link to the stability of the identity, in that if an identity is strongly collectively endorsed as part of a group, for example, leaders or followers or role models, then the stronger that identity construction will be. Claims and grants do not occur in a vacuum however, they happen in sequence, and it is this sequence which reveals how the response of others, that is not the initial claimant or granter, can have an impact on the claim or grant itself (Marchiondo et al. 2015).

5.6.1 Individual-level influencers on claiming and granting

As an individual nurse, perceived leadership development mirrored growing experience and knowledge as a registrant and aligned to traditional nursing structures and anticipated competence in formal managerial roles. Adopted understanding of leaders and leadership was relative to the participants'

operational role and subjective viewpoints. The way that participants described and situated their personal leadership resonated with the work of Lord and Hall (2005) who proposed that leadership performance is organised in terms of progression from a novice to intermediate to expert, the individual's capability growing through identity work, values and mental representations. The Band 5 Staff nurses can be broadly considered novice leaders, the Band 6 Sister and Charge nurses, intermediate leaders and the Band 7 Ward Managers expert leaders. The following sections explore how some of these factors influenced identification of role models and recognition of this by participants. This contributes to a new understanding of role modelling.

5.6.2 Staff Nurse perspectives

In the cases, Staff nurses at Band 5 talked about leading and leadership in terms of everyday practice, nursing and the day to day running of a team or leading care.

'so someone who is able to take charge...' (Vicki, Staff Nurse, Cedar)
'...remain assertive and be slightly aloof at times just to run the department...make sure it runs smoothly...' (Laura, Staff Nurse Beech)
'... a willingness and ability to listen, rather than sort of the giving out of commands ...sometimes that's important, being able to say when things are not working well [...]...giving people the benefit of the doubt and allowing them a voice, that's quite an important thing for me' (Teresa, Staff Nurse, Beech)

Staff nurses claimed a tentative identity as a leader by warrant of their experience and formal positions as embryonic team leaders. This tempered their personal perceptions, although some acknowledged that others might see them as leaders. This focus was limited to the self and the recognition that others, junior staff and students, may depend on them.

Researcher: *Do you see yourself as a leader? Do others?*

'No not really but I know I could do it though but I think my confidence could struggle... I've been a nurse for a long time and I have been in leadership positions years ago but that was before ...I don't mind leadership if it's an area like in theatre for example, I know exactly what I'm doing so I'm quite happy to lead in there, it's all about knowledge a lot of it and in recovery I don't spend as much time out there so I'm a little bit more weak in confidence ... no, I'm a team player I think they'll

see me as a team player someone who works hard but I don't think they see me as a leader no' (Laura, Staff Nurse, Beech)

'yes but perhaps with a small 'i' (laughs)... I think some of my colleagues who are either haven't been here as long as I have or perhaps health care assistants or other members of staff I hope would see me as somebody that they could come and talk to if they needed to or you know a listening ear ... the difficulty with that often is that the time pressure that we're all working under there's not always the time for that sort of interaction but I do try and be somebody who is encouraging and supportive especially if somebody is having a bad time' (Teresa, Staff Nurse, Beech)

'No (laughs) that's the answer... Colleagues? – I think so... yeah... a lot of new qualified staff ask me for advice and I say yes you can do this or this is how you make antibiotics up like this and things like that and what is that antibiotic done like that and you can do it this way you can look at medusa and things like that...' (Paul, Staff Nurse, Acacia)

'I think 3 years is such a small amount of time to see yourself as a leader... we have on nights I can coordinate, which I can do, but I don't think I would be able to do it effectively on a day not as well as other people would ... so in that sense no, maybe a smaller group of people I could do not the whole ward' ...Yeah I think some of them' (Vicki, Staff Nurse, Cedar)

They were recognised as registrants who led practice for the patients within their care, possessing the requisite knowledge, skills and experience. A 'tentative' claim reflected that this was made without overconfidence and limited by lack of experience. Staff nurses can be granted a novice leader identity as registrants, mentors and preceptors by junior staff and students, largely by virtue of this professional role, and from an organisational structural perspective in their status as qualified nurses. Staff nurses as novice leaders, can be granted an identity as an embodied role model by students and junior staff on an aspirational basis for the above reasons. They could also be granted a role model status on the basis that anyone can be a role model. Novice leaders who acted as role models for junior staff and students, particularly in the role of mentor had a growing cognition of how they may be perceived, this was a tentative claim of a role model identity.

Researcher: Do you see yourself as a role model? Do others?

'No not really... I try not to have any ideas above my station really, I hope that I am for example for students, yeah I like to think I am for students... I don't think I ever considered myself a role model until I started working professionally ...maybe I was to people, growing up I remember people saying to me 'you're so kind' it's just little comments

that your friends refer to you as but yeah mainly it's in my professional work' (Laura, Staff Nurse, Beech)

'I do...um I wouldn't say I'm perfect but I've been around for quite a long time (laughs) hopefully other colleagues of a similar banding But I'm quite, I have a bit of a thing about, I would want to advocate all the different grades actually being a team and not being too hung up on who is in a position of authority...because I think we all have a role to play and whether it's the housekeepers or you know the people who empty the bins or the consultant , whoever, we can help each other do our job so it's the right outcome for the patient' (Teresa, Staff Nurse, Beech)

'Umm not all the time no... sometimes I doubt myself quite a lot ... oh yeah even though I say to myself this is definitely right, it's definitely right, is it?... (laughs) even though it is ...Oh ok, so then I went off and done my mentorship, but until then I didn't really think, I just focused on the job and made sure the patients were ok...' (Paul, Staff Nurse, Acacia)

'I've been a preceptor a couple of times and I [think] that although I may not have the most experience, I feel that because I'm quite easy to talk to people will come to me rather than going to someone higher up if they've got something, something small to ask so I suppose in that way I'm a role model... I wouldn't call myself a role model in terms of experience because 3 years is nothing' (Vicki, Staff Nurse, Cedar)

It was at the point of taking on an educational role that role modelling begun to have a conscious element and recognition of impact. The staff nurses' perceptions were similar and revealed a developmental and operational trajectory that was aligned to their positions as staff nurses.

Identity changes can often accompany career changes (Ibarra 1999) and can shift over time and across situations (DeRue and Ashford 2010). Formal position impacts on leader identity claims and grants. If the leadership claims and grants that a nurse had previously held, derived from a more senior position, then when that position changes so will the claim and grant. A staff nurse with years of experience felt that she was a leader with a 'little I':

'So yes a leader but perhaps with a small 'I' because of the hierarchy structure and the fact that I work part time its quite clear that there are other people who get more of a say in how things happen than I do which some of the time or most of the time is fine but sometimes is a bit grating.' (Teresa, Staff Nurse, Beech)

This inferred a claim to leadership that was not reciprocated or granted by the team she worked in. This could be explained as a gap in the relational identity

process, her positional role not being aligned with formal leadership expectations of that group. She may not have been seen as a leader in that current position.

5.6.3 Sister and Charge Nurse perspectives

Nurses at Band 6 described leadership from an interactive and group perspective, they described how others go to them for advice and support, confirming this position themselves and being seen clearly in this role. This section explores their perspectives as leaders and role models. The interactive element involved interpersonal skills and motivation:

'...someone who is good at getting other people to do what needs to be done um without them hating it too much (laughs) ...yeah, to do things, and hopefully to do them without having to kind of twist their arm too much because they want to do it for the team not just because they have too... although they have to do that as well...I know but I can't word it... um they need to be persuasive...'(Jane, Junior Sister, Acacia)

'...the main thing is good communication and assertiveness and honesty and good manners... good interpersonal relationships and knowledge... able to manage the situation appropriately...' (Adrian, Junior Charge Nurse, Cedar)

Leaders needed to be able to have foresight, knowledge and flexibility:

'...they always seem to have knowledge of it, it is the foresight, seeing the bigger picture ...' (Claire, Junior Sister, Beech)

They claimed a firm leader identity through their formal roles, that is 'position', this was reciprocated as a grant in reflection of that same positional role expectation and the possession of experience, knowledge and skills that others wanted to learn from:

'I have to be because of the position I am so I'm leading a team when I'm here everyday so yeah I am a leader' (Jane, Junior Sister, Acacia)

'...they will ask advice from me and I help them out, they are recognising something in me or they won't come to me' (Adrian, Junior Charge Nurse, Cedar).

'I've got my own team and they're coming to me with problems and things for me to sort out, advice and I know the other staff nurses as well and health care assistants are using me as well so I'm thinking yeah they're actually seeing me in that role now so...' (Claire, Junior Sister, Beech)

The Band 6 nurses as intermediate leaders can also be granted an identity as a role model as a result of their perceived knowledge, experience and skill in the same way as above; this was strengthened by formal position. Formal position was associated with professional role expectations and a wider influence, more inclusive team behaviours and interactions. Intermediate leaders made 'tentative' to 'firm' claims of a conscious role model identity, this was associated again with their formal positional role expectations inherent in the organisational structure and traditional role hierarchy. This reflected a degree of self-awareness of the effect and impact their behaviour may have:

'I think something probably I realised when I was mentoring students way back and they are copying you, they are literally following you round...[...]. always give the care that you would want to receive ...got to make sure they're doing it properly because they may be looking after me in a few years... I want them looking after me properly'
(Claire, Junior Sister, Beech)

As said, a 'firm' claim infers magnitude, in the manner of the response and confidence within which it was given. Being a role model was considered important and part of a conscious effort. It aligns with the work of Perry (2009) and was reflective of recognition that nurses were always being watched (discussed in section 4.17), one of the Band 6 nurses reported that staff were, *'always after me to learn things because they know I will help them'* (Adrian, Junior Charge Nurse, Cedar)

5.6.4 Ward Manager perspectives

The Band 7s at expert leader, Ward Manager level, referred to more strategic issues in the context of the whole ward, such as developing and gathering feedback from the team, and service development. Leadership was seen to *'brings out the best in people...'* (Alison, Ward Manager, Acacia) they referred to development, *'celebrate someone's strengths but also to constructively look at their weaknesses with a view to improving them'* (Alison, Ward Manager, Acacia) and *'recognise the skills you've got in your team and to use those... [...].to their best advantage.'* (Heather, Ward Manager, Cedar). Time was made to *'speak together very very regularly about how we're dealing with*

different issues and in that team there will be different people leading on different things' (Heather, Ward Manager, Cedar) and succinctly put, as a role model:

'...so leading by example, offer support, guidance, sometimes making difficult decisions, ensuring that quality is adhered to... taking the buck and ensuring that policies and procedures, everything is done properly, yes overall managing... but you know support perhaps stepping in where need be, perhaps having awkward conversations delegating...' (Jill, Ward Manager, Beech)

These expert leaders claimed a firm leadership identity related to their formal position, experience, knowledge and skills, this was strongly endorsed by the collective and organisation which added a strong prototypical element. This means that the role of the Ward Manager is a recognised and established position that reflects leading the ward and acts as a bridge between the team and the organisation. The expert leaders displayed a degree of self-awareness in the critical way they expressed their claims of personal leadership, whether they considered this effective and productive and recognised personal challenges:

'...it's about awareness.... yeah, yeah I am aware of it I am aware of it.. people I think I'm scary but I'm not so I think they're like, when I first met you you were scary but I'm not in the least scary person but to other people I guess I might come across like that' (Alison, Ward Manager, Acacia)

'... the other thing about here is quite strange I was sister of the nurses but then I got something through the post which said 'name' manager... I thought who's this? Oooh it's me, quite daunting I sort of have two roles, doesn't always go well with other members of staff, cos we have [others] and [one] in particular doesn't feel I deserve to be in this post...I don't know I find it quite sad and quite an uncomfortable relationship...I have worked on it and I have had advice from other people but whatever I try doesn't seem to improve the situation... just that one particular individual.' (Jill, Ward Manager, Beech)

Experiences were influenced by relationships and how others might have perceived them. Expert leaders were granted role model identities as they were expected to typify good nursing practice from an organisational, professional and idealistic perspective and be the 'embodiment' of a nurse. They were granted role model identities by their teams:

'...different aspects from NAME and the Ward Manager ... I mean the Ward Manager got her own things which I can learn, not all of them, some of the parts from her... NAME is more strict but she is stern she is quite assertive so I can [get] some bits and pieces from NAME and also the Ward Manager, they got weakness and strengths so I look for the good...' (Adrian, Junior Charge Nurse, Cedar)

'I would say I'm a bit crazy about my ward sister, but don't tell her I would see her as a role model because I think she is very efficient, she's not um, some people might see her as harsher sometimes but I think she gets that balance between getting um the job and still you know being pleasant as well...' (Jane, Junior Sister, Acacia)

'Ward Manager, quite a good role model, the matron ...she does a good job' (Paul, Staff Nurse, Acacia)

The Ward Managers as expert leaders recognised and claimed their identities as role models with some forethought as to when and why, *'probably not until we started to talk about it... but well no that's not true'* (Alison, Ward Manager, Acacia) and attributed growing confidence *'I think it's more since the band 7 cos my confidence has grown'* (Heather, Ward Manager, Cedar).

The transition of nurse to nurse/leader and then formal leader is not a requisite within every nursing role. Whilst leading from a professional perspective may be subsumed within the professional nurse identity, taking on a leadership role may include activities associated with management tasks that offer a less desirable aspect to the role. This is recognised as an area of tension as explored in section 4.8. Retaining nurse identity, competence and skills is salient to the expert nurses in this study and makes their claims as leaders accepting and part of their organisational and formal role. To stay in line with in-group expectations they need to maintain the prototypical behaviours that engender collective endorsement. They clearly expressed a desire to stay involved with clinical practice.

'...you shouldn't ask somebody to do something you're not prepared to or can't do yourself... also if a band 2 asks me to get a patient a commode I get the commode, it doesn't matter what band you don't lose sight of who you're here for...' (Jill, Ward Manager, Beech)

'I have to give an impression of myself and the way I work and the way I manage that this is how something for everyone to aspire to...' (Heather, Ward Manager, Cedar)

If they were perceived more as managers and part of the outgroup, that is 'the management', the grants afforded to them would be reduced.

5.7 Factors affecting claiming and granting

As noted in section 2.6.2, progression as a leader is reflective of a cognitive bootstrapping process whereby micro-level skills are first learned through problem-related experiences or observational learning (Lord and Hall 2005). Lord and Hall added that skills are then organised into higher-level systems that guide knowledge, behaviours and social understanding. The path of nurse/leader development in each of the cases displayed an increasing awareness of individual everyday operational leadership to the wider strategic perspective, demonstrated by the established nurse leader. Reference was made to the broader context; this was aligned with developing leadership activity and looking beyond a personal sphere of practice. It was suggested that being able to see outside of the current situation into the bigger picture was an important distinction in a leader. This infers a move from an individual perspective to one that encompasses both the clinical area and the broader context. It also typifies how leadership claiming can be linked to expectations and seen as a form of leadership behaviour. Leadership was concerned with being able to listen, being non-judgmental; being unafraid of talking to people, making difficult decisions, acting assertively and sometimes keeping a distance.

Similarly, recognition of self as role model followed an incremental path through the nursing band roles for comparable reasons. Acting as a role model was primarily focused around delivering best care and behaving in an aspirational way - overt behaviours aligned with effectiveness as a nurse. The kind of craft knowledge that Perry (2009) suggests is possible to obtain through role modelling is not usually documented or in an accessible format for other nurses, by its nature it is idiosyncratic and practical, therefore it is difficult to share further than the immediate context. In this study role models were perceived as those who lead by example on a range of aspects, they epitomised their roles, were self-aware and inspired others. An 'embodied'

perspective fits with a prototype of the 'good' nurse; this was seen in everyday practice and as highlighted, typified by this response,

'I think everyone is a role model... it can be for everyone up or down...'
(Jill, Ward Manager, Beech)

Emerging leaders, that is the band 5 staff nurses, articulated a growing recognition in regard to being a role model, this inferred that any 'good' nurse could be a role model to an individual aspiring to improve. These concepts merged when role models were leaders – from then on, the expectation to be a role model, was more defined and aligned with position. Being seen as a leader was more strongly allied with formal position and managerial type tasks. Within the social milieu that the cases provided, this type of practice learning took place within a complex interchange of professional and social identities.

The trajectory of claiming and granting identities followed an incremental journey. This coincided with existing structural models in leadership but was less linear and formal regarding role modelling. Application of Bandura's (1977) social learning theory contributes to the understanding of how participants identified their role models and similarities and differences therein. This can be multifactorial, the impact of the model themselves is relative to the observer, whether they are engaging and personable, how frequently they are observed and whether the behaviours are salient and/or complex.

5.7.1 Embodied and conscious role models

There was a tension between being an embodied and conscious role model. Identities as embodied role models were granted to nurses in response to a variety of factors. Participants afforded a 'grant' as a role model to those with aspirational behaviours and also 'claimed' an identity as a role model if they then saw that in themselves. Poor role models were also recognised across the cases; examples were congruent with personal motivators, in that someone who did not perform well, or display the desired behaviour, in their

role, was viewed as a negative role model (Int 8.3.16) This means that role models who were perceived as poor were not granted that identity.

A grant as an 'embodied' role model did not necessarily occur in response to a claim though, as being seen as a role model did not require a consenting relationship. Embodying a role as a model occurred as part of everyday practice. This adds to Felstead's (2013a) work and the effect of conscious role modelling and 'playing a role' rather than being an embodiment of a behaviour which happens naturally. Jack et al. (2017) suggest that the act of identification makes someone a role model, rather than someone being perceived as a role model simply because of the position they occupy. Nonetheless, formal leadership roles in this study attracted identities as role models, reinforcing this through self-identification, albeit with a degree of irony as illustrated in this response:

Researcher – *Do you see yourself as a role model?*
'...it's probably in my job description truth be told...I know I have to try and be a role model' (Alison, Ward Manager, Acacia)

Identities as conscious role models were afforded and granted to those who purposefully performed as a role model and recognised the implication of this where being a role model was expected as part of the individual's formal position.

5.7.2 Ideals

Claiming an identity as a role model was confounded by how a role model was seen by some to be perfect, almost idealistic and slightly out of reach, as in these responses:

'it's almost like a kind of association with the role model being perfect'
(Alison, Ward Manager, Acacia)

'you see this person that you're trying to be, trying to mimic and you're not getting anywhere near it and sometimes it can make you feel mightily inadequate...' (Claire, Junior Sister, Beech)

Researcher - *Do you see yourself as a role model?*
'No not really... I try not to have any ideas above my station really, I hope that I am for example for students, yeah I like to think I am for students I know what I'm doing here and I like giving that information to students and I like to make them feel comfortable because I can

remember what it was like when I was a student and had some good experiences and some really bad ones so I always try to explain everything' (Laura, Staff Nurse, Beech)

This was tempered as *'being the best you can be'* (Alison, Ward Manager, Acacia) and in particular situations as with students above. It was suggested by this study's participants that attention to personal role modelling meant showing others what you expected to happen, someone would learn from observing another's behaviour, *'the best you can be in your job so that others will want to be the same...'* (Alison, Ward Manager, Acacia). This was referred to when describing leadership, *'lead everyone into how you want to work so you're going to work that way that you want to be'* (Claire, Junior Sister, Beech) implying the modification of personal behaviour knowing that people would follow.

5.7.3 Self-Comparisons

The change in perceptions and modification of behaviour reported by participants inferred a degree of conscious performance and increasing awareness. Lord and Hall (2005) highlight different type of identities: individual, relational and collective, these refer to how and to what the self is perceived; uniqueness, roles and relations or groups respectively. Dependent on need, they could direct attention to specific types of role model comparisons and ally with Bandura's (1977) attentional phase. The performance of different role models were viewed as comparators for behaviour, the participants critically appraised different approaches to delivering care with the aim of providing a high-quality service:

'My first manager as a nurse she ruled by fear, amazing at her job... but even the patients used to dread Friday mornings because that was the bath, never asked or wanted, just got, she was a brilliant, brilliant nurse but yes she was just scary, I used to think I don't want to be like you...' (Jill, Ward Manager, Beech)

'..like our Ward Manager for example, to me she's so calm and collected and together all the time, she's sort of umm ... you know I sort of aspire to be like that I think (laughs)' (Jane, Junior Sister, Acacia)

'I know what I'm doing here and I like giving that information to students and I like to make them feel comfortable because I can remember what it was like when I was a student and had some good

experiences and some really bad ones so I always try to explain everything' (Laura, Staff Nurse, Beech)

This gives a double loop aspect to claiming and granting identities as a role model, because it is through comparing with a model that an individual then goes on to claim a particular identity, this can be seen in this response from one of the Ward Managers:

'I think a role model is what you're trying to achieve for yourself so I suppose my best role model for me would be the ward sister that I took over from, who is now my matron so yeah I do think how would she have dealt with that and yes some things I deal with completely differently cos I might have seen her deal with and think yeah that's not me, so I think as a role model you don't have to follow exactly what that person did because this is my ward now and I had to make it my ward. So, I will deal with things differently but it's ... yeah I suppose admiration does come into it, you admire how somebody works...'
(Heather, Ward Manager, Cedar)

Gibson (2003) suggests that role models challenge the stable self- concept. This self-comparison process is important because it drives future behaviour. Participants made judgements on whether or not they possessed the necessary skills to be effective clinicians and role models through a series of self-comparisons with their 'ideals'.

'... sometimes you think yes...I've done it, if that person was here and they saw me they would think yeah you're on it...' (Claire, Junior Sister, Beech)

Markus and Nurius (1986) tell us that possible selves are derived from past representations and previous social comparisons; they include representations of the future self but are different from current selves. Possible selves are considered important because they can drive the acquisition or avoidance of future selves in addition to taking an evaluative approach of the self (Markus and Nurius 1986). For example, striving to keep the morale up was considered a positive quality of a role model and therefore a behaviour of a desirable possible self. Ibarra (1999) argued that people adapt to new professional roles by experimenting with images that serve as 'trials' for possible but not yet fully elaborated professional identities. These can be linked to professional role frameworks, progression and promotion. He called these 'provisional selves' and in the cases, they represent the

embryonic role identities that are emergent. This also relates to the work of Guillen et al. (2015) who proposed that there are two types of internal comparisons: self to prototype and self to exemplar; the former being abstract, general representations of a social group and the latter, comparisons to specific individuals with whom people have interacted or still do to a degree in their daily lives. These comparisons motivate individuals to achieve modeled skills when perceived as similar to the role identity, however there are significant differences in how these self-comparisons are contextualised and therefore are unique to the person.

The use of self-comparisons helps us to understand how participants in this study developed role identities. They moved from not being aware that they were role models and leaders to recognising they were, this contributes to new knowledge. This was exposed in the language that participants used when making claims. Hesitant language was used when the participant was unsure, or without great confidence, claims are tentative and expressed in a questioning way, 'I hope I.....?' (For example, '*I know I have to try and be a role model I hope*' Jane Junior Sister, Acacia) or initially in the negative, or when a role was new, awareness that they might be perceived in that role as evolving. This altered to a more confident response that changed from 'not really' and 'hopefully' to 'yes'. When claims are made 'firmly' they are explicit and known, they change to 'Yes, I am a...' (For example, '*...I believe most of my junior you know like newly qualified nurses...*' Adrian, Junior Charge Nurse, Cedar, for someone who had been on the same ward for many years). Claims also contained a level of acceptance which was underpinned by formal position and feedback on efficacy in role. Possible or provisional roles become actual.

5.7.4 Leaders as models

The participants with more experience and insight into management type tasks tended to see fewer role models in current leaders although this was qualified by their views on what a role model should be, for example:

Researcher - *Do you view your leaders as role models?*

'No not really (quiet)... I don't think that they're not any good and I don't not respect them and have a lot of time for them and I do feel generally supported by them but I don't think they're role models no... it's almost like a kind of association with the RM being perfect and because I know that nobody's perfect.' (Alison, Ward Manager, Acacia)

Participants granted role model identities to individuals from within their team (section 4.5, 4.5.1, 4.10, 4.10.1, 4.17) though, and/or their Ward Managers viewed as sources of emulation, for example:

'Two people in this department, 1 female and 1 male – they both have a lot of knowledge and experience, they've got a way of handing people and it's just the way they get things done and yeah I look up to them for all those reasons, it's good to have somebody to aspire to.' (Laura, Staff Nurse, Beech)

This concurs with Gibson's (2003) work which found that the social environment can serve to restrict access to role models by making them more, or less, available. Participants in this study referred to particular role models and generally more aspirational nurses. The leadership aspect was evident, in that role models were initially described with reference to 'lead', particularly by those with more formal leadership roles, such as the Ward Managers as seen in the below.

'My understanding would be that somebody that leads by example' (Alison, Ward Manager, Acacia)
'ummm role modelling I would say is leading by example' (Jill, Ward Manager Beech)

In contrast to this, the Staff nurses focused on the more nursing role modelling perspectives first. Essentially a role model would embody identified skills, qualities and attributes associated with effective nursing and a growing recognition of this, whereas a leader would be expected to display them purposefully by warrant of their position. This represents a movement from a 'person' level explanation to 'position' with accompanying 'results' and 'process'. At the most basic level as a nurse became more experienced, they were expected to lead care for an increasing number of patients and teach and support junior staff in the context of their ward. Expecting to 'lead' on a relatively formal incremental trajectory contributed to the participants ongoing professional role identity within their social groups. Yaeger and Callahan (2016) and Kragt and Guenter (2018) propose that the strength of the self-

view as leader and alignment between role expectation and individual leader identity make people more likely to develop and act as a leader. It was seen in this study that participants in a more senior leader position (Band 6 and 7) saw themselves as leaders more readily than those who occupied a more junior Band 5 role. The perspectives of the Ward Managers and team members reflect 'leading' and 'following' despite the differences within each ward context. Koskiniemi et al (2017) suggest that an individual constructs a social identity as part of a specific group, this is manifested in relationships with each other and their perceived place in the team. As previously stated, leaders and followers are interdependent roles embedded within a social system (Hogg 2001), this means that leadership and group driving forces reflect social cognitive processes inherent in group membership.

5.8 Summary

The findings in this chapter present an argument for how the care context can influence leader behaviour. It supplements the typology of Grint (2010) by including care context as a key factor for leader location. This has an impact on how and where the Ward Managers operated in their everyday roles. Common to all was the desire to contribute to care delivery as the professional lead and manager, this was realised in different ways in the different contexts. This foundation for nursing practice affects the wider team and followers. The social nature of those contexts formed the foundation for leader and role model identity co-construction through a series of grants and claims. It provides a new insight into how awareness of self as role model can occur and corresponds with growing leader identity construction in formal roles. The main factors underpinning this are complex and plural. This followed an increasing trajectory of self-development based on feedback and interaction with others.

Chapter 6 - Conclusion

6.1 Introduction

This chapter outlines the contribution that this study makes to professional nursing practice and leadership. It presents the key findings and contribution to knowledge discussing the implications for nursing practice. A critique of case study methodology in relation to this study is offered in combination with how the limitations of the study were addressed. A summary of key reflexive aspects is offered with reference to personal and researcher development. The chapter concludes by proposing areas for further research.

6.2 Key findings and contribution

This study makes a unique contribution to nursing knowledge as it provides a new way to look at leadership and role modelling in nursing. It contributes to several streams of literature. The key findings were that the care context had a significant influence on Ward Manager leader location and set the terrain for the social groups from which co-construction of leader and role model identities stemmed. This primary research study demonstrated that formal leaders are role models, role models lead by example, but role models are not necessarily formal leaders. This simple statement captures the basic premise seen within the cases. Developing a professional role identity necessitated learning and that was accessed partly through the observation of a role model. Nurses did not automatically become formal leaders; they did however take on a leadership persona in a social group by virtue of their perceived experience and competence, this supports the work of Lord and Hall (2005). Nurses were looked on as role models whatever their positional role, this was associated with behaviours, experience and knowledge, embedded within traditional hierarchical cultures and enduring organisational structures in nursing. Utilising DeRue and Ashford's (2010) application of claims and grants as a role model presents an original contribution to knowledge.

This study has illuminated how role modelling was displayed in the cases and illuminated the relationships between being a leader and being a role model.

Although the connection is based around influence, whilst sharing common aspects associated with learning and behaviour the leadership rhetoric contains role modelling as an element rather than role modelling as a distinct concept. The nature of the care context and how the nurses subsequently delivered care as part of a nursing team and social group, impacted on the notable role that Ward Managers as directors of the team performance (Goffman 1959) played in the cases. The distinct uniqueness of each case and care context therein, transcended similar job titles and organisational structures. The participants worked in their respective teams contributing to the character of the ward social groups. How they interacted with each other and the environment was linked to the care context. The leader location of the Ward Managers: I am in front; I am beside you and I am behind you, aligned with these. The shared desire to contribute to care delivery in their ward locations had a pivotal impact on leadership positioning and location. The care contexts were different across the cases. The visibility of the Ward Manager as leader and role model therefore differs across the cases with the care context having the discriminating impact and afforded a high priority. Physical factors such as office location, uniforms and care delivery model were contained within this and influential. The leader location formed the backdrop for the modelled content whether originating from the Ward Manager or other staff. It encompassed the clinical climate within which leading and following occurred. The key impact and learning point being the role of a model in leadership, leading and following.

The association between role modelling and leadership can be expressed through identity development. Nurses claimed and were granted identities as leaders and role models on a developmental trajectory. This development was attributed to self to prototype and self to exemplar comparisons. Self-comparisons amplified claims and grants and had a double loop effect – observing a role model, conducting self to exemplar comparisons - to becoming a role model. Identities as role models attracted fewer claims in individuals until they recognised themselves more strongly as leaders. The cases also revealed the unrelenting fact that ‘position’ holds a continued prominent effect regarding leader and role model identity construction. Leader

identity construction aligns with an experiential and hierarchical pathway. To a certain degree role model identity mirrors this when associated with a leadership perspective. However, this is in contrast to when role modelling is related to excellence, in that instance anyone potentially can represent this and therefore it is non- positional and not related to a specific role.

Being afforded a grant, that is given an identity as an embodied role model was affiliated with someone who did not necessarily claim that identity. This means that some individuals did not recognise themselves as a role model but were regarded as such. They were considered in a favourable light as exemplars. This supports previous research around how an individual identifies a role model. I have advocated that leadership is within the remit of all, based on the drive for a collective, compassionate and inclusive approach to leadership in current literature and political discourse. Whilst this is theoretically feasible, it carries a critical tension in that there are significant factors, such as lasting hierarchical structures, which make this difficult to put into practice however the 'leadership' aspect of role modelling is accessible to all nurses.

6.3 Implication for nursing and healthcare

The desire to 'Do a good job' as part of an effective and cohesive team figured prominently in this study. Effective teams necessitate effective leadership. Stanley (2008) found that clinical leaders were seen as being approachable, visible, adept in communication, clinically competent and viewed as role models. In section 1.6 I suggested that collective, compassionate, inclusive, authentic, approaches to leadership were becoming synonymous with effective leadership in the health service rhetoric. The value placed on leadership and the high profile of it in today's healthcare, reflecting an enduring drive that NHS staff have a desire to provide the best healthcare, as suggested by Dixon-Woods et al. (2014). This case study holds true to that tenant.

The challenges in current health and social care remain and have been heightened during the unprecedented time of the Covid-19 pandemic. The call for leadership, and the responsibility placed on the health care service to rise to the challenge from a national and global perspective has been enormous. Leadership and positive role modelling at this time has been critical. Indeed, nurses have been at the epicentre of this response, needing to display resilience and adaptability as do the rest of the workforce (James and Bennett 2020). Being seen as a role model was one of the most important tasks of nurse leaders according to Mollahadi et al. (2021), in their study of nurse leadership style during the Covid-19 crisis. Hulks, from the Kings fund (2020), asked whether heroic leadership was the order of the day, suggesting that despite the unparalleled circumstances and expectations placed on leaders, it is important to recognise that leadership is about relationships. Ironically in the context of covid-19, with a task so enormous, the model of leadership followed a command and control, master -servant approach as safety and well-being of the population was paramount (Rosser et al. 2020). However, as the world navigates through new territories in the search for a 'new normal', staff still need to be led and treated with compassion and that remains at the forefront of the 'Courage of Compassion' report commissioned by the RCN foundation (West et al. 2020). Nursing leadership should be strong whether by the bedside, in the boardroom or classroom (Dickow 2021). Um-e-Rubbab et al. (2021) examined how supportive leadership behaviours influenced nurse well-being during the pandemic. They found a positive and significant relationship between supportive leadership and psychological capital. Clear, strong and visible leadership was seen to reduce the impact of high stress events (Phillips et al. 2021). This continued entreaty means that this study offers a means to explore a space in the leadership rhetoric, it exposes role modelling as a leadership behaviour and contributes to enhanced understanding of the interface between role modelling and leadership and the exchange of follower and leader roles.

There are a number of implications for nursing, nursing leadership and nursing education arising from this study. These emanate from an individual, team and organisational basis and have an impact on practice at a personal

and professional level. Essentially acting as a role model can be seen as leading in the sense of leading by example. This is the first connection to leadership. The second connection is when being a role model is expected as part of being a leader. In this study overarching factors have emerged: the act and impact of learning from a role model is evident in the nursing team; being seen as a role model is within the gift of anyone at any positional level, essentially constituting being 'followed'; and at some point in their developmental trajectory an individual begins to recognise themselves as a role model and this can happen when they become formal leaders. These factors have an impact in different ways.

6.3.1 Being a role model and leader for nursing practice

The participants' perceptions of themselves as conscious, that is purposeful, role models were congruent with, and matched the expectations of their everyday work role: Ward Manager, Junior Sister, Staff Nurse, Mentor and their life outside of work. Public expectations derived from generally held traditional 'common sense' perceptions of what nurses do and how they should behave, but also contributed to the group prototype and collective endorsement. Being seen as a role model did not require a consenting relationship. Identities as conscious role models were afforded and granted to those who purposefully performed as a role model and recognised the implication of this where being a role model was expected as part of the individual's formal position. As presented in section 5.4 the evidence in this study demonstrated that formal leaders were role models by virtue of expectations and behaviours. However, whilst role models 'lead' they were not always formal positional leaders. The practice of leadership and leader identity development in the cases, was particularly associated with clinical effectiveness that sprang from experience, knowledge, skills and formal position which had been gained over time.

Recognising that individuals are seen as role models by those around them, whether in a professional capacity or otherwise, consensual or not, can make being a role model a conscious strategy. This case study supports previous

research but has deliberately explored role modelling through a leadership lens. Although there is some criticism of the embodied role model from a conscious perspective, the positive impact of awareness from a leadership perspective is beneficial. Cruess et al. (2008) saw conscious role modelling as a way to improve performance. Therefore, this study acknowledges that role models are prevalent and influential in the practice environment for a variety of reasons and can impact practice positively or negatively. Recognising self as role model and therefore leader can be crucial in expanding leadership capacity across teams and organisations. Adopting a role modelling standpoint in the drive for shared, collective, inclusive leadership assists with appreciating the impact on those around which is a cornerstone of leadership behaviour.

6.3.2 Awareness of role model as leader

As discussed in section 1.3, the social collective element of leadership is rooted in the notion of leaders and followers, roles which can be interchangeable and dependent on any given time and space (Ladkin 2010, Haslam 2011, Barr and Dowding 2016). A role model is followed in the most basic sense, as Bandura (1977) reports, the modelled behaviour has relevance and captures attention. The critical element is influence through communication, intentional or otherwise.

The path of nurse/leader development in each of the cases displayed an increasing awareness of individual everyday operational leadership to the wider strategic perspective, demonstrated by the established nurse leader. This was situated within each role and the incumbent expectations at that time, for example, Staff nurses focusing on more nursing role modelling perspectives first. Essentially a role model would embody identified skills, qualities and attributes associated with effective nursing and a growing recognition of this, whereas a leader would be expected to display them purposefully by warrant of their position. This represents a movement from Grint's (2010) 'person' individual level explanation, to the wider 'position' with accompanying 'results' and 'process'. At the most basic level as a nurse

became more experienced, they were expected to lead care for an increasing number of patients and teach and support junior staff in the context of their ward. Expecting to 'lead' on a relatively formal incremental trajectory contributed to the participants ongoing professional role identity within their social groups. It provides a new insight into how awareness of self as role model can occur and corresponds with growing leader identity construction in formal roles. Coupled with this is the notion that nurses learned to lead from role models themselves, this is redolent of Perry's (2009) work.

Developing self-awareness and purposeful attention to role modelling and its associated behaviours in routine practice can be useful as a means of distinguishing areas for leadership development. If the next generation of nurses are to access great and inspirational leaders and role models to nurture and promote excellence in practice (Sines 2013, Scully 2015) then understanding the underlying concepts are crucial. Dickow (2021) suggests that nurse leaders need to demonstrate persistence in the goal to push forward and inspire others.

At some point, in their growing self-awareness, an individual recognises that they are a role model; being able to capture that moment could assist with purposeful development, role identity and leader identity. The juncture where being a role model and being a leader connects could be that point. The rhetoric on leadership discussed in chapter one details the challenges of leadership development. The provision of guidance and support in the form of organisational processes specific to role modelling as a leader could increase understanding and drive positive performance, resultant behaviours and service impact.

The participants enacted their roles as nurses in the social situatedness of their ward teams. As discussed in section 5.6 nurses in this study saw themselves as leaders and role models, this was linked to formal roles, expectations, knowledge, experience and perceptions. These identities, professional and otherwise, were created in the social context of the wards and are important as they help to explain these concepts in nursing and

strengthen the positive aspects of learning from leaders and role models by conscious attention to these roles. Effective leadership is reliant on enabling the development of effective leaders who can meet the needs of all stakeholders (Manley et al. 2011, Hewison and Morrell 2013, West et al. 2015, Akhtar et al. 2016). As noted in section 5.6.4 the transition of nurse to nurse/leader and then formal leader is not a requisite within every nursing role, although leading from a professional perspective may be subsumed within the professional nurse identity. How self-comparisons were utilised helps us to understand how participants in this study developed role identities. They moved from not being aware that they were role models and leaders to recognising they were, this contributes to new knowledge.

Learning from a role model involves a process of self-comparison or internalisation and encompasses a variety of nursing applications. Learning from a role model has an impact on an individual in two ways; firstly, through direct learning and emulation and secondly through the observed reactions of others (Horsburgh and Ippolito 2018). As highlighted in section 5.7.3 the performance of different role models were viewed as comparators for behaviour, the participants critically appraised different approaches to delivering care with the aim of providing a high-quality service. Therefore, harnessing the impact of a role model through direct application to professional roles, which include displaying leadership behaviours, could have an effect on an individual at personal, team and organisational level. The impact diffusing throughout structures. This is already widely known and acknowledged in educational settings, the NMC (2018b p. 6) expect that all student nurses will be supervised by Practice Supervisors who serve as role models for safe and effective practice in line with their code of conduct. It could also be considered and applied to the leadership function across nursing teams. This study clearly demonstrates that nurses as leaders are followed, whether in a formal role position consciously, purposefully acting as a leader or embodying the positive behaviours of effective nurses.

6.3.3 Future objectives for development

In summary, registered nurses provide leadership for effective practice as role models, they are expected to understand what effective leadership is and lead and coordinate care (NMC 2018c). Including the concept of being and learning from role models, encompassing leading and following, explicitly in all aspects of pre-registration and post-registration development is recommended on the basis of this study and could specifically consider the aspects below:

- Explore and critically reflect on the underlying concepts associated with role modelling and leadership
- Identify individuals who are seen as personal role models, whether in a professional capacity or otherwise, consensual or not.
- Recognise self as role model and leader, crucial in expanding leadership capacity across teams and organisations.
 - At some point, in their growing self-awareness, an individual recognises that they are a role model; being able to capture that moment could assist with purposeful development, role identity and leader identity.
- Employ being a role model as a conscious strategy,
 - adopt a role modelling standpoint in the drive for shared, collective, inclusive leadership to assist with appreciating the impact on those around which is a cornerstone of leadership behaviour.
 - harness the impact of a role model through direct application to professional roles, include displaying leadership behaviours.
- Contribute to the provision of guidance and support in the form of organisational processes specific to role modelling as a leader in order to increase understanding and drive positive performance, resultant behaviours and service impact.
 - Leadership development strategies, preceptorship programmes, support of practice learning and nurse education.

6.4 Contribution to methodology

One of the strengths of this study is the use of a collective case study that enabled the exploration of leadership and role modelling in the 'real world' of nursing. Previous research has focused on either concept separately with the respective alternate role emerging in the findings. The qualities, attributes, impact and identify of role models and leaders has been investigated. Leadership studies in nursing have supported role modelling in leadership. Role modelling studies have been contextualised in educational perspectives. This case study has explored leadership and role modelling in the same space from different perspectives, different clinical environments with different nurses using different methods of data collection.

Triangulation added rigour; this concentrated on systematically detailing the steps and rationale for decision making throughout the research process, utilising different methods, collecting different participants perspectives and undertaking rigorous reflexivity myself as researcher. The flexible integration of theoretical perspectives in this work also contributes to the rigour of case study methodology and enabled navigation through the complexity and plethora of theory associated with leadership and role modelling. In particular the methodology of Stake supported an open and relative approach. Upholding the central principle of maximising learning aided an effective focus for design choices. A constructivist approach underpinned this which allowed data to be presented and analysed through a socially constructed lens. It was important to capture the contextual nature of nursing within the subtle, but expansive subjective realities of clinical practice. The abundance of data and ability to provide a rich, detailed picture of each case supported the tenet of naturalistic generalisation which enables the reader to make their own personal connection with the phenomenon.

6.5 Reflexivity

There were times during the research process which I found personally challenging, however, through rigorous reflexivity I believe I maintained my objectivity and consequently the integrity of the research. Initially, this was on

commencement of data collection and being present in the clinical environment. I found this quite overwhelming, largely because at the outset of this study I was singularly focused on leadership and the importance of this in nursing. I had forgotten that this was very obviously not the everyday priority for the nurses in my study: being a 'good' nurse and providing effect care were the primary aims. This aligned with my personal ideology as a nurse but has been obscured by my present role as an academic away from clinical practice. It had been many years since I was in a clinical practice environment for any length of time and it caused me to consider whether I could call myself a nurse anymore.

Being familiar with the literature on leadership, had contributed to my personal beliefs and values on nursing leadership, this had developed over the many years I have been nursing and by its insidious nature was not open to me. I found it particularly challenging not to look for and make comparisons that were outside the boundaries of the case. I also felt very concerned that I might encounter and witness poor practice but in fact the reverse was true and contributed to my admiration of those who I was observing. There was a risk that because of this I would lack that critical gaze. Nevertheless, systematically reflecting on my role as a nurse, educationalist and researcher at every stage of the research process enabled me to acknowledge and recognise any biases and rationalise decisions throughout this case study.

6.6 Study limitations

Any study is not without limitations. Stake (2006) sees a case as dynamic, operating in real time, with other cases. The cases are purposive, interactive and strong, but also at risk of encountering obstacles. In the sense of this study, the day-to-day challenges of running a health service in the field. Undertaking research in the real world requires a level of understanding that the context may change. A change in service design resulted in difficulty obtaining documentary data and challenges in recruiting participants to attend a focus group. Whilst three job descriptions were provided, only one of these were specifically aligned to the ward cases. Accessing documents can be difficult and considered a weakness (Gangeness and Yurkovich (2006).

Whilst indicative of broad role descriptors they were not sufficient to confidently gain an understanding of what was expected in relation to specific nursing roles in each case.

Nonetheless, methodological triangulation and the design choice of an instrumental collective case study mitigated for this. It allowed for multiple participants in the cases, with some participants being involved in both non-participant observation and interview. This means that there was a variety and richness in the data that offered meaning to the subjective and multiple constructions of the participants within and across the cases. Theoretical triangulation also allowed for deductive thinking and further advanced the analytic stages of the research.

Case study methodology does not aim for generalisation in the sense of a positivist stance and this can be considered a limitation. However, Stake advocates for naturalistic generalisation and it is within the context that this study is framed. The individual cases present a means through which readers can encounter role modelling and leadership with which to reflect and explore, comparing with their own personal constructions, the cross-case analysis, the quintain and an abstract view. Stake (2006) discusses a case/quintain dilemma, this means that both the quintain (the whole target) and the cases, become more worthy of attention, as fast as they are studied. The notion here that the more something is understood, the more there is to understand, at the core of the epistemological argument for generalisation (Stake 2006). He suggests that both the collective and the specific are worth knowing. Thus, the narrative text should be sufficiently detailed to give a picture of each case and insight into each concept, separately and together. This case study acts as a stepping stone for further interpretation.

6.7 Recommendations for future research

Further work is required to bring greater insight and understanding on the existence of role modelling as a leadership behaviour. Research that explores how leaders develop and act as role models in contemporary nursing practice,

needs to gain a profile in the nursing research agenda. Currently this research is scarce, and literature mainly located outside of healthcare or from non-empirical sources. Findings from this study demonstrate the potential and actual impact of the leader and role model.

The current backdrop, finding a way out of a pandemic, significantly impacts not only on the service but the staff within. The first follow up study could go back to the cases and seek data as to the impact of Covid-19 on role modelling and leadership within those contexts, to explore the impact of any change on leadership location. Leadership during times of crisis is particularly relevant at this point in time. This connects to the work of Meindl et al. (1985) on the romance of leadership and instrumental risk in leadership, linked by DeRue and Ashford (2010) to granting a leadership identity to someone during uncertain times.

Based on the findings of this case study, additional case studies in different contexts could contribute to the discourse. Whilst this case study explored the concepts from a nursing perspective, the continued political drive for shared leadership across integrated care systems would allow further exploration within a multidisciplinary frame and enable investigation outside of nursing hierarchical structures. Equally additional exploration of leader location in alternative settings could extend understanding of this aspect of nursing leadership.

Personal leadership effectiveness could be enhanced by leadership development and the inclusion of role modelling awareness. This could be the subject of further research and either focus, for example, on individual experiences to increase understanding on those experiences through a phenomenological study. Alternatively, an action research approach could enable collaborative development on leadership within a specific team, based on a leadership programme.

These approaches propose making the benefits of role modelling as a leadership behaviour tangible and definitive in nursing, there could also be

contribution to knowledge in the wider leadership field for example through a grounded theory study of nurse as role model, specifically to seek to discover how this occurs. From a leadership perspective, a discourse analysis on the language used in nursing leadership would be illuminative in understanding the political influences.

6.8 Dissemination

Translating and sharing findings is critical for the nursing profession. Dissemination is planned which considers the target audience and potential impact nationally and internationally. Publications are planned which encompass three areas. These are the impact of care context on leader location and the role of the Ward Manager; the development of role model and leader identities as a series of claims and grants; and the notion of role model as leader and impact on leadership development strategies. This will be set within educational and practice arenas with presentations at conferences planned for 2022/3.

6.9 Conclusion

This study makes an original contribution to understanding how leadership and role modelling are associated and demonstrated in nursing. The care context had a significant influence on Ward Manager leader location and set the terrain for the social groups from which co-construction of leader and role model identities stemmed. This primary research study demonstrated that formal leaders are role models, role models lead by example, but role models are not necessarily formal leaders. Understanding and harnessing the potential of role modelling would support the development of a shared, multi-role wide approach to leadership which is advocated in contemporary healthcare.

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Appendices

Appendix 1

<p>Antecedents – personal history and trigger events, family influences, role models, life challenges, work experiences, personal growth and development</p>		<p>Authentic Leadership (Gardner et al. 2005)</p>
	<p>Application to nursing practice</p>	
<p>Self-awareness – Values, Identity, emotions, motives/goals reflected in high levels of self-clarity and self-certainty, who they are and what they value</p>	<p>To model authentic behaviours:</p>	
	<p>To express committed values through sharing vision and goals, operationally and strategically</p>	
	<p>To treat others fairly with respect and equity, to be trustworthy</p>	
	<p>To be credible, aware of accountability as practitioners and display this in practice through decision-making, prioritising, enacting expectations of the role</p>	
	<p>To lead, guide, support and enable the team to deliver a timely high-quality service</p>	
<p>Self-regulation – Internalised, balanced processing, relational transparency, authentic behaviour – the exertion of self-control, self concordance. Accurate perceptions of self and others, communication, consistency</p>	<p>To be aware of the emotional environment and respond with empathy and insight</p>	
	<p>To be able to motivate others to achieve short and long term goals</p>	
	<p>To be able to contextualise and operationalise organisational goals into the local context</p>	
<p>Organisational climate – inclusive, caring, ethical, strength based</p>	<p>To be open and honest in relationships, to be visible and available</p>	
	<p>To be inward and outward facing as a leader in the organisation</p>	

Application of Authentic Leadership (Gardner et al. 2005) to Nursing Practice

<p>Attentional processes – determine what is selectively observed and extracted: modelling stimuli and Observer Characteristics</p>		<p>Learning through Observation - Social Learning Theory (Bandura 1977)</p>
<p>Retention processes – People need to remember it, two representational systems - imaginal and verbal Symbolic coding, Cognitive organisation, symbolic rehearsal, motor rehearsal</p>		<p>Application nursing practice</p>
<p>Motor reproduction processes – converting symbolic representations into appropriate actions</p>	<p>Perceived similarities in role influencing attention to modeled behaviour – ‘to nurse’ - Communicating with patients, public and staff, Delivering care competently, Being a lifelong learner, Managing challenging situations, Making clinical decisions, Delegating and prioritising tasks in a complex environment, Managing resources, Developing confidence as a practitioner</p>	<p>Frequency of contact with role models – everyday team – occasional contact</p>
<p>Motivational processes – people are more likely to adopt modeled behaviour if it results in outcomes that are valued</p>	<p>Relevance to current job role – gaining experience, changing roles, skills, knowledge</p>	<p>Transfer of Learning from previous experience and observed behaviour - comparisons</p>
	<p>Ability to practice modeled behaviours – expectations of role, developing</p>	<p>Access to training in support of these – learning opportunities, endorsements, expectations</p>
	<p>Opportunity to self-evaluate reproductions of modeled behaviours</p>	<p>Receipt of feedback – from other team members</p>
	<p>Clarity of salience and relevance of modeled behaviour – expectations, achievement, role</p>	<p>Link between desired behaviour and personal/team goals</p>

Application of Bandura’s Social Learning Theory (1977 to Nursing Practice

Appendix 2

Participant Information Sheet

Study title – ‘A critical exploration of the variety of forms in which role modelling as a leadership behaviour can be performed in nursing’

My name is Rachel Heathershaw and I am in the third year of undertaking a PhD at the University of Brighton. My specific area of interest is leadership in healthcare. As part of that interest I would like to invite you to take part in a research study that will be looking at role modelling and leadership in nursing.

Before you decide whether to take part, it is important for you to understand why this research is being done and what it will involve. Please take the time to read this carefully. Ask me if there is anything that is unclear or if you would like more information.

Background to the study and research aim.

The aim of the research is to explore role modelling and leadership in nursing practice. Effective leadership in healthcare is very high profile and seen as necessary in order to provide high quality care. This research will explore role modelling and how this might connect with leadership. In order to do this I will be carrying out observations of registered nurses, assistant practitioners, healthcare assistants and student nurses in clinical practice. I will also conduct focus group and individual interviews.

Who will be taking part?

I am looking to recruit assistant practitioners, health care assistants, student nurses and registered nurses of different bands from a single division. I would like to invite all of these individuals from the division to take part.

If I take part, what will I have to do?

I want to collect information in two different ways: firstly by observation of nursing practice and secondly by speaking to assistant practitioners, health care assistants, student nurses and registered nurses.

Initially, I would like to undertake some observation of practice. This means observing practice within the ward and clinical division; and would require me spending some time with nursing staff as they go about their normal duties and also carry out general observation in the clinical environment. I would like to explore how staff interact with each other; this could be as part of their daily routine; handover, directing care, interacting with other staff and attending meetings.

If you agree to take part in this research I would then like to ask you some questions about your experiences and opinions during a focus group or individual interview. The focus groups will be made up of staff from the same

band but possibly different wards. I will use a prompt sheet but there are no right or wrong answers; I just want to hear about your experiences and explore role modelling and leadership behaviours in practice.

It is anticipated that the focus group or interview will take no longer than 45 minutes and will be recorded on a digital Dictaphone.

The research will take place over a period of approximately one year.

If you do decide to take part you will be asked to sign a form giving your consent to be included in the study.

You are free to leave the study at **any time before, during or after the observation, interviews and focus groups**, without any consequence.

All participants will remain anonymous, although it will be helpful to name the band of the participant. However no names will be used in the study.

What are the possible disadvantages and risks of taking part?

There are no disadvantages of taking part in the study. All of the data collected will remain confidential.

If you require support during or after the interview and/or observation then you can access support from myself or through the [REDACTED] Support scheme in the Trust

What will happen if I don't carry on with the study?

If you withdraw from the study all of the information and data collected from you to date, will be destroyed and will not be included in the study.

What are the benefits (if any) of taking part?

The information that I gain from the study will help to increase understanding about role modelling and leadership. Your involvement may help development in this area. You may also be able to recognise personal strengths that you have and valuable qualities in colleagues that you can learn from.

Observation of mal-practice

Any instances of mal-practice will be reported to the departmental manager in accordance with Trust policy.

Who will have access to information about me and how will information about me be used?

- The interview will be recorded using a digital Dictaphone and the discussions will then be downloaded onto a password protected electronic storage area.
- Observation data will be collected through my notes and through completion of observation charts.

- All the information you give **will be confidential** and only used in this study. All information will be collected and stored in accordance with the Data Protection Act 1998.
- All participants will be anonymised and your contributions will be rendered unidentifiable.
- Parts of the interview recordings and transcripts will be shared with my research supervisor.
- Extracts from interview transcripts may be presented in the final report, journal publications and/or conference presentations
- All audio recordings will be held securely in a password protected system accessed only by me, and will be destroyed at the end of the study.
- Consent forms will be stored separately to recordings and transcripts
- All information will be stored in accordance with the Data Protection Act 1998 and in line with the University of Brighton guidelines.

Who is funding and organising the research? This study is being funded and organised by the researcher as part of my PhD at the University of Brighton.

Who else can I talk to about the research if I need to? If you would like to contact anyone else to discuss this please contact [REDACTED]

What would I do if I had a complaint about the research conducted? If you feel there are aspects of the research study that you are not happy about, you can contact [REDACTED]

What do I do now? Think about the information on this sheet and ask me if you are unsure of anything. If you agree to take part please contact me as the researcher directly using the contact details below:

[REDACTED]

Appendix 3

Research Participant Consent Form – Observation

Title of Project: ‘A critical exploration of the variety of forms in which role modelling as a leadership behaviour can be performed in nursing’

Name of Researcher: Rachel Heathershaw

(please circle your answer and write your initials in the box – yes or no)

- I confirm that I have read and understood the information sheet for the above study and what my contribution will be.

Yes	No
-----	----

- I have been given the opportunity to ask questions (face to face, via telephone and e-mail)

Yes	No
-----	----

- I agree to being observed within the division

Yes	No	NA
-----	----	----

- I understand that any incident of mal-practice will be reported to the departmental manager in accordance with Trust policy as indicated in the participant information sheet

Yes	No
-----	----

- I understand that my participation is voluntary and that I can withdraw from the research at any time **without giving any reason** with no personal detriment.

Yes	No
-----	----

- **I agree to take part in the above study**

Yes	No
-----	----

Name of participant

Signature

Date

Name of researcher

Signature

Date

Appendix 4

INTERVIEW SCHEDULE

Title of Project: 'A critical exploration of the variety of forms in which role modelling as a leadership behaviour can be performed in nursing'

Topics (Anticipated questions but would be developed throughout stage 1 of data collection)

Questions for exploration and probing, this will be informed by observational data analysis

Role modelling

What motivates you in your work?

Are there people in your team who inspire you?

Are there people in your team that make it difficult to stay motivated?

Describe to me your understanding of the term 'role modelling'?

What behaviours do you associate with role modelling?

Can you identify someone who you see as a role model?

Why do you think that?

How do they make you feel?

Do you consider yourself a role model?

Who to?

Leadership

Can you define leadership for me?

Can you describe how a leader behaves?

How do they make you feel?

What characteristics do you think good leaders should have?

Do you see yourself as a leader?

Do you think your colleagues see you as a leader?

Why do you think that?

Role modelling and leadership

Do you think there is a connection between role modelling and leadership behaviour?

Do you view your leaders as role models?

Can you expand on this?

What made you come to this understanding?

Appendix 5

Example of colour coded interview data

Facilitates others	Leads by example	Aware of strengths and weaknesses and be able to discuss them and improve	How they treat others especially in a junior position	to see someone else in the job you are doing and want to emulate them by their behaviour	Not by written instruction	leading by example	ROLE MODEL	being positive	
Epitomise their capabilities	ROLE MODEL	Be the best you can be so that others will want to be the same	Get the job done without upsetting everybody	ROLE MODEL	Get the job done	teaching students	showing what you should be doing as nurse	Getting information to them (STN)	
	Not one specifically at this time	In past at certain points in career			No one outside work	Parental influence	Proactive	does a good job	Experienced nurse
Aspire	YOUR ROLE MODEL	Parts of different colleagues	WM	efficient	YOUR ROLE MODEL	HCA		YOUR ROLE MODEL	Ward manager

			negative when people unnecessarily sharp	can seem harsh but gets the balance right	keeps morale up	get the job done and keep cheery
			no explanations for behaviour			
			Not the most junior	Yes	Doing a good enough job hopefully	
	For my team, colleagues, managers, senior colleagues	Probably in JD				Provide information
						Started with feedback from students, then became a mentor
						Assess level of students
Not conscious	YOU AS A ROLE MODEL	To a degree, not really thought about it	After settling in time as a band 5	YOU AS A ROLE MODEL	Behaviour being watched	Think about mine sometimes and how to approach things e.g., being proactive
						People follow
			Taking students	Conscious - remembering own experiences		Facilitate a good placement
						Not all of the time...some self-doubt

Appendix 6

Example of 'instances' in raw data extract – 'talking'

	Observations by number	Behaviour	Why	Perception
2.7.2	RN1 is at the desk talking to B62 about a patient. Obs he was going to do are already done	Talking, obs already done		Tasks are completed by all seamlessly
2.7.3	RN1 then talked to patient	Talking		Time with patients for service delivery
2.7.5	HCA1 and B62 talking about which patient is due down next	Talking		Service delivery - preparing and planning
2.7.8	RN5 at computer as is B62 no talking, looking at screens	No talking, looking at		Focused on task so not chatting
2.7.9	HCA1 standing at the door of kitchen, talking to someone inside	Talking		
2.7.14	B62 talking to a student who was leaving an evaluation form for a consultant...'ooh I'm nervous now...how will I remember'	Talking		
2.7.17	RN4 down to kitchen to get something for patient to eat.	Moved, talking		Patient care

	HCA1 talking to the patient			
2.7.37	RN1 out from behind curtains – gloves on talking to HCA1 as she updated board	talking, updated board		
2.7.44	RN1 talking to patients softly, he speaks quietly and is crouching down	Talking to patient, quietly	softly, crouched down	good communication, at the same level...
2.7.48	RN4 and RN1 talking about why a patient doesn't have fluids up	talking		service delivery
2.7.50	RN1 came out of bedspace straight into talking to another who was doing stores then over to computer	talking	straight into	swift, not hurried or urgent

Appendix 7

Example of raw data extract – Working together

	Observation by number	Behaviour	Why	Perception	Reflection
1.1.10	The nurses smile and chat to each other, they appear relaxed , they answer each other's questions and are helpful	Smile, chat, answer questions, helpful	Smiling here indicates support and friendship, interest in each other and their work	Relaxed...	Their body language is relaxed, their non-verbals indicate that they are happy in their work and to work with each
1.1.11	The ward manager smiles as she goes around, 'efficient' , her voice carries and is loud but not too loud . She moves quickly and looks in 'charge' ... industrious, getting on... she looks happy and easy to approach...	Smiles, voice carries, moves quickly, happy	Her tone of voice is unfaltering, can be heard and distinguished from others, carrying out tasks as she moves e.g. answering questions, making a note, talking to a patient, staff member, greeting people... her no verbals and smile make it ok to approach and seek advice/answers/help...	Industrious, getting on, easy to approach	Are ward managers efficient? Where does this come from? Me? My personal beliefs and values? The key person on a ward...everything to everybody? 24-hour accountability? Personal reflections

1.1.13	N 1 needs help with a patient, she helps another by tying her apron , they smile together 'thank you'	Helps, ties an apron, smile	Provides support by tying apron, to be able to help, human connection, being kind to each other	Thank you in the smile, eye contact and a nod	They act kindly towards each other and chivvy each other along....
1.1.14	N 1 helped another out and appeared willing – went to patients	Helped	Went to help without hesitation	Willing	The care delivered needs a team, individuals do not work alone
1.1.22	B61 willing to help HCAs when asked. She has lots of discharges planned over the next couple of days – trying to get them done . Limited eye contact, carrying folders around.	Help others	Stopped what she was doing and helped others when asked but going back to paperwork after	Willing, trying to complete tasks	Patient safety is seen as important and adhered to... the ward seems well staffed for the amount of beds that I have previously worked in... For a medical ward I didn't think the buzzers went off that much.
1.2.19	HCA2, asked what needed doing	asked	similarity in role, as in competence but not familiar with patients or necessarily ward routine		The HCA demonstrated a willingness to help, didn't wait to be asked.

Example of raw data extract – Getting the job done

	Observation by number	Behaviour	Why	Perception	Reflections	2 nd reflections
1.1.14	P1 helped another out and appeared willing – went to patients	Helped	Went to help without hesitation	Willing	The care delivered needs a team, individuals do not work alone	
1.1.18	'Quiet' time on the ward – nurses catching up with paperwork.	Doing paperwork	The afternoon, no ward rounds, treatment and so on, main tasks complete, opportunity to complete paperwork when other ? Real work done	Quiet, catching		Have to learn to prioritise quickly... undertake and deliver care that is the most important... for whom? Patients or the available resources.... Increased workload means that people speed up and have to categorise (W&H book)
1.2.6	WM1 answers phone twice...	answers phone	this can interrupt care delivery... can be challenging for whoever is ringing in if not answered. Sometimes		The phone isn't left to ring when people are busy, during the day the ward clerk would answer... can be anyone at other	

			managed with a communication of better times to ring e.g. relatives after 0900		times...did notice though that it didn't ring constantly.	
1.2.11	WM1 and HCA 1 discussing a patient who wanted a drink	discussing	to keep each other up to date and deliver good care		A quick exchange, about giving a patient fluids, I feel there's equity and respect....each get the opportunity to speak and listen to each other. Band 7 to band 2	
1.2.17	WM1 gave P1 and HCA1 the opportunity to give feedback to her.	give feedback	WM1 in control of feedback though, she sought it, would they freely give if not invited... the impressions though this time... touching base, good delegation	gave	By asking for feedback. To keep up to date with care delivery	
1.2.22	WM1 involved in delivering care behind curtains	delivering care			The WM did not take on the coordinator role instead contributed to care delivery	

1.2.41	WM1 busy in the bay, went to check roster for the weekend on the ward next door	in the bay, check roster next door	Prepare for the next day, still involved in care delivery			
1.3.15	P2 and HCA1 delivering care to dependent patients		Working together			

Appendix 8

Example of questioning stance, observation of behaviour, asking why, recognising perceptions and reflecting on these

	Observations by number	Behaviour	Why	Perception	Reflections
2.5.27	0855 – general atmosphere feels calm and relaxed . At least half of the staff are waiting. XXX very smiley, went off to find off duty. XXX with ECG machine walking up the unit			General atmosphere feels calm and relaxed.	There is time to complete tasks at the start of the shift and prepare for the patient care. Admitting patients are largely 'well' in as much as fit for procedure and have been on a waiting list. The calmness is evident in the way that staff go about their tasks. Body language is relaxed and open, purposeful but not urgent.
2.6.38	... walked past and smiled and said hello				She won't know who I am – only that I'm watching and writing
2.6.42	smiled at me				Got that industrious feel, high ratio of trained staff – 2 or 3 get a patient ready for theatre it appears.... slick
2.6.60	0935 ... at the top room which I think is the coffee room. XXX. came in looking for someone – greeted in a friendly way – big smile to me – went through to theatres				Note that this is the first time I have seen xxx sit down

2.7.12	B62 lightly to patient 'we here again to attack you'... jokingly, to sooth with a smile (had heard them say her BP was low)	Talking to patient	Jokingly, to soothe	Humour used to diffuse anxiety at increased attention	I'm keeping out of sight of patients as they are awake and alert... I stand near the entrance, I can see the desk but not the patients
2.7.13	N1 asked a patient to complete a feedback form, said with a smile	Asked	with a smile	Relaxed and open, not coercive	
2.7.40	RN4 RN5 and N1 doing paperwork although RN5 at computer printing something. RN5 turned a monitor alarm off and smiled to patient	doing paperwork, turned off, smiled		service delivery	

Appendix 9

Example of raw data extract– Acacia ‘Helping each other’

	Observation by number	Behaviour	Why	Perception	Reflection
1.1.10	The nurses smile and chat to each other, they appear relaxed , they answer each other’s questions and are helpful	Smile, chat, answer questions, helpful	Smiling here indicates support and friendship, interest in each other and their work	Relaxed...	Their body language is relaxed, their non-verbals indicate that they are happy in their work and to work with each
1.1.13	N 1 needs help with a patient, she helps another by tying her apron , they smile together ‘thank you’	Helps, ties an apron, smile	Provides support by tying apron, to be able to help, human connection, being kind to each other	Thank you in the smile, eye contact and a nod	They act kindly towards each other and chivvy each other along....
1.1.14	N 1 helped another out and appeared willing – went to patients	Helped	Went to help without hesitation	Willing	The care delivered needs a team, individuals do not work alone
1.1.22	B61 willing to help NAs when asked. She has lots of discharges planned over the next couple of days – trying to get them done . Limited eye contact ,	Help others	Stopped what she was doing and helped others when asked but going back to paperwork after	Willing, trying to complete task	Patient safety is seen as important and adhered to... the ward seems well staffed for the amount of beds that I have previously worked in... For a medical

	carrying folders around.				ward I didn't think the buzzers went off that much.
1.2.19	HCA2, asked what needed doing	asked	similarity in role, as in competence but not familiar with patients or necessarily ward routine		The HCA demonstrated a willingness to help, didn't wait to be asked.
1.2.28	N2 working with TN1, N1 asks for help to take a patient to the toilet.... working as a team	working with, asks for help		working as a team	There appears to be a silent acceptance to work together... this was not expressed as such, occasionally asked for specific help, always given
1.2.33	N1 and WM1 catching up with paperwork, helping each other, talked about satisfaction of ticking jobs on the list off.	catching up with paperwork, helping, talking	working together, satisfying work		Mutual respect, feeling the same
1.2.34	N2 and TN1 smiley and helping each other	smiley, helping	general demeanour, getting toward the end of the shift, teamwork		

Appendix 10

Example of raw data extract – Acacia ‘Communicating’

Observations by number	Behaviour	Why	Perceptions	Reflections
1.1.20	B61 working at computer, look of concentration, happy to talk to others when needed – keeping each other up to date, asked another for some feedback but answering questions too.	Working at computer, talk, asked questions, answered questions	Concentration, happy	Look of concentration means not smiling or scowling either, looking at screen. Happy to talk, looks like smiling when interrupted...that affirmative behaviour...’it’s ok to ask’
1.2.6	WM1 answers phone twice...	answers phone		The phone isn’t left to ring when people are busy, during the day the ward clerk would answer... can be anyone at other times...did notice though that it didn’t ring constantly.

			communication of better times to ring e.g. relatives after 0900		
1.3.45	HCA3 asked for advice re transporting patient to x-ray	asking	seeking advice from others, trust and not afraid to ask		
1.2.11	WM1 and HCA 1 discussing a patient who wanted a drink	discussing	to keep each other up to date and deliver good care		A quick exchange, about giving a patient fluids, I feel there's equity and respect...each get the opportunity to speak and listen to each other. Band 7 to band 2
1.2.42	TN1 and N2 discussing obs, HCA1 listening	discussing, listening	Inclusive		Keeping up to date with care delivery
1.2.14	N1 took time to speak to xxx sitting at the table, made him a cup of tea and spoke to doctors.	speak made a cup of tea	this was during a period of much activity, demonstrates the ethos of the ward, their priorities, human contact, putting the patient's needs first	took time	I thought this was great... the ward was busy but the TAP was able to feel confident enough to sit down beside the patient and make him a drink...good interaction. Personal

Appendix 11

Extract of raw data – Acacia ‘Smile’

		Behaviour	Why	Perceptions	Reflections	2 nd Reflection
1.1.13	N 1 needs help with a patient, she helps another by tying her apron , they smile together ‘thank you’	Helps, ties an apron, smile	Provides support by tying apron, to be able to help, human connection, being kind to each other	Thank you in the smile, eye contact and a nod	They act kindly towards each other and chivvy each other along....	
1.1.16	B6 1 – quietly spoken, shy smile, looks quite chilled on the outside. Busy with paperwork and tasks... not smiling when concentrating but smiles quickly when spoken to and doesn't appear unhappy to be interrupted.	Quietly spoken, smile, not smiling, smiles quickly	The tone of voice is quite low and quiet, smiles but doesn't always maintain eye contact indicating that she is a bit shy. When focused on a task (computer) doesn't smile and doesn't make eye contact but when spoken to non verbals don't indicate annoyance....	Shy, chilled, concentrating, not unhappy		
1.2.15	WM1 doing IVs – asked doctors to write some fluids up, said with a smile and easy assurance .	doing lvs, asked doctors, smile	relative to position and role, working together as a team... mutual expectation that this would be done? Asked	easy assurance	When I was a ward manager people generally did as I asked, I had an	

			respectfully of the other's role.		awareness of power associated with the role...but I was nice to people too as found this was the person I wanted to be and it gave more rewards.	
1.2.18	WM1 discharged a patient – told N1 and HCA1 – smiled.	discharged, smiled	Almost like in support and to show respect for everyone's role... important enough to tell		Keeping them up to date	
1.2.31	N1 and WM1 talking – N1 asking WM1 what she is up to at the weekend... and back AP1 off too – both looking forward to weekend.	talking asking questions about out of work	showing interest in life outside of work... work/life balance strategy for building resilience		General feeling demonstrated through smiles, getting on with work, not aware of people looking fed up... interested in each other	
1.2.34	N2 and N1 smiley and helping each other	smiley, helping	general demeanour, getting toward the end of the shift, teamwork			
1.2.43	N1 big welcoming hello! To night staff	greeting staff coming on	said a little louder, emphasis on hello. Said with a smile	big welcoming hello	Thankful to see staff at end of shift	

Appendix 12

Example of raw data extract – Acacia ‘Leaders’

Alison	Do you see yourself as a leader?	2.1.13 I hope so...I think... have you asked ppl about how they see me as a leader because I think that will be quite interesting because I think they would say, I know I am a bit fast and frenetic because I've got a lot to do and can come across as being a bit abrupt and I know that ppl who don't know me very well think that but once they get to know me know I'm not But initially and I try really hard not to come over like that although sometimes I do a little bit ...but those I have worked with for a reasonable amount of time know I'm not like that at all...everyone has got their faults laughs... I sponse... it's about awareness.... yeah I am aware of it I am aware of it.. ppl think I'm scary but I'm not so I think they're like, when I first met you, you were scary but I'm not in the least scary person but to other people I guess I might come across like that
Paul	Do you see yourself as a leader?	6.1.15 er No (laughs) that's the answer
	So do you kind of think that people who are almost in leadership positions are leaders?	Yeah
	You say that you don't consider yourself as a leader, do you think other people see you as a leader though?	6.1.16 Colleagues? – I think so... yeah
	Why is that? Can you give me an example?	6.1.17 a lot of new qualified staff ask me for advice and I say yes you can do this or this is how you make antibiotics up like this and things like that and what is that antibiotic done like that and you can do it this way you can look at medusa and things like that...

Jane	Do you see yourself as a leader?	7.1.22 To a certain extent, I have to be because of the position I am so I'm leading a team when I'm here everyday so yeah I am a leader, how good of a leader in I don't know because I don't feel as though... I get a certain amount of feedback you know from my PDR here yeah I think I'm doing ok but it's ..it's like I have my doubts so... (laughs)
	Do others see you as a leader then or one of the leaders?	7.1.23 um yeah I mean they pretty much do as I ask so I guess if it's for the job function ... yeah I am
	So you say about 'in the position' do you think there's an expectation with certain positions then to be a leader?	7.1.24 yeah I think that once you get into a band 6 you're meant to be sort of showing, trying to show some leadership qualities because you're in sort of a position with a certain amount of power or you're left on your own in charge a lot more so you've got to make decisions safe

Appendix 13

Extract of raw data – Beech – ‘Leadership’

CUES	RESPONSES
JILL	
Defining leadership	role model, so leading by example, offer support, guidance, sometimes making difficult decisions, ensuring that quality is adhered to... taking the buck and ensuring that policies and procedures, everything is done properly, yes overall managing... but you know support perhaps stepping in where need be, perhaps having awkward conversations delegating...
Why	I've changed my idea of leadership...when I came into this post I was ok I was a band 6 and I was clinical not managerial I found the shift very difficult still do...it took me a long time to realise that it was ok to say I don't know how to do that as I've stopped doing that ... it's not my role anymore and my role has changed, I've found that quite difficult to accept, I still make sure that I'm clinical because, one, I have to because of the numbers but also it's a skill I don't want to lose... I've rambled on and forgotten your question (laughs)
	they need to be good listeners, they need to be quite strong characters sometimes,
Characteristics	they shouldn't be judgmental, they should be good listeners, they should be up to date they should know what they're talking about, I also feel, I don't know, you shouldn't ask somebody to do something you're not prepared to or can't do yourself.. also if a band 2 asks me to get a patient a commode I get the commode, it doesn't matter what band you don't lose sight of who you're here for...and I think sometimes if you go up the ladder too well, as you go up the ladder your priorities may...ah it still should be patient first focused. But sometimes your priorities change...but I always try to put the patient first, that is my priority and sometimes I become unpopular... but I'm not here to be popular

<p>Yourself as a leader?</p>	<p>Yes , the other thing about here is quite strange I was sister of the nurses but then I got something through the post which said xxxx manager... I thought who's this? Oooh it's me, quite daunting I sort of have two roles, doesn't always go well with other members of staff, cos we have xxxxx and xxxx and I don't think they always like the fact that it's run by a nurse... one xxxxx her in particular doesn't feel I deserve to be in this post...I don't know I find it quite sad and quite an uncomfortable relationship...I have worked on it and I have had advice from other people but whatever I try doesn't seem to improve the situation... just that one particular individual</p>
<p>Connection? association?</p>	<p>yes um, you don't necessarily have to, I mean I've mentioned skills and things... but a stranger could come in here and become a very good manager but not have the clinical knowledge because ideally she wouldn't need the clinical knowledge it should run on its own... I think a good leader needs to have any awareness of what's going on out there so that you can empathize with your staff...you can say you know I know what you're going through feeling and I think no you don't...ummm (struggles to finish)</p>
<p>How do leaders or role models make you feel?</p>	<p>sometimes I think ok I will aspire to be like you so it can have a positive influence on you ... but like I've said I've had managers who.... Not good, I'd do that slightly differently... so it's watching and learning...</p>
<p>do colleagues see others as role models or the leadership team?</p>	<p>I hope so... I stress to the band 6's that when they're in theatre or on the unit or recovery that they need to lead by example, it probably means that their bums never hit the chair because I don't like people sitting down... if I had my way, I would take all the chairs away... there's only 3</p>
<p>CLAIRE</p>	
<p>Defining Leadership</p>	<p>oh blimey... Leadership is where you are going to take ownership of something and you're going to take it forward it's like you'll come on...some people are just natural born leaders; some people have to work very hard at it ... it's like coming onto a shift and there's no one allocated to be the actual coordinator for the day and just taking it on</p>

natural born leaders, can you expand on that, how do you know that? How do they behave? What is it about them?	it just comes so naturally to some people, it just oozes from them everything just seems to be streamless, they don't have to think about it they just do it
Can you break it down	it's professional, it's knowledgeable, they always seem to have knowledge of it, it is the foresight, seeing the bigger picture umm just juggling everything together you know they've got their eyes everywhere and they can see, they can think outside the box ... but you know the really good ones think outside the box but not just about one problem but about several problems and sometimes it's boggling me because I'm not a natural and I have to sometimes just step back and think right what have we got to do here and it's you know ticking away in my brain and you can see a natural leader and they just go bosh and do it and you think why didn't I think of that
How do leaders make you feel?	I think that comes with whether they're a good leader or a bad leader
Example of a good leader	a good leader would make you feel quite happy umm you know that you could try things if it's not going to work, it's not a failure, you've not done it wrong, you've tried something and it's just not worked at that particular time therefore they will give you the positive encouragement that you would like to try something differently to see if that would work
Not so good	oh, they would just say that wasn't going to work and just completely absolutely poo poo it and just completely demoralize you so that you're not even going to try again
Characteristics of a good leader	good sense of humour, very fair, uhm motivated, compassionate, consistent
Yourself as a leader?	yes, I hope so (laughs)
Do colleagues see you as a leader?	yes

why do you know that?	Well I know that because they will come to me with problems cause I've only recently become a band 6 on here anyway so it's a little bit difficult because I have been a band 5 here and then been given the band 6 and I know that people are already thinking of me as that leader type role I've got my own team and they're coming to me with problems and things for me to sort out , advice and I know the other staff nurses as well and health care assistants are using me as well so I'm thinking yeah they're actually seeing me in that role now so...
LAURA	
Defining leadership	somebody who can oversee an area and help delegate help run manage and support the environment
How they behave	remain assertive and be slightly aloof at times just to run the department, make sure it runs smoothly by not getting.... ooh it's a hard one to answer
Characteristics and qualities?	strength, assertiveness, delegation skills, somebody who is not afraid of talking to people, not controlling them but just organising and having some kind of order
How those leaders make you feel	I've had good leaders and bad... I'm fine with leadership, I'm fine with being told what I need to be doing how we need to be working and how everything needs to be running as long as backed up with some good feedback
Good leaders?	again it's always about feedback because when you're working in an environment and you're working really hard and no one ever tells you how you're doing it's not great but when you get good feedback... yeah basically good leaders make you feel like you're doing a good job and like you want to come back to work because you're working in a team
What about the less good	make you pxxx off basically (laughs)... you just think I'm doing all this work and there's no recognition ...it's having a bit of recognition knowing that you put in a little bit extra ... you get that a lot from the patients anyway but you still need it from work

Do you see yourself as a leader	no not really but I know I could do it though but I think my confidence could struggle... I've been a nurse for a long time and I have been in leadership positions years ago but that was before children kind of slightly different now ... at home I'm all over it ... a great leader (laughs)
Transfers into work? you have been but now you're not	years ago after qualifying I was a band 6 and was part of developing a new surgical assessment unit so I was there from the very beginning so a lot of hands on that wasn't a problem, I don't mind leadership if it's an area like in theatre for example, I know exactly what I'm doing so I'm quite happy to lead in there, it's all about knowledge a lot of it and in recovery I don't spend as much time out there so I'm a little bit more weak in confidence
Do colleagues see you as a leader	no, I'm a team player I think they'll see me as a team player someone who works hard but I don't think they see me as a leader no
TERESA	
Defining leadership	it's not easy, um leadership... well I think a bit like the phrase role modelling, um I would see a good leader would be somebody I would want to emulate and follow their example I think sometimes where leadership isn't so good is when we're not, its not thought as of being a service role...when I see someone who's in a sort of perhaps a privileged position of being in a leadership role , there's quite a lot of responsibility that comes with that and a bad leader would be somebody who is using their status and power perhaps for selfish ends rather than for the good of the whole
How a leader behaves	well it depends, if we're talking about leadership in terms of Donald Trump (laughs) quite different behaviour to somebody who as a good role model as a nurse would behave.... yeah I think um I would want to have a leader who was concerned for the good of everybody, not just what suits them , sort of cherry picking and do or say...
Characteristics?	a willingness and ability to listen, rather than sort of the giving out of commands ...sometimes that's important, being able to say when things are not working well um followed up but I think...giving people the benefit of the doubt and allowing them a voice, that's quite an important thing for me

How do they make you feel	if they're listening and giving me a voice that makes me feel me feel important and valued and equally the opposite is true that if that's not happening it's very demotivating and um yeah can feel quite unfair because certainly I think in the job that we do there's quite a lot of pressure to get things right and be on our game all the time which is reasonable but um you know its like two sides of a coin ...um if you've got the responsibility you need the authority to say how things could be different or better...at least to be listened to ... it doesn't mean you get your own way all the time but you know again for the good of the larger team as it were
Yourself as a leader	um yes but perhaps with a small 'I' (laughs) um I think there are skills and abilities and experience that I've got gleaned over the years that I think are useful and um valuable but ...
Do colleagues see you as a leader?	um some of them may do but I think we're still a bit trapped in the sort of... I can't think of the word really... sort of hierarchy set up where some people are very conscious of what band or grade they are and don't always treat lower grades with the respect that perhaps would be helpful ... I think some of my colleagues who are either haven't been here as long as I have or perhaps health care assistants or other members of staff I hope would see me as somebody that they could come and talk to if they needed to or you know a listening ear ... the difficulty with that often is that the time pressure that we're all working under there's not always the time for that sort of interaction but I do try and be somebody who is encouraging and supportive especially if somebody is having a bad time ... um so yes a leader but perhaps with a small 'I' because of the hierarchy structure and the fact that I work part time its quite clear that there are other people who get more of a say in how things happen than I do which some of the time or most of the time is fine but sometimes is a bit grating

Appendix 14

Example of raw data extract -Cedar 'Move'

	Observations by number	Behaviour	Why	Perception	Reflections
3.8.35	Heather went to do IVs but patient not ready, so went back a bit later.	delivering care, moving			
3.8.42	RN1 goes off the ward, smiles	moves, smiles			
3.8.51	RN1 doing obs Heather into sluice	delivering care, moves			
3.9.3	RN1 walking around, xxxx at the desk, looks upset and anxious. 2 or 3 asked her if she was ok	moves		Nurses don't stay in one place for long	
3.9.4	B61 plus RNs in the clinic room. People look busy, they are moving quickly.	clinic room, moves			It's not particularly noisy but it is warm. There isn't much chit chat
3.9.16	RN1 walked up the ward holding a drug chart and a paper bag. Another nurse asking for the keys please ...'I need both' as she goes into the clinic room	moves, documentation			They talk to each other only in short bursts on the ward, I can't really hear or get what they are saying all the time but it sounds like it is linked directly to patient care generally.... Where do they

					chitchat?
3.9.18	RN1 walking back with folder into bay and out again, smiled at something someone said. Student in there too	moves, smiles			Are there desks in the bays???
3.9.21	Nurses and B61 walking around with drug charts and undertaking documentation.	moves, documentation			There appears to be lots going on... a little quieter than an hour ago
3.9.23	RN1 and student looking for notes	documentation, moves			
3.9.26	1 patient being transferred out, RN1 bustling around	moves		bustling = busy, quickly	They seem pleasant enough not lots of smiles though
3.9.43	1830 – RN1 in her last bay, looking for a drug chart again	documentation, moves		looking for information directly related to care	The environment is not static, this matches the movement of patients, so lots of people involved, they need to ask for updates, move paperwork and so on
3.10.3	B61 walking round with another nurse, sounded like she was explaining something	moves			Got the impression that this might be NQ induction or shadow type of shift

3.10.11	RN1 at computer doing documentation, walking purposefully with a drug chart into the clinic room and back out. A student asked a sister to check some obs as she went into the clinic room	documentation, moves, clinic room			No sign of Heather, was expecting to see her
3.10.12	RN1 into clinic room. Another nurse around looking for something	moves, clinic room			
3.10.13	1410 – B61 walking with notepad into bay. xxxx doing obs laughing with patients... writing in notes at the desk	moves			This sister seems a bit more friendly and relaxed today...smiled hello
3.10.14	B61 looks like she has joined the ward round, with another nurse – was in fact getting a commode. xxx doing obs	moves, talks	ward round going on	Good practice for contemporaneous communication	
3.10.15	RN1 flitting around – on telephone	moves		flitting = not staying in one place for too long	These guys move quickly and most of the time appear to work alone

Appendix 15

Example of raw data extract – Cedar ‘Talk’

	Observations by number	Behaviour	Why	Perception	Reflections
3.8.9	0735 – Then handover for each end – night staff to day staff, they use the COW. Quiet and calm atmosphere	talking			Sounds like a full handover – history and plan Both sides very attentive and writing down
3.8.13	0755 – Heather took a call – asked night staff for feedback	talking	give information to caller		
3.8.18	0825 another sister handing over to Heather. Heather chatting to consultant as well	talking		keeping up to date	Heather appears to be getting a full handover too

3.8.21	Heather now handing over to the sister	talking	handover		The sister is down as the ward coordinator I think so wants a full handover and although the Heather is in the office she also wants the same = good practice and communication
3.8.23	RN1 and STN1 in bay making beds and chatting	delivering care, talking			
3.8.24	0845 – more people on the ward – ‘busier’ curtains around various beds, trolleys out, linen, skips. Xxx answered phone several times. Heather answering phone too. Another came onto ward as bleep holder, quick hello. Heather voice is calm and soothing	talking	give information to caller	Heather speaks calmly her manner is soothing, this has a positive effect, it doesn't appear to raise urgency unnecessarily	The OT, PT and Ota appear to be listening to handover so not sure whether this is a planned thing.

3.8.32	Heather gave a big hello to a friendly looking porter	talking		greeting other staff, being friendly	Easy familiarity
3.8.33	xxxx asked Heather if she could help with IVs as she had to go off the ward, Heather said yes but I must get in the office for the best part of the day to get ready for holiday	talking, seeking help		help freely given but with a caveat	Willing to help with some conditions though
3.9.13	RN1 talking to a student at the COW. Another nurse asks a doctor for something on drug chart – she smiles and laughs	talking		giving information to student about care	
3.9.25	B61 asked the visiting student to let the nurses know they have another patient	talks		keeping up to date	
3.9.33	1800 – B61 referred to ‘we all know who doesn’t like to take a break’ in front of a nurse who doesn’t, made her smile	talks		bit of banter like teasing	Nobody has been for a break – they have to try and fit it in between patient meal breaks, IVs and the end of the shift.
3.9.37	B61 asks nurse if they were there	talks		asking a question	Don’t know what she is referring to...
3.11.28	RN1 asks another RN if she had an iPod and then went into sluice	talking		needs help	

Appendix 16

Example of raw data extract – Cedar ‘Role models

Researcher cues	Heather	Adrian	Vicki
Understanding of the terms	8.3.4 - Role model is... yeah I have to give an impression of myself and the way I work and the way I manage that this is how something for everyone to aspire to. You know, it kind of like I spose don't do as I do do what I say but it's do what I do	9.3.4 - Yeah I mean being a role model basically because I'm a sign off mentor for the nursing students and sometime we do get students and we don't get students and you know when you're working with a student or your colleagues, they're watching you and they are looking how good you are as a nurse and the other people probably think I want to be like that person, and er the best I can so you're reflecting as a good team worker in front of other people and patients and therefore will get motivated and respect that person because they are doing the best they can...	10.3.9 - I think it brings certain people and what they are like cos you want to act and be like them and be able to do jobs like them as easy as they do

<p>Examples</p>	<p>8.3.5 - Like how I manage the ward , how I deal with discipline issues , how I deal with patient complaints I'm not saying I'm the best at everything and I need to get help from my role models and I have to think you know who's the best person I could ask for help who I've seen do this before if it's a new situation for me so as a role model when my guys come across a situation they haven't come across before I don't like them to come to me and say can I deal with it I like to say well how are you going to deal with it . I'd always, as I said to the new HCAs to the new RNs to the Band 6s if there's an issue and they don't know what to do I far rather they come with an idea of what they're going to do and we talk it through than just come and say what shall I do?</p>	<p>9.3.5 - Um the kind of things are like um you know, compassion to your patients how polite you are and your mannerisms and how effective you are in your role and um you know how you deal with a situation because sometimes in your work you can face any kind of issues, some people did get panicked and get things worse, some people take it easy, same time they resolve the problem without causing any further issues so that kind of things</p> <p>9.3.6 - Yeah one of the other people who chat the way they do they think oh he's doing really well so I want to try that way</p>	<p>10.3.10 - So maybe like their attitude if they are quite calm um again it's quite busy on here so we can have days where we're discharging so many people and some people go into a little bit of a panic, other people will be so calm, they will have a plan they'll know what they are doing, be so organised about it, makes it so much easier you just want to be like them</p>
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<p>Who role models are</p>	<p>8.3.6 - Yeah yes, it's like before that people I admire on the ward and who inspire me um I think a role model is what you're trying to achieve for yourself so I suppose my best role model for me would be the ward sister that I took over from, who is now my matron so yeah I do think how would she have dealt with that and yes some things I deal with completely differently cos I might have seen her deal with and think yeah that's not me, so I think as a role model you don't have to follow exactly what that person did because this is my ward now and I had to make it my ward. So I will deal with things differently but it's ... yeah I suppose admiration does come into it, you admire how somebody works...</p>	<p>9.3.9 - I do, I mean when ... I mean I do got different aspects from NAME and WM ... I mean Heather got her own things which I can learn, not all of them, some of the parts from her... NAME is more strict but she is stern she is quite assertive so I can some bits and pieces from NAME and also Heather, they got weakness and strengths so I do look for the good, you know strength from NAME and try to follow some of them and also things like that</p>	
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<p>other leaders around you as role models?</p>	<p>8.3.6 - Yes definitely, our RADON for medicine, she's brilliant and she's so easy to talk to and she does sometimes make me think in a different way because she thinks in a different way and also I think you don't have to be praised all the while for a role model, I work really well from constructive criticism. If something hasn't turned out how I've wanted or I think it has but then they say but did you think of doing it this way, would that not have been better I'm the type of person that would say yes that would have been better. I don't take criticism as negative I need it I think to grow um I don't want to be told I'm fantastic and do everything right because I know I don't</p>	<p>9.3.10 - Yeah I mean it's like um ... umm if there is an issue or something happening WM will manage it as a really final/finite problem, she'll keep it calm and she'll talk to both parties without hurting them and give them some extra chances or time if that is something to move them and eventually after a few weeks the person need to be changed then they manage to change and um... they're fine and she manage to resolve the problem...undercover like in a calm manner. And sometimes the other person can be a bit harsh like um straightforward, it can hurt the second party and sometimes that feeling never goes... you know the second person is she's doing fine absolutely fine but it's too harsh the way that she deals with other people's feelings</p>	<p>10.3. 14 - Yeah I can think of a couple of people, before I was even in nursing I worked in a care home. There are a couple of people that again come to mind when you say that and they were again pretty much the same type of people who were positive and you could tell that they wanted to be there, and they actually cared, unfortunately I've come across a couple of people who not necessarily that they don't care but maybe burnout and things like that....not necessarily their fault but</p>
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<p>what other behaviours do you see as good for a role model to display?</p>	<p>8.3.7 - Confidence, um ... I suppose that they are still learning as well, we learn from each other , um like I've said how they deal with a situation, how they interact with other people I suppose just the whole way that they carry out their role ... and that could mean that it's from one of my peers not somebody senior to me.</p>		
<p>How do these role models make you feel?</p>	<p>8.3.8 - I think it's always good, and I think especially in this hospital; it's not a big, big hospital and it's a friendly hospital and I think you can go to your peers to say how would you deal with this or um I've done this and I'm not sure if I've done the right thing or just that you've, I suppose even thinking back to when I was less experienced myself remembering people who you've seen do something and think they did that really really well, it doesn't have to</p>		

	<p>be recent experience Yeah yeah I think it's learning from how other people do things, how you've seen them act with people um yeah and interact with people</p>		
<p>Do you see yourself as a role model?</p>	<p>8.3.9 - Yes</p>	<p>9.3.12 - I think after a couple of years I started after 2004 working on NAME ward, then first 2 years I'm learning things, then after 2 or 3 years I'm almost learn everything then people started recognizing me and probably I think 2007 onwards they're asking me to go for band 6 , I always stay back because of acute side of things so likely after 3 years I would say I started recognising...</p>	<p>10.3.11 - I've been a preceptor a couple of times and I that although I may not have the most experience, I feel that because I'm quite easy to talk to people will come to me rather than going to someone higher up if they've got something, something small to ask so I suppose in that way I'm a role model... I wouldn't call myself a role model in terms of experience because 3 years is nothing 10.3.12 - Yeah I've had a couple of students, do you mean what I do for them?</p>

<p>example?</p>	<p>8.3.10 - I think probably on here I am because as well as doing all my management stuff in the office I like to get out on the floor as well and work with people and work with the junior staff and work with the HCAs so I think it's being a good role model and showing that there is nothing that they do that I am not prepared to do myself being it making a bed, doing observations, cleaning a bottom, delivering commodes, answering bells, helping with the meals, there's nothing I won't do that they themselves have to do and I think that probably is good role modelling because it improves the team work ... yeah... we don't have HCA and RN jobs, yes it's true there are some jobs an RN has to do because an HCA isn't qualified to do them like drugs, things like that ... but all the other stuff the basic good nursing care, it's for all</p>	<p>9.3.8 - I believe most of my junior you know like newly qualified nurses, they do come and um they always after me to learn things because they know I will help them and they always say I want to be like you, even WM sometimes says.... Laughs... lots of my colleagues are well respected me and they are like how I manage things and I'm not exaggerating but that's a clear fact they all need to ask anything they always come to me</p>	<p>10.3.13 - I guess I'm fairly calm as well ... I'm not sure I can't think of anything else</p>
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	of us.		
When did you first recognise yourself as a role model?	8.3.11 - I think probably, um my confidence has grown since I've had this band 7, I think as a band 6 I probably was cos I worked jolly hard and um I you know like people and team leading and things like that so I think probably was aware of it but I think it's more since the band 7 cos my confidence has grown ... so much that I think yeah I do know what I'm doing and I can pass that to other people		

Appendix 17

Leadership and role modelling descriptors

What is a Leader/Leadership	What is Role model/role modelling
<p>A role model</p> <p>leading by example</p> <p>offer support, guidance</p> <p>making difficult decisions</p> <p>ensuring that quality is adhered to</p> <p>taking the buck</p> <p>following policies and procedures (Int 1.2.9),</p> <p>knowing what you want to achieve or your team to achieve</p> <p>getting that message across</p> <p>give clear instructions or clear guidance</p> <p>evaluate</p> <p>be willing to make changes</p> <p>keeping the finger on the pulse all the time (Int 8.3.13)</p> <p>Non- judgmental</p> <p>good listeners</p>	<p>Leads by example</p> <p>facilitates others</p> <p>professional</p> <p>aware of strengths and weaknesses (Int 2.1.3)</p> <p>leading by example</p> <p>showing others what you expect to happen (Int 1.2.4)</p> <p>behave well towards other people get the job done well without upsetting everybody (Int 7.1.6)</p> <p>really efficient, effective</p> <p>chirpy (Int 3.2.7)</p> <p>compassionate to patients</p> <p>polite</p> <p>effective in role</p> <p>deal with situations well (Int 9.3.5)</p>

<p>up to date</p> <p>knowledgeable (Int 1.2.12)</p> <p>good at getting other people to do what needs to be done (Int 7.1.14)</p> <p>professional</p> <p>knowledgeable</p> <p>foresight, seeing the bigger picture juggling everything together</p> <p>think outside the box ... not just about one problem but about several problems (Int 3.2.21)</p> <p>good communication</p> <p>assertive</p> <p>honest</p> <p>good manners</p> <p>good interpersonal relationships knowledgeable</p> <p>able to manage the situation appropriately (Int 9.3.15)</p> <p>takes charge</p> <p>knowledgeable</p> <p>outgoing</p> <p>calm</p> <p>think about answers</p>	<p>leading by example</p> <p>showing others this is what you should be doing as a nurse</p> <p>teaching students</p> <p>make as positive a role for students (Int 6.1.5)</p> <p>treat other people, staff, patients with courtesy and respect</p> <p>willing to work hard but</p> <p>willing to kind of give a bit of slack, a bit of give and take</p> <p>support me and others in their role (Int 5.2.5, 5.2.6)</p> <p>calm</p> <p>have a plan</p> <p>know what they are doing</p> <p>organised (Int 10.3.10)</p> <p>knows what they are talking about from experience,</p> <p>people who are good with students, the way they talk to people</p> <p>makes all the difference,</p> <p>not ignoring people (Int 4.2.6)</p>
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<p>good decision makers</p> <p>proactive (Int 6.1.12, 6.1.13)</p> <p>willingness and ability to listen</p> <p>giving people the benefit of the doubt and allowing them a voice (Int 5.2.15)</p> <p>able to take charge</p> <p>a role model (Int 10.3.15, 10.3.16)</p>	
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