Leadership experiences of London-based Advanced Nurse Practitioners: A Case Study

Thesis completed in partial fulfilment of the examination for the degree of Doctor of Education (EdD), University College London.

August 2017

Claire Anderson

Acknowledgements:

Abstract:

The National Health Service is widely applauded as the highest quality healthcare system in the world (Grint and Holt 2011). However, there have been many changes to healthcare provision in the UK in the last eight years. These included the introduction of the Health and Social Care Act (2012) in response to rising costs and increasing clinical delivery demands on the National Health Service (NHS). Later the Mid Staffordshire Public Inquiry (HM Government 2013) identified failings in leadership throughout the NHS. These failings were linked to leadership lacking clear definition across all professions within the healthcare team (HM Government 2013). Within the nursing profession, the role of the Advanced Nurse Practitioner (ANP) is seen as part of the solution to this leadership dilemma.

In this study, eight London-based ANPs were interviewed to explore how they define, understand, express and enact their leadership practice. Using an instrumental and collective case study methodological approach, each participant ANP was considered individually and then comparatively.

The findings were focused around five themes. How the ANP viewed their leadership role and whether this was from within or at the forefront of the multidisciplinary team, their '**placement on the leadership pyramid**'. The leadership position the ANPs often adopted was empowering and '**motivating the team**'. The ANPs had a strong nursing identity, which, at times, they would relate to, by '**retreating to the safety of the nursing profession**'. Influences upon the ANP's expressed understanding of leadership included their relationship with medical colleagues and whether the ANP, '**assumed and accepted medical hierarchy**'. The impact of the ANP role on improving healthcare relates clearly to '**ANPs impact on patient outcomes'**.

ANPs have a pivotal leadership role in current healthcare provision. The participant ANP's demonstrable leadership, enables nursing and the multi-professional team, in meeting the increasingly complex needs and expectations of patients.

Declaration and Word Count:

I hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

Word Count - (excluding title and content pages, references and appendices), 49,107.

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Reflective statement:

When I embarked on the Doctorate in Education, I was very conscious of my limited exposure to different research designs. I had even more limited experience of undertaking research studies. Even though I had undertaken small studies to complete my Masters award and my Post-Graduate Certificate in Higher Education, I still felt naïve to the research process. Therefore, I felt that the taught time of the Doctorate would help to orientate my research journey. I had not fully comprehended the accumulative nature of the first two years of the programme. Each module unfolded into the next, increasing my insight into varying approaches to research methodology and eventually informing my approach for both my Institution Focused Study (IFS) and Thesis.

The Ed D taught courses and Institution Focused study

We began the taught courses with *Foundations of Professionalism*. In relation to nursing, this was particularly relevant. Although nursing had developed in status throughout the twentieth century, there are still charges of nursing being only a 'semi-profession' (Etzioni 1969). Even if nursing is a profession, it remains an oppressed profession under the tyranny of medical masters (Stein *et al.* 1990). I registered as a nurse in 1989 and have seen many changes in nursing since that time. My nurse education was based in a school of nursing and was very much focused on learning in practice and unfortunately, at times, through trial and error. Nursing has changed. Since 2012 nursing in the UK has become a graduate profession (Eaton 2012). Consequently, within the UK the status of the nurse, in an increasing complexity health care climate, increased. Within nursing, the role of Advanced Nurse Practitioner (ANP) evolved and has been challenging traditional professional boundaries in the UK for decades.

I have been involved in the development of the ANP role firstly with children's ANPs (CANPs) and then more generally ANPs. I helped develop and taught for a decade in an inner London University – the MSc Children's Advanced Nurse Practitioner – for CANPs. The ANP is expected to work with a degree of autonomy. They are also expected to study a formal Masters programme. The ANP role has been accused by many professions, including nursing, of being confused, at times, not blurring boundaries between professions but either being 'a maxi nurse or a mini doctor' (Taylor 2005 p2). My assignment for *Foundations of Professionalism* explored the value of ANP formal learning being employed alongside their experiential learning. It also explored the need for all nurses to value the unique professional nature of the nursing and not attempting to gain status by emulating another profession.

The second module, *Methods of Enquiry One*, was also informed by my work and leadership of the MSc CANP. Within the assignment, I explored the impact education has on CANP's ability to demonstrate leadership. Nursing has historically been associated with the role of the followers in the multi-professional team (MPT), acting as decision influencers rather than decision makers. Even the role of the ANP appeared confident only when leading nursing teams.

At that time, I still practised as a CANP, and also looked at the implications of insider research. As a member of this professional group, I had an understanding of their behaviour and thinking which may include unspoken or behaviour that is impenetrable to a non-member (Malone 2003). There were also considerable ethical implications in undertaking research with a group who clinically practised caring for children. This was pertinent as the methodological approach I had suggested for the proposed study included observing clinicians in practice while they reviewed a child's health care, a data collecting strategy I would return to. The module asked us to prepare a research proposal, including the consideration of ethical implications rather than undertake a research study. While ethical implications do not prevent research being undertaken, this module helped me understand the need to anticipate potential barriers or limits to what research can ethically be undertaken.

The specialist module I undertook was *Using Psychoanalytical Perspectives to Make Sense of Education and Educational Research*. I was interested in this approach as along with the social constructionist approach, beliefs and values of individuals are seen as meaningful data, I was also interested in what the individual did not express as their beliefs but displayed in behaviour. Using a Psychoanalytical approach to research design could explore alternative explanations for actions or behaviours.

In the MSc CANP, I taught on we employed various group learning approaches including problem-based learning (Price 2003). This approach uses case-based exploration, and as such it reflects the group work employed by the MPT. In this module, I looked specifically at Klein and Bion's Psychoanalytical theories (Klein 1957, Bion 1961) and how they related to the CANP group behaviour. I explored nursing being the 'subordinate' group in the MPT but also how they identified with different groups. The CANP student group forms a distinct group each CANP is also a member of nursing as a group and the MPT as a group. I looked also at the difficulty some CANP students had in identifying with each other as a group and how this may be due to more embedded identification with groups such as nursing or the MPT.

Dartington (1994) describes the nurse as stoic, someone who absorbs the anxieties of others. While Stokes (1994) likened the hospital ward to Bion's Basic Assumption Dependency Group, where the ward sister is the group leader upon whom all the patients are dependant. I wanted to understand the process the CANP student undertaking group work has to contend with. I found that the CANP student had to overcome their learnt stoic 'nurse' behaviour before they were able to face the uncertainty associated with the learning process.

The final module for the taught programme was *Methods of Enquiry Two*. In *Methods of Enquiry One* I had developed a proposal for a research study, but in *Methods of Enquiry Two,* I was actually going to undertake a study. The aim of this study was to identify what educators involved in the education of advanced nurse practitioners, believed were ANP core qualities. I had learnt that observation as a data collecting strategy presents ethical challenges. I also recognised that this was a small study that had to be conducted over a brief period of time, so I collected data using semi-structured interviews.

In the process of conducting interviews with the participant ANP educators, I learnt a great deal. Firstly how important it was to consider how questions are worded and to ensure that they related to the overall research aim. I had read how important it was to immerse yourself in the original data and how valuable transcribing your own interviews is (Robson 2002). As such, I transcribed two of the three interviews in full and with the third recorded key points that were made. This process took a long time. Perhaps this was influenced by it being the first time I had transcribed interviews, and it did ensure I was fully familiar with the data.

In the study, I was particularly interested in exploring the views of educators. A previous research study had been undertaken exploring similar educator views (Gerrish *et al.* 2003). In their study Gerrish (*et al.* 2003) had found that, instead of describing actual demonstrated behaviour of their ANP students, the educators described aspirational qualities. The qualities that the educators wanted the ANP to demonstrate were the qualities that they described. In my study, all three educators also described the qualities they felt were core to the ANP role. These included clinical skills; ensuring quality; professionalism and leadership; knowledge; barriers; involving the patient and their family; communicating and emulating physicians.

The completion of the two taught years of the Doctorate in Education equipped me with many skills that had an undoubted impact on my future research but also my professional practice. It coincided with my decision to leave clinical practice and work full

time in Higher Education. This progression in my professional career also coincided with a major transition within my Doctoral journey and is also seen later in this statement.

The *Institution Focused Study* built on the *Methods of Enquiry One* and *Methods of Enquiry Two* studies and interviewed CANPs about their beliefs and values on leadership and followership. The Royal College of Nursing has worked closely with the Nursing and Midwifery Council offering a definition of the role of the ANP (HM Government 2010a) and also identifying core competencies that they should demonstrate. One of the core competencies identified is that of leadership (Royal College of Nursing 2012). In my *Institution Focused Study*, I considered followership alongside leadership as they are seen as interdependent (Kean et al. 2011). The *Institution Focused Study* identified five themes which were approaches to leading; listening and speaking; the importance of knowing; constraints of leading and indirect influences on leading.

There were some similarities between what the educators had identified in the *Methods of Enquiry Two* study as core qualities of the ANP and what the CANP students considered when reflecting on leadership and followership. These including the confidence that increased knowledge can afford the CANP and the value of effective communication. The views of the educators and the CANPs differed in how they described the relationship between the CANP and the medical profession. The CANP viewed doctors as a barrier to their leadership. In contrast, the educators saw the ANP attempting to taken on medical characteristics to gain professional status. I considered the status of the CANP participants and realised that, as students, they were at the very beginning of their CANP role and their experiences of leadership may change once they completed their studies and became an established role member of the MPT.

I have since had the opportunity to present my results from my *Institution focused study* at both national and international conferences. (Advanced Practice Nursing Network Helsinki August 2014; Royal College of Nursing; International Nursing Research Conference, Glasgow April 2014; Australian College of Children and Young People Nurses 4th International Congress on Paediatric Nursing August 2013.)

Thesis

I began this research study by preparing a proposal. This aimed to capture the expressed views of qualified ANPs on their leadership experiences. I proposed working with a range of ANPs who had been qualified across a range of years. With both newly qualified and ANPs that were more established, thereby looking at a range of ANP experience. I also considered, again, the data collection approach of observation. I recognised that this

approach to data collection had additional ethical challenges. However, as I had longer to undertake the study, I felt sure that I could meet those challenges and triangulate my data with the combination of interviews and observation. Not only would I learn about how ANPs described their leadership practice I would observe them leading in clinical practice. I met with my external reviewers, and with some minor amendments, my proposal was accepted.

At this point, I made the decision that I needed to change supervisors. On reflection, this is not a decision to be taken lightly, and I did not make it without deep consideration. My new supervisor had to get to know both me and my study and be confident herself that the study would be robust and at a standard, she would expect from anyone that she supervised. This took time. With her guidance, I revised my proposal, it was accepted, and I began to recruit to my study. Except I did not recruit or rather only recruited two participants. I worked again with my supervisor, and the decision was made to remove the observation data collection. I could not know that this is what dissuaded participants, but as I had established educational and geographical boundaries to the study, I did not have a big pond to fish in. Removing the observation data collection meant I recruited the further six participants that made the full ANP group of eight who participated.

As I felt it important that I added to my personal challenges shortly after data collecting, I changed my professional role moving from a role in Children's Nursing to a role that was involved in a wider sphere of health care professionals. I like to think that this reflected the move in my research from CANPs to a wider range of ANPs leadership experience. My research journey through my thesis study has been a longer one than I had anticipated. Each stage taking longer than planned for, but I have reached the end of this research journey so much more enabled and informed than when I began.

Chapter 1: Introduction

The National Health Service (NHS) in the United Kingdom (UK) was introduced in 1948 and is 'free at the point of delivery' to all UK citizens. It is widely applauded as the highest quality healthcare system in the world (Grint and Holt 2011). However, there have been many changes to healthcare provision in the UK in the last eight years. For example, the introduction of the Health and Social Care Act (2012) in response to rising costs and increasing clinical delivery demands on the NHS. This Act established the need for increased clinician involvement and local accountability over healthcare commissioning. Not long afterwards the Mid Staffordshire Public Inquiry (HM Government 2013) identified failings in leadership throughout the NHS. These failings were linked to leadership lacking clear definition across all professions within the healthcare team and an overarching working culture where each profession worked 'in silos' (HM Government 2013). In 2015 as a direct consequence of these leadership failures, the Secretary of State for Health asked for an NHS leadership review called 'Better leadership for tomorrow: NHS leadership review (Rose 2015). The aim of the Rose review was to attract strong leadership that would transform healthcare provision in the UK.

To further complicate the UK healthcare landscape, in 2009 the European Working Time Directive (Dobell 2009) reduced the number of hours that doctors can legally work. This challenged the complex health-care based work conditions within which national and review led calls for stronger and professionally defined leadership were being made.

Within this context, Rose (2015) identified the need for solutions to the lack of clearly identified leadership from within the healthcare professions. Within the nursing profession, the role of the Advanced Nurse Practitioner (ANP) was seen as part of the solution to this leadership dilemma, partly as they were able to deliver some of the work that had previously been undertaken by doctors.

However, the ANP in the contemporary NHS practises in a working climate that continues to escalate in complexity. The cost of the NHS increases alongside this complex care delivery, and controversial measures to try and limit this escalation in cost included attempts to reduce wage bills. In 2016, one attempt to reduce costs was to reduce the number of hours junior doctors were paid unsocial additional payment, resulted in English junior doctors going on a nationwide strike for the first time in forty years (Junior doctor contract negotiations, 2016). In nursing, another significant cost has been the historic bursary payment to pre-registration nursing students. From September 2017 pre-registration student nurses will no longer receive a bursary payment and instead will need a student loan to fund their studies. Although this may reduce the costs to the NHS of educating nurses, it

is anticipated to have a significant impact on nursing students' recruitment *(The 2015 spending review changes to Nursing, Midwifery and AHP education)*.[1]

NHS professionals in the 21st Century are cognisant of the financial pressures and acknowledge that they are expected to do more for less (*et al.* 2014). Aware of the increasingly complex healthcare needs of NHS patients; today's ANP needs to respond to, inform and influence policy, political and practice changes that create new healthcare demands (Rose 2015).

1.1. London-based ANP leadership practice

This study explores how a small sample of ANPs, practising in various healthcare settings in London, define, understand, express and enact leadership within their professional practice. In order to understand more about the complexity of ANP work and the perspectives of ANPs on their roles as leaders within the NHS, this case study research explores ANPs perspective of their leadership practices.

The case study analysis has made it possible to consider each ANP distinctly but also to compare between them which enhances the depth of data analysis.

London has a higher density of teaching hospitals in comparison with the remainder of the UK (London's NHS infrastructure no date). This has the potential of increasing differences between ANPs practising in London compared with more rural ANPs. This density of teaching hospitals in London also reflects a diverse range of healthcare providers, and so increases the likelihood of diversity in the ANP population for the study. At the time data was collected, the Royal College of Nursing (RCN) Accredited Advanced Nurse Practitioner Educator (AANPE) group had representation from over 40 educational programmes that educated ANPs around the UK. The RCN accreditation of the educational pathway for ANPs, although not the only approach to ANP education, reflected a nationwide ANP educational framework. All ANPs participating in the research therefore, needed to have been educated by an RCN accredited educational programme and to practise in the London or Greater London area.

1.2. Researcher Profile

From 2001 until 2011, I practised as an ANP and observed the evolution of the ANP role and the NHS. The ANP role has increasingly included the demonstration of leadership

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[1] Some of the developments in 2015/16 described in this occurred after this study was undertaken, but they are representative of the ever-changing and dynamic healthcare system that is the NHS.

across multiple professional teams. Since 2005, I have been an active member of the RCN AANPE group. I have also been instrumental in ANP education establishing one of the first Masters courses for Children's ANPs in the UK. Having also worked in Higher Education since 2004, the combination of my experience and previous roles places me in a unique position to be able to explore the role of the ANP and specifically their views about their leadership practices.

1.3. Research Questions

My previous research has explored the role of ANPs including 'What are the beliefs and values of the Children's Advanced Nurse Practitioner student about leadership and followership?' (Anderson 2013); 'Does studying to become a Children's Advanced Nurse Practitioner change an individual's belief in their autonomy?' (Anderson 2008) and 'A Delphi Survey to identify the Defining Characteristics of the Clinical Site Practitioner Role' (Anderson 2003).

A review of the current Nursing and Healthcare policy landscape inspired by my previous studies framed the literature review process and contributed to the development of the conceptual model guiding this study. The overarching aim of this current study is to develop a more robust and nuanced understanding of ANP leadership practice and to contribute to the future research, policy and development of ANP leadership practice. As a result, the study was framed and guided by the following emerging questions.

- **How does the ANP understand their role and interpret the leadership component?**
- **How does the ANP enact the leadership aspect of their role?**
- **What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?**
- **What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?**
- **What personal, interpersonal and organisational and professional support does the ANP need to be able to enact leadership?**

1.4. Contribution to the field: theory and practice

Leadership is central to the definition, policy and practice ambitions for the role of the ANP in the NHS (HM Government 2010a). By making leadership the focus of this study, the evidence and analysis offer a valuable contribution to the small body of existing research that explores ANP core characteristics and responsibilities. Participating ANPs practise in specialist acute, specialist community, primary and acute healthcare settings, representing a diverse range of healthcare provision across London.

The ANP role offers a clear career development pathway for nurses (Rafferty 1996, Enterkin *et al.* 2012). Facilitating this career development pathway involves developing a range of organisational and educational support strategies. This study, by offering a greater understanding of how the ANP defines, understands, expresses and enacts their leadership practice may inform future ANP educational programmes.

1.5. Overview of thesis

The thesis is presented in eight chapters. Chapter Two outlines the UK health policy and practice context with a focus on healthcare delivery in the NHS, describing the perceived healthcare leadership failures, demands for improvements in leadership and the impact on the ANP role.

To frame the design of the study Chapter Three explores the published NHS leadership research and how this has developed through time. The published research related to personal, interpersonal and organisational factors that influence the role and practice of ANP leadership are reviewed including the influence of professional identity. Differing approaches to leadership in the NHS are also considered. The chapter explores the opportunities and conflict that ANP's experience in becoming leaders. The ANP by becoming a leader, for example, to some extent becomes distinct and detached from the identity of the 'nurse' and the support this nursing identity has offered them (Goodrick and Reay 2010). The relationship between professional identity and gender identity is considered in relation to leadership. The chapter concludes with the presentation of the proposed conceptual model emerging from the literature review.

Chapter Four outlines the design and implementation of the study including the philosophical underpinning of the adopted case study approach. The elements of the research process are described including sample selection, data collection and analysis. The process of interviewing eight ANPs is described, including details of how data was collected and analysed. The Chapter also highlights ethical implications of the study including the potential bias or influence introduced by my previous and current roles as a children's ANP and an educator of ANPs. Limitations of the study are also discussed.

Chapter Five, drawing from the interview data, introduces the participating ANP and presents individual case study descriptions of their perceptions of their leadership experience with interpretative comment.

Chapter Six presents the analysis of the interview data by offering a collective comparison of the ANP's experience and views. The chapter is structured around the themes emerging from the overall analysis including 'placement on the leadership pyramid',

'assumed and accepted medical hierarchy', 'retreating to the safety of the nursing profession', 'motivating the team' and the 'ANP's impact on patient outcomes'.

The Chapter Seven revisits the conceptual model emerging from the literature review and the themes generated in Chapters Five and Six in relation to published literature and ANP practice.

The final chapter concludes by offering recommendations for future research and practice.

Chapter 2: The role of the ANP in the NHS

> 'It will provide you with all medical, dental and nursing care. Everyone – rich or poor, man, woman or child- can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness' (The New National Health Service, 1945)

A full exploration of the NHS infrastructure is not possible within the constraints of this study. However, to further contextualise how the role of the ANP evolved, this chapter begins with a brief overview of the NHS. The evolution of nursing and the ANP are briefly introduced along with the context of the ANP's leadership practice within the NHS. Recent and very public statements about failures in leadership within the NHS are considered. These highlight the need for a contemporary review of leaders in the NHS, and how they are developed and supported in their practice.

2.1. The National Health Service

In 1948 the National Health Service began offering healthcare 'free at the point of delivery' to the UK population. Although described as 'socialised medicine' there was initially, significant political control over the NHS. This 'political stewardship' adds to the complexity of how the NHS was conceived and how it has evolved over the last seventy years (Webster 2002 p1).

Although 'free at the point of delivery', the services offered by the NHS had to be paid for through taxation of the employed population. Thus NHS funding was reliant on the overall health of the UK economy. At a time of economic uncertainty in the 1970s, costs of NHS services were growing, in part due to increased population numbers. In addition, Government imposed managerial complexity had led to massive increases in administrative costs. In 1974 there were two general elections, symbolising a time of political unease, there was also a rationalisation and re-organisation of the NHS. The cost of care, however, continued to increase in response to increasing demands for a wider range of complex and innovative treatments (Webster 2002).

Conflict arising out of perceptions and realisation of power relationships between clinicians and politicians has happened throughout NHS history, and this was particularly highlighted in the 1980's. The conflict arose from a lack of consensus between the politician and clinician in how the NHS should be led and managed. Roy Griffiths (1983) in his governmental commissioned report, highlighting this ineffectual leadership using the Florence Nightingale analogy of her 'carrying her lamp through the corridors of the NHS

searching for the people in charge' (Griffiths 1983 p12). The NHS's response to the Griffiths report was to encourage more clinicians to take on management and leadership posts. However, the uncertain nature of fixed-term contracts being offered at the time resulted in little clinician uptake of leadership roles. Griffiths also proposed a business model for NHS leadership and management. Although Griffiths was unsuccessful in securing significant clinician involvement (Griffiths 1983), it highlighted a vital need for clinicians to be actively involved (Jonas *et al.* 2011).

2.2. The current structure of the NHS

In response to increased clinician involvement in the leadership of the NHS a closer relationship between the Government and the clinicians has evolved (Webster 2002, Rivett 1998). The Secretary of State for Health is responsible for the work of the Department of Health, and the NHS is controlled but at arm's length by the Department of Health. The active involvement of clinicians in leadership and management within the NHS has been realised by the establishment in 2012/2013 of Clinical Commissioning Groups (CCG). Commissioning of healthcare involves deciding what healthcare will be delivered and by whom. The CCG, led by clinicians, commission health services both in primary care such as general practitioners, dentists or pharmacists and secondary care, such as planned hospital care or urgent care such as Emergency Departments[2] (NHS Clinical Commissioners 2015).

2.3. The evolution of the nursing profession

Nurses within healthcare have often been considered followers rather than leaders (Croft *et al.* 2014). Nursing and nurses were historically described as 'handywomen' or watchers who were there to deliver the infant, watch over the sick and lay out the dead (Dingwall *et al.* 1988 p9). In the 19th century nursing changed, influenced by a role model in Florence Nightingale, nurses were viewed as moral creatures upholding the virtues of the female gender (Rafferty 1996). Although not perceived by either the patient or the medical profession as a leader, previously the nurse had had some level of autonomy as healthcare was delivered at home and the nurse was the ever-present deliverer. By the 19th-century nursing care was beginning to be delivered in the hospital and with this, the nurse lost the power associated with being the only person present in the home to deliver care. In hospitals, a hierarchy was established between doctors and nurses. There was an approach to healthcare with the microcosm of the hospital, that has been compared to a 'Bentham's panopticon' (Rafferty 1996 p18). Visible at all times the nurses were watching over the patients, but they too were visible and had become supervised and subordinate to doctors.

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[2] See Appendix 9 for diagrammatic examples of NHS structure, current, 1974 and 1948

However, nursing practice continued to evolve and was aspiring to attain professional status (Davies 1996). This aspiration of professional status encouraged organisational change. In the UK a central register of nursing was developed at the beginning of the 20th century, and there was simultaneous reform of the educational approach for nursing. The defining characteristics of a professional include an extended period of education and the ability to self-regulate leading to autonomy in their practice (Freidson 2001). By establishing a professional register and a more formal approach to their education, the realisation of nursing as a profession began (Davies 1996).

Despite the aspiration of professional status, even as the NHS was being proposed in the mid-twentieth century, Rafferty (1996) describes anti-intellectualism directed at nursing. The practical skills of nursing and intelligence are seen as 'incompatible'. The dominance of the 'male' medical profession over the 'female' nursing profession encouraged a 'gendered stratification of cognate health care labour' (Rafferty 1996 p190). This pattern was influenced, to an extent, by the nature of the changes to nurse education. Instead of developing a distinct body of knowledge to reflect the distinct nature of nursing, nurse education, 'assimilated' 'the language of education and research' used by other, more established professional groups (Rafferty 1996 p7). This was further illustrated by Goodrick and Reay (2009) who reviewed the language in text books used in educating nurses from 1950-1966 and found terms such as 'subservience' describing how the nurse should practise. This would possibly suggest an acceptance of medical dominance by the nursing profession itself. If nursing were to establish its professional status and develop intellectually, it needed to persuade the professions around them, general society, but also nurses themselves, that a professional status would be of value to nursing and to developing healthcare (Rafferty 1996).

2.4. Nursing in the 21st Century

In the UK, the nursing profession's organisational structure has historically been hierarchical. In a hospital environment, the matron was at the pinnacle of the nursing hierarchy and entirely in charge of nursing, policy and practice. The ward sister was also in charge of and leading a team of nurses. However, with a medical model applied to healthcare delivery and popular public acceptance of the subservient nurse, both roles remained dominated by the medical profession (Doyle *et al.* 2006).

In the UK, the implementation of 'Agenda for Change' (Department of Health 2004) replaced the Whitley Council approach to assessing healthcare workers' pay scales (Buchan and Evans 2007) This influenced nursing by completely re-organising all NHS pay scales and grades. The principle behind these pay structure changes was seen by the nursing

regulatory body the Nursing and Midwifery Council (NMC) as potentially emancipatory. Instead of a pay structure being determined by role title, each practitioner would be paid according to what they actually did in practice. Ultimately, though, a lack of strong nursing leadership and the potential additional burden of an increased wage bill, the implementation of Agenda for Change resulted in many nurses being graded, and paid, lower than they had anticipated (Buchan and Evans 2007).

Concurrent to the implementation of Agenda for Change, the hospital ward sister or charge nurse role also transitioned to the ward manager. The role of ward manager encompassed additional management and administrative responsibilities (Enterkin *et al.* 2012). Ward managers were assigned these additional responsibilities and were still expected to be the leader of the nursing team. MacPhee *et al.* (2011) looked at approaches to supporting leadership development for roles such as ward managers. Twenty-seven participant ward managers were interviewed a year after they had undertaken a Canadian leadership educational programme and the researchers found the ward managers had a sustained belief in their own empowerment (MacPhee *et al.* 2011). If the nurse leader felt they had 'meaning', 'competence' 'self-determination' and 'impact' on the care they delivered, they felt empowered to lead (MacPhee *et al.* 2011 p167). Conversely, Enterkin *et al.* (2012) explored how hospital ward managers were being prepared for leadership roles in the UK and found approaches used were often ad hoc. This lack of explicit and consistent preparation for leadership roles influenced nurses in their career development decisions. Many nurses reacted to the lack of leadership preparation and the burden of administration associated with the ward manager role by aspiring instead to becoming clinically focused leaders such as ANPs (Enterkin *et al.* 2012).

2.5. Defining the role of the ANP

In the UK nurses undertake a three-year graduate programme which leads to their registration as a nurse along with an academic award of a bachelor degree (Nursing and Midwifery Council 2015). The Advanced Nurse Practitioner (ANP) is a registered nurse. The ANP, however, differs from the role of the Registered Nurse as there is an expectation that the ANP will enact leadership skills with both nursing and the multi-professional teams. There is not a distinct registration qualification for the ANP. The expectation is that alongside developing competence in advanced clinical practice, the ANP will complete a Masters academic award (HM Government 2010a). The Department of Health (DH) (2010) published a position statement that differentiated the role of the Registered Nurse from that of the ANP. The DH emphasised the role of the ANP was not limited to a speciality but instead defined

by their level of practice. That is, the nurse who is an ANP is nursing at an advanced level. The advanced nursing care the ANP practises is further defined by four themes which are,

- clinical/direct care practice;
- leadership and collaborative practice;
- improving quality and developing practice, and
- developing self and others. (HM Government 2010a).

The formal introduction and recognition of the ANP role allowed for a nursing career progression which enabled them to retain a clinical focus while developing other, more strategic and advanced skills.

The role of the ANP has been in existence, initially in the United States (US), since the 1960's. The earlier adoption of the ANP role was reflective of overall American healthcare culture where formal nursing education programmes had resulted in US nurses being more readily accepted, by other healthcare professions, as a profession (Rafferty 1996). Despite a different educational preparation system for nurses and less of a professional profile, nursing in the UK also wanted to create a clear career progression for nursing (Rafferty 1996). Therefore the ANP role was introduced to healthcare in the UK in the 1980s. However, despite the definition offered by the DH (HM Government 2010a), even four decades later, there remains a lack of understanding from other healthcare professionals, patients and the public of what the ANP role is (HM Government 2010b).

In 2009, the reduction of doctors' working hours meant in the absence of a doctor ANPs were required, out of necessity, to expand their practice to ensure high-quality healthcare continued to be delivered (European Working Time Directive 2009). This expanded practice included undertaking tasks that had previously only been practised by doctors. Tasks adopted by the ANP included conducting patient physical examinations, ordering and interpreting clinical tests and ultimately identifying a range of differential diagnoses and managing patient care. In the UK, although the expanded development of the ANP role, by the early 21st century, was a career development for the nurse, it was also directly a result of a shortage of doctors (Bryant-Lukosius *et al.* 2004, Fagerström 2009).

2.6. The leadership role of the ANP

The RCN and the NMC as organisations had strongly influenced the DH position statement related to the role of ANP (HM Government 2010a). The RCN also stipulates leadership as a competence for the ANP (RCN 2012) emphasising leadership practice as a key aspect of the ANP role. Despite being seen as a skill that defines the ANP, confusion remains about the leadership component of the ANP role and the implications for ANP practice. This confusion is understandable when even the overall concept of leadership has

been described as nebulous, with evidence supporting theories of leadership being described as lacking rigour (Jonas *et al.* 2011, Williams 2004, Alimo-Metcalfe and Lawler 2001).

A small body of research has explored characteristics of the role of the ANP (Castledine 1998, Ashworth *et al.* 2001, Gerrish *et al.* 2003, Hanson and Hamric 2003, Higgins 2013, Mantsoukis and Watkinson 2006, Carryer *et al.* 2007). Most recently, Shearer and Adams (2012), in the UK, explored how educational preparation increased the ANP's clinical assessment skills and confidence. Watkins (2011) also found that Masters-level education encouraged the ANP to champion the nursing profession and increased the ANP's personal level of confidence. Gerrish *et al.* (2011) found that undertaking further education encouraged the ANP to promote evidence-based practice. However, despite the inclusion of leadership in the DH position statement relating to ANPs (HM Government 2010a) most studies do not focus specifically on how ANPs define, understand, express and enact their leadership knowledge and skills. This gap in the body of evidence related to the characteristics of the ANP role points to the importance of undertaking a leadership-focused ANP study. The demand for research examining NHS-based leadership is also supported by the high-profile failures that have been identified in the last few years.

2.7. Failures of leadership in the NHS

Today's NHS demands the contribution of multiple professions to ensure successful healthcare delivery. There have been some high-profile failures attributed to ineffective leadership at all levels of healthcare delivery. For example, following identified unacceptable standards of care and significantly increased rates of mortality within the Mid Staffordshire NHS Foundation Trust, the Trust was described as being led by 'a leadership which was deficient and unable to command confidence' (HM Government 2013 p45). Many factors were identified as influencing how the Mid Staffordshire NHS Foundation Trust had deteriorated to such poor standards (HM Government 2013). Foundation Trust status allows NHS organisations to adopt greater internal control over their own leadership and management. The Mid Staffordshire Foundation Trust public inquiry found that the organisation had been focused on achieving Foundation Trust status at the expense of responding to evidence of poor standards of practice (HM Government 2013). Individual employees were aware but did not acknowledge poor practice. In one instance where a nurse did 'whistle blow' the unacceptable standards in the Accident and Emergency Department, the governing team did not respond (HM Government 2013). Throughout the Trust, nursing was cited as having 'poor leadership and staffing policies (*and*) a completely inadequate standard of nursing' (HM Government 2013 p45). The final recommendations of

the public inquiry report included the need to develop 'strong leadership in nursing' and with this a strong support and regulatory systems for all NHS leaders once they were appointed (HM Government 2013 p66).

An earlier study on 'Followership in the NHS' (Grint and Holt 2011) also recognised the power that individuals have either by non-compliance with leadership. As demonstrated by some of the professionals in Mid Staffordshire, there was a culture of 'passive acquiescence' (ibid p16). In a healthcare professional community, the leader of any profession is reliant on their followers and that 'leadership is the property and consequence of a community' (ibid p7).

Despite identification and public scrutiny of NHS leadership failures, the NHS is described as the most efficient healthcare system in the world (ibid).When compared with other developed countries the NHS spends least per person to achieve this efficiency (ibid). Leadership talent is present across the NHS but it is not being explicitly and strategically developed (ibid). Rather than develop leaders that have the time to understand the complexities of the NHS, there is a blame culture where leaders strive to avoid failure rather than achieve innovative success (ibid). Within the NHS the leader of the leaders, the Chief Executive Officer's average tenure is less than two years (Rose 2015). The leader is rewarded when they cope well in a crisis and the leader that avoids the crisis developing remains unacknowledged (Grint and Holt 2011).

Instead of remaining 'stubbornly tribal' with no understanding of 'each other's priorities' Lord Rose's recommendations support the need for all professions in healthcare to work collaboratively (Rose 2015 p33). With this aim, Lord Rose proposes the development of a collective vision for all partners in healthcare delivery together with consistency and co-ordination in leadership education (Rose 2015).

Lord Rose also described many professions, within the NHS, as viewing the roles of both manager and leader negatively,

> 'there is a widespread and deep-rooted perception that management is 'the dark side'. Doctors and nurses can be seen and often position themselves in opposition to management' (Rose 2015 p30).

The role of the leader, in healthcare, is often associated with the implementation of changes in practice. However, the NHS is described as unsettled by change or so weary of constant change and restructure that there was an atmosphere of 'change fatigue' (Rose 2015 p22). NHS employees are described as its greatest asset and yet appear to be little

valued (Rose 2015). Instead of leaders being offered effective support through development the training, the leadership education and support being offered are described as inconsistent (Rose 2015). The negativity with which leadership is viewed within the NHS may be influenced by a culture of constant change. It is also a culture where NHS leaders are not being rewarded for doing well or managed when they underperform, instead, the leader is left 'drowning in bureaucracy' (Rose 2015 p40).

Contemporary discussion around failure in NHS healthcare leadership identifies the need for effective leadership within healthcare and why it is important to demonstrate how in each profession, including the ANP, leadership practices contribute to this. This chapter has offered an analysis of the role of the healthcare professional and the challenges that leading a multi-professional team can bring. The healthcare professional does not work in social isolation, and it is important their leadership is contextualised within the NHS.

In response, to understand more about leadership and the role of the ANP, this study focuses on how a small sample of London-based ANPs defines, understands, expresses and enacts leadership within their professional practice. The study also explores how the ANP's perceive leadership and the interpersonal and organisational opportunities and challenges that they experience in their roles. The following chapter will consider the published evidence that examines healthcare leadership, the role of the ANP and leadership strategies employed in both developing and supporting leadership practice.

Chapter 3: Literature review

The role of the ANP has become increasingly significant in healthcare delivery in the UK. Chapter one outlined the rationale for this preliminary study of London-based ANPs' definition, understanding, expression and enactment of leadership practices and chapter two established the healthcare context in which ANPs work. To frame the design and analysis of this research, this chapter reviews the relevant research literature that explores leadership in the NHS, the role of the professional in the NHS and the dialogue between leadership and the role of the ANP. This review has been undertaken in a formal, systematic way to ensure the overall study design reflects and builds on, what is already known about ANP leadership practice.

The review of the literature was focused on sources from 2005 onwards to reflect the developments that influenced the ANP role around this time and since. Four specific developments influenced limiting the timescale of the review. First, in the UK, in 2005, there was proposed regulation of the role of the ANP following a national consultation, and this was put before Privy Council (a process that precedes an Act of Parliament) to create a sub-part of the nursing register for ANPs (aape.org.uk). Despite the sub-part of the nursing register not being established, the national consultation and the process of the proposal was a significant point in the history of the ANP in the UK. Second, the role of the ANP expanded in response to the mandatory and legal reduction in the number of hours doctors could work (European Working Time Directive 2009) but also to strategically enhance the professional role and scale of responsibilities of nurses (HM Government 2010a). In 2010 the publication of the position statement of Advanced Nursing Practice offered a clear definition, including leadership responsibility, assigned to the role of ANP (HM Government 2010a).

Third, although ANPs have practised in the UK for over forty years, the expectations of healthcare providers and recipients of ANP expertise continue to evolve, reflecting the complexity of healthcare today (Hardy *et al.* 2013). Finally, in the UK, there have been major changes in healthcare in the last five years including the need to reduce costs while still delivering complex and innovative healthcare to an increasingly ageing and growing population (The Health and Social Care Act 2012).

This preliminary identification and gathering of the literature for the review included identifying sources by searching multiple online databases including Science Direct; CINAHL, Medline; PsycARTICLES and PsycINFO. Initial searches were conducted using the search terms 'leadership' and/or 'nursing', and to explore how the ANP was prepared for leadership; and/or 'education'. The initial search generated a large number of results (26,896) and it appeared, on review of some titles, that the literature was often not directly

relevant to the main concepts of leadership in the NHS, the role of the ANP, leadership preparation and the nature of their leadership practice. To retain a breadth to the review, the search was refocused using the same databases, and additional search terms which included 'Health profession' and 'Leadership' (917). I also added the limits of 'peer reviewed journals' and 'published after 2005' which generated 543 results. I read all 543 titles and short abstracts in full to identify inclusion of empirical evidence and to exclude duplication. Even employing this search strategy, within the aforementioned shortlist, some resources remained distinct from the focus of the review. For example, titles that focused on Dentistry were excluded. This generated 55 results that were included in the full and final review.

In order to include a broad range of relevant literature the first search had not specified 'the role of the ANP'. To refine the search to include ANP leadership practice a second search was undertaken. Using the same databases, the search terms 'nursing' (209), 'Advanced Nurse Practitioner' (52) and 'leadership' yielded a further 22 results that were also included in the full and final review. Some studies referred to nurse leaders rather than ANP specifically. These were included in the full review. In addition, several key journals – Journal of Advanced Nursing, Nurse Education Today, Journal of Nurse Education and Journal of Nurse Management were specifically searched using the same search terms. All reference lists from articles from both searches were also reviewed for additional publications. This process generated less than ten additional papers. Finally, 'grey literature' such as white papers; publications and policy statements from the professional body NMC and nursing union RCN were also reviewed. The findings of both reviews are presented in this chapter.

The chapter organises the findings of the review focusing on leadership in the NHS, the role of the professional, gender influences on leadership, how the ANP is prepared for leadership and the impact that ANP leadership has on patient outcomes.

3.1. Leadership in the NHS

The NHS has a rigid hierarchy which is made even less flexible by the impact of Parliamentary laws on front line healthcare decision makers (Hurley and Linsley 2007). The evolving climate in healthcare and the challenge facing leaders of the multi-professional team has been described as 'herding cats' (Jonas *et al.* 2011). Alimo-Metcalfe and Lawler (2001) studied leadership outside of the NHS to see what lessons could be learnt and applied from non-healthcare leadership approaches. Their study found that leaders outside of the NHS preferred to focus on market position, ensuring they were leading in the market rather than developing constructive relationships with the people they were leading. Although to a lesser extent, this can also be seen within leadership practices in the NHS.

The leader instead of developing a relationship with their team focuses on a business approach to achieving targets (Alimo-Metcalfe and Lawler 2001).

An approach to leadership often seen in the NHS is where the leader is at the fore-front employing a 'heroic' leadership approach, again not developing a relationship with their teams but simply expecting the team to follow (ibid). While this approach to leadership, in some instances, can be effective, there is a risk that the personality of a heroic leader can also be seen as arrogant and over–confident. This can result in those being led developing an over-dependent relationship with their leader (Alimo-Metcalfe and Franks 2011).

In the NHS the heroic leader can be seen as enacting transactional leadership. The NHS transactional leader offers rewards for effective performance. Not only do transactional leaders get the job done they take full accountability leaving their followers without the stress of responsibility (Giltinane 2013). For the NHS transactional leader, the impact of culture or context is only acknowledged as something that needs to be rewarded in order to ensure the outcome (Haslam *et al.* 2011). Again, this leadership approach has been described as effective but when employed in the NHS, has been criticised. The NHS transactional leader, by being more focused on achieving targets, reflects the principles of management rather than those of leadership (Dawes and Handscomb 2005).

In contrast, other leadership approaches often employed in the NHS have been described as setting a vision (Jonas *et al.* 2011) and motivating people to achieve common goals (Haslam *et al.* 2011). These approaches may be more closely aligned with a transformational leadership approach which has been described as a partnership between the leader and their colleagues (Jonas *et al.* 2011). The partnership is focused on working collaboratively and identifying opportunities for each other to develop. Transformational leadership means that the care delivered is enhanced, reflective of each profession's contribution and is seen as a more holistic leadership approach. The leader exerts power through the group rather than power over them (Oakes *et al.* 1994). The complex and changing nature of healthcare can be overwhelming for practitioners, and transformational leaders prioritise demonstrating their emotional intelligence to empathise with their colleagues. Transformational leadership thus allows the team and their leader to express frustrations and explore together the challenges they encounter (Giltinane 2013).

The partnership relationship employed by transformational leadership can be observed between fellow professionals and between the leader and the patient, as the healthcare provider and receiver. In this instance, the role of the leader is not an autocratic one but more one of empowering the patient. O'Neill (2013) suggests that with developed emotional

intelligence the transformational leader can adapt their behaviour and empathise with their followers, which in this instance is the patient. O'Neil's commentary is drawn from United States of America (USA) healthcare and the involvement of the nurse leader in implementing recommendations of the 'Affordable Care Act'. However, as the study emphasises effective team work, it still has relevance in the UK and within the NHS (O'Neill 2013).

Giltinane (2013) suggests that the UK healthcare leader has to assume a leadership approach appropriate to the situation, and how, at times, there is a need for transactional leadership when autocratic decisions have to be made or outcomes achieved.

3.2. Professional identity and the 'unstable knot' of multi-professional working

The professional identity of each individual professional members of the multi-professional team has some influence on the leadership approach the professional will employ. A professional has been described and defined by their ability to self-regulate and their level of autonomy in their practice (Freidson 2001). Professions are guardians of their unique and specialist knowledge and the extended periods of training allow the professional to attain professional status. This contrasts with non-professions that are seen as implementers of knowledge, their concern more focused on 'efficiency and effectiveness' (Freidson 2001). The professional role identity of the individual defines 'how they interpret and behave in work situations' (Goodrick and Reay 2010 p59).

Evetts (2009) describes two differing professional types. The organisational professional manifests itself in a culture where hierarchical structures determine responsibility and decision making. This contrasts with the occupational professional whose authority affords them autonomy and discretionary judgement and who is controlled only by codes of professional ethics. This defining autonomy is not something the professional will readily relinquish. Sustaining a singular professional approach to leadership affords each profession the 'safety net' of maintaining their own autonomy by profession-specific individual routines and established custom (Edwards 2010). Goodrick and Reay (2010) also described the difficulty that professionals have in 'legitimising' changes to their leadership approaches and what has been their accepted normality.

The organisational structure for bodies such as the NHS has been termed a professional bureaucracy and which describes what the individual goes through in knowledge and skills attainment to participate in the profession as 'indoctrination' (Mintzberg and Ivonne 1995). The delivery of healthcare is a complex process and leadership within healthcare systems involves many different professional groups all of whom are used to their individual professional autonomy, power and authority (Evetts 2009).

Leadership is a topic of significant policy, public and research interest across the NHS. Almost all health professionals, distinct from one another, have dedicated research and advocacy to the topic of leadership. Leadership in the NHS has been described as tribal between nurses, doctors and managers with all professional groups separately working in silos rather than collaboratively (Rose 2015). Each separate profession is only competent and confident in leading their own profession, that is, nurses are confident leading nurses and doctors leading doctors but less confident leading each other (Jonas *et al.* 2011).

The NHS of today is delivered by more than one profession, simultaneously, in almost all settings. As such, there is almost always some component of multi-professional working. Engeström (2008) suggests that health professionals work together as an 'unstable knot' of interdependent practitioners consistently revising their roles in the multi-professional group. Multi-professional team working can be viewed by each of the participating professional groups as a risk rather than a benefit to their professional identity. By not placing the emphasis on the distinct nature of each profession the risk is a dilution of the unique contribution that each profession gives to the multi-professional team (Headrick *et al.* 1998). Indeed the professional has been described as having first an allegiance to their profession and not to their employing organisation (Mintzberg and Ivonne 1995). Each profession often makes autonomous decisions independently from, or peripherally to, each other (Mintzberg and Ivonne 1995). The professional identifies most with others in their profession and often finds it challenging to acknowledge or adopt cultural practices from another profession (Goodrick and Reay 2009, Wenger 1998). This creates challenges for multi-professional working.

Despite potential challenges with multi-professional working Edwards' (2010) concept of 'relational agency' is helpful for understanding the relationships between different professional actors and how this differs from 'individual agency'. Successful multi-professional working needs the individual professional to recognise the 'standpoint' of other professionals and thereby enrich their own understanding of complex problems. The reality is often that professionals are working together and demonstrating shared professional values, but they are rarely working inter-professionally (Edwards 2010). Relational agency outlines that in the current social climate there is a need for re-evaluating the exclusive expert professional. To achieve true inter-professional working, individual professionals need to accept their expertise may be challenged by others but that this is necessary to achieve 'enriched understandings' and improved outcomes (Edwards 2010).

Despite the description of separate uni-professionally focused working within the NHS (Jonas *et al.* 2011, Engeström 2008), there are many professionals within the system that do

work closely together to achieve coherent and effective healthcare delivery. Across NHS settings, the multi-professional team can consist of doctors, nurses, social workers, physiotherapists, occupational therapists and a range of other professions depending on the health needs and clinical environment. Rather than diluting the individual professional's contribution, effective multi-professional teamwork has been described as making the team greater than the sum of each individual profession within the team (Illingworth and Chelvanayagam 2007).

Wenger describes the concept of a community of practice, not only within healthcare, yet highly applicable to healthcare working; the multi-professional team is defined by the practice they undertake together (Wenger 1998). Although being part of the community of practice (COP) does not imply that each professional offers an equal contribution, recognition of their contribution does mean equality (Wenger 1998). Each professional can also belong to multiple, competing, communities (Croft *et al.* 2014). For example, the ANP while a member of the multi-professional community is also part of the community of ANPs and nursing (Wenger 1998). Similarly, the other professions in this multi-professional team can also be members of multiple COPs, and these can be distinct or single professional groups such as the ANP or the nurse, or shared communities such as the multi-professional team.

Healthcare professionals within the MPT are said to behave in distinct ways while leading (Barrow *et al.* 2010, Goodrick and Reay 2009). The actions of one professional are modifying or constraining, the present or future actions of another (Foucault 1983). In healthcare, Engeström used the analogy of each profession putting their 'spoons in the soup' without an awareness of what the other was doing (Engeström 2005).

3.3. Front Line Leadership

'Front Line Care' (HM Government 2010b) a report for the Prime Minister's Commission on the future of nursing and midwifery, focused on nursing leadership and barriers that were preventing nurses (and midwives) from leading. It engaged with all branches of nursing and midwifery across all sectors, both within the NHS and outside of the NHS. The Commissioned Report stated amongst its aims the need to,

- 'Identify the competencies, skills and support that frontline nurses and midwives need to take a central role in the design and delivery of 21st-century services for those that are sick and to promote health and wellbeing. In particular, identify any barriers that impede the pivotal role that ward sisters/charge nurses/community team leaders provide.
- Identify the potential and benefits for nurses and midwives, particularly in primary and community care, of leading and managing their own services.

- Engage with the professions, patients and the public in an interactive and robust dialogue which will identify challenges and opportunities for nurses and midwives'.   (HM Government 2010b p16)

The 'Front Line Care' Commissioned Report collected the views of a wide range of stakeholders in two stages. The Commissioners recruited expert nurses and midwives, and a range of organisations including the House of Lords, Department of Health, NHS Acute Hospital and Primary Care Trusts, professional organisations and trade unions. In stage one, the views of stakeholders were sought from over 300 organisations and including the less frequently heard voices of users of health and social care. The second stage involved an equally wide range of stakeholders who were asked to discuss any 'hot topics' or areas and concepts where consensus had not been reached in stage one.

The Front Line Care Commission Report (HM Government 2010b) identified confusion amongst the public about the role of the ANP. Only patients that had experienced care delivered by the ANP were aware of their specialism and expertise, with most patients continuing to see the role as indistinct from the registered nurse. As described in the report, 'People who had encountered advanced practitioners appreciated their specialist expertise and ability to make decisions and referrals and prescribe medicines' (HM Government 2010b p40).

The report also referred to the nurse as a stoic, overworked and underpaid, passive, female who lacked ambition (HM Government 2010b). This view is reflective of public perception but was perpetuated by the media misrepresentation of the nurse and resulting in the expressed view from one service user (patient), who shared, 'I'm not sure you need to be a leader to be a good nurse' (ibid p95).

Barrow *et al.* (2010) suggested that the public views the roles of doctors and nurses along traditional gendered lines; doctors as male curers and nurses (including the ANP) as female carers (Barrow *et al.* 2010). The public perception also has an impact on the individual profession's perceptions of themselves (ibid). As Wenger describes, the individual negotiates their social and in this case professional identity, through their historical experiences (Wenger 1998). This may suggest that as nurses historically were not seen as healthcare leaders, their professional identity and behaviour may reflect non-leadership behaviour.

3.4. ANPs attachment to their nursing identity

Successful and influential ANP practice relies on organisational culture within the NHS where colleagues and managers are sufficiently confident in ANP skills to allow them to practise them (Cotterill-Walker 2012). As such, ANP leadership practice can be a dependent

on other members of the multi-professional team's acceptance (Gardner *et al.* 2004). If ANPs identify more with the professional identity of the nurse they may be more resistant to moving forward to a new ANP professional identity (Goodrick and Reay 2010) and by this the ANP reduces the likelihood of multi-professional team acceptance of their leadership. Even by becoming an ANP, they are described as a nurse able to maintain a clinical focus to their career development (Addudel and Dorman 2010). By focussing on direct clinical care, the ANP is also described as having a lack of awareness and understanding of issues around power, finance and healthcare policy. This has often resulted in further constraints to the ANP's leadership ability (Addudel and Dorman 2010).

Croft *et al.* (2014) explored the challenges of developing a leadership identity at the expense or instead of a nursing professional identity in the UK. Using participant observers Croft *et al.* (2014) examined the leadership views of 32 nurse managers enrolled on a leadership programme. All participating nurse managers were interviewed twice – once shortly after the end of the programme and again around twelve to eighteen months post-programme. The intention was to capture if and how their identity transitioned over time. The researchers discovered that the nurse managers were consistently and emotionally attached to their nurse identity which was often 'incongruent' with the nursing leader identity. The transition to the new identity of leader was needed to establish their leadership influence. However, the nurse managers were simultaneously losing the influence they had over the nursing group by no longer being seen as a nurse (Croft *et al.* 2014). The nurse managers felt that they were in a 'hybrid' role, part nurse and part leader.

The time between completion of the programme and a year or eighteen months later was viewed as a transitional period and brought about feelings of conflict with the nurse managers between their role as a leader and their role as a nurse. While the nurse managers talked passionately about their nursing roles, they were often more negative about the leadership role. Three key issues influenced the negative feelings towards their leadership responsibilities. The first, nurse managers felt vulnerable, due to a lack of peer support. The nurse manager also reported feeling disconnected from their nursing identity. They experienced an overall lack of support for their role as nurse managers to develop and practice as a leader. However, even with their negative experiences, the nurse managers who participated in the study largely remained in these hybrid roles with only five out of the thirty-two progressing to roles that were purely leadership roles (Croft *et al.* 2014).

The contrast between the two groups of nurse managers was with those in the 'hybrid' management role remaining keen to emphasise their attachment to a nursing identity and how different they were from the usual healthcare manager. The second group of nurse

leaders seemed to have accepted that as leaders they had a new role identity within nursing and this was 'not a rejection or contradiction of older identity but a progeny of it' (Goodrick and Reay 2010 p59). Nurse managers who had moved away from hybrid roles to senior management roles had adopted a distinct healthcare management identity and consequently felt less reliant on the nursing professional identity (Croft *et al.* 2014).

3.5. Doctors and ANPs collaboration

There are many factors that influence ANP intentions to become healthcare leaders, including personal historical experience and elements of their nurse identity (Wenger 1998). The historical public perception of nursing as a caring, not leading, profession may also influence the ANPs desire to take on leadership roles (Barrow *et al.* 2010). This might suggest that ANPs as nursing and MPT leaders need to evolve from the traditionally accepted perception of the professional identity of nursing.

O'Brien *et al.* (2008) explored the collaborative relationship between junior doctors and ANPs working in primary (out of hospital) and in-hospital care. The study was undertaken in the USA where the role of the ANP, for nearly sixty years, has a rigorous education and certification infrastructure combined with a regular verification process to ensure the ANP's competence (APRN 2008). The doctors who participated in the research still appeared unsure of what an ANP could actually do and therefore restricted the ANP's scope of practice. The doctors believed that their status of doctors made them ultimately in charge. Healthcare in the USA is insurance based and also has become a highly litigious culture. The reluctance from the medical team to allow the ANPs to work independently may have been based on the medical teams simply being averse to the risk of litigation (O'Brien *et al.* 2008).

The same study identified differences between how doctors and ANPs perceive effective communication. The ANPs tended to communicate detailed and lengthy patient handovers often containing what the doctors thought was unnecessary information. In contrast, the doctors were described by the nurses, as, at times, verbally aggressive and autocratic in their communication. The ANPs felt undermined rather than empowered by the doctors in their team (O'Brien *et al.* 2008). Rather than working together to achieve the enhanced holistic care, ultimately the two professions were not working collaboratively. Instead, the doctors were the transactional leaders subordinating and controlling the ANP's (O'Brien *et al.* 2008). It is important, again, to recognise the differences between healthcare delivery context in USA and UK and that O'Brien *et al.'s* (2008) study was describing healthcare delivery from nearly a decade ago. The American Patient Protection and Affordable Care Act

(Summary of provisions in the Patient Protection and Affordable Care Act, 2012[3]) has brought significant changes to USA healthcare provision. The role of the ANP has developed in both the USA and UK. In the UK, it has already been identified that the public perception in relation to the leadership aspect of the role of the ANP remains limited (HM Government 2010b).

3.6. Hierarchy and the role of the follower

The studies cited above focus on the concept of leadership rather than the powerful role of the follower. The follower can be pivotal when agreeing with the leadership approach and also formidable in disagreeing with it. Effective leadership can be achieved or thwarted by effective or destructive followership (Haslam *et al.* 2011).

Barrow *et al.* (2010) also explored the relationships between, in this instance, doctors and nurses. In this study, they explored the leadership and followership identities that junior doctors and nurses demonstrated while working with each other. Barrow identified that the professional status of medicine and 'the sheer size of nursing' (as a profession) would ensure that both professions would eventually assume leadership roles in healthcare delivery. Describing it as 'capillary power' (Barrow *et al.* 2010 p25) found that nurses, because they remained in the same clinical environment for longer than doctors, whose stage of training dictated their movement between clinical environments, used this greater sense of familiarity, of clinical environment and practices, to claim authority. The capillary is the smallest of blood vessels. The power that the nurses elicited could be seen as minor as it was derived from detailed knowledge of local policy and protocol. Yet, by nurses adhering to policies that were unfamiliar to the highly mobile doctors, the nurses were able to undermine junior doctor's leadership efforts.

Despite the nurse's attempts to claim power and control, doctors retained an absolute belief in their authority and used a transactional 'command and control' leadership approach (Barrow *et al.* 2010 p24). Similar to O'Brien's (2008) study, rather than collaborative working between the two professional groups, the working relationship between doctors and nurses was only a 'loose coalition' (Barrow *et al.* 2010 p18). This said, in both studies the ANPs, nurses and junior doctors identified their accountability to the patient and that effort to influence, impose, undermine or change decisions were made to achieve better outcomes for the patient.

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[3] This may change with under President Trump

3.7. Gender, nursing and leadership

The concept of followership has been accused of lacking relevance in the organisations of the 21st Century where hierarchy no longer exists (Grint and Holt 2011). Hierarchy does exist in the NHS. The hierarchical relationship between and within professions would suggest the follower still has currency in healthcare delivery. There has also been a historic perception of male hierarchy and the influence of gender on the ability to lead is discussed next.

The concept of professional identity has already been discussed, along with the description of professional bureaucracy within the NHS (Mintzberg and Ivonne 1995).The hierarchical and bureaucratic nature of the NHS has also been described as affording the organisation structure and stability (Davies 1996). Davies also describes the nature of professional knowledge and adherence to regulations as a patriarchal hierarchy that functions as an environment that can exclude female employees (Davies 1996). Conversely, the scientific nature of medicine has resulted in it exerting a prestigious patriarchal role in healthcare. In contrast, the caring aspect of healthcare, including nursing care, has been described as 'feminised' with 'care' work being deemed less prestigious. Prestige has been aligned with technological and scientific healthcare roles (McMurry 2011, Bell *et al.* 2014). Consequently, nursing and social work are often the professions most associated with the emotional, caring aspects of healthcare. Both are, in turn, often less valued by other professionals in the healthcare culture (Bell *et al.* 2014). An example of this was seen in O'Brien *et al.*'s study (2008) where doctors did not value the detailed nurse-led patient handovers and asked for a factual summary, while the nurses in the study viewed the detail essential to effective communication.

The sheer numbers of women employed as nurses would suggest a proportion of them would become leaders but women are chronically *'*over-represented in the lower ranks and underrepresented in the higher ranks' (Tracey and Nicholl 2007 p680).

Tracey and Nicholl (2007) explored the impact of gender on career progression for women in nursing and describe three levels of influence. The macro-societal level reflects the socialisation of women, indicating they are less likely to pursue a career in a predominantly male dominated work environment. This negatively impacts on their potential employment opportunities. The second level of influence (Tracey and Nicholl 2007) is the intermediate level. This level relates to an organisation's structure and its impact on the individual's career opportunities within it. The nursing profession's traditional focus on 'caring' is seen as lower in the NHS hierarchical structure and is, therefore, closer to the patient. The focus of most nursing work is at the front line of patient care. This may limit the

nurse's opportunities within the healthcare organisation. Finally, is nurse's micro-occupational level of influence, which tends to view nursing, not as a profession but as practitioners. That is, what the nurse as a practitioner has to contribute to the practice of healthcare. The micro-occupational level assigns power and influence to each individual role and nursing as practitioners are only afforded a low level of power or influence (Tracey and Nicholl 2007).

The ANP is a member of the nursing profession but also has a defined role of leader in healthcare delivery. The leadership role of the ANP could be seen to challenge the assumption of a gender-associated, less prestigious contribution to healthcare delivery. The development of the ANP and their leadership of different aspects of healthcare more usually associated with medical practitioners could be seen as diluting the traditional expectation of medical patriarchal dominance (Bell *et al.* 2014).

Nillssen and Satterlund Larsson (2005) interviewed 18 female and 18 male lead nurses to explore their conceptions about gender influence in their roles. They found that male lead nurses were better at asserting themselves and more direct in their communication. The researchers concluded that the participating nurse leaders believed that there was no real gender difference between leadership styles of male and female nurse leaders. Yet, how long it took for the male and female nurses to become, formally recognised as nurse leaders did differ. Male nurses became leaders relatively early in their careers, and female nurses often were described as 'finally' becoming nurse leaders. This, the researchers felt, was influenced by a masculine construction of both the healthcare system and the leadership role. Again, the participating female leaders demonstrated a preference for caring for patients while participating male leaders focused on work away from direct care-giving (Nillssen and Satterlund Larsson 2005). Although the leaders did not perceive differences between the male and the female leader, the focus of clinical care by female leaders seemed to have an adverse impact on their career progression. This, again, could be seen to reflect the less prestigious association afforded to 'care' in healthcare (McMurry 2011, Bell *et al.* 2014).

Williams (1992) first used the term 'the glass escalator' to describe the more rapid male career trajectory in four occupations (including nursing). Williams interviewed 76 men and 23 women between 1985 and 1991. The study focused on non-traditional occupations for men and found that their gender had a positive impact on their career progression. However, some men perceived disadvantages to being seen as on a fast track to leadership. For example, the participating male kindergarten teacher and librarian who wanted to focus on children's teaching and children's book collections and did not want to pursue a

leadership role. However, this focus on children was associated with care-giving for the male professional. Their roles were considered feminised, and the men in them who had no ambition to become a leader were considered exceptional to their gender (Williams 1992). Although some men feel pressured into leadership roles, most embrace the privileges that gender affords them and pursue a leadership role when working in a predominately female profession (McMurry 2011). Drawing on this evidence, it may be fair to say that to develop as a leader; the ANP needs to overcome the negative association with the caring aspect of their role and the expectations of their gender but also be educated, supported and empowered into the leadership aspect of the ANP role.

3.8. Developing the ANP leader

As identified earlier, explicit leadership development across the NHS has been described as inconsistent (Rose 2015). East *et al.* (2014) surveyed UK based ANP development needs. The research team received 136 responses and found considerable variation between role titles of practitioners that there were to being called ANPs (East *et al.* 2014). Even today, although there are identified defining characteristics, there are no current regulatory requirements to define the ANP role. This was re-enforced by the Government's position statement defining the role of the ANP in 2010 (HM Government 2010a). In this statement, the Government agreed that there should be nationally agreed standards that the ANP would use as a 'bench mark' to be measured against, but without regulatory power, the standards still allow for different interpretations of the ANP role. The practitioners in East *et al.'s* (2014) study, for example, who defined themselves as an ANP included 93 Clinical Nurse Specialists and a Band 5 nurse. Agenda for Change pay scale banding would suggest a Band 5 nurse was practising at newly qualified registered nurse rather than ANP standard (Buchan and Evans 2007).

The recruitment of such a wide spectrum of nurses considering themselves to be ANPs could have been influenced by the recruitment strategy employed in the study. The researchers asked for lists of ANPs to be nominated by Matrons who employed the ANP rather than the practitioner self-selecting. However, it suggests a concerning and persistent lack of understanding of what the ANP role is and what skills the ANP role should demonstrate (Rose 2015). This range of role definitions meant the development needs between the ANPs varied considerably with only 65% having being educated to a Bachelor's degree level, despite the researchers anticipating the nurse working as an ANP would have completed a Masters degree (East *et al.* 2014).

The majority of the ANP respondents identified educational development and clinical skill based training needs. Some commonality emerged relating to the need to undertake a

higher degree or at least specialist learning. Other participant ANPs felt they had no developmental needs, either because these were being met by their medical colleagues 'keeping them up to date' or that they were working in such a specialist field that no development opportunity would be relevant (East *et al.* 2014 p6). This, too, is concerning as these ANPs believed that they were only able to be developed by their medical colleagues. The ANPs in this study, who reflect that they have no distinct educational or developmental needs, raises and perpetuates the belief that there is not a separate and distinct knowledge base unique to nursing and the ANP role (Rafferty 1996).

Higgins *et al.* (2014) explored what influences an Irish ANP's ability to enact leadership. Using a case study design, 23 clinical nurse specialists and ANPs were interviewed. The Irish National Council for the Professional Development of Nursing and Midwifery Framework (NCNM 2008b) identify very similar core aspects to the ANP role in the UK (HM Government 2010a). The Irish ANP role description includes autonomy and expertise in their practice, leadership and research (NCNM 2008b). Higgins *et al.* (2014) distinguished different aspects of leadership and defined clinical leadership as developing practice while professional leadership meant involvement in professional developments at a national and international level (Higgins *et al.* 2014).

The study, in contrast to O'Brien (*et al.* 2008), found that ANPs were able to act as leaders without 'turf wars' arising between different professional groups (Higgins *et al.* 2014 p899). However, the researchers also found that as the ANP was often working as a sole practitioner, the ANP did not have the time to take on activity leading to involvement in professional leadership developments. This lack of time was directly influenced by ANPs taking on what had previously been tasks associated with the medical workforce. This left ANPs unable to develop additional skills and constrained in their participation in leadership outside of the direct care-giving arena (Higgins *et al.* 2014).

As seen in earlier studies (Cotterill-Walker 2012, Gardner *et al.* 2004), another factor that inhibited the ANP's leadership practice was reliance on their immediate line managers, often also nurses, to nominate them to become involved in strategy developments. These strategic developments could either be within or external to the ANPs' employing organisation. The managers of the ANPs were often not involved in national and international strategy development and were reluctant to nominate the ANP into these strategic roles ahead of themselves (Higgins *et al.* 2014). Higgins *et al.* (2014) found that there was no conflict between other professional groups and the ANP enacting leadership roles. However, they also describe the ANP being limited to the clinical leadership role by

their clinical responsibilities, with little involvement in developing 'policy and practice' (Higgins *et al.* 2014 p 900).

Without developing and embedding leadership into education for ANPs and continued support from the other members of the multi-professional team, including their nurse managers, the researchers predicted that the role of the ANP, although an able and educated leader, risked becoming 'sleeping giants' (Higgins *et al.* 2014 p903).

3.9. Exemplary Leadership Practice

Kennedy (2008) commented on nurse managers and leaders in the UK and suggested that they are often appointed without any preparation for the leadership role they are being appointed into. UK nurse leaders see a tension between the management they have to undertake and the leadership that they would like to enact. The nurse leaders gain their leadership roles because they have expert clinical skills but this does not always translate to the skills needed for leadership (Kennedy 2008). Based on this evidence, it would appear that nurse leaders may not be offered specific leadership education or development.

Kelly *et al.* (2014) undertook a large study with 512 nurse leaders from 23 US hospitals exploring leadership preparation and development. The participating nurses appointed to leadership positions were required to have a demonstrable academic ability at either Bachelor or Masters Level but were identified as not having had specific leadership education. The nurse leaders described instead how their new roles were adding to their responsibilities. These added responsibilities came without concurrent formal additional authority from within the healthcare team around them, in order to enact their leadership. Instead of formal leadership education, nurse leaders learnt from situations that required them to lead. This resulted in the potential for adopting leadership approaches based on poor leadership models (Kelly *et al.* 2014).

Kelly *et al.* (2014) in their study, introduced Kouzes and Posner's model developed in the late 1980's that identified exemplary leadership practices. In this study, nurse leaders completed a Leadership Practices Inventory tool which identified how closely the leadership practices of nurse leaders modelled Kouzes and Posner's exemplary leadership practices. The five exemplary leadership practices were, inspiring a shared vision, challenging the process, enabling others to act, encouraging the heart and modelling the way (Kouzes and Posner 2011). Three of the practices were described as specific to enabling the team around the leader, inspiring a shared vision, enabling others to act and encouraging the heart, were all practices that involved encouraging others to act. The two other exemplary leadership practices contrasted where modelling the way had the leader demonstrating exemplary

practice while challenging the process involved the process of confidently challenging poor practice (Kouzes and Posner 2011).

The nurse leaders assessed all identified themselves as employing a transformational style of leadership. This was supported by Kouzes and Posner's model of transformational leadership in that all of the nurse leaders declared leadership behaviour that 'modelled the way' 'inspired a shared vision' 'enabled others to act', 'encouraging the heart' and 'challenged the process' (Kouzes and Posner 2011).

Kelly *et al.* (2014) concluded that there were three predictors that enabled nurse leadership ability. Firstly, a nominated leadership title within their employing organisation, secondly initial, and thirdly ongoing, specific leadership training and education. Nurse leaders in this study suggested that training enabled them in their role modelling behaviour (Kelly *et al.* 2014). However, specific leadership education empowered nurse leaders to 'challenge the process' and 'inspired a shared vision' (Kelly *et al.* 2014).

Transformational leadership is empowering the team together with the leader to effectively achieve common goals (Haslam *et al.* 2011). Ross *et al.* (2014) suggested that nursing as a profession, perhaps as a consequence of an historic lack of individual empowerment has a natural affinity to transformational leadership. Ross *et al.'s* (2014) study also used the Kouzes and Posner model and surveyed 134 nurse leaders about their leadership practices. They found the two practices most often undertaken were 'enabling others to act' and 'encouraging the heart'. Furthermore, echoing Kelly *et al.* (2014) the more leadership training the nurse leader had – although Ross *et al.* (2014) did not identify what this training had been – the more likely that the nurse leader would also practise 'modelling the way', 'inspiring a shared vision' and 'challenging the process' (Ross *et al.* 2014 p202).

However, Omoike *et al.* (2011) and Higgins *et al.* (2014) both found that even when formal leadership education is undertaken the nurse leader remains reluctant to 'challenge the process'. Omoike *et al.* (2011) explored the impact of an educational leadership programme on a range of nurse managerial and technical skills (Omoike *et al.* 2011). This small study included 37 nurses from two different programme cohorts that were recruited from three different hospitals. These nurse leaders were reluctant to 'challenge the process'. The study identified that there were limited opportunities for formal education that focused on leadership. As with Kelly *et al.* (2014), most nurses 'learnt on the job' (Omoike *et al.* 2011 p329).

Omoike *et al.* (2011) found that nurses who undertook a formal education programme to develop a range of leadership skills. The programme employed a blended approach with

40% on-line learning and 60% face-to-face and learning in clinical practice. Participating nurses were surveyed prior to and after completing the programme about their self-reported levels of competence and how important they felt the skill was to their roles. After completing the programme, the nurses reported an increased level of competence in eleven out of twelve of the measured skills. Nurses also reported an increased level of competence and placed greater importance on those skills they could most easily have influence over, including communication skills or dealing with conflict. While dealing with conflict could be compared with a willingness to 'challenge the process' this competence was only expressed when the conflict was internally focused and with other members of the nursing team. The participating nurse leaders expressed being less confident with skills such as being an externally focused spokesperson for their organisation or employers.

Omoike *et al.* (2011) also found that none of the nurse leaders had changed their professional roles one year after completing the leadership educational programme. The nurse leaders, despite increasing competency as a result of the educational programme, had not been given the opportunity to develop their leadership skills. The skills that the nurses felt more confident with were those within their scope of influence, within their clinical area and within their organisation rather than external to the nurse leader's organisation. Similar to Croft *et al.* (2014) Omoike *et al.* (2011) found the nurse leaders still lacked the confidence and were often unwilling, even after their leadership education, to move into new roles that were external to their organisation and as such outside of their scope of influence (Omoike *et al.* 2011).

3.10. Formal leadership education

Not only do nurse leaders need to be encouraged and enabled to lead the multi-professional team, but they also need to become involved in developing strategy and policy for healthcare (Higgins *et al.* 2014). As health care delivery becomes ever more complex the education of nurse leaders needs to reflect this. Murphy, Warshawsky, and Mills, 2014a) described the development of doctoral-level educational programmes for nurse leaders as enabling them at a 'macro level' to manage both the business of healthcare and the multi-professional team. The nurse educated to Masters Level, in comparison, is described as leading only at 'micro-level' and 'mesolevel'. Murphy, Warshawsky and Mills (2014a) surveyed a number of nurse leaders and educationalists involved in delivering Doctorate of Nursing Practice (DNP) in the USA and again, as such would reflect differences in both health and educational systems between the UK and the USA. Despite advocating the need to develop the doctoral-level prepared nurse leader many educational institutions continued to offer nurses the opportunity to exit with a Masters award and 82% planned to

maintain both programmes of leadership education. This suggests that even if doctorally prepared nurse leaders are better prepared, there are nurse leaders not prepared to study at doctoral level (Murphy, Warshawsky, and Mills 2014a).

The survey also identified that despite an increase in applicants for nurse practitioner educational programmes; only 13% of nurses who responded considered themselves leaders. Brooks *et al.* (2014) acknowledged the depth and the breadth that educational programmes can have on nursing practice and suggest nurse leaders need more focused education modelled on a Masters of Business Administration (MBA) style of delivery. Undertaking an educational leadership programme will empower the nurse leaders of the future and using weekend or blocks of study immersion into their studies is a more pragmatic approach. This model would allow the nurse leadership student to practise around the study blocks. By employing this approach, the student has earning potential to fund their education when student loans or scholarships are unlikely to be available to them[4] (Brooks *et al.* 2014). In the UK, education for ANPs is normally undertaken on a part-time basis and with a combination of advanced skills acquisition gained in the workplace and academic knowledge acquisition undertaken in a Higher Education Institution (RCN 2008). Instead of only employing traditional educational approaches, innovative new approaches will enable ANP participation (Brooks *et al.* 2014). Reducing healthcare costs can be achieved by improving patient outcomes. Therefore, educating the ANP in leadership or to develop their leadership skills also needs to demonstrate a positive impact on healthcare and patient outcomes, and this is discussed in the following section.

3.11.   Making the Patient Better

The complexity of healthcare in the 21st century not only requires a better educational preparation for the ANP but it is important that the preparation and role have demonstrable, positive impact on clinical outcomes for patients. Identifying specifically how nurse leaders or ANPs influence patient outcomes has been described as being 'in a black box' (Cummings 2013 p707).

It is a difficult task to evidence the impact of the ANP on patient outcomes. Neville and Swift (2012) employed a case study critical analysis of the literature that evaluated the advanced practice role. They explored two key aspects of healthcare, the impact on patient outcomes and the impact on healthcare costs the advanced practitioners (AP) role had. The researchers used the term AP rather than only ANP as in the North West of England, where the study was undertaken, the advanced role was open to other practitioners in addition to

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[4] Particularly with the removal of the bursary for pre-registration nursing students from September 2017 and the consequent financial burden of a student loan

nurses, for example, paramedics. Although exploring the distinct AP impact on patient outcomes and healthcare costs, the AP role definition their study employs did not include leadership despite the programme leaders including it as an essential component of their AP educational programmes.

The study found that a positive impact on reducing the cost of care was reliant on how expensive the alternative professional to the doctor was (Neville and Swift 2012). If the doctor substitute was an ANP, for example, this could mean that there was no substantial saving. Where the AP role did have a positive impact on patient outcomes included increased survival rates when the AP was part of a neonatal transfer team. Another example was given when an AP led a children's walk in centre and a rapid assessment unit, and there was reduced waiting time. Neville and Swift (2012) also found that an AP led service reduced waiting times in the management of patients in an ear nose and throat (ENT) service. With treatment of deep vein thrombosis, the AP service reduced the patient's length of stay (Neville and Swift 2012). With several examples of the impact of the AP role on patient outcomes, the overall recommendation from the study was that the AP role should assist in proving their positive impact on patient outcomes, by developing a portfolio of evidence that demonstrated this (Neville and Swift 2012).

More specifically, reviewing twenty research studies that had explored the impact of styles of nursing leadership on patient outcomes, Wong *et al.* (2013) found a significant positive association between nurse leadership and patient satisfaction and a negative association with medication errors and patient mortality. They identified two leadership styles that were employed in the studies they reviewed, 'transformational' and 'authentic' leadership (Wong *et al.* 2013). Both styles, when employed by the nurse leader placed particular emphasis on their relationship with their followers. This offered an increased likelihood of positive patient outcomes (Wong *et al.* 2013).

Once the positive impact on patient outcomes through ANP leadership practice has been established, it needs to be sustained. The final aspect of ANP leadership practice considers the need to plan for the ANPs of the future.

3.11. The nursing profession: recruitment and retention challenges

To positively influence patient outcomes, ANPs need to be prepared effectively. Other factors that potentially influence the impact of the role of the ANP leader include a shortage of nurse leaders; even the role of the ward manager, because of the additional burden of responsibilities has become increasingly unpopular (Enterkin *et al.* 2012). Nurses, who want to retain a clinical focus to their role, may prefer career development for roles such as the

ANP but there is also an overall shortage of nurses. Current nursing leaders are an ageing population. This has resulted in nurses taking on leadership roles earlier in their careers and at a time when they are underprepared (Griffith 2012). There is a consequent need to succession plan and develop future ANP leaders.

Inspired by the global shortage of nurses Cowden *et al.* (2011) undertook a systematic review of literature that studied the relationship between leadership styles and retention of nurses. The review considered research from a wide range of healthcare environments and in several different countries including USA, Canada, Australia and Taiwan. The review identified that currently practising nurse leaders are an increasingly ageing population. This is at a time in healthcare delivery where there are increased complexity, life expectancy and public expectations. The review concluded that nurse leaders are under pressure to achieve improved patient outcomes and demonstrable team leadership. Their nursing team's decision to remain in the nursing profession is directly influenced by the leadership approach the nurse leader chooses to employ (Cowden *et al.* 2011).

Similar to Wong *et al.* (2013) Cowden *et al.* (2011) described two distinct approaches to nurse leadership, those that focused on tasks or those that focused on relationships. They found a positive relationship between nurse leaders who focused on relationships and employ transformational leadership styles and their nursing team's intention to stay. The nurse viewed the transformational and authentic nurse leader as having influence in their organisation. The nurse that saw that the nursing leader was empowered in the organisation also feels in 'control over their practice' (Cowden *et al.* 2011 p469). In contrast, when a nurse leader used a more autocratic style of leadership with the nursing team this had a negative relationship with nurses wanting to remain in the workplace. For example, a style that was described as 'management by exception', where a leader actively looks for errors being made by nurses in their practice, was associated with the most negative impact on nurse retention in their workplace (Cowden *et al.* 2011 p469).

In relation to succession planning, Keys (2014) undertook a study that explored the characteristics of the next generation of nurse leaders, 'Generation X'[5]. Several factors were identified that might influence the behaviour of this generation in comparison with the older current nurse leaders. These factors included growing up with political uncertainty and being more likely to value teamwork and a flexible approach to working. Generation X nurse leaders, it was suggested, were less likely to be intimidated by authority. The study conducted telephone interviews with 16 nurse managers who had been identified by their Chief Nursing Officers. Generation X leaders were described as deriving satisfaction from

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[5] Generation X describes those born between 1961 and 1981

having a positive impact on their teams' practice but found that they felt clinically and educationally ill prepared for the leadership role (Keys 2014). This had resulted in the Generation X leader having to choose between work and family and often feeling pressured to prioritise work. Similar to Cowden (*et al.* 2011) the Generation X leader described being micro-managed as if their manager was looking for where they had failed (Keys 2014).

Some caution needs to be considered when looking Key's (2014) study findings, as some telephone interview questions appear to lead to a specific response. They asked the participants if they had encountered barriers. If not, the participants were asked if they had heard of other 'women' encountering barriers. Both questions may have encouraged responses identifying barriers. In addition, a number of questions also focused on family life and asked about what made the nurse leader feel fulfilled or what they considered most important in their lives. This may have influenced responses by suggesting, the nurse leader, had to choose between professional and family life (Keys 2014). Despite this, all of the studies that explored the implications of an increasingly ageing nurse leader population identified the need to succession plan for the nurse leaders of the future. Identifying what is needed to enable nurse leaders and specifically, ANPs will allow a future workforce to be better prepared to take on these roles.

3.12. Conclusion

The literature review identifies ongoing issues, challenges and opportunities to the leadership practice of the ANP. These included the ANP as a leader gaining acceptance within the multi-professional team and not waiting to be nominated to influence strategy, practice and policy. Other challenges identified included the ANP or nurse leader not having enough time with their direct care responsibilities to lead. The ANP does not feel prepared to develop an external focus to their role and their need to 'challenge the process' were also discussed. The importance of the ANP positively influencing clinical outcomes for patients and ensuring cost efficiency within the NHS were discussed. Finally the need to adequately prepare and support current ANP leaders, the reality of an ageing nursing population and the need to prepare the ANP nurse leaders of the future was considered.

As noted within the gathering and reviewing of previous research, few studies have focused on ANP leadership. This together with identified high-profile failures in leadership in the NHS in the last few years supports a focused exploration of ANP leadership experience. A lack of robust educational and support programmes for ANP leaders also supports a study that can offer increased understanding of how the ANP defines and expresses leadership and the challenges and opportunities they encounter while doing so.

3.13. Conceptual model

This literature review has offered an exploration of the relationship between the concept of leadership and how professional identity, NHS culture and the ANP role's influence on leadership practices. Additional influences on leadership practices include gender, inter-professional working, educational support and a need for demonstrable impact on patient outcomes. This is illustrated by the conceptual model in Figure 1.

Figure 1: A Conceptual Model: Leadership Practice of ANPs contexts and Influences

The following chapter is informed by the conceptual model generated in this chapter and describes the methods used to explore how the ANP's define, express and enact their leadership practices.

Chapter 4: Methodology

To understand more about the current evidence-base related to the context and role of the ANP the literature review examined many potential factors that can influence how the ANP may understand and practise leadership. These include the nebulous nature of the concept of leadership, the challenges associated with a multi-professional workforce and how the role of the ANP remains an enigma to both the public and these other professions. This lack of understanding of the role of the ANP and how they enact leadership is also influenced by a sometimes indistinct relationship between ANP leadership and improved patient outcomes. The ANP and their leadership practice are also not seen as distinct from the influence of their professional identity, education and gender. Additionally, the culture within which the ANP practises is alongside the multiple professions that contribute to the multi-professional team and the complex culture of the NHS. The conceptual model (Figure 1) constructed from the literature reviewed provides a context for ANP leadership practice and shows how these concepts inter-relate.

Eight London-based ANPs were interviewed to explore how they define, understand, express and enact their leadership practice. This chapter outlines how participants were selected, how interviews were transcribed and how data was analysed. This chapter also sets out the strategies employed to ensure research rigour and the ethical implications of the interview process. In particular, this includes the ethical implications and potential influence of my being an ANP previously. This includes an acknowledgement of how this may influence the responses the ANPs gave in their interviews and my analysis of the data generated. Limitations of the study are also considered. The research questions underpinning this explorative approach are listed below.

- **How does the ANP understand their role and interpret the leadership component?**
- **How does the ANP enact the leadership aspect of their role?**
- **What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?**
- **What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?**
- **What personal, interpersonal and organisational and professional support does the ANP need to be able to enact leadership?**

The chapter begins with a justification of the underpinning epistemology and theoretical perspectives of the study.

4.1. Epistemology

Epistemology is the understanding of the social world. In the complex social world of healthcare, there have been identified failures in leadership (HM Government 2013, Rose 2015). In addition, the influence of the European Working Time Directive (2009) that reduced the hours that doctors could work has influenced the development of the leadership aspect of the ANP role. This study exists and is influenced by this social world and aims to explore how the ANP, expresses, defines, understands and enacts leadership

The ANP exists in alternative social worlds such as the social world of a nurse and the social world of a spouse, parent, son or daughter all of which will influence their leadership practice but it is their social world as an ANP that is explored. The social world that the ANP exists in is that of healthcare, although the health care environment can differ widely between in hospital-based health care and out of hospital-based health care. To reflect these differences, the participant ANPs practised in a range of healthcare environments.

Two contrasting epistemological positions are positivism and interpretivism. The positivist view is that there are causes and effects and that the researcher's role is to establish this relationship (Denscombe 2003). Knowledge is objective (Robson 2002) and this approach is a 'gold standard' and a 'dominant model' for scientific research (Denscombe 2003 p7). From this perspective, the researchers themselves are neutral with no influence on the phenomena being studied. As such, the positivist position risks an over simplification of how an ANP expresses their leadership practice. The positivist position would consider that a cause influences the ANP and the effect is how they practise leadership. A cause that could influence ANP leadership practice could be the way that the ANP has been educated, with the effect enabling the ANP to practise leadership. However, this study considers the multiple influences including professional identity and education upon the ANP leadership practice rather than that it is only how the ANP is educated that informs ANP leadership practice.

The contrasting interpretivism position is that research is an interpretation of social actions (Robson 2002) influenced by those that are conducting it (Denscombe 2003). I practised for ten years as a paediatric hospital based ANP. I originally established an MSc course for Children's Advanced Nurse Practitioners (CANP) and led this for ten years before becoming involved as an educator, supporting ANP students to complete their Masters dissertations. My experience and employment alone would suggest the study will be influenced by my own views and interpretation of my personal and professional experience. I

have participated in the social world of an ANP and have a level of interpretation of the ANP perspective that can offer the advantage of an understanding of ANP culture and language. Yet, my personal and professional experience differs from the ANPs in this study as I no longer practice as an ANP and my former practice and experience took place in a world and social context with influences beyond being in the role of an ANP. An interpretivist stance of social constructionism which views research as a partnership between researcher, the social context and the studied, was therefore considered the epistemological philosophy to underpin this study (Crotty 1998).

4.2. Theoretical Perspective

A theoretical perspective that acknowledges societal influence is social constructionism. This perspective acknowledges the influence of societal culture on the views of the individual (Cresswell 2007). That is, the individual is defined by the culture 'into which we are born' (Crotty 1998 p79). Social constructionists are sceptical of the positivist's position that absolute truth can be claimed. Although this could be considered in itself an oversimplification of the positivist stance, rejecting the absolute truth and power associated with traditional positivist knowledge enables transformational change (Cruickshank 2012). There is an intersubjective reality created by discourse between individuals and which constructs their identity within the social environment. In the context of this study, ANPs may be influenced by their work environment but also experience their roles differently and adopt different patterns of enacting leadership in response to the culture they work within (Cruickshank 2012).

There is a clear relationship between the interpretivist epistemological stance and a social constructionist theoretical perspective. The social constructionist believes that the individual is conditioned not determined by social and historical influences; their identity is influenced by their environment but not this alone (Cruickshank 2012). Through differing social, environmental and historical conditioning, there will be differences between the ANP's leadership experiences. The individual and their 'reality is made up of individuals and intersubjective meanings' (Cruickshank 2012 p80). Social constructionists also suggest that an absolute truth is not possible in Western democracies where an individual has more freedom to make choices and decisions based on these choices (White 2004).

As a nurse before they become an ANP, the social context within which the ANP exists is intrinsically linked to the development of nursing as a profession. Characteristics that are associated with a professional identity are autonomy, extended periods of education and the ability to self-regulate (Freidson 2001). These were characteristics that developed in the nursing profession throughout the 20th Century beginning with a central register that

allowed self-regulation (Davies 1996) and culminating with University-based and extended periods of education for nurses in the beginning of the 21st Century (NMC 2010) and so professional status in nursing itself is a relatively recent development (Dingwall *et al.* 1988).

The development of the ANP role is both experiential and educational and there is not a distinct registrable qualification (HM Government 2010a). ANPs, while part of the culture that is healthcare provision, identify with the professional nursing culture but have developed a distinct ANP professional culture. However, a social constructionist theoretical perspective acknowledges the individual ANP has their individual beliefs and differing intersubjective experiences. So, while part of the professional nursing culture and also part of the ANP professional culture, each participant ANPs in the study will have a different lived experience. This study, while exploring the relationship between the participant's views, recognises that the subjective individual truth may differ from that of other ANP participants (White 2004).

The social constructionist perspective has been criticised for suggesting that exploring individual views and acknowledging the influence of culture is authentic research. The critics suggest the social constructionist, without maintaining an objective, detached approach compromises the quality of the research project (White 2004, Cruickshank 2012). However, objectivity and absolute truths have been described as an autocratic view of the world which is not reflective of the society in which we live (White 2004). By remaining detached, aspiring for only objective positivist truth and rejecting the influence of culture and environment, there is a risk that results do not reflect the reality of advanced nursing practice (Stevenson 2005).

4.3. Methodological approach

The methodological approach employed in this study reflected the interpretive nature of the epistemology and the multiple influences acknowledged by the social constructionist theoretical perspective. When deciding on a methodological approach I selected an explorative approach (Crowe *et al.* 2011, Joohun *et al.* 2009). Case exploration is an established approach used within clinical healthcare practice as it explores phenomena in depth and in context (Crowe *et al.* 2011). Reflecting the influence of society and culture, case studies are viewed as an exploration of a phenomenon within the context in which it exists (Yin 2009). For this study, the case study approach acknowledges the inextricable relationship between culture and ANP experience, views and beliefs (Crowe *et al.* 2011).

4.4. Inclusion criteria for participant ANPs

The ANP in the UK is a member of a small distinct community within the nursing profession (DH 2010). Identifying the total number of ANPs within the UK is challenging as there is not a separate part of the NMC register for ANPs. However, out of a provisional number of registered nurses in the UK of 316,101, there are 4779 (1.5%) in leadership roles commensurate with the ANP role including roles such as Nurse Consultant or Modern Matron (Health and Social care information centre website: Home page, 2016).

In 2015, the Royal College of Nursing Accredited Advanced Nurse Practitioner group (AANPE), represented over 40 Universities that are recognised providers of ANP education in the United Kingdom. The registered nurse may undertake an AANPE accredited programme at any of these 40 identified UK based Universities. The publication of a position statement in 2010 differentiated between the role of the registered nurse and that of an ANP (HM Government 2010a) and identified four defining areas of practice for the ANP. These are clinical and direct care practice; leadership and collaborative practice; improving quality and developing practice and developing self and others. All of the accredited educational programmes are framed by Department of Health ANP competences (HM Government 2010a). Accreditation of an educational programme aims to afford the public an expectation of a level of equivalence between ANPs who have completed an RCN accredited ANP educational programme (HM Government 2010a).

The study was focused in London and only four central or greater London Universities run ANP educational programmes (http://www.aanpe.org). In the last ten years, these four universities in central and greater London have accredited 354 nurses as ANPs. (details accurate from RCN confirming email 23rd October 2015 appendix 1).To ensure the sample of participants has a similar educational experience and knowledge base, potential participants were drawn from the population of ANPs who had completed a London-based AANPE accredited educational programme.

4.4.1. Approach to data collection

Data collection for the study involved undertaking semi-structured interviews. The interview as a method is an approach that also challenges positivist views on authentic knowledge. The interview allows those being interviewed to express their views and their interpretation of their lived experiences. The interview, however, allows the researcher to gain an understanding of an individual's 'inner world' (Fadyl and Nicolls 2013 p25). Using semi-structured interviews allowed a guided exploration of participants' stated views and beliefs (Mason 2002). The interview represents social interaction, and the social

constructionist approach explores the individual interacting with the world and how they interpret this.

Any interviewer influences the process of data collection. Asking questions about ANP leadership practice will cause the participant to reflect on and question their practice (Stephenson 2005).The ANP responds with examples of their experiences, but they are also reacting and responding to the questions being asked. The social constructionist approach acknowledges the influence and impact of the researcher on the research and the interview is considered 'a social practice' with both the interviewer and the participant complicit in the data generated (Fadyl and Nicolls 2013 p26). There is also the influence of the context of the interview, events on the day and events immediately preceding the interview can all influence how a participant responds to a question (Burawoy 1998). As the study aimed to consider each ANP distinctly and then comparatively, this does not prevent comparison between participants but does emphasise the need for a detailed description of the research process (Tuckett 2005).

Furthermore, using a semi-structured interview meant that the questions and follow up prompts were the same for each interview allowing some comparison between participants. This standardising of questions does not, however, mean that participants' understanding of a response to the question does not differ (Burawoy 1998). As a previously practising ANP, I have some understanding of the ANP role. With this comes an ability to speak the language of the community and therefore being able to offer an interpretation to the participant thereby facilitating the interview process (Edwards 2010).

4.5. Research Methods

Having selected a case study approach, it was important to establish what was to be considered within the case and what would be external to the case. Case studies have distinct boundaries which identify precisely what will be studied (Crowe *et al.* 2011) without limiting the richness or complexity (Sangster-Gormley 2013). The case study approach also allows for the boundaries of the case to be developed over time (Sandelowski 2011). As described earlier, London has a higher density of teaching hospitals in comparison with the remainder of the UK (London's NHS infrastructure no date) which increases the potential differences in the ANP practising in London compared with a more rural health care provider. This density of teaching hospitals in London however also reflects a diverse range of health care providers and so increases the likelihood that there is still diversity in the population of participant ANPs for the study.

To construct a small, yet robust, sample for this study of the leadership practices of the ANP a total of three key boundaries and recruitment criteria were constructed. All ANPs needed to have undertaken a Royal College of Nursing (RCN) accredited AANPE educational programme. In addition, participant ANPs were employed in central or greater London and all were currently in an ANP role.

4.5.1. Sample methodology

After ethical approval was gained from the Institute of Education Research Ethics Committee (Appendix 6).I began the process of recruiting ANPs to participate in the study. As a member of the RCN AANPE group, I sent each programme leader an email explaining the process of sample selection and a brief outline of the study asking the other London-based University representatives in this group to identify potential ANP participants. All potential ANP participants who met the above recruitment criteria were contacted by their University RCN AANPE representative via email (Appendix 2) and given information about the study. To ensure participation was entirely voluntary there was no direct access between myself and potential participants. Therefore, building on professional and personal contacts I requested and secured a commitment from each of the four London-based AANPE educational programmes that they would participate in the study. The participant recruitment email (Appendix 2) offered a brief outline of the study and included attachments of the participant consent form (Appendix 3) and participant information sheet (Appendix 4). This process was designed to protect participant anonymity as well as ensuring potential participants were able to consider the details of the study before agreeing to participate in the research study. ANP's who agreed to participate in the study emailed me to confirm this. When I received the email, I responded via email to arrange time, date and venue to undertake the interview,

4.5.2. Re-design of data collection approach

The initial sampling selection strategy recruited only two participants. One factor that could have influenced this was the original study design which included two phases of data collection. Phase one involved interviewing the ANPs and phase two was to have involved observing the ANPs in their clinical practice. I had a high degree of confidence in the original design and a desire to create a robust triangulation of data (Houghton *et al.* 2013). Direct observation could have identified differences between how the ANP describes their leadership practices and how they enact them or 'perceived action and actual action may differ' (Williamson *et al.* 2012 p1581).

However, retrospectively, it is possible to identify several reasons for the initial low response rate which could relate to the observation phase of the original study design. These include power imbalances in relationships between ANP and the multi-professional

team (Rafferty 1996) or the anticipated anxiety of the observed interaction (Robson 2002). Research had also identified ethical challenges in gathering consent from all colleagues within the multi-professional work environment which could potentially also include patients (Robson 2002). As the observation would involve other members of the multi-professional team, potential participants in the study may have been apprehensive in involving other professionals and patients in the study. Other factors that may have influenced a reluctance to participate included that the ANP was aware that leadership practice, when observed, would differ from that described.

With there being a relatively small number of potential participants who met the inclusion criteria for the study, it was felt that further conjecture as to why they were not engaging in recruitment to the study was not constructive. The value of undertaking a study which allowed the ANP to express how they define, understand and enact their leadership practices was considered much greater than the potential disadvantage of not having an observational stage of the study. Based on low response rate and consent challenges the study was re-designed to recruit participants for semi-structured interviews alone, without an observational stage. Ethical approval for the changes was sought and gained from the Research Ethics Committee (Appendix 7).

4.5.3. Sample methodology employed (following re-design of data collection approach).

The sample selection process was repeated with details of the changes made to the data collection approach. That is, all the educational leads representing the Universities based in London and members of AANPE agreed to send a second email to all ANPs who met the identified recruitment criteria. This email again offered a brief outline of the study including details of changes to the data collecting approach, attachments of the study consent form (Appendix 3) and the participant information sheet (Appendix 5). This, again, enabled all participants to consider the details of the study before agreeing to participate. ANPs who agreed to participate in the study emailed me to confirm this.

4.5.4. The sample

The changes in data collection approach and the second round of recruitment emails generated an additional six ANPs interested in participating. The total sample size was now eight. As the original data collection approach was refined participants might have been approached more than once. Therefore all ANPs indicating their willingness to participate in the study were included. This could be viewed as introducing a bias in that it might suggest that participants were already interested or confident in their leadership practices (Robson 2002). Alternatively, it could be viewed that by agreeing to be interviewed participants were motivated to explore the concept of ANP's leadership practice. As this was an aim of this

study and all participants met all other criteria for involvement in the study, all volunteers were recruited to participate.

4.5.5. Summary of ANP participants

The eight participating ANPs were employed in and by seven different healthcare providers. Four were based in General Practice, one in specialist community care, two in accident and emergency departments and one in acute inpatient hospital-based care. Three ANPs were male, and five ANPs were female. Years spent practising as ANPs ranged between two and twenty-five years. A summary table is below (Figure 2).

Participant	Employer	Years since qualifying as ANP	Gender
Stephen	Hospital	2	M
Maria	Community	3	F
Daisy	General practice	5	F
Rachel	General Practice	18	F
Jill	General Practice	25	F
Sarah	A&E	3	F
Mike	General Practice	10	M
David	A&E	2	M

Figure 2: Demographic details of participant ANPs

4.6. Data Collection

Following the re-design to the study data was collected only using semi-structured interviews. This section provides clarity on the process of developing the interview protocol and how the interviews were conducted.

4.6.1. Interview protocol

The research questions for this study were generated from my previous research studies (Anderson 2013, 2008, 2003) combined with additional resources and input from the reviewed literature. The interview protocol, therefore, stemmed from the overall research questions. Figure 3 details the actual questions and follow-up questions used in the study.

1. **Question: The NMC definition of an ANP includes leadership within it. How do you demonstrate leadership in your role?**

Follow-up question: would you describe your leadership role to include leading other professions?

2. **Question: In your team who would you say is the leader?**

Follow-up question: Why do you think this is?

3. **Question: How would you describe your leadership style?**

Follow-up question: Are there other leadership styles that you think are effective?

4. **Question: Can you think of an example when you have led a situation well?**

Follow-up question: What do you think influenced this?

5. **Question: Can you think of an example when your efforts to lead have not gone as you would hope?**

Follow-up question: What do you think influenced this?

6. **Question: What do you think influences ability to lead?**

Follow-up question: Can this be learnt or is it something we are born with?

7. **Question: Who do you think leads well and can you give an example of when they have?**

Follow up question: What factors do you think influenced this?

Figure 3 : Interview questions

Once the ANP had made email contact expressing their interest in the study, I communicated with the ANP via email to ensure they had read the participant information sheet and as much as possible, understood the purpose and practicalities of the study. During this initial contact, the interview was arranged at a time and venue mutually convenient to the participant and me.

4.6.3.   During interview
On arrival, I welcomed the ANP, and together we reviewed the consent form again. This included confirming that audio recording of the interview was acceptable. The interviews lasted between 45 to 60 minutes and with the participant's permission were audio recorded using a digital recorder. The participant was encouraged to ask questions for clarification if necessary throughout the interview. Once this was agreed, both the ANP and I signed the consent form. The interviews were undertaken in a range of venues including a small private room at a participant's place of work (five interviews) and a booked private room within my own place of work (three interviews). It was ensured, as far as possible, that

the venue was free of potential distractions and interruptions. Most interviews were conducted in venues free from computer screens or telephones. Two ANPs were interviewed in their own offices and were interrupted by the telephone during the interview. A further one ANP was sought by their colleague for advice despite the interview being in progress. Although this was disruptive it did not prevent the interviews from being completed, the recording was paused and recommenced when the interruptions were responded to.

4.7. Data Management

All data generated, including contact details of the participant ANPs was stored on a password protected computer file. I was the only person with access to this data. The data generated through interviews was audio recorded and saved in an anonymised password secured computer file and identifiable by the date of the interview, for example, 300115. In addition, during the interview field notes and comments were made. These were also identified by the date of the interview and the handwritten notes were added to the transcribed interview and also stored in a password secured computer file. In addition, to help organise the data Nvivo version 10 was used. I, alone, accessed both the Nvivo data storage and the computer files containing interview data. To maintain confidential management all original hand written notes were shredded.

4.8. After interview

I personally transcribed the first two interviews while the remaining interviews were sent by audio file to an external transcriber. The audio files were anonymised by using the date of the interview as the file name of their interview. I audited the accuracy of all interviews by listening to the original recording while reviewing the interview transcripts (Tuckett 2005).

Using their preferred email address, all participants were emailed a pdf copy of the transcript of their interview. Again these were anonymised by using the date of the interview as the file name of their interview. The participant was asked to review the transcript and respond if they had anything further they wanted to add. This process is described as member checking and allowed the ANP to review their own interviews but also to add clarification to their responses (Houghton *et al.* 2013). Participants were asked to check the transcript to add clarification to their responses rather than to confirm accuracy. If a participant had challenged the accuracy of the transcript, this would have been acknowledged, and further discussion would have been had. Two participants were asked for specific clarification including what abbreviations meant for example 'CQUINS' which sounds like 'sequins' but is an acronym for 'commissioning for quality and innovation'.

4.9. Approach to data analysis

There are differing approaches when undertaking case studies. In this study, during the initial analysis, each participant was considered separately, and distinct from each other which Stake (1995) described as an instrumental case study. However, the focus of this study was not only the individual but that of the phenomenon of the ANP and their leadership practice. The approach adopted for this research was also a collective case study where individual cases were comparatively explored (Thomas 2011). While each case is an example, the object and focus of the case study is the ANP's definition, expression, understanding and enactment of their leadership practice (Thomas 2011).

The validity of case study approaches to research is enhanced by the transparency of the research process (Gerring 2007). This particularly applies to the analysis of data that is generated. Analysis of case studies has been described as telling a story (Yin 2009) or drawing a picture (Thomas 2011). While organising data is helpful, it is important to recognise the risk of not offering an analysis of the data and simply describing the case without drawing a conclusion or supporting a theory (Thomas 2011).

For this study, an overarching thematic analysis approach was used which has been described as an approach 'that works both to reflect reality and to unpick or unravel the surface of reality' (Braun and Clarke 2006 p81). With thematic analysis, initial codes and eventual themes are not simply generated they are decided upon by the researcher. Acknowledgement is made that the decision is that of the researcher rather than a neutral emergence (Braun and Clarke 2006). In order to organise the data so that it either answers or refutes the research questions of this study, a process of pattern recognition of codes and themes was undertaken. The process of thematic analysis involves searching for themes that are important to the phenomena you are exploring (Fereday and Muir-Cochrane 2006), and selecting the evidence that we consider important (Braun and Clarke 2006). The decisions were data driven and not made to fit a preconceived coding framework (Braun and Clarke 2006). All interpretations of the data were therefore accompanied by examples and illustrations from the interview transcripts (Fereday and Muir-Cochrane 2006).

4.9.1. Analysing the data

Braun and Clarke's (2006) approach to thematic analysis has six stages. The first stage is familiarising yourself with your data, the second stage is to generate initial codes, the third stage is searching for themes, the fourth stage reviewing themes, the fifth stage is defining and naming themes and the final stage of analysis is producing a report. The phases of thematic analysis are summarised in Figure 4 (page 63).

Reflecting the first stage of Braun and Clarkes (2006) thematic analysis 'familiarising yourself with your data', the transcriptions of each interview were imported into the Nvivo 10 programme on my password secured computer and read again, line by line, noting original ideas and considering initial codes. The second stage of analysis involved coding interesting features of the data in a systematic fashion across the entire data set which identified if initial codes needed further refinement.

The next stage of analysis was identifying any relationships between these codes. Although codes may not seem to have a close relationship it was important that when reviewing the codes the original section of data was also considered. This helped identify if there were relationships between codes. Collating codes into potential themes allowed gathering of all data relevant to each potential theme. The penultimate stage of thematic analysis involved reviewing generated themes for further refinement. This involved revisiting the whole data set from all the interview transcripts to ensure that the theme reflected the sense and intention of the participant's responses.

Phase	Description of process	Examples of data that influenced emergent theme	Emergent theme
Familiarising yourself with your data	Transcribing, reading and re-reading data, noting original ideas		
Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set		
Searching for themes	Collating codes into potential themes gathering all data relevant to each potential theme	'*I am the absolute, sort of, pinnacle leader*' **– Leadership** '*you need to be able to walk the walk and talk-, and not just talk the talk*' **Credibility**	**Placement on the leadership pyramid** **Retreating to the safety of the nursing profession**
Reviewing themes	Checking if the themes work in relation to coded extracts (level 1) and the entire data set (level 2)		
Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells generating clear definitions and names for each theme		
Producing a report	The final opportunity for analysis. Selection of vivid, compelling extract examples		

Figure 4: Stages of thematic analysis (Braun and Clarke 2006)

Although the coding process was evolving and not structured around the research questions (Braun and Clarke 2006), Figure 5 outlines the emergent relationship between each interview question, the research questions for this study and themes generated from the data.

Research Questions	Indicative Questions
1. How does the ANP understand and interpret the leadership component of their role?	The NMC definition of an ANP includes leadership within it how do you demonstrate leadership in your role?
2. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?	In your team who would you say is the leader?
3. How does the ANP enact the leadership aspect of their role?	How would you describe your leadership style?
4. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice? 5. What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice? 6. What personal, interpersonal and organisational and professional support does the ANP need to be able to enact leadership?	Can you think of an example when you have led a situation well?
	Can you think of an example when your efforts to lead have not gone as you would hope? What do you think influences ability to lead?
4. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice? 5. What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?	Who do you think leads well and can you give an example of when they have?

Figure 5: Research questions and indicative questions

4.10. Ethical issues and risks to participants

Ethical approval was sought and obtained from the Research Ethics Committee at the higher education institution I was enrolled with and all aspects of the study adhered to the British Educational Research Association (BERA) Ethical Guidelines for Educational Research (2011).

4.10.1. Insider research

As a previous ANP and as I am currently involved in the education of ANPs I could have been known to some of the participants and so the ethical implications of insider research also needed to be considered (Malone 2003). If the researcher is known to the participant the anonymity of their responses does not include the researcher (Malone 2003). Furthermore, if the researcher has insight into the role and world of the ANP combined with any degree of perceived anonymity the participant may reveal more than they intend and

regret this afterwards (Malone 2003). Conversely, the participant may be acutely aware of what they are revealing by agreeing to be interviewed and observed, and this may also have an impact on what beliefs or behaviour the participant is prepared to reveal (Malone 2003).

In addition, although the identity of the participant was anonymised according to NMC guidelines, if they had demonstrated or disclosed unsafe practice the researcher would have to report this to their line manager (Nursing and Midwifery Council, 2015). All participants were able to withdraw consent at any time. If they chose to withdraw consent, all audio recordings and transcripts of their interview would be destroyed.

Although the data used from the interviews was an interpretative choice of the researcher, the participants were also able to choose how they responded. By adopting an interpretative epistemological position, there is an acknowledgement that the researcher will offer a level of interpretation of the individual's views and expressed beliefs and this will, in turn, be influenced by their own beliefs and values (McIntyre and McLeod 1993, Mason 2002). Therefore, it is recognised that participation in the interview process is potentially intrusive and could leave participants feeling vulnerable. The design of this study adhered to previous studies which suggest considering whether what was proposed in the research study was something the researchers themselves would be willing to participate in (Malone 2003).

4.11. Rigour

The case study approach has been described as lacking rigour and often being used to confirm a researcher's pre-conceived idea (Flyvberg 2006, Yin 2009). Flyvberg (2006) contends that rather than confirming pre-conceived ideas the case study exploration often refutes them. Furthermore, the case study intention is not necessarily to have generalisable findings but to facilitate a narrative exploration of phenomena.

Lincoln and Guba (1985) proposed criteria to assess the quality of interpretative, constructive or qualitative approaches to research which included credibility, dependability, confirmability and transferability. In order to demonstrate credibility, they suggest that the researcher employs strategies such as prolonged engagement and persistent observation, triangulation of data collection, peer debriefing and member checking (Houghton *et al.* 2013). In this study, data was collected using semi-structured interviews and participants were given the transcripts of their interviews to add further comments if they wanted to (Houghton *et al.* 2013). Although the purpose was not necessarily to confirm accuracy, if a participant had disagreed with the contents of the interview transcript this would have been recorded (Houghton *et al.* 2013). This method of member checking occurs prior to any level of analysis has been undertaken and allows participants the opportunity to respond and

recognise their own words before the researcher has inserted their own interpretation. This disclosure of the data collected to the participant increases transparency between the researcher and participant (Stake 1995).

Peer review of the researcher's interpretation has been described as unlikely to reach the same decisions, but by including excerpts of original data, my decision making process is made transparent (Fereday and Muir-Cochrane 2006). This identification of each step of the research process also allows the reader confidence in the dependability or confirmability of the study (Ryan *et al.* 2007). Similarly, the detail or 'thick description' of each stage allows readers to assess the transferability of the study to their own context (Lincoln and Guba 1985). In this study, this was demonstrated by the process of detailed description of participants; verbatim examples of their responses and transparency in the decision-making when identifying codes and themes in the analysis process.

4.12. Limitations

As this is a preliminary exploratory study into the leadership practices of ANPs the number of participant ANPs provided a wealth of data and it was possible to explore this in-depth. There were, however, some limitations to the study.

By employing geographical boundaries of London and Greater London this also enabled some comparison between the ANPs but would not allow the findings to be truly generalisable to the national or international ANP population. In addition as the sampling strategy was purposive and as there were only eight ANPs that responded to the invitation to participate the decision was made to include all eight in the study. There were implications of this introducing a bias as it might suggest that participants were already interested or confident in their leadership practices. This was considered along with the small sample size (eight out of a total population of 354 ANPs that had been educated on an RCN accredited ANP course within the last ten years) and which could be seen as unrepresentative of the total ANP population. However, as the participants came from a range of clinical healthcare environments, this would support the sample to be considered representative of the ANP population.

The original study design also included periods of observation and the aim was that data would be generated, not only through self-report but through observation of their leadership practice. As it was not possible to recruit participants with the original design the study was revised to include only semi-structured interviews for data collection. Although this has produced rich and insightful data the opportunity to collect data by observing participants actively leading in their ANP roles was not possible.

The approach to analysis was undertaken by a single researcher who made decisions based on the data to generate the initial codes and eventual themes. As the process was transparent and the decision-making process included in the description of analysis, this allowed increased confidence in the rigour of the decisions made.

4.13. Conclusion

The emerging case study of a small-scale sample of London-based ANPs is a unique opportunity to explore ANP's values and beliefs. Within this research project, the aim was to develop a better understanding of how an ANP expresses, defines, understands and enacts leadership. Crowe (*et al.* 2011) identified influences on the ANP, and a case study from a social constructionist perspective makes it possible to consider other, wider social and political cultures of possible influence in the world and leadership practices of the ANP. The following two chapters present a detailed account of the findings generated from the interviews with the ANPs. Chapter five begins with an individual analysis of each ANP. This allows an introduction to each ANP and their distinct responses as a series of instrumental case studies. Chapter six, by considering the ANPs as a collective case, offers collective and comparative analysis of the entire group of ANPs.

Chapter Five: Findings for individual ANPs

This chapter presents the analysis of individual ANP experience of leadership. The purpose of the analysis is to gain a sense of their individual perspectives on leadership. This serves not only as an introduction to the life and work of each ANP but also provides the opportunity to present a descriptive analysis of the individual interviews. The chapter illustrates the emergent data analysis process with quotes from ANPs and offers initial interpretative comments. To add further clarity, the interview protocol is included again (Figure 3).

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1. **Question: The NMC definition of an ANP includes leadership within it. How do you demonstrate leadership in your role?**

Follow-up question: would you describe your leadership role to include leading other professions?

2. **Question: In your team who would you say is the leader?**

Follow-up question: Why do you think this is?

3. **Question: How would you describe your leadership style?**

Follow-up question: Are there other leadership styles that you think are effective?

4. **Question: Can you think of an example when you have led a situation well?**

Follow-up question: What do you think influenced this?

5. **Question: Can you think of an example when your efforts to lead have not gone as you would hope?**

Follow-up question: What do you think influenced this?

Figure 3: Interview questions

All participant ANPs are given a pseudonym to preserve their anonymity. The ANPs are presented in the chronological order, that is, the order in which they were interviewed. This approach, rather than reaching saturation of expressed views on leadership, allows and emphasises the value of individual ANP views.

5.1. Stephen

Stephen is an ANP who works in a general hospital and completed the MSc Advanced Nurse Practitioner course two years ago. He describes his leadership style as '*easy going'* and he shares that people can '*walk all over me'*. Stephen states that sometimes he gets *'involved a little too much',* intervening rather than allowing his team to find their own solutions. Stephen also describes how his leadership practice includes an awareness of and a role in securing the financial aspects of health care. He illustrates this where he needs to

ensure adequate numbers of patients are utilising the service. To meet 'key performance indicators' (KPI) is a condition of the contract with the Clinical Commissioning Group and if not met incurs a financial penalty. He explains, '*if we don't meet our KPI's I mean there's quite a few of them but there's one in particular which if don't meet which is access to services and we get a million pound fine'.*

Stephen does not believe in leading by being '*forceful'* or 'a *bit of a bully'*. When issues occur, Stephen prefers '*to take a step back and look at it really objectively'*. He describes a collaborative approach to managing change which means that he is usually able to successfully implement changes. However, in one example he offers, Steven was unsuccessful in implementing a change of practice. This particular change needed the co-operation of a Medical Consultant. The Medical Consultant instead appeared resistant to the change, and Stephen viewed this as a rejection of his attempt to lead the change. Reflecting on this Stephen appeared frustrated, '*it's something that could easily be done but he's completely blocking it and all I keep getting from him is no we can't remodel the service it has to be delivered as it is'.* To resolve the situation Steven had to involve a Medical Director – a role senior to the Medical Consultant - as despite attempting many approaches he has not been successful in gaining the needed co-operation to implement the change.

Stephen reports that during his ANP Masters course he participated in a module of study exploring different leadership theories but says that he has little recollection of this. In response to the question about leadership style, he describes his leadership style as adapting to the circumstances or that of a situational leader. To illustrate this approach Steven describes his leadership of a response to a major incident in which health care providers are responding to a crisis situation. Major incidents require all resources to be co-ordinated in an extraordinary response by the designated major incident team. Major incidents are situations such as the response to the '7, 7' bombings or road traffic incidents where there are many seriously injured casualties. The major incident team and their response to the major incident is pre-determined by a local major incident policy. The roles of each participant of the team are pre-determined as are the resources that will be made available.

Stephen expresses his surprise to be the nominated leader of the major incident as there are other more senior members of the multi-professional team present he states, '*oddly enough the director wasn't in charge'*.

Stephen felt that he leads the major incident well and this was reinforced by the feedback he received from the other professionals involved. He shares, '*the feedback from everyone at the end of that week was how well I had managed from everybody'* but there

was one exception. Early in the major incident response, Stephen is challenged by a ward manager wanting to transfer a patient from their hospital into the hospital currently managing a major incident. Perhaps reflective of his self-assessment as an easy going leader, in this instance, Stephen is undermined in his leadership. Despite that, usually the routine activities such as patient transfers cease during a response to a major incident, the ward manager insisted on the patient being transferred from their hospital and the patient was admitted. Stephen describes, '*so we had quite a heated debate, but I lost that debate'*.

Stephen consistently illustrates his approach to and experience with leadership using examples about patient outcomes which involve others in the delivery of patient care rather than Stephen being the person giving direct care. Although this could suggest his leadership focus as being task orientated Stephen's concern for his team suggests his leadership approach is both task and people focused. Leading the response to the major incident Stephen describes a tense, crisis situation and appears confident in his role and performance as a leader. During the event he describes himself as being '*really bossy,*' but that *'nobody argued with me'*. This is despite having no previous working relationship with many of the professionals, and yet he still appears to have commanded respect from them.

Responding to the question 'can you think of an example when your efforts to lead have not gone as you would hope?' Stephen describes a situation using the terms '*bullied*' and *'manipulated'*. In this example, he is being made to do something that he does not agree with. As prevalent throughout the NHS, there was a need to save money. Stephen's line manager implemented a cost improvement plan, and this involved reducing numbers of staff. Stephen describes a group of nurses that were underperforming and how he negotiates with them *'I managed to politely encourage some staff that couldn't do their roles to move on'*. In his negotiation, Stephen appears to be trying to sustain the nurses' self-esteem and keep his own relationship with them intact. Stephen's line manager used a more direct approach and without discussion makes all five posts redundant. Stephen describes feeling *'guilty'* allowing the redundancies to happen.

As a leader, Stephen expresses feeling responsible, if there is a problem he steps in to fix things. Although this often results in the problem being solved, Stephen recognises that this could be seen as disempowering for other team members, in that they are not given the opportunity to solve their own problems. Alternatively, Stephen could be viewed as a leader who will come and solve everything and that his team can rely on him. He explains, *'I do like very much like to be involved because for me if it then goes wrong or it doesn't quite go to plan part of that responsibility then will sit with me'*.

Although he describes himself as focused on achieving targets and financially aware, Stephen gives the impression that his team work well with him, that he has a good relationship with the team and that they respect him. However, Stephen's attempt to implement change which a Consultant opposed and the scenario where the ward manager insisted on transferring a patient, show that despite this good relationship with the team there are examples where Stephen is less successful in his leadership.

Stephen does not see himself as a born leader, stating '*I wouldn't ever of said that I was a born leader*'. Instead, he states that '*I lack terrible confidence*' (sic) despite giving clear examples of his leadership. He sees the ideal leader as someone who is approachable and supportive but that they also have an awareness of the business aspect of leadership in the NHS, and yet seems unaware that he is describing himself.

5.2. Maria

Maria works in a specialist team that works with patients in the community. She completed her ANP education three years ago. The team includes doctors, nurses and psychotherapists. Maria makes a clear distinction between line managing the team and leadership. She often sees health services professionals appointed into leadership roles because they have proven to be effective managers but who lack the additional skills that a leader would have. Maria shares *'maybe people get there because they do know how to manage staff and they know how to manage services but, I think, that's a bit different to actually having those real leadership qualities'*.

Maria believes leadership involves '*setting the agenda'* and focusing on '*how the nursing role is going to evolve*'. Maria, while a leader of a team, also has a direct delivery of care role. She describes how she enables the nurses in her team so that '*the nursing presence at all levels of nursing to be more strongly felt'*. This relates to the role of the nurse in the team before Maria was employed. She describes the nursing team as being disempowered. A culture had developed where, even when doing basic nursing care, the nurses needed to be directed. Maria wants to reinforce that nursing is '*a role that isn't just running round after doctors'.* Maria strives to act as a role model for the other nurses in the team. Maria feels she '*leads by example'.* She is aware of financial constraints on her practice but also the negative effect on team morale of '*complaining constantly about how terrible it is'*. So, Maria role models positivity and supports the team that she works with. She is protective of them at times; as she describes that she will '*kind of shoulder a bit of flak'*.

Consultants admit patients and the finance for patient treatment is attached to who admits the patient, as such, Maria identifies the medical clinical lead as the ultimate leader in

her workplace. Despite demonstrating innovation and leadership in her role, the patients that Maria is responsible for are reviewed at intervals by the medical team. This is a process that is only undertaken with Maria's patient group and does not appear to be a quality assurance or audit process. In this context she is managing a group of chronic or stable patients, the doctors will check on her management even though Maria feels able to confidently manage the patient group. In her role, Maria feels that the medical team think '*they are senior*' to her but does not challenge this. As she shares,

> '*the medical staff have quite a tight rein on that in terms of meeting with me to review notes and sometimes you'll be sitting there and they'll say oh you need to do this for this patient or make sure you've checked this or that and I'm sitting there thinking, of course I know that*'.

Maria describes how ten people can all be taught the theory of how to be a leader in exactly the same way but perhaps '*only one of them would be a really outstanding leader*'. She offers an example of inspirational leadership reflecting on a discussion between two medical Consultants. One Consultant persuades the other but is non-confrontational in how they achieve this. Maria wonders whether the lack of conflict is only achieved as they are both doctors. Reflecting her view that the medical team consider themselves to be senior to her, Maria wonders if she was having the same discussion, using the same approach, whether the doctor would '*pull rank on me'*.

Maria describes being at ground level delivering innovative health care practice. However, she sees a lack of enthusiasm and motivation amongst her peers. This is manifested where the peer group declare that they do not have time to present their innovative practice to the outside world. Maria is chair of a local group of ANPs who seem to be reluctant to take on anything additional such as involvement in external events or conference presentations. Maria describes how she feels that '*a lot of the time nurses just don't have the kind of drive to take things forward'*. Maria appears to try and motivate the ANP group but is frustrated by the other ANPs' lack of willingness to undertake anything additional to their direct care-giving roles. Maria is unclear why the ANPs '*do not have time'.* This reluctance may be reflective of health care pressures, or a reluctance of the ANPs to delegate their involvement in direct care-giving.

Communication is very important to Maria as she describes, '*communication is so important*' and she not only offers a '*listening ear'* but also in a time of many changes for her team Maria acts as a conduit and ensures they are informed about all that '*is going on'.* Maria also seeks to resolve ineffective communication between team members. She has experienced each team member individually complaining to her. Maria sees this as

destructive to team communication and organises a weekly team meeting where the team have face to face discussions to resolve issues. Maria, in her ANP role, initially also acts as a mediator to ensure the resolution is constructive.

Throughout the interview Maria, when discussing her leadership experiences, uses terms such as motivated and enthusiasm and believes the effective leader should *'inspire your team'*. Maria highlights the importance of delegation in creating motivated team members. She illustrates her own ability to delegate when, although the nursing colleague was initially reluctant to lead the weekly meeting, Maria enables them to facilitate the weekly meetings in her absence.

Maria articulates the balance leaders are required to make between making decisions and delegating to colleagues. She recognises that there are times when decisions have to be made and does not appear to be reluctant to make them on her own. Despite using military terminology such as '*take the flak*' and '*pull rank'*, Maria does not appear to be in a battle with her medical colleagues. She seems keen to reduce the isolating nature of the ANP role and to increase ANP influence on clinical practice by collaboration with other ANPs.

5.3. Daisy

Daisy works in the community in a general practice alongside a group of general practitioner doctors and leading the team of practice nurses. Daisy has been qualified as an ANP for five years. In the practice, she is the clinical leader for the long-term management of diabetic patients. Before becoming an ANP, as a registered nurse, Daisy would have been developing her leadership skills in relation to leading other nurses. She describes the influence of the ANP education she has had. She explains, *'I led before but much much more since qualifying as an ANP'.* She is keen to assure her credibility with her nursing team and also describes a willingness to let other people take the lead '*I'm still very happy doing the basic, not the basic, the care and let other people take the lead*'.

Daisy identifies an individual who attempts to lead the team. Daisy does not respect their approach to leading and seems conscious and unhappy that she is being directed by someone she does not consider an effective leader. Daisy describes the individual,

> *'the person is the thinks she's the lead, maybe if she had studied it further then she would become a better leader but at the moment she is not a good leader she winds everybody up and she gets everybody's back up'.*

When asked who she felt was the leader in the team that she works with Daisy describes the senior medical partner in the practice as inspirational and has great respect for their knowledge. She shares that if they '*would say jump I would jump'*.

Daisy believes in leading by example. In leading she prioritises the value of communicating effectively and wants to role model this for her colleagues. One example Daisy shares is enabling effective communication and facilitated communication between two reception staff at the practice. Daisy describes how she intervened between the two members of staff and facilitates a face to face discussion between them to resolve their dispute. While describing how she role models effective communication Daisy also identifies where communication is ineffective and describes another team member who '*doesn't listen'* and is '*dictating to people'*.

Daisy mostly gives examples of leadership that relate clearly to patient care and does not get involved with the financial aspects of leading the practice. Within the practice, there is also a non-clinical Practice Manager whose role includes the management of financial aspects of patient care. Daisy openly shares her lack of understanding of this aspect of the practice management, '*I don't pay a huge amount of attention to the management of day to day running of the finances'*.

In response to the question about where their leading a situation had not gone as planned Daisy gives an example of delivering direct care. Daisy is conscious that managing the patients with long-term conditions such as diabetes is a partnership relationship. Decisions are made with the patient rather than for them. She allows the patient, therefore, to make decisions even if they conflict with recommended medical advice. Daisy is aware of the risks and ensures the patient is too but believes the patient has to be in control of their condition, even to the point of there being consequences. The patient did make decisions and choices that were contrary to the advice given by Daisy and the patient became ill as a result. To this day, Daisy feels very guilty about this. She shares,

> '*I certainly regret that sort of behaviour that you know that I allow some, not allow but persuade, no I don't think even that's right because I think people should have their own choice you can give them as many facts about health and information but I'm not going to make anybody do something that they don't want to do'*.

Although Daisy is the lead for patients with diabetes within the practice, she reports to one of the general practitioner doctors her clinical decisions and appears ready to change them if the doctor were to disagree with the decision. Daisy describes the pattern of a conversation she may have with the doctor and how she will say; '*this is what I have*

suggested but obviously I am very happy to go with what you want to do'. Although a nominated practice lead for this group of patients within this practice, this would suggest that Daisy views the ultimate leader here is the doctor.

Daisy gives the impression that how she practises leadership as an ANP has been underpinned by her academic preparation. She makes clinical decisions about patient's treatment, although not always independently. Daisy often states a lack of enthusiasm to be a leader.

5.4. Rachel

Rachel qualified as an ANP many years ago, and working in general practice she sees herself as a role model, sharing '*I try and model what I consider to be good working practice'.* Rachel acknowledges that in her senior role she has additional workload and added work pressure and attempts to role model behaviour that demonstrates how she manages this. She describes how she demonstrates '*calmness, professionalism, working smartly, giving myself a little bit of mental space'.*

Rachel believes in making herself available to her team and has an '*open door'* policy. She considers herself innovative but emphasises the importance of enabling others in their clinical practice '*we encourage and nurture good practice'.* Referring to all the multi-professional team that she works with but perhaps particularly her nursing colleagues Rachel shares,

> '*if you want to come and really extend your practice and work at an advanced level then come and work here'; 'as well as offering leadership we're nourishing leadership'.*

In her role, Rachel does a weekly review of the medical notes of all practitioners and in this way has access to all clinical decisions that are made. This can apply to decisions such as prescribing of antibiotics or making decisions around referring on for a specialist's opinion. As both of these have financial implications, which as an employer Rachel has some control over, she sees the review as ensuring '*governance*' in the decisions made at the practice. Although it could be seen as scrutiny, the practitioners, both doctors and nurses, accept or even welcome the review. As Rachel describes they view it more as '*sort of like a peer-review thing'.* Rachel considers this reflective of '*an organisation where people are allowed to ask questions'.*

When responding to the question of who is the leader in her team Rachel confidently shares, '*I am the leader' 'I am the absolute, sort of, pinnacle leader'.* Rachel believes this is because of her senior leadership role in the practice. There is a second reason for Rachel's

sense of being respected as a leader in the practice and that is her clinical expertise. Rachel places the patient at the forefront and expects her team to do so as well. She states that it is much easier to lead when you have the same values and purpose as your team.

Rachel is also keen to empower others and provides an example where she empowers a district nurse. Multi-disciplinary meetings are held regularly to review groups of patients, their health status and plans for their ongoing treatment. In one multi-disciplinary meeting, a district nurse was demonstrably not keen to participate – Rachel describes how the district nurse kept their coat on and asked to '*hand over'* her part first so that they did not have to stay for the full meeting. Rachel persuades the district nurse to stay by asking for specific information that only they could contribute and enables them to recognise the value of their contribution to the meeting. As Rachel describes,

> *'I'd managed to find something that was to do with district nursing. I asked her opinion, and actually, she gave a very concise, very good opinion and I thought, 'Yes! I hope made you feel that you are included,'*

Rachel demonstrates that even though she wants to nurture her team and allow them to develop advanced skills, she does not always succeed. One example of this is when one team member is reluctant to make decisions and Rachel recognises that she is impatient with this. She describes being a '*little bit harsh'*. Rachel recognises that she can make an impact with subtle forms of communication, which if written down may not appear harsh but Rachel knows that her body language and her attitude communicates something differently.

Rachel does not see herself as a born leader but feels that '*you can learn to become a leader'*. However, she believes that you cannot be a leader in health care if you do not have clinical credibility within the team of healthcare professionals. Rachel shares, '*you need to be able to walk the walk'*.

Despite being in a senior role in the general practice, when Rachel leads the doctors in her practice she describes adopting '*different styles when you're leading upwardly'*. Not only does she see leading the doctors as upward in a hierarchy but, because it is effective, she also employs a '*less assertive style'*.

> *'I tend to use probably a little bit more of my coercive style with him, suggesting things as opposed to being absolutely assertive, I don't particularly like myself doing that but it seems to work'*.

Rachel describes herself as the absolute leader and emphasises developing and enabling others. Conversely, if the individual does not think or work as she does, she feels

less effective, she shares her views on one member of her team '*I find her quite hard work. She is so disempowered. I find I get to the point where I feel a bit disempowered when I'm with her*'. It may be that Rachel has surrounded herself with a team that mirrors her views and thereby reducing the risk of them not accepting her leadership.

5.5. Jill

Jill is also a senior ANP in a general practice and qualified as an ANP 18 years ago. She describes herself as leading by example but also a strategic leader. Jill shares the example of how she implemented a new communication strategy for the practice. This involves, each day the team will have a five minute, five points *'huddle'* which is then summarised and sent to team members not present for the huddle. The 'huddle' process ensure important information is communicated to all of the team and also identifies daily priorities. Jill believes in shared decision-making. In her workplace, the decision-making process is informed by the views of both senior team members and junior team members to '*help people grow their ideas'*.

Jill's role within the practice involves leading other professionals. She describes amending her leadership style depending on which professional group she is leading. Her leadership style is also informed by her '*experience and knowledge, and personality'*. Jill believes her experience and knowledge affords her authority and her personality engages her team to work with her as their leader.

As a leader, Jill also models behaviour that she thinks is a good example for the team to follow. She prioritises being time efficient. This is exemplified by strategies such as the huddle. She also states '*leadership is not about working twenty hour days it's about effectively managing and incentivising'*. Jill describes herself as a charismatic leader who is focused on getting the job done. One example Jill offers involves the challenges she faced when the practice moved locations and how she had to be '*directive*'. Jill is outcome driven and is not afraid to face challenges. She also describes scenarios where she is being resisted by team members. During the process of the practice moving locations, there was resistance to her leadership approach. Jill feels that this was a '*power struggle*' between her and some of the doctors that work for her. However, when describing the resistance, it is not only from one professional group, and instead of being resistant to Jill's leadership, the resistance could be simply resistance to change.

Jill appears confident of her leadership role. She is in a very senior position in the general practice and this seems to influence her sense of empowerment. Jill approaches leadership strategically and enables change to happen even when others challenge or resist

her leadership. One example Jill offers is where she appears offended when faced with a doctor claiming academic superiority, her approach was to challenge this. Jill initiates a conversation with the doctor. A conversation, the doctor acknowledges, that they would not have initiated,

> *'It was one of the doctors actually. I said, 'I feel that we talk but I don't think we communicate very well'. That person came back with, 'Well, I'm an academic'. I'm not sure that's very relevant. It continued but by the end of it he said, 'thanks for having this conversation, actually I would never have done it, I think we made some headway'.*

Although sometimes Jill is challenged in her leadership she remains confident of her ability to lead. This appears to be related more to her knowledge and clinical expertise than her senior role in the general practice. Jill approaches leadership democratically and encourages other professionals to offer their opinion. Her focus is, however, ensuring the work is done and that her leadership enables this to happen.

5.6. Sarah

Sarah works in a large hospital and qualified as an ANP three years ago. She undertook her Masters in Advanced Nursing Practice with a group of nursing peers who all worked in the same speciality within the hospital. On completing the course, the other ANPs have gradually left the speciality with Sarah being the only one remaining there from this cohort. Sarah works for an organisation that sometimes operationalises the role of the ANP by adding them to the junior doctor's rota. As such, in her role, Sarah works as an ANP but is seen by the health care professionals working with her, as part of the medical team. Sarah is, however, conscious that she is not a doctor and the doctors with whom she works know this also. Sarah shares, '*even though I'm working with them, they still know that I'm not a doctor'.*

There are no other ANPs in Sarah's immediate clinical environment, so in an attempt to reduce her feelings of isolation; Sarah is trying to establish an ANP forum with other ANPs employed by the hospital. Despite these other ANPs being employed as ANPs, Sarah estimates that several ANPs are not actually practising as an ANP. Sarah suggests this is reflective of the appointment of the ANPs into a culture that does not allow or encourage the enactment of the role.

Sarah does not see leadership as being part of her current practice and is keen to expand her role in particular to include leading nurses. She sees a leader as someone who teaches from their experience without '*undermining*' others' confidence or contribution. She

likes to lead by example but recognises that sometimes instead of enabling others, by teaching or delegating, she resorts to '*doing things myself*'. Sarah finds her reluctance to delegate stressful and describes herself as becoming '*too assertive*' when stressed. This contrasts with her belief that a leader needs to be approachable and be willing to do the work, as Sarah asserts, '*you have to go down to the same level as your colleagues*' not only to get things done but to sustain credibility with the other team members. At the same time, Sarah views a leader as bringing something extra such as advice, correction or offering alternatives.

When discussing the influence of completing her ANP course Sarah shares, '*I just feel that my knowledge level is different*'. Sarah appears to recognise that her knowledge enables her to practice at a more advanced level. Sarah, in her ANP role, is involved in direct care-giving but this frustrates her at times as she would like to have more leadership and strategic elements to her role, she describes, '*ANPs are not just about delivering service we have to have a visible leader*'. Sarah offers examples of her delivery of clinical care where she demonstrates expertise and confidence. As a self-described natural introvert, she has had to work hard to be able to demonstrate these qualities. Sarah feels that a born leader is an extrovert. In her response to the question 'who do you think leads well?' Sarah describes a leader who is approachable, visible, credible and empowering of others but states that they do not '*necessarily give you the answers*'.

Sarah is angry about the circumstances that led to her peer group of ANPs leaving and describes a scenario where she asked for support. She seems to feel her wanting a leadership role is dismissed as not important by her managers. The response from her nursing manager to Sarah's request for a more overt leadership role is '*you don't have to be nominated as a leader*'.

Sarah, throughout the interview, talks about being constrained in her leadership practice. She has completed her ANP Masters degree and had anticipated this would enable her to practise all aspects of the ANP role in her clinical role. The reality has been that she has been placed on a medical rota and has enacted her ANP role more as a junior doctor. In this enactment of the ANP role, Sarah has a very limited sphere of leadership. Sarah attributes this, to some extent, to the team with whom she works being aware that she is not a doctor. Sarah seems frustrated and wants to develop her leadership and her influence on nursing practice but has no time allocated to allow her to do so. The suggestion from Sarah's line manager is that Sarah does not need to wait to be nominated as a leader. This could imply that the organisation had an expectation that the ANPs would have established a

leadership sphere of influence for themselves without waiting for permission or being allocated the time to do so.

5.7. Mike

Mike qualified as an ANP ten years ago and works part-time in higher education institution as a lecturer on a Masters programme for ANPs. His clinical role as an ANP is within a general practice. He discusses leadership and the management of change. Mike describes '*I go about making change so that everybody will adhere to that'*. He also refers to leading the patient to ensure '*concordance and compliance'* with their treatment. Mike describes the lead General Practitioner (GP) as his leader but who leads by also consulting with the team rather than imposing decisions upon the team, as Mike shares, *'I don't see this lead GP as someone who dictates'.* Mike describes his own leadership style as being '*situational'* and that it changes depending on what the situation demands but he also describes himself as '*strict'* and '*assertive'.* It seems that Mike wants to align his leadership style with someone who consults with their team but at the same time asserts their authority.

Mike is driven by his clinical practice and cites his own leadership examples where his decision has had an impact on patient outcomes. One leadership example he offers is about the use of The National Institute for Health and Care Excellence (NICE) guidelines for the antibiotic treatment of urinary tract infections. NICE guidelines are seen as the gold standard in treatments but Mike's patients were not recovering. When choosing to use a treatment other than the NICE recommended treatments, it is important that you have sufficient evidence to support this. As the patients that Mike was caring for were not responding to the antibiotics recommended by NICE the next step would be to identify the specific organisms that were causing the infections and what antibiotics they were sensitive (reactive) to. Mike, therefore, conducted an audit of the patient's responses to the antibiotics they had been given and the organisms identified to be the cause of their urinary tract infections. Mike describes how he changed the antibiotics being prescribed to an option different from NICE recommendations but identified as more effective on the identified causative organisms for his patients.

Mike believes that '*not everybody is cut out to be an ANP,'* but he does believe you can learn leadership skills. His ideal leader is the fictional character *'Captain Kirk'.* Although it may seem strange to use a fictional character as an example of their ideal leader Mike had clearly thought carefully about this. Mike believes that Captain Kirk not only engaged with his team but could also be firm and assertive when the situation required.

Mike also describes a case where a patient had the incorrect dressing put onto a burn wound by a nurse at another general practice. The impact of the incorrect dressing was that the patient was '*screaming in pain'.* Mike states that he wanted to make a formal complaint to the practice but ultimately did not as it was late by the time he finished his clinical work. He also describes other general practices, where he has worked as a locum ANP, and how by trying to reduce the costs of treatment the practices are so unsafe he refuses to work there. Mike shares '*because obviously they're trying to cut costs, and I think it's not safe'.* By making the choice not to return to a clinical setting, Mike could be seen as avoiding highlighting poor practice. However, Mike explains that even if he did this would not result in anything changing. He describes, *'If you report it back to the locum agency, they won't do anything because they also want their money'.*

Mike offers an example of his leadership which is centred on ensuring patient compliance with treatments; he describes *'getting the patient involved, so they do what you ask them to do'.* His phrase '*do what you ask them to do'* would suggest although he involves the patient, his approach is more of a strategy to ensure the patient does what you have told them to do.

Mike is not able to offer a response or example of a leadership scenario that had not gone as well as he would have liked. Although, in the clinical examples of managing the patient who had the incorrect burn dressing applied and in describing his reluctance to '*whistle blow'* Mike finishes the interview with what could be considered examples of challenges he had experienced to his leadership. Mike describes using a 'strengths, weaknesses, opportunities and threats' (SWOT) analysis and describes how this helps him to avoid making mistakes. It seems that Mike is unwilling to discuss any potential challenges that he has had. The reluctance to discuss any challenges to his ANP leadership might be reflective of Mike being aware that I had practised as an ANP and that I may judge him if he were to reveal his personal challenges.

Towards the end of the interview, Mike discusses two episodes of poor clinical practice. It appears, despite encouragement for practitioners to '*whistle blow'* in the health care culture, that, as Mike describes, the practitioner is still fearful of the consequences if they do so.

5.8. David

David has been qualified as an ANP for two years and works in a large hospital. He describes dividing his role into two halves one medically focused, and one nursing focused. David enacts his ANP role with some leadership of the medical team but also sees that as

he is a senior nurse, he is a role model for the nursing team. David leads by example. He demonstrates this with an example of how he tries to dress smartly, or as he shares, *'I adhere to the uniform policy'*. This smart adherence to uniform policy seems to be how David demonstrates professional behaviour. He sees that as an ANP he is distinct from the nursing team. As a role model David describes other nurses looking at him and asking '*what is so different about him?' 'how did he get there?'*

David's role modelling extends to how he responds to patients. In his clinical environment, patients present with what some of his colleagues consider trivial complaints. However, David impresses upon the team that this is a patient who is anxious. The patient may have little understanding of what is happening to them, and their complaint is not to be trivialised.

David describes how he often gets mistaken by patients for a doctor, but he always corrects this. He considers this is because the public perception of doctors is that they are decision makers at the top of the hierarchy. As the ANP role holder also often makes clinical care decisions, the public can become confused. In David's workplace there are decision making or sign off clinicians, and this can be a doctor or an ANP. The sign-off clinician is the clinician who makes the final treatment decisions for the patients. David is the '*sign-off*' clinician for paediatric patients. It would be more usual that the doctor would be the sign off clinician and David describes how he thinks some doctors find it challenging. He describes how *'sometimes it is my perception, but some doctors find it hard to come to me and ask me, you know, certain things, nothing specific, but just, like for example, paediatrics'.*

In David's workplace, there is a clinical shift by clinical shift division of leadership with both a nurse in charge and a consultant in charge, on duty at the same time. Although sometimes these roles overlap there are defined professional boundaries. David describes, '*Yes, there's definitely a professional boundary. Sometimes they overlap, but yes, there's definitely a divide between the two'.*

David includes educating as being a quality of a good leader. When reflecting on his own leadership he describes a scenario where he intervened in the treatment of an adolescent. The adolescent had a fractured leg and was having a plaster cast applied but was finding this very painful, David was asked to help. Not only does he ensure that the adolescent is adequately analgised for the procedure he was about to undergo, but David also used the procedure as a teaching opportunity for the nurses who had initially started the treatment. Supporting and education is something that David is keen to do more of in the future.

David often refers to the pressures of working in an NHS that is target driven and detached to an extent from actual patient outcomes. He shares, *'it is target driven, and there's always someone above you that's putting pressure on you to achieve those targets'.*

In response to the question asking for an example of where his leadership had not gone as planned, David describes missing a diagnosis with a patient. On arrival into the Accident and Emergency Department patients are handed over, and the clinician makes a rapid decision about their treatment. In this instance, David missed that the patient had a leg fracture. Although David gives reasons for this including the influence of clinical time pressures, he is clearly unhappy with himself about missing a diagnosis; he states, '*I don't like missing things'.* David describes in detail how he missed the diagnosis for the patient. He seems distressed, disappointed and almost angry with himself. He appears to think that this one episode has been destructive to his credibility with the medical team.

David does not see himself as a born leader and does not particularly like the leadership aspect of his role but acknowledges the ANP role does require it. He describes '*I kind of don't really want to be leading people, but in actual fact, for the role that I do, it does involve leading people'.* In contrast, he offers an example of an ideal leader who is good at communicating with their team while also commanding respect, '*she knew how to get the best out of people'.*

David is in a high-pressure direct care-giving role. As an ANP on a medical rota he could be considered part of the medical team but seems to have established a wide sphere of influence. He is trusted to make independent decisions about clinical care. Despite his concerns about losing credibility, David has some authority with the medical team and appears to also have credibility with the nursing team. David does not describe a leadership style as although he has studied leadership theory he has no recollection of what he was taught; this seems to be because he found the teaching focused only on leadership theory rather than using leadership theory and applying it to clinical practice.

5.9. Conclusion

This chapter has introduced all participant ANPs and offered a descriptive presentation and analysis of their individual interviews. Stephen appears to be an easy going but outcome driven leader; Maria an empowering and team-focused leader. In contrast, Daisy is a reluctant leader but is aware of how knowledge has improved her leadership ability. Rachel and Jill, while different, are both assured of their leadership roles. Mike leads his team in their acceptance of a change in practice. Sarah practises with skill as an ANP but against an organisation that seems reluctant to allow her to lead. Finally, David is, again, at times a

reluctant leader but he is respected by the nursing team and able to assert leadership across other professional groups.

This chapter has allowed consideration of the ANP's individual perspectives as an initial, instrumental, stage of the collective case study (Thomas 2011). This is consistent with the social constructionist belief that each of the ANPs has a unique experience to convey (White 2004). As the boundaries chosen for this case study included geography, educational preparation and current ANP employment, further exploration in the following chapter allows comparison between the ANPs.

Chapter 6: Findings - collective analysis of all ANPs

In the previous chapter I have introduced the participating individual ANPs expressed views on leadership. This chapter will further explore how ANPs experienced and discussed leadership, by presenting the patterns and trends from across the interviews of all eight participating ANPs. The links between the emergent findings from this study and published literature will be explored in chapter 7. In this chapter, emerging from the analysis of the interviews, patterns that describe how and why ANPs experience their leadership as they do will be presented. I will then highlight the coherence and divergence between the participants. As in the previous chapter, I have selected quotes from the ANPs that offer an illustration of the voice of the collective. Again, as in the previous chapter, interpretative comment is offered. Within the chapter concepts and expressed ideas that the ANPs refer to most frequently have been considered. However, even those concepts or ideas that are referred to less frequently and by fewer ANPs, as these were significant to the participant, are also considered. To introduce the chapter and before a detailed presentation of the overarching themes and their relationship with the contributory codes, a short explanation is given. Each theme is illustrated below in bold italics.

Placement on the Leadership Pyramid emerged as an important strand of discussion across all ANPs. When describing their views on leadership ANPs reflect on their own leadership roles. When discussing leadership, the ANPs also debate whether leadership is an innate quality or something that can be taught.

Within ***Motivating the Team*** ANPs and the leadership qualities they believe are important to create and sustain organisational change and performance are explored. Leaders are role models and visionary according to participants. The ANPs identified how they empower others as a leader and how they are supported by their team members. The theme ***Retreating to the Safety of the Nursing Profession*** identified how factors that influence credibility were central to how ANPs can execute their roles. This included the level of expert knowledge and willingness to undertake basic nursing care. ***Assumed and Accepted Medical Hierarchy*** explores ANP's experiences of barriers to their leadership practice, often but not always, related to their medical colleagues. The final theme of ***The ANP's impact on Patients Outcomes*** describes what enables ANPs to implement change and apply leadership to clinical practice.

Figure 6 is included below to demonstrate the relationship between, not only the research questions and indicative questions, but also the emergent themes.

Research Questions	Indicative Questions	Emergent theme
1. How does the ANP understand and interpret the leadership component of their role?	The NMC definition of an ANP includes leadership within it how do you demonstrate leadership in your role?	Placement on the Leadership Pyramid
1. How does the ANP understand and interpret the leadership component of their role?	In your team who would you say is the leader?	Placement on the Leadership Pyramid
2. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?	How would you describe your leadership style?	Placement on the Leadership Pyramid Retreating to the Safety of the Nursing Profession
3. How does the ANP enact the leadership aspect of their role?	Can you think of an example when you have led a situation well?	Placement on the Leadership Pyramid Motivating the team Retreating to the Safety of the Nursing Profession
3. How does the ANP enact the leadership aspect of their role?	Can you think of an example when your efforts to lead have not gone as you would hope?	Assumed and Accepted Medical Hierarchy
4. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice? 5. What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice? 6. What personal, interpersonal and organisational and professional support does the ANP need to be able to enact leadership?	What do you think influences ability to lead?	Placement on the Leadership Pyramid Motivating the team Retreating to the Safety of the Nursing Profession Assumed and Accepted Medical Hierarchy The ANP's Impact on Patient Outcomes
4. What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice? 5. What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?	Who do you think leads well and can you give an example of when they have?	Placement on the Leadership Pyramid Motivating the team Retreating to the Safety of the Nursing Profession The ANP's Impact on Patient Outcomes

Figure 6: Research questions: indicative questions and emergent themes

6.1. Theme 1: Placement on the Leadership Pyramid

Throughout the interviews, ANPs reflected on and explore their views on leadership within the ANP role and the innate nature of leadership acumen. The ANPs were being asked how they express, define, understand and enact leadership and it could be anticipated that they would frequently refer to 'leadership'. In this theme, the ANPs express how they approach leadership (Leadership) and how they feel an ANP can become a leader

(Nature or Nurture). How the ANP's level of confidence influences their leadership (confidence) is explored. The final subtheme in this theme considers the extent and isolating impact of leadership (Autonomy).

6.1.1. Leadership

While all the ANPs referred to the concept of leadership, they have differing views on the responsibility and authority vested in ANP leaders. Metaphorically this could be described as a 'leadership pyramid'. The range of leadership positions begins with the isolated leader at the top of the leadership pyramid. A second leadership position is where the leader is placed in the centre of both the pyramid and the multi-professional team. The third leadership position could be described as a foundation of both the pyramid and the team, focused on the patient. Rachel and Jill seem to be examples of leaders at the 'top of the pyramid' leader. Jill makes a clear statement about her leadership role, stating *'I am the leader'.* Similarly Rachel states *'I am the absolute, sort of, pinnacle leader'.* Their statements seem to relate to their roles in their practice. Both Rachel and Jill have nominated leadership responsibilities in the general practice where they work and are seen as leaders of all the other practitioners.

In contrast, although Maria, Sarah, Stephen, Mike and David all work in different clinical areas, both in and out of hospital clinical environments, they appear to view their leadership from within the core of the multi-professional team. Mike identifies his leadership approach as being defined by the importance of working with others in the multi-professional team; he describes, *'your engagement with other professionals to achieve a common goal'.* David has been identified as an ANP established in both nursing and medical teams so could also be seen as a leader from within the multi-professional team.

Daisy appeared least sure of her leadership role and began by stating how the ANP academic qualification had transformed her leadership practice. Daisy indicates that she adopts the leadership role with some reluctance. She expresses a preference for remaining a 'hands on' nurse and aligns herself more with nursing practice and profession. Daisy stated that *'I will lead, but I'm still very happy to do the very basic'.* Daisy is a leader who is direct-care delivery and patient-focused, neither leading from the top of the pyramid nor from within the multi-professional team. Instead, Daisy is the leader in episodes of care for her patients. Daisy makes additional statements that suggest that she did not see herself as a leader in her practice when she describes *'I don't think about leading very much… I don't think that I am a leader'.*

Ultimately there is a range of responses from the ANPs with some identifying themselves as being the definitive leader and others showing some hesitation in taking on this role.

6.1.2. Nature or Nurture

The ANPs were asked what influences the ability to lead. David was very clear that leadership ability was not something that you were born with. He felt that it was a skill you could develop when you were put in a position to lead. David also described being forced into a position of leadership when he was in a different leadership role in the armed forces at a young age. He *'barked orders'* believing this an effective leadership approach, he recalls *'it not going down very well, people didn't do what I told them'.* All the other ANPs describe that you could learn to be a leader but that the exceptional leader was born with some leadership ability. As Maria describes,

> *'I think you know you could you could take ten random people and teach them the same things about leadership but maybe only one of them would be a really outstanding leader and it doesn't mean other people can't lead a team effectively'.*

Mike also believes that while a born leader has inherited traits that enabled them to be an '*A plus leader'* you could learn to be a '*B standard leader'*. Ultimately, he believes that *'not everybody is cut out to be an advanced nurse practitioner, no matter what they do'.*

Other responses from the ANPs appear to demonstrate that it is possible to become a leader without having inherent leadership ability and it is possible to develop those leadership skills. Despite his early leadership failure, David believes that he has developed leadership ability because he is working in a role that requires it. However, the majority of the ANPs believe that the leader that is exceptional does have some innate leadership quality. Despite being in leadership roles, none of the ANPs claims this exceptional leader status.

As described in the earlier metaphor of the leadership pyramid, it could be anticipated that the patient focused leader or the leader who leads with or through the multi-professional team may not consider themselves exceptional. That it would be the leader, who leads from the top of the pyramid who would view themselves as an exceptional leader. This is partially supported as both Stephen and Sarah, who appear to be leaders who lead through the multi-professional team, state that they do not believe they were born leaders. Even Rachel as a '*pinnacle*' leader still does not consider her leadership practice either inherent or exceptional.

6.1.3. Confidence

Despite this lack of belief in innate leadership qualities Stephen and Sarah give examples of where they demonstrate confidence in challenging clinical scenarios. This is in contrast to other members of the team who do not appear as confident. Stephen's example of how he remained confident relates to his leadership of the major incident at his hospital. This is a stressful and challenging scenario, and it can require a wide range of resources such as needing to accommodate a large number of patient admissions or in this case the need to move patients and close clinical areas to maintain safety. The major incident carried on for several days, and Stephen was responsible for safely managing the response. He was working with a team of clinicians that he did not know, some of whom were more senior than him. Stephen remained confident and described the '*feedback from everyone at the end of that week was how well I had managed from everybody'.*

Sarah describes how she managed an acutely deteriorating patient and remained calm and able to respond confidently to do what the patient needed, as she described '*I think I didn't panic. Some of my colleagues, I noted, they were, a little bit panicked, so I thought, someone has to gather the whole situation'.* Confidence is not only about how to respond in a crisis. As Sarah explains '*I have that knowledge to say and that kind of confidence to say'.* Fundamentally it is the confidence needed in their skills and underpinning knowledge with which the ANP has their voice heard in the multi-professional team.

On occasion, the ANPs seemed reluctant to delegate to their team. Stephen describes intervening to repair situations. He recognises by doing so he does not allow the team to develop its own problem-solving strategies he recognises that '*I think perhaps I just get involved in a little bit too much'.* Stephen suggests that as the ultimate responsibility lies with him if he does the task rather than lead others or delegate, he can be assured it is done. As Stephen explains, '*because for me if it then goes wrong or it doesn't quite go to plan part of that responsibility then will sit with me'.* To take full responsibility for an action suggests a confidence in his ability to perform the action successfully. However, Stephen also states '*I lack terrible confidence'* (sic) which may suggest that his need to intervene may stem from his lack of confidence and how this affects his ability to trust and enable his team to develop a level of independence in their practice.

6.1.4. Autonomy

Clinical decisions are often made by the multi-professional team, and so there is some debate around whether true autonomy by any healthcare professional is even achievable in the clinical workplace. The ANPs identified the isolating nature of their role and how important it is to support and be supported by their team. However, this isolation also

allowed them some degree of autonomy and independence in their practice. Even Sarah, in her ANP role in Accident and Emergency, recognises '*I work pretty independently'.* The examples of autonomy in practice include Daisy managing her group of patients with diabetes and Maria, with her group of patients with chronic conditions. In both of these examples, there appears to be some supervision of their perceived autonomy. It is perhaps independent practice more than autonomy that is an expectation of the ANP role and the ANPs in their responses emphasise their ability to do this.

Placement on the leadership pyramid identifies where the ANPs position their leadership approach. It also describes the extent to which the ANPs feel leadership is innate. This theme also explores the extent to which the ANPs feel their level of confidence and sense of autonomy influences their leadership.

6.2. Theme 2: Motivating the Team

The formal description of the role of the ANP includes demonstrating leadership and expertise (Leadership Qualities). The ANPs in this study view being a role model (Role Model), motivating (Leading Others) and empowering their team (Empowering Others) as being core elements of the ANP role. In this theme, ANPs also consider the impact communication with the team has on effective leadership (Communication; Resolving Conflict). They delineate between leading a team and managing a team (Line Management). The ANPs discuss the different challenges between leading a team you know well and leading a team of strangers. Finally, ANPs view effective leadership of a team as two directional. The leader can be the motivational role model, but they are also supported and empowered by their team (Support for You as a Leader).

6.2.1. Leadership Qualities

All of the ANPs identify qualities that they personally demonstrated that positioned them as leaders. The differences between the ANPs in appointed leadership positions were related to the leadership qualities identified and these varied. Some of the ANPs suggested innovation, (Rachel), organisation (Daisy), or visibility (Sarah) as leadership qualities. Other ANPs feel they need to maintain a high level of personal motivation to be able to motivate their colleagues. Maria is clear that her level of motivation has a direct impact on the motivation of her team, she shares, *'it's just how motivated I am feeling and how enthusiastic I'm feeling about my work and my job'.* For Maria, being motivated and enthusiastic impacts on and influences the mood of the team. Maria sees that the opposite is also true. She feels that if you are not motivated or enthusiastic then neither is the team that you work with. As Maria describes *'if you're the leader of a team and you're putting that message out* (that you

lack motivation) *then all that happens is that your team also complains terribly about how awful everything is'.*

Maria chairs a local group of ANPs and appears to be an instinctive motivator in this group. She describes a scenario where she feels the group were lacking motivation. A national conference was arranged, and several doctors were presenting. The ANP group were unhappy that they had not been asked to present at the conference. They felt that this meant the ANP's contribution to the subject expertise was not being recognised. Maria, however, felt that it reflected more the ANP's lack of motivation to volunteer their willingness to present at the conference. To prepare a conference presentation requires taking on additional work and as Maria describes, *'when it boils down to it nobody ever wants to do any work'.*

Lack of motivation may not have been the reason the ANPs were reluctant to take on additional, external, work. Many of the participating ANPs describe their roles as either new to the organisation or that they are the only ANP employed by the organisation. The initial motivation of the ANP may be to establish impact within their organisation before attempting to achieve more far-reaching external impact.

In contrast, other ANPs demonstrate that they see an important leadership quality that motivates the team, is to encourage others. Jill's approach is to share the decision making while Rachel also builds leadership capacity explaining that *'as well as offering leadership we're nourishing leadership within the organisation as well'.* Sarah also describes a leader she found inspirational who did not provide the answers but instead encouraged you to ask the questions *'So she didn't necessarily give you the answers, but she might throw you something back to make you think'.*

Although the ANPs practice in a range of clinical specialities the leaders that motivated and inspired them had similar leadership qualities. These included inspiring respect, being easy to approach, visible in the workplace and retaining clinical credibility. The qualities and behaviours that ANPs identified in themselves as leaders were closely aligned with the qualities of leaders that had inspired them. For example, a leader who has a strong work ethic was associated by the ANPs with ensuring positive clinical outcomes for patients and the leader being approachable and visible.

The participant ANPs make a distinction between being respected, having the authority and being controlling as a leader. Daisy discusses a member of her team whose leadership approach was to control the team rather than motivating or engaging them. Daisy describes how this leader *'winds everybody up and she gets everybody's back up but she has a lot of control within the practice'. As* Daisy describes, this leader is someone who,

'*bulldozes through just making people or dictating to people what she wants them to do'.* It suggests that this leader through not motivating and inspiring their team, in turn, is not respected.

Leadership qualities that seem to enable the ANP in their practice include motivation and confidence, both their motivation and confidence but also the ability to instil these qualities in others. A leader that is controlling and does not listen to the views of those around them is not viewed by all the ANPs as an effective leader. Instead, an effective ANP leader is approachable, visible and hardworking. These leadership qualities will earn the ANP respect from their team.

6.2.2. Role Model

Although not explicitly naming themselves exceptional leaders, all of the ANPs aside from Stephen, referred to themselves as a role model and leading by example. They strive to ensure the people they are leading can be inspired. As Rachel describes *'I hope that the other nurse practitioners and nurses and doctors who work in the surgery see me as somebody they can model themselves on'.* The purpose of the role model is therefore not to distinguish the ANP from their team but as Rachel explains that she can '*demonstrate those behaviours myself and then to show that actually you can all do this'.* In this way, the ANP can inspire their team. Being a role model appears to be something important to ANPs as they also gave examples of role models and leaders that have inspired them. Maria describes a ward sister she had worked with as a junior nurse *'I found very inspiring because of the way that she practised and you think I would like to be like that one day'.* Aiming to practise as well as your role model could support the idea that leadership, rather than an innate quality, is something that can be learnt. It would appear that the inspirational leaders described by the ANPs are those whom they base their current leadership practice on.

6.2.3. Leading others

By knowing their team and each team member's individual qualities, the ANP leader can use this knowledge to refine how they motivate others. Here the ANPs describe both their leadership strategy in leading others and also observed leadership approaches to leading others. Developing a personal relationship with team members establishes a trust in the ANP as a leader and increases motivation for all team members that there is a shared vision of what is to be achieved. In describing her leadership relationship with the multi-professional team, Daisy describes, *'understanding people and understanding the way different people function'.* Rachel instils in her team a set of values and beliefs. She shares, *'it's so much easier to lead them if they have the same values and beliefs and purposes'.* While David describes his ideal leader as one who establishes a personal relationship with

their team. In doing so, the team would feel they had personally let the leader down if they did not succeed. With this approach, David explains the leader *'knew how to get the best out of people'.* Leading a team is sometimes identified as being willing to take a risk, and this can involve protecting the team from unnecessary stress as Maria describes *'so I think you have to be able to kind of shoulder a bit of the flak for the team'.*

The ANP leadership role can involve leading individuals of other professions. This can be a challenge. Some ANPs describe using different approaches with different professions within the multi-professional team. Although there are similar principles of establishing trust and credibility, while motivating the multi-professional team, the actual approach may differ. Rachel describes how she approaches leading the doctors in her team,

> *'I think one adopts different styles when you're leading upwardly, it's sometimes tricky, I think sometimes one adopts possibly less assertive styles, I'm being honest, and more coercive styles, depending on the person'.*

Leading others is further demonstrated where the ANPs describe their team working. Examples of shared learning and joint achievements are given. Rachel describes how her team works *'We work very well as a team',* and that the role of the leader relies on involving others in decision making. She shares *'It just makes people feel that they're not alone so it sort of shares the risk and creates that environment where we're constantly learning'.*

Both Jill and David believe the effective leadership of a team relies on being clear about aims, setting boundaries and clearly identifying their expectations. As Jill explains, it is important to *'be very clear what the expectations and boundaries are'.* Similarly, David explains the need to be about what your expectations are from the team but also what they can expect in return from you. He explains *'You need to outline to those individuals what your expectations are, what you expect from them but also what they expect from you'.* Team leadership is most effective if there is a common goal. The leader that acknowledges what each profession can contribute to that goal ultimately enables the multi-professional team to become a community that transcends individual professions in achieving this.

6.2.4. Empowering Others

Leadership is often viewed by the ANPs as empowering others. This can be either empowering for the individual or the team. Empowered, the individuals and the team, together, achieve goals and outcomes. The leader empowers their teams by instilling confidence and self-belief in their teams. For example, Rachel describes how she nurtures her individual team members in order to enable and empower the team,

'if you come and work somewhere like this practice, where you are allowed to grow and extend your role but in a safe, protective, supportive environment it's a bit like, you know, you can plant a seed on stony ground, and no matter what happens it's not going to do terribly well, but if you plant a seed and you nurture it, you feed it, you give it plenty of compost and feed and all that sort of stuff and you water it on a regular basis, then people will flourish'.

This contrasts with Sarah who is ambitious to widen her leadership influence but has had some difficulty in establishing her leadership in her clinical environment. Sarah describes enabling and empowering her team in the future, *'So I'm hoping that whatever I'm doing might improve my own situation but also improve the future ANPs'.* There are differences between the ANPs' responses. However, there are several examples where the leadership qualities that the ANPs describe and what the ANP needs to enable their leadership are very similar.

6.2.5. Communication

It may be as a consequence of the amount of time the ANPs describe working in isolation, but they appear to view effective communication as a core quality of leadership. Not only do they describe effective communication but also how they are improving their communication or where communication is ineffective. Non-verbal communication between the ANP and their team is also considered. It appears that the ANPs view effective communication not simply as a leadership quality but something that a leader is reliant upon. As Rachel shares, *'part of leadership is about good communication'.* David, as he does with developing his ability to lead, believes that you develop your communication skills over time and in association with your role. He shares, *'I think it's a skill that you develop when you're in a position, and it comes with experience as well and how you communicate'.*

Communication involves the ANP communicating with their team and encouraging the team to communicate with each other. As the multi-professional team is made of different professions, communication involves moderating their approach at times. Daisy is one of several ANPs who describe using different approaches to communicating with different professional groups, *'I think you need to be able to talk to people at all different levels about the same thing'.*

ANPs believe effective communication involves recognising that sometimes your attempts at communication are ineffective, as Daisy identifies, '*just because I think I am making sense it does not always follow that I am making sense'.* Ineffective communication is also identified by other ANPs. For example, Rachel has some insight into what affects her ability to communicate effectively and how this disintegrates when she is tired or overwhelmed. This can be overt, in what she says or more subtly in how she behaves. She

describes how *'when I do get a little bit overwhelmed I get a bit snappy'* and goes on to describe that even indirect communication can have a negative impact *'I think my body language or the way I respond to an email might come as a little bit harsh'.*

The ANPs identify where other team members are not communicating effectively. Daisy describes a colleague, stating *'she doesn't listen and she doesn't hear she does it only her way'.* It suggests that the individual is blocking communication. By not listening to the ANP and continuing to do things their own way the team member could be seen as not acknowledging the ANPs' leadership and that there is, potentially, a different view than their own.

As the ANPs view communication as so important, several ANPs describe deliberately employing strategies to encourage communication between themselves and team members. This can be to hear their concerns, as Maria does when she describes, *'sometimes you know and be a listening ear for them'.* Or where Rachel acknowledges in her clinical environment how a physical barrier can adversely impact on communication. She shares, *'So, I try and have an open door policy, people can come to see me and talk to me about anything'.* Maria describes being a facilitator to communication with her team,

> *'that was just a good example of how communication is so important and that actually just sitting down together as a group with somebody to be there and be the mediator to give everybody an opportunity to speak in a respectful way in a supportive environment so that things could be resolved'.*

The ANPs discuss their open door policy and the value of having regular face to face meetings, so all team members are kept informed but are also given a forum to discuss their concerns. These face to face meetings are also employed to defuse situations where there has been a breakdown in communication between team members.

6.2.6. Resolving Conflict

The tensions from working in isolating roles or even from working in a high pressured health care environment can lead to conflict. Facilitating a forum to talk openly as a team can help defuse this. Stephen, Maria, Daisy, and Jill all refer to verbal communication as a tool to resolve conflict. Either they would initiate a conversation, or they would facilitate others to have a conversation and resolve differences. Maria has already described how she uses face to face meetings to enable effective communication, but here she describes a regular meeting she arranges to help avoid or defuse conflict,

> *'so I set up a meeting a weekly meeting so that we could all meet and have this conversation together rather than different people behind each other's backs to try and resolve the issues that were kind of repeatedly coming up'.*

The ANPs describe novel approaches to enable effective communication and strategies they employ to resolve ineffective communication. The ANPs describe how their role modelling approach enables effective communication. As a group, they use terms such as 'open' when describing how they make themselves available to their team to discuss any concerns they may have.

6.2.7. Line management

Management and leadership are often terms that are used interchangeably and yet they seem to be viewed distinctly by the ANPs. All of the ANPs were involved in direct line management of colleagues, but this is seen as a different responsibility from leadership. An example is given when Maria describes other nurses appointed to leadership positions '*they do know how to manage staff and they know how to manage services but I think that's a bit different to actually having those real leadership qualities'.* The role of the manager could be viewed negatively if it is associated with managing changes and initiating cost cutting to the service. In contrast, the role of the leader is potentially viewed more positively as one who inspires, motivates and shares a team vision.

6.2.8. Support for You as a Leader

To lead, a team needs to believe and trust in you as a leader. This is made more challenging for the ANP who describe how they are often working in isolation, whether they are the only ANP in their clinical environment or they are a new member of the team. Establishing the role of the ANP where it has not previously existed brings with it the challenge of integrating a new role into the multi-professional team dynamic.

Even where the ANP role is established in the clinical environment, they remain, to some extent, isolated as there is an expectation that they can work independently. Conversely, it seems a challenge for some of the ANPs to acknowledge and accept support. An example is seen with Stephen's and Sarah's reluctance to delegate, arguably, they are not able to ask for support as they feel that they should be able to cope without support. Other of the ANP leaders, such as Maria, recognises the potential support they can offer the team but also that the support can be reciprocal and may make this ANP leader more able to accept support.

Underpinning many of the emergent themes is a core credibility that an ANP must demonstrate. The ANP is in a position of leadership because they have developed and demonstrated the expertise for the role but also sustain their professional credibility. They have been inspired by nurse leaders in their past and maintain that distinct nursing identity. They lead because they are part of the nursing community but also because they can step over the traditional boundaries and achieve credibility with other professional communities.

The following theme further explores how the ANP is reliant upon their professional credibility to be an effective leader.

6.3. Theme 3: Retreating to the Safety of the Nursing Profession

The ANP is registered as a nurse before undergoing the education and gaining the experience they need to become an ANP. Many of the ANPs continue to relate strongly to their nursing identity (Credibility). Furthermore, the ANPs identified that their leadership practice involved them being a role model for their team; it is important to examine what makes the ANP the role model (Basic Nursing Care; Knowledge).

6.3.1. Credibility

The ANPs all offer scenarios to demonstrate their credibility in dealing with complex and challenging clinical scenarios. The ANP's credibility as a leader appears to be reliant on demonstrating a willingness to undertake any aspect of the nursing role. However, the ANPs see their credibility as being associated with being able to perform their clinical role expertly and, at times, to add something more than other members of their team. As Rachel explains, *'you need the credibility and that's what I've got here because I can do the job. I can do the job really well and that really helps and if you can't do the job really well, nobody would respect me'.*

There appears to be a need for the ANP to demonstrate credibility with the medical team by demonstrating skills normally associated with doctors, to at least the same standard, if not better. Mike who works in general practice describes how *'sometimes I see myself as more efficient than some GPs'.* It would be a reasonable expectation, from both employers and patients, that the quality of health care delivery between different professions is equivalent. For example, if an ANP is undertaking a patient consultation the patient has the right to the same standards of care as if a general practitioner were to undertake the consultation. Mike aligns efficiency with speed. He is efficient as he has reviewed a patient with symptoms in less time than it takes the General Practitioner. It is potentially true that if the ANP were to take longer than the doctor to review the patient, they could be seen as less efficient. However, it could be suggested that Mike is seeking credibility with the medical team rather than recognising what he offers as an ANP is at least equivalent.

David describes an episode where his credibility was questioned. In his initial review, he had missed a key symptom in the patient's clinical presentation and as a result had missed that they had fractured their leg. David had been under time pressure, and the decision about the patient's treatment had to be made quickly. In this instance, the patient was not able to offer a reliable history and made no mention of a fall or trauma to either David or the paramedic team who had brought him to the hospital. David is clearly

disappointed in his decision and describes how he felt *'I don't like getting things wrong. I don't like missing things'.* David expects a high standard of clinical practice from himself and feels that by not demonstrating this he has lost some clinical credibility.

There are disadvantages to establishing credibility; one example Daisy described was her role in caring for all patients that have diabetes in the practice, *'if anyone presents with diabetes they always send straight to me'.* While it adds to her credibility in being the expert on managing the condition Daisy feels it means that other practitioners become de-skilled.

6.3.2. Basic Nursing Care

While striving to achieve credibility in taking on some clinical skills associated with doctors the ANPs also strive to distinguish, by their expertise, between the role of the ANP and other nursing roles. Despite this, some of the ANPs emphasise a willingness to undertake all aspects of nursing care. It would appear that they have a need to demonstrate that they were still part of this community and that the ANP role did not mean you believed yourself 'above' delivering basic care. Daisy states *'I'm still very happy to do the very basic'* and Maria also feels that she should not *'expect anybody else to do things that I wouldn't be prepared to do'.* Sarah sees this need to remain credible in the nursing profession as an ANP slightly differently. She shares, *'you are actually doing the same, what they're doing, but maybe you bring that extra knowledge in as well to maybe do things slightly differently'.* This suggests that, even when the ANP is describing the basic nursing care, they deliver they are simultaneously enhancing and advancing this basic nursing care.

6.3.3. Knowledge

As discussed, ANPs undertake a formal academic qualification at Masters Level to support their practice. They must also have a wealth of experiential knowledge as there is an expectation of expertise in the ANP field of practice. The impact of this knowledge on their credibility is acknowledged by several ANPs, as Daisy describes, *'I need to know exactly what I am talking about and beyond'.* Sarah sees the combination of the experience she has had in nursing and having completed her ANP Masters degree makes her think differently, as she describes,

> *'It's different in the sense that being an ANP, I feel that the level of education I've achieved to become an ANP, I've had years of experience in nursing and studied and finished my Masters. I just feel that my knowledge level is different and I probably see things differently'.*

There is suggested power associated with knowledge. Jill describes a doctor talking to her and claiming academic superiority, *'I'm an academic. So, therefore, I know what I'm talking about'.* Or, *'I'm potentially more intelligent'.* While Jill is unhappy with the attempt to

imply a higher status through academic achievement, it does suggest that the doctor associated academic achievement with status. This would offer support for the formal education requirements for ANPs. Having achieved the academic award, there is potential for associated increased professional status and credibility within the multi-professional team.

The ANP, while remaining a nurse, is viewed as slightly outside of the nursing professional group and not fully part of any other professional group. The ANP has to establish credibility with all health care professional groups while, to some extent, is isolated from them.

6.4. Theme 4: Assumed and Accepted Medical Hierarchy

At times the ANP was prevented from asserting their leadership. All of the ANPs make reference to barriers preventing or inhibiting their leadership. The ANPs attribute this challenge to many factors, including other professional's acceptance of ANP professional status or clinical credibility. There is a tension in how the ANPs experience leadership, related to an assumed medical hierarchy. As Maria acknowledges, '*the person who would make the final decision would be the clinical lead who is a doctor'* (Doctors)*.* Other factors that influence ANP's ability to lead appear to be more internally focused. On occasion, it appears that the ANP is reluctant or lacks the confidence to take on the responsibility associated with leadership (Disempowered).

6.4.1. Doctors

As the ANP undertakes many clinical skills that are usually undertaken by doctors, there is potential for this to be challenging to either or both professions. Historically, medicine has been the more dominant profession in health care. The process of leadership in the NHS is often portrayed as professions only accepting leadership from their own professions. All the ANPs aside from Daisy, describe the challenges of attempting to lead doctors. There is an assumed hierarchy that sometimes is difficult to challenge, and Maria depicts a traditional dominating professional structure that '*sometimes for other professionals, it's quite hard to infiltrate'.* Jill refers to some of her experiences of working with doctors as a '*power struggle'.* Maria also feels that the medical team believe in their seniority and that as a nurse and even as an ANP, she shares, *'that at the end of the day they can always pull rank on me sort of thing'.*

Maria, who runs her own patient clinics, has her work reviewed and is advised how to manage their care. This could be seen as ensuring governance; the doctors are reassuring themselves that the care given is equivalent to their standards. It seems though that this review is only in one direction, the doctor reviewing the ANP clinical decisions. It would be

unlikely that the doctors would welcome a similar review from the ANP of their clinical decisions. However, Maria describes '*thinking*' rather than '*saying*' to the doctors that she is confident in her decision making for her patient group. This apparent reluctance to challenge could be seen as acceptance of medical hierarchy.

It has to be the ANP's responsibility to assert their ability to lead their patient groups Sarah who works with a team of doctors also describes her need to assert herself,

> '*I think I need to trust my own instincts and actually start doing more leadership amongst the SHOs[6], but like I said sometimes it's difficult because they still see me, even though I'm working with them, they still know that I'm not a doctor'.*

In this example, Sarah has more experience in the clinical environment than her junior medical colleagues. Her workplace's enactment of the ANP role is one where Sarah is working alongside junior doctors, even performing the same clinical skills, but she still feels unable to lead them because she is not part of their profession.

Even where the ANP is leading the situation, the public perception is that they must be a doctor to do this as David suggests,

> '*There's a perception that doctors are, it's a better skill or you're on a path to be a doctor but I think that's a general, population perception of nurses and doctors and,* (a) *hierarchy'.*

Sometimes there is a barrier where the doctor will not accept the ANP leading the situation, Stephen describes a scenario where he has been asked to implement a change in the service and which is blocked by one of the Medical Consultants, '*it's something that could easily be done but he's completely blocking it'.* Stephen sees this as the doctor refusing to be led by the ANP. There are, however, alternative explanations. The re-modelling of the service meant that the Consultant, who had set up the service, was being asked to change their practice to reduce costs and potentially offer what they appeared to consider a lower standard of care. The lack of engagement may therefore not be a deliberate barrier to the ANP leadership but presenting a barrier to the change in practice.

Some of the barriers are real and put in place by medical colleagues, but the barriers to the ANP leading are also sometimes the behaviours, views and actions of the ANP preventing their leadership. When they lack motivation or drive these are factors that prove a barrier to their leadership. Maria questions the motivation of her fellow ANPs. She describes how they '*just don't have the kind of drive to take things forward or maybe they don't believe that they can maybe sometimes, there's a bit of oh, we can't be bothered'.* The outcome of

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[6] Senior House Officers

whatever barriers are preventing ANP leadership practice often leaves the ANPs feeling disempowered.

6.4.2. Disempowered

Disempowerment can be immersed within a culture. Sarah describes how ambition in nursing is not always a favoured quality. She sees a nursing culture that discourages nurses who want to develop themselves, Sarah describes how *'if that regular nurse tries to be like the sister, it's not really looked upon necessarily very well'.* Sarah is working as the only remaining ANP out of the group that were educated together. She had anticipated that as a group they would be supported to establish the role of the ANP in her clinical workplace. Despite the employing organisation supporting the education of the ANPs, Sarah feels this has not continued into clinical practice. She describes how the other ANPs on her course have *'done the course and they were hindered by the managers because they say it's not needed'.* The other ANPs left the organisation rather than being constrained by these managers and not being able to practice as ANPs. Sarah who has, so far, stayed uses phrases such as '*confined',* to describe how she is practising. It seems that there is a lack of awareness in Sarah's workplace of what an ANP can offer to clinical practice. Sarah has learnt the theory and is keen to put this into practice but states *'I think it's been three years of a battle, of people understanding what an ANP is'.*

It could be that the clinical workplace or Sarah's colleagues have not understood what an ANP can offer or the impact the role can have on patient care. For them, the ANP role is still not fully defined or understood. Additionally Sarah's nursing manager comments '*you don't have to be nominated as a leader*' which may reflect a culture that had expectations from the ANPs that have not been met. It could also be that as Sarah identified, the ambitious nurse is not always welcomed, and as an ANP, Sarah is seen as the ambitious nurse.

Sarah is not the only ANP to feel disempowered Stephen describes examples where he has given up and describes '*I kind of allowed it all to happen'.* A different type of disempowerment is where Daisy describes attempting to persuade a patient to comply with the treatment they needed. They are diabetic and needed to make lifestyle changes but were reluctant. Daisy describes not wanting to impose the changes on the patient. She explains *'I think I was probably trying to make them do it themselves when actually they weren't going to do it'.* In this instance, Daisy has the knowledge about what treatment and what lifestyle changes the patient needs to make. By empowering the patient, so that they make the decision for themselves, she is disempowered and not able to get the patient's compliance with their treatment. Effective leadership includes how the leader responds to a

culture that is inhibiting their practice. The disempowered leader needs to develop their confidence and credibility, which can empower them and their team around them.

6.5. Theme 5: The ANP's Impact on Patient Outcomes

The nature of health care means that it is constantly evolving and responding to developments and complexity of diagnoses and therapeutic treatment available for patients. The expectation that there should be equivalence in the standards of care between different professionals has already been introduced, but there is an additional, important concept that the ANP needs to demonstrate a positive impact on patient care. The ANPs involvement in patient management often involves introducing new approaches to care (Managing Change). In addition, the occasionally isolating nature of ANPs practice would suggest networking with other practitioners had the potential to enhance an awareness of developing practice (Networking).The impact the ANPs have on improving patient outcomes can be seen in the ANP ensuring governance across local or national standards and reducing the costs of the health care being delivered (Save Money, Maintain Quality and Governance).

6.5.1. Managing Change

Maria is the first ANP in her speciality, and the nursing culture she describes before she was employed in the organisation was disempowered. The changes Maria implemented were to empower the nursing team to have a more significant role in the patient care. She sees as her responsibility to change the mind-set behind this lack of confidence in nursing contribution to patient care. As Maria describes, '*I started that change so I think leadership was also about bringing the nursing role and the nursing presence at all levels of nursing to be more strongly felt within the clinic'.*

People are often reluctant to change even if when it proves empowering and Jill acknowledges the challenges of implementing change. She was managing the move in the location of the general practice and found, *'That it took some time and some convincing'.* The change involved not only new location but also new technology. She gives several examples where her team demonstrated a reluctance to engage with the location change, whether it was physical in refusing to pack their clinic rooms or practical skills and knowledge acquisition by refusal to learn how to use the new technology. Jill concludes that '*People don't cope with change very well'.*

Jill and Mike describe strategies they employ to enable change to happen. This did involve allowing time for the change to be accepted. As Jill describes, *'You keep saying the message, people then remember, repeat it, do it again in a relaxed way'.* Alternatively, the ANP can provide sufficient evidence to convince that the change is positive. Mike sees the process of managing change involves using advanced practice skills, researching and

identifying supportive evidence to persuade *'sometimes I have to give the new evidence, and then sometimes they can change if they think what you're saying is right'*.

6.5.2. Networking

Despite any potential advantages of working together as a 'community' of ANPs, networking does not appear to be a strategy that the ANPs, at least overtly, employed. Only Rachel refers directly to the value of networking and describes a forum she attended which introduced her to several different types of clinical leaders and how this had helped her in developing her practice,

> *'I did an awful lot of networking with other leaders, nursing and non-nursing leaders, who I've since kept in touch with on LinkedIn and things like that. That sort of networking stuff that really helps your confidence, knowing that somebody else has sort of done that'.*

Although not using the term 'networking', both Maria and Sarah refer to ANP groups where they work to support each other as ANPs. This is perhaps a missed opportunity for the ANPs. If they actively networked outside of their immediate areas of practice the ANP could benefit from the support an external network can offer.

6.5.3. Save Money, Maintain Quality and Governance

Health care has to be safe, high quality and improve patient outcomes. The development of the role of the ANPs was influenced by many factors but was always focused on ensuring the quality of care being developed. As Mike describes *'obviously helps in terms of moving towards one goal and that one goal is obviously governance for the patient'.*

Health care today involves introducing innovative treatments with an aim to improve patient outcomes. More infants survive prematurity, more people live with chronic or inherited conditions, and the elderly are living for longer. This increases the cost of healthcare and with the financial constraints being imposed upon the NHS as a whole, there is more to do with less financial resources. The ANPs describe the financial constraints on their local practice. In primary care, even Daisy with her self-identified lack of understanding of the financial aspects of health care, explains *'but primary care with all the complications and the finances'.* Maria, managing a group of patients in the community with long-term health care needs, describes how it constrains what support they can offer *'I think particularly in the current climate we've got lots of constraints on our work financial constraints we don't have enough resources'.* Stephen, whose role involves the direct management of budgets and achievement of targets within this budget, describes, *'at the*

time we were overspent and have to find savings'. Overspend on a budget often means a financial penalty, further reducing financial resources.

With the introduction of the NHS, there was a focus on improving the health of the nation and that this should be available to all and free at the point of delivery. Some of the ANPs seem to focus only on care-giving and are reluctant to accept the responsibility of making financial decisions. Mike comments *'I don't see a leader as someone that is probably pulling the strings that holds the budget as the leader'.* David has a different view, with an acceptance of the reality of a target driven NHS. This adds pressure, not only to the ANP in their role but this also means they have to pressure the team that they lead. David recognises that this can have a negative impact on your relationship with the team, he describes,

> *'I know, especially not in the environment that we work in, which is all, it is target driven, and there's always someone above you that's putting pressure on you to achieve those targets. You have to put the pressure on the people below you to be able to achieve those targets as well, and sometimes, you know, people don't like that'.*

Rachel in her role is a further contrast in her views. This is perhaps because she has a very senior role and makes the decisions that influence what income the general practice will generate. As such, she describes,

> *'So that means financially, so the decisions that we make affect the finance that comes in, so we make decisions on pay rises, on profit-share, bonuses, that sort of thing and everyone knows that and so, that's a very distinct role'.*

It would suggest the successful leader in the NHS can respond to these financial demands and recognises the importance of delivering within budget but also has the clinical expertise and credibility.

6.6. Conclusion

This chapter has provided an exploration of the codes and overarching themes generated by comparative analysis of the ANP participants in this study. There has been some discussion about the differences between some of the ANPs views on leadership with some less confident of their leadership role. There were many similarities in the ANPs beliefs around factors and qualities that enabled a leader. These included clinical credibility and the ability to act as a role model. Factors that proved a barrier to effective leadership was also explored including the complex and at times, constrictive nature of health care today. The final chapter will discuss the relationship between the conceptual model generated in chapter three, the themes generated in this chapter and current literature.

Placement on the leadership pyramid	Motivating the team	Retreating to the safety of the nursing profession	Assumed and Accepted Medical Hierarchy	The ANP's impact on Patient Outcomes
Leadership	Leadership qualities	Credibility	Doctor	Managing change
Nature or nurture	Role model	Basic Nursing Care	Disempowered	Networking
Confidence	Leading others	Knowledge		Save money, Maintain Quality and Governance
Autonomy	Empowering others			
	Communication			
	Resolving conflict			
	Line management			
	Support for you as a leader			

Figure 7: Emerging themes and contributing subthemes

Chapter 7: Discussion

To ensure the study was embedded in the current and historical evidence relating to ANPs in UK healthcare, a comprehensive literature review was conducted and presented in Chapter 3. In turn, the conceptual model introduced at the end of chapter three reflects the outcomes of the review and informed both the rationale and the research questions for this study. The model also illustrated the relationship between ANP leadership, their professional identity, their gender, the process of inter-professional working, education and the impact of ANP leadership on patient outcomes.

The NHS overarches healthcare in the UK and the role of the ANP is one of many professionals involved in NHS healthcare delivery. The literature review identified the relationship between and influence of education on the leadership skills of ANPs. Equally, there was an identifiable relationship between ANP leadership and improved patient outcomes. Despite the role existing for several decades in the UK, the concept of a distinct ANP professional identity continues to evolve. This is often underpinned by a lack of understanding of the ANP role from other healthcare professionals and consumers. As initially a nurse the ANP still identifies with nursing as a profession. As they establish as an ANP they appear reluctant to establish a new and distinct ANP professional identity. The reviewed evidence also suggested that gender, as ANPs are predominantly female, can have an adverse influence on their ability to enact leadership. This has a consequent effect on how the ANP as a leader, is viewed when working inter-professionally.

Figure 1: Conceptual model: Leadership Practice of ANPs contexts and Influences

The initial interpretation and exploration of the experience and insight of the eight ANPs interviews were presented, distinctly in chapter five and comparatively in chapter six. During the analysis process, five themes emerged from the collective analysis of the interviews. These themes capture a unique yet overlapping strand of how the ANPs understand, interpret and articulate their experience of leadership.

Within this chapter to capture the essence of each theme I will present a brief summary of the patterns emerging and offer comparison and /or contrast between how the ANP's express, define, understand and enact their leadership with existing theory. Each theme is introduced with examples given from the ANP's descriptions of their experiences. This chapter will also attempt to articulate the relationship between the original research questions, the conceptual model and the themes emerging from the interviews. Conclusions drawn will be related to current theory and practice.

Figure 8 aims to depict how the emerging themes are interdependent with each other. No one theme is distinct from another with overlapping concepts arising between them all.

The ANP's impact on Patient Outcomes → Placement on the Leadership Pyramid → Motivating the team → Retreating to the Safety of the Nursing Profession → Assumed and Accepted Medical Hierarchy →

Figure 8: Relationship between themes

7.1. Placement on the Leadership Pyramid

The underpinning concept of a leadership pyramid in relation to how the ANPs approach leadership emerged in previous chapters. The leader who positions themselves at the peak of the pyramid is leading from an isolated position. From this position, their leadership approach could be compared to the innate, heroic and charismatic leader (Conger and Kanunga 1998). In contrast, the leader that positions themselves within the centre or core of the leadership pyramid is empowering their team in the style of the transformational leader (Oakes *et al.* 1994). This contrasts again, with the leader who positions themselves as a foundation to the pyramid and appears focused on direct care episodes. Their outcome orientated approach echoes the style of the transactional leader (Giltinane 2013).

The different leadership positions that the ANPs placed themselves in are described in detail in Chapter 5 and 6. Rachel and Jill confident of their leadership appear to act as role models placed at the peak of the leadership pyramid. Stephen, Maria and David, place themselves as part of the multi-professional team, leading from within the centre of the leadership pyramid. While Daisy, Sarah and Mike appear to consider themselves primarily a

leader of direct care-giving episodes, forming the foundation of the leadership pyramid. In contrast to the hierarchy suggested in the conceptual model, this is not suggesting that there is a leadership hierarchy in the placement on the pyramid; rather that each position represents a different leadership approach.

7.1.2. Levels of leadership

Evetts (2009) describes an approach to leadership that is structured similarly to the concept of a leadership pyramid. The leader can lead from three levels the macro level, the mezzo level and the micro level (Evetts 2009). Both the macro and mezzo levels relate to the leadership of the organisation as a whole or the social structure within the organisation. The micro level of leadership is complex and specific to the profession. The professional can act as an autonomous professional at all or some of the three levels. To relate this to the leadership practice of the ANPs in this study, they all can be considered leaders at the micro level as they all have specialist and profession specific leadership skills. For example, Daisy, with her focus on direct care-giving would be at the foundation of the leadership pyramid demonstrating her specialist and specific leadership at the micro level. Rachel as a '*pinnacle*' leader would lead predominantly from the top of the pyramid. Although, as she has a specialist specific leadership role, Rachel would have leadership authority at all of the three macro, mezzo and micro levels. Maria too could be described as a leader macro and mezzo levels as she is focused on being the leader of her team '*you are the person leading the team'*. Although she positions herself in the centre of the leadership pyramid, by also being active in the delivery of direct care, *'I don't expect anybody else to do things that I wouldn't be prepared to do myself'* Maria is also leading from a micro level.

7.1.3. The Outstanding Leader

Alimo-Metcalfe and Lawler (2001) have previously described the concept of the outstanding or heroic leader as being outdated. Even though the participating ANPs do not consider themselves as such, they appear to identify with the concept of an exceptional leader.

David and Daisy even describe themselves as reluctant leaders and even Rachel, a *'pinnacle leader,'* still does not consider herself a born leader. A consistent reluctance amongst the participating ANPs in this study to claim the outstanding leader role might suggest that the ANP continues to relate to a feminised professional identity. Describing female leaders, Sandberg and Scovell (2013) suggest women often do not believe that they will become a leader and this becomes a self-fulfilling prophecy. Even if the female leader does succeed, they attribute this success to factors other than and external to their ability

(Sandberg and Scovell 2013). In this study, it could be suggested, by not claiming outstanding leadership ability, the ANPs appear to remain cautious about their leadership practice.

The potential influence of gender in health care has been identified; with Barrow (*et al.* 2010) describing the nursing role as feminised carers while the masculine medical role is that of a curer. It has also been suggested that medicine is patriarchal, excluding the profession of nursing which by being associated with 'care' is seen as a feminine and a less prestigious profession (McMurry 2011, Bell *et al.* 2014). Despite the range of evidence suggesting gender can impact on how leadership is enacted and expressed, aside from not claiming outstanding leadership ability, this study did not identify gender-specific experience of leadership between the male and female participant ANPs. This could reflect how the ANP role challenges the historical or traditional associated low prestige and feminised status, given to nursing's contribution to health care (Tracey and Nicholl 2007).

7.1.4. Professional Autonomy

Participating ANPs vary, in the level of autonomy they describe within their roles. However, the isolating nature of ANP practice, whether this is in a consultation room in a general practice or with a specific group of patients, means that the ANP will make independent clinical decisions about the treatment of patients. There are, however, examples where these decisions are not independently made, and the ANPs confer with or have their decisions changed by the doctors. This is demonstrated when Daisy affirms her decisions about the patient's care by asking her medical colleague if they agree. Similarly, Maria assents to her group of patients having their care reviewed regularly by her doctor colleague. Sarah further describes the team of doctors that she works with as not only limiting her independent practice but having little understanding of the role of the ANP and what exactly she is able to do, understanding only that '*they still know that I'm not a doctor'*.

A defining quality of a professional has been described as autonomy in their practice (Freidson 2001). A factor that influenced the participating ANP's leadership confidence relates to the extent that they were able to practice with autonomy. In healthcare, the ANP is not the only professional asserting autonomy. The NHS has been described as a professional bureaucracy (Minzberg and Ivonne 1995) with many professionals simultaneously claiming professional autonomy. Once autonomy is gained, the occupational professional that Evetts (2009) describes has assumed autonomy, which they are reluctant to relinquish. In an 'increasingly litigious culture…further undermining trust and professionalism' Evetts (2009 p259), there is a risk in allowing a single profession full autonomy in healthcare leadership.

The NHS is also said to function as a rigid hierarchical culture closed to the potential for change (Hurley and Linsley 2007). There is increasing complexity in the healthcare needed. This, alongside the requirement to respond to political and financial constraints, may not have entirely dismantled the hierarchical infrastructure but it has blurred the professional boundaries (Hurley and Linsley 2007).The role of the ANP as a leader needs to challenge the occupational professional leader's autonomy, to work together as a multi-professional team with each profession contributing to the rich and complex health care delivery.

O'Brien *et al.* (2008) explored the extent of autonomous practice and collaborative working between a team of Advanced Practice Nurses (APN) and doctors. Rather than collaborating, the APNs described feeling micro-managed and not being afforded the professional autonomy that their knowledge and experience merited. The doctors, in contrast, did consider themselves autonomous and perhaps conscious of the risk involved, in an increasingly litigious health care culture, would not relinquish their autonomy to the APN, 'I am in charge, but we are a team' and 'they work under me, and under my license' (O'Brien *et al.* 2008 p139).

The APNs in O'Brien *et al.'s* (2008) study needed to prove their ability to the doctors before collaborative working could happen. Illustrative examples of each profession's differing perspectives included, as described earlier, the APN giving detailed and lengthy handovers and discharge summaries. This is seen as unnecessary by the doctors. While the APN's see the detail offered as essential and simply demonstrating differences between professional approaches, 'it's coming from a nursing orientation, not a medical orientation' (O'Brien *et al.* 2008 p141). The two professional groups were not working collaboratively, each with earned autonomy contributing to enhancing the health care given (Barrow *et al.* 2010) The doctors in the O'Brien *et al.'s* (2008) study see only one approach that can be employed and this is the medical approach.

There could be a lack of motivation that underpins the doctor's lack of understanding of the APN approach to handing over. The doctors view the only handover approach to be the medical model; other approaches would not be equivalent (Bell *et al.* 2014). The ANPs participating in this study are similar to O'Brien *et al.* (2008) in that they identified a lack of understanding of the ANP role and what they can do, by doctors. The skilled ANP undertakes tasks and skills that have previously been undertaken by doctors, and yet, they are not a doctor.

7.2. Motivating the Team

Recognition of their distinct ANP role but with an awareness of their nursing identity affords the ANP an understanding of the role of the nurse. However, the ANPs also discuss how important effective communication is in motivating the whole team. Several of the ANPs describe the power and influence of emotional intelligence and how this can inform transformational leadership. They describe empowering the team and acting as a role model to motivate the team. The ANPs also identify the value they place on the role of the other team members or the 'followers' that enables their leadership practice.

7.2.1. Communication

All participating ANPs felt that communication skills are imperative to be able to lead effectively. Communication was a skill alongside their development of leadership skills. In motivating the team, it is seen as essential. The forms of communication the ANPs describe varied. It could be facilitative communication, where the ANP used communication to resolve conflict or encourage a more open communication between team members. Another approach was inclusive communication, being able to communicate across a range of different professions and roles in the multi-professional team. Other ANPs demonstrate insight into the impact of their communicating ineffectively, for example, Rachel, when tired, is conscious of a 'tone' in her email.

The impact of written communication was also seen in Goodrick and Reay's study (2010) where they reviewed the language used in nursing texts written in the mid-twentieth century. In these texts, the role of the nurse was described as subservient to the doctor. In contrast, Rafferty (1996 p7) described the impact of education on communication skills. By learning 'the language of education and research,' the ANP can raise their professional status. Waite *et al.* (2014) also focused on the power effective communication had, in establishing a transparent and trusting relationship between a leader and their followers.

7.2.2. Followership

As the ANPs describe their leadership approach being that of empowering their team it is also important to consider the role of the follower. The ANPs discuss involvement with their teams or followers when giving examples of their leadership practice. For example, Maria is leading a team that is going through significant change, and she demonstrates transparency in her approach '*I try to be quite open with the team tell them as much as I know about what's going on listen to their feedback take their ideas on board try to involve people as much as possible'.*

Leadership has been described as being reliant on the extent the leader is 'protoypical' of the group and how the leader can influence the development of the group's social identity (Collinson 2006 p180). Although, this could be interpreted as the leader ensuring their followers are reflective of themselves, Rachel describes, *'when you're leading people, it's so much easier to lead them if they have the same values and beliefs and purposes'.* Collinson (2006 p183) describes different types of followers including 'position based followers' who follow as they respect the nominated position of the leader or safety based followers who follow as they need the security that the leader offers them. The follower does not follow passively even if their following is based on influence or power the leader has over them.

Followership has been described as 'the anvil of leadership' (Grint and Holt 2011 p7). Kean *et al. (*2011) also identified that the follower is not just a passive recipient of leadership. The follower can be challenging, supportive, passive, critical or devoted and the challenge of the leader is to engage all types of followers (Kean *et al.* 2011). By not acknowledging the importance of the follower role (Dawes and Handscomb 2005) any study of leadership is not recognising the interdependence of the two roles (Kean *et al.* 2011).

7.2.3. Emotional Intelligence

There is a suggested relationship between emotional intelligence and transformational leadership approaches. The leader with emotional intelligence empathises with their team and shares their frustration as they work together to achieve solutions (Giltinane 2013, O'Neill 2013).

Stephen described not recalling details of being educated about leadership theory but also describes a transformational leadership style when offering examples of his leadership. Transformational leadership theory suggests the leader does not use followers to achieve organisational goals but to develop their role as a follower and thereby develop the organisation. This approach recognises that rather than the leader having 'power over' the group that they lead, they only truly have 'power through' the group that they lead (Oakes *et al.* 1994). The transformational approach is said to take leadership beyond simply problem solving by inspiring followers to 'transcend their self-interests to achieve the collective goal' (Conger and Kanunga 1998 p14).

The partnership relationship employed in transformational leadership is not only between fellow professionals, but it can also be the relationship between the nurse leader and the patient, the healthcare provider and receiver. In this instance, the role of the nurse leader is not to inform the patient of the decisions made about their care but to empower the

patient to make their own decisions (O'Neill 2013). Daisy describes this with her experience in the decision-making about care with the diabetic patients. By allowing them to make lifestyle choices that conflict with medical advice Daisy is nonetheless empowering the patient. This can be contrasted with Mike, who also describes how he worked with patients to change their treatment. Although in this example where he describes ensuring *'concordance and compliance'* it appears to be less empowerment of the patient and more decision making for the patient.

The ANPs are striving to empower their team and the patients receiving their care. Not only do they motivate and inspire, the ANP demonstrates credibility and acts as a role model for their teams around them.

7.2.4. The ANP as a Leadership Role Model

All the ANPs describe how they strive to demonstrate good practice and aim to act as role models for their team David, in particular, uses phrases such as '*I see myself as a role model, in being professional,' 'I try and lead by example'. 'I would lead from the front. I try to be a role model'* in describing his practice.

Several studies (Kelly *et al.* 2014, Waite *et al.* 2014, Spence-Laschinger *et al.* 2011*)* explored how leaders were prepared for or supported within their leadership practice. All of these studies employed Kouzes and Posner's (2011) 'The five practices of exemplary leadership' model. Kouzes and Posner (2011) describe an exemplary leader who acts as a role model by demonstrating five core practices. These include inspiring a shared vision, challenging the process, enabling others to act, encouraging the heart and modelling the way. Spence-Laschinger *et al.* (2011) found a correlation between the leader that employed the exemplary leadership approach and their teams feeling empowered and increased levels of staff retention. In their exploration, Kelly *et al.* (2014) also looked at educational preparation for nurse leaders and specifically explored what impact this had on their leadership practice. Kelly *et al.* (2014) found three factors that influenced exemplary leadership 'title, training and education'. However, the nurse leaders were only enabled to 'challenge the process', when they had been supported through a formal leadership education programme (Kelly *et al.* 2014).

The high profile failures in leadership in the NHS have already been outlined (HM Government 2013, Grint and Holt 2011) and the most recent review of leadership in the NHS still found a lack of collaborative working with no real understanding of other professionals' contribution to health care (Rose 2015). The NHS Healthcare leadership model is aimed at all health care professionals (@nhsleadership *et al.* 2015) and appears to measure the

effective leader against similar practices to those advocated by Kouzes and Posner (2011). The NHS leadership model advocates practice that the leader can develop to enhance leadership effectiveness. These include 'inspired shared purpose'; 'sharing the vision'; 'engaging the team'; 'holding to account'; and 'influencing for result'. Both the NHS leadership model and Kouzes and Posner's exemplary leadership model, recognise the need to engage the team in following the leader as their role model.

7.3. Retreating to the Safety of the Nursing Profession

At times, rather than engaging the entire multi-disciplinary team, the ANPs in this study appear to seek affirmation from their nursing identity. Four out of the eight participating ANPs discussed their readiness to undertake basic nursing care. This was often expressed as demonstrating their credibility within the nursing team as Rachel describes, you have to be able to '*walk the walk*'. In addition, the ANP is able to demonstrate their ability to do basic nursing care but as Sarah shares, *'maybe you bring that extra knowledge in as well to maybe do things slightly differently'*.

An alternative interpretation of this ability to undertake basic nursing care relates to the nature of the ANP having multiple competing professional identities and suggests they are retreating to their nursing identity (Croft *et al.* 2014). The ANP as a leader and the role of the nurse have been described as incongruent ((HM Government 2010b, Rafferty 1996). By re-establishing a connection with the nursing profession, the ANP also re-establishes their sense of being in control (Croft *et al.* 2014).

7.3.1. Internal or external locus of control

The ANPs vary in their description of their feelings of being in control, and often there seems to be a direct relationship between feeling in control and the ANP's perception of leadership. For example, Rachel is confident of her leadership role in the organisation and describes how she influences the environment around her. One example is the scenario she describes when enabling and empowering the district nurse's participation in the multi-professional team meeting. This contrasts with Sarah who is battling to achieve a level of control of her environment and practice. Sarah feels challenged by both her line manager and the need to gain acceptance within the team of doctors with whom she works.

Spector (1988) developed a scale to assess 'work locus of control' and defined locus of control as

'locus of control is defined as a generalized expectancy that rewards, re-enforcements or outcomes in life are controlled either by one's own actions (internality) or by other forces (externality)' (Spector 1988 p335).

Reduced levels of internal locus of control have been associated with increased perceptions of work stress and emotional exhaustion, leaving the practitioner without energy or motivation (Günüşen *et al.* 2014). Although not within health care employing organisations, Spector (1986) had previously undertaken a meta-analysis exploring employee's perception of their level of control and participation. Participation was related to resistance or participation, with changes at work. If the employee did not feel in control, they were less participatory, and there was a negative association with employee retention.

The findings from Spector's (1986) study offer an example of the impact on retention where Sarah, who was educated with a group of ANP students, is the only remaining ANP of this group, employed in the organisation. It could be argued; there was an association with the ANPs leaving the organisation and their perception of locus of control. Sarah's perception is that despite being willing to educate the ANPs, the organisation is not willing to enable or empower them to practice.

Spector (1986) explored the impact of an increase in internal locus of control and found that it was associated with an increase in responsibility and workload. He described,

'There may be circumstances in which possible negative outcomes outweigh the positives for an individual, especially in circumstances where the individual does not have the ability to exercise control appropriately' (Spector 1986 p1014).

Again, reflecting on Sarah's experience, she does not appear reluctant to take on additional workload. However, the comment from her line manager that Sarah did not need to wait for nominated leadership could suggest a reluctance to claim a leadership role that has not been given. Sarah feels that her organisation does not value her skills sufficiently to allow her the time to dedicate to leadership. Sarah has also described her reluctance to delegate; stating that she is '*not good at delegating'* and it may be her consequent workload prevents her from adopting a leadership role. To allow an ANP to become involved in more external and strategical development of health care would need them to be able to delegate. The ANPs identify their own personal reluctance to delegate, and another example is given from Stephen where he describes feeling ultimately *'if it then goes wrong or it doesn't quite go to plan part of that responsibility then will sit with me'.*

Maria gives an example of where she is trying to motivate a group of ANPs and finding it a challenge to persuade any of them to accept additional responsibilities. Although frustrated by group Maria acknowledges that they are busy '*because it involves taking something on when you're already busy'*. Both Sarah and Maria are demonstrating the difference between clinical leadership and professional leadership (Higgins *et al.* 2014). The clinical leader has an impact on practice within their immediate sphere, and the professional leader has a wider impact on strategical development at national and international levels. The ANP, overloaded and working in isolation in an ill-prepared organisation would have no time to take on a strategic role (Higgins *et al.* 2014).

The decision to accept delegated nursing workload was considered by O'Brien *et al.* (2008) who identified that, when asked to help with a nursing task, the APNs would prioritise the nursing tasks over their tasks or skills associated with their APN role. The doctors in O'Brien *et al.'*s (2008) study saw this as an APN's refusal to delegate nursing responsibilities. It could also reflect a need for the APN to remain credible with their nursing colleagues and by demonstrating a willingness to take on nursing tasks the APN was retreating to the safety of the nursing profession.

7.4. Assumed and Accepted Medical Hierarchy

The public have been described as confused by the role of the ANP (Rose 2015) and this could be attributed to the ANP undertaking tasks that are normally undertaken by doctors. Equally, as described earlier, there is an acceptance of the medical hierarchy and leadership in healthcare as payment for this healthcare is attached to the admitting, almost always medical, consultant. Despite, identifying, at times, with a nursing professional identity, David describes his experience of being regularly mistaken for a doctor by the public. He relates this to his role as a leader in the clinical environment he practices in. To return to the levels of leadership model (Evetts 2009) and the leadership pyramid concept, the role of the doctor is associated with the occupational professional leading from the top of the pyramid at macro, mezzo and at the micro level. In contrast, the recent exploration of nursing leadership in 'Front Line Care' (HM Government 2010b) identified public perception that does not expect the nurse to be the leader. There are identified challenges for the ANP as leaders and assumed medical hierarchy appears to remain contemporary in some of the examples the ANPs describe.

7.4.1. The oppressed profession

Several ANPs in this study shared examples of where they had faced an assumed medical hierarchy. Maria describes the medical hierarchy that is '*quite hard to infiltrate'*. Sarah also depicts working as an ANP in her workplace as '*three years of battle'* against

medical hierarchy. In contrast, some of the ANPs are more accepting of medical hierarchy; Daisy describes herself as the lead for managing patients with diabetes and yet checks that her decisions are approved by the doctor.

It would appear, however, that the ANPs have an awareness of medical hierarchy without necessarily being fully accepting of it. Maria does assent to the review of the group of patients by the doctor, with some frustration, but does not challenge the behaviour, stating that sometimes it is easier '*just get on with it* '. Rachel's approach similarly demonstrates awareness of her medical colleagues' belief that they are placed higher in the leadership hierarchy. She describes modifying her leadership style to be more coercive with some of her medical colleagues, again with some frustration, but to be successful '*I don't particularly like myself doing it, but it seems to work'.* This approach of suggestion or coercion echoes the doctor-nurse game described by Stein (1967).

In 1967, there was a clearer hierarchy in health care delivery where doctors were seen as a profession who were dominant over nurses. In the 'Doctor-Nurse game' Stein (1967) described the doctor as 'omnipotent' but suggested that this was their protective stance. The doctor, while the dominant and powerful professional was simultaneously experiencing a deep sense of anxiety and in constant fear of harming patients (Stein 1967). The doctors and nurses, therefore, 'played a game' where the doctor was able to sustain their sense of power and allay their fear of harming the patient because they were never directly challenged by the nurse. Instead, the game was the nurse 'gave' and the doctor 'received' recommendations. If nurses did directly challenge a doctor's decision or 'not play the game by the rules,' they were not popular. Intelligence and opinion in a nurse were not welcomed (Stein 1967p103).

Stein, in a second observational study, revisited the doctor-nurse game in 1990 and found that the assumed hierarchy was being threatened by roles such as the ANP. These nursing roles, instead of offering recommendations to the doctor, modelled collaborative practice. The nurse was no longer playing the game by the rules and instead was fighting for emancipation from their medical oppressors (Stein *et al.* 1990). It is not unusual for oppressors not to recognise themselves as such (Friere *et al.* 1996) and Stein, in this second study, describes the doctors as being surprised by the nurse's need for equality as they had not considered the nurse to be oppressed (Stein *et al.* 1990). The process of achieving equality was not only beneficial to nursing. Removing an oppressor's power to dominate has been described as being able to restore the oppressor's humanity (Friere *et al.* 1996) and liberating for both the oppressor and oppressed (Stein *et al* 1990).

Sometimes what appears to hinder the ANPs from leading is not a medical hierarchy but a lack of acceptance of their leadership from nurses. When Stephen is leading a response to a major incident, he has full acceptance of his leadership by the multi-professional team around him. It is the nurse ward manager who challenges his leadership when they transfer a patient to the hospital. It would be conjecture to consider that had a doctor been leading the major incident response, whether the ward manager would have accepted a medical refusal to transfer their patient.

7.5. The ANPs' Impact on Patient Outcomes

Menzies-Lyth's study of nursing in 1960 explored how nurses, out of fear of not being able to cope with the emotional demands, detached and de-personalised patient care to the extent that nursing care was broken down into a series of tasks to be completed (Menzies-Lyth 1960). Similarly, Dartington (1994) described the nurse as fearing attachment to the process of health care as they would be 'overwhelmed by emotional demands' (Dartington 1994 p105). Both of these studies are dated and reflect a different health care than that of today. However, there can be some comparison with health care today where patient care is becoming protocol driven and delivered by a non-registrant workforce. The introduction of the associate nurse, who will be primarily responsible for direct care-giving to the patient, means that the registered nurse will be detached from delivery of care (Leary 2016). Employing protocol driven health care is further simplifying nursing to a series of tasks (Merrifield 2015). The nursing contribution to healthcare in 2017 is echoing the nurse in 1960. The changing nature of healthcare has an impact on all healthcare professionals. It has to be integral to the ANP leadership role, distinct from but still part of the nursing community, to ensure the unique contribution they offer, is not diluted.

The ANPs in this study were not specifically asked about improving patient outcomes but throughout their interviews give examples where they have made improvements to health care. These were related to both long and short-term initiatives. Maria, for example, describes expanding the services that are offered for the patients in the community,

> *'I think that's been quite an exciting opportunity to develop lots of services for patients within the community. The patients that we see there tend to be quite complex have lots of challenging needs that we have had to work quite innovatively'.*

Examples of improving patient outcomes with more immediate effect include Mike who describes how he changed the antibiotic used to treat urinary tract infections in his practice. Sarah also describes how she manages a patient who was undergoing an acute cardiac

event. Although the medical team had reviewed and considered the patient to be stable Sarah reviewed the electro-cardiogram and saw changes that reflected an acute cardiac event. Sarah referred the patient for specialist care and there was a consequent better outcome. As Sarah describes,

'the consultant who first saw the patient with me and saw the ECG, he wasn't too convinced, so he left the area and I spoke to one of the cardiac nurses, just to back my own suspicion as in, 'Have a look at this ECG, I'm not happy,' and I blue-lighted him to xxx's and the next day I rang (hospital name) *and he was having a triple bypass'.*

Neville and Swift (2012) undertook a study in North West of UK, where they described how it was challenging to produce hard evidence of direct impact on patient's outcomes by the ANP role. Their study did suggest that cost savings were important to align to the impact of the ANP practice and related this to a reduction in the length of time the patient spends in hospital. However, they also suggested that the ANP was seen as a substitute for the doctor and as their salary was significant this adversely impacted on any cost savings (Neville and Swift 2012).

Paterson *et al.* (2010) suggested that by increasing job satisfaction in particular by improving leadership skills, there would be a direct impact on patient outcomes. They found an association between a positive working environment in which staff are happy to remain and improved patient outcomes. Contemporary healthcare is multi-professional, and nurse leaders need to move away from traditional working approaches, or perhaps even their nursing identity. As Paterson (*et al.* 2010 p79) describes, 'if nursing leadership is to be effective then such deeply rooted traditions and oppressive leadership models need to be discarded'.

It is also argued that with healthcare being a complex and stressful working environment, combining with reduced staffing levels and expertise the ability of nurse leaders to maintain current standards of care will prove challenging (Wong *et al.* 2013). Demonstrating a positive impact on patient outcomes can be seen in how the ANP manages or introduces change.

7.5.1. Managing Change

All the ANPs describe examples of where they managed change. Jill's example was where she managed the move of the general practice to another location. She experiences practitioners refusing to engage with the change of location in a very physical sense, by not

packing their belongings but Jill acknowledges '*People don't cope with change very well'.* Stephen found when attempting to change or re-model a service following a significant reduction in funding that one of the medical consultants refused to accept this by '*completely blocking it'.* Stephen appears to feel undermined as an ANP leader by this behaviour, although, this, too, appears to be an example of how people are resistant to change per se and not necessarily who is initiating this change.

Mike also managed a change of practice where he changed the antibiotic treatment of urinary infections. He had recognised that the patients were not responding to the treatment they were being given and even though this was based on national guidelines researched alternatives. As he shares, '*That, for me, was a good kind of leadership, where I was able to change practice through using my advice, practice principles that I researched, and developed in practice'.*

The ANPs discuss the barriers to implementing change in healthcare, and this does sometimes relate to other team members accepting the ANP's authority. It also addresses issues of finance, quality and equality in care-giving. While again, there is no clear focus on the ANP's impact on patient outcomes the ANPs do recognise the constraints imposed by having to save money. In a climate of 'commercialised professionalism' (Evetts 2009 p250) and restricted financial resources coupled with an increasingly high expectation of clinical delivery from the NHS, the professional is being held to account. Both Stephen and David mention feeling constrained by the need to achieve targets in their health delivery. They explain,

> ' *if we don't meet our KPI's I mean there's quite a few of them but there's one in particular which if don't meet which is access to services and we get a million pound fine'* (Stephen)

> '*it is target driven, and there's always someone above you that's putting pressure on you to achieve those targets. You have to put the pressure on the people below you to be able to achieve those targets as well, and sometimes, you know, people don't like that'.* (David)

There is an acknowledgement of the impact of significant financial pressures influencing changes and innovations in practice being implemented too slowly and too late to reflect currency in practice. Edwards *et al.* (2014 p342) recognised that the NHS required 'more for less'. This also reflected a culture that recognised that the health care failings identified in Mid Staffordshire (HM Government 2013) could be realised in their own health care climate. The complexity of the changes needed meaning that instead of this being led from the top down the change had to be powered from the bottom up. As Edwards (*et al.* 2014 p343) identifies, 'a collaborative process that engages with the workforce and takes

into account the cultural diversity of the many local organisations, professional groups and teams that make up the NHS'.

The NHS Change Model was developed as a framework (Capacity and Capability 2012) to facilitate change happening. Similar to the NHS Leadership model, the focus is collaborative work, and central to the framework is 'our shared purpose'. There is an awareness that, at times, change needs to be delivered with components including 'engagement to mobilise' and 'rigorous delivery'. The model describes engaging the team who are committed to making change happen. The model also acknowledges that some of the team may not be as committed and an expectation of their compliance for change to happen is sufficient (Capacity and Capability 2012). The leader, therefore, enables change by developing a balance between commitment to change and compliance with change (Capacity and Capability 2012).

The ANPs in this study describe the impact they have had on implementing change in their practice, but perhaps the most significant component of the NHS change model is the component of transparent 'measurement'. In a climate of financial challenges measuring cost efficacy of the ANP is crucial. Demonstrating the impact of the ANP role in the leadership of change applies leadership theory to clinical practice. The following section, therefore, explores how the ANP develops their leadership practice.

7.5.2.   ANP leadership education

Paterson *et al.* (2010 p79) suggested that the fundamental errors being made in leadership educational approaches were that the nurse leader was prepared for this role only once 'they were appointed into formal leadership positions'. David describes himself as a leader because he has been appointed to a leadership position. However being nominated is only one of three factors that Kelly *et al.* (2014) identified as influencing successful leadership. David also gives an example where he does not lead effectively. In a different role when younger he attempted to lead by *'barked orders'* and found this ineffective. This supports the remaining two factors identified by Kelly *et al.* (2014) as influencing successful leadership, training and education. David is an example of an ANP who has learnt to be a successful leader having had training, education and being appointed to a nominated leadership role.

The ANPs in this study appear to have increased confidence having completed the MSc in Advanced Practice. For example, Sarah describes *I have that knowledge to say and that kind of confidence to say'* when describing her management of patients. The impact of education can be an increased feeling of confidence. Watkins (2011) found that completing a Masters academic award made nurses better able to communicate with confidence within the multi-disciplinary team. In addition to their 'increased internal locus of control,' the higher level degree enabled the nurse leader to stand up for nurses and nursing as a profession (Watkins 2011 p2610).

Several studies have found that nurses are not prepared for leadership positions (Kelly *et al.* 2014*,* Higgins *et al.* 2014, Paterson *et al.* 2010). The nurse leader learns 'on the job' and is often appointed into leadership roles because they were good clinicians rather than proven leaders (Omoike *et al.* 2011 p329). Both Eraut (1997) and Cunningham (2009) identify the value of learning from experiences and non-formal approaches to learning. However, similar to the change of emphasis after 'Agenda for Change' in the role of the ward sister when they became ward managers (Enterkin *et al.* 2012), Kelly *et al.* (2014 p159) describes the nurse leader being given 'an increase in responsibility without an increase in authority and a lack of leadership education'.

The ambiguity that still surrounds what defines an ANP increases the complexity in what should be included in their leadership education. As East *et al.* (2014) found the needs of those that assess themselves as practicing at an advanced level differed when the nurses ranged from a band 5[7] to a nominated ANP. Without regulation for the role of the ANP, it

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[7] In late 2016 the RCN introduced the process of credentialing to offer clearer definition of what constitutes an ANP role and what does not - https://www.rcn.org.uk/professional-development/professional-services/credentialing

remains 'difficult to introduce governance frameworks without a clear reference point as to who is and who is not an advanced level nurse' (East *et al.* 2014 p6).

The ANP is influenced by multiple factors and their participation in multiple communities of practice has been considered. Although this study offered boundaries to allow comparison between the ANPs, these included only where they are currently working and their educational preparation and did not account for the multiple factors that had enabled them to embark on an ANP educational programme and role.

> 'A leader's development and construction of true self can be discerned through contextual factors associated with that leader's narrative process' (Waite *et al.* 2014 p283).

The ANPs in this study had undergone some specific leadership education, but this had been based on an understanding of leadership theory. Waite *et al.* (2014) describe a different leadership approach in the authentic leader. This leader has a 'deep sense of self' while the transformational leader who has a 'clear sense of purpose, on valuing and empowering, on achieving' (Waite *et al.* 2014 p283). Leadership education that enables the authentic leader needs to move away from the traditional model of 'theoretical overview' into approaches that are applied in practice (Waite *et al.* 2014 p284).

The skills that a nurse leader must demonstrate are changing as rapidly as the health care they are providing (Omoike *et al.* 2011). Therefore, a new model of nurse leader needs to be developed to cope with the 'challenges and complexities of the ever changing health care system' (Aduddell and Dorman 2009 p168). Not only does there need to be a new model of leadership education, but also the process should be imbedded at all stages of nurse education.

Omoike *et al.* (2011) developed a leadership programme that was offered to nurse leaders who had had no formal leadership education. The educational approach applied the knowledge the nurse leaders acquired to provide problem-solving solutions in the clinical workplace. Leadership education needs to be applied to this complex clinical practice. Preparing the nurse leaders for the health care of today needs to be undertaken in 'authentic contexts' (Paterson *et al.* 2010 p81).

7.6. Conclusion

This is a small study reflecting the views of a small number of ANPs. As the ANPs came from a range of health care settings, this heterogeneity allowed a comparative richness that would not have been achieved if they had all worked for the same employer. The ANPs also

had a range of years of experience practising as an ANP. There were some differences in how the ANPs expressed views on leadership and with some of the participants which may be reflective of how long they had practised as an ANP. Rachel and Jill have been ANPs for many years and are well established in general practice. This contrasts with Sarah who is more recently employed as an ANP and appears to be struggling to establish herself in her role. Experience and its influence on views on leadership is a factor that would warrant further exploration. A social constructionism perspective has provided a cognitive framework for this study. This approach acknowledges the influence of societal culture on the views of the individual (Cresswell 2007). It appears that the ANP's expressed views on leadership are influenced by many factors, considering how their views on leadership develop over time would offer insight into the influence of clinical and professional experience. The next and final chapter considers conclusions that can be drawn from this study and offers recommendations for educational policy, practice and future research.

Chapter 8: Conclusion

This study aimed to explore how a small sample of ANPs practise in London defines, understands, expresses and enacts leadership within their professional practice. By this exploration, it was hoped that a greater understanding of ANP leadership practice would emerge and contribute to the future development of ANP leadership educational policy, practice and research. In this final chapter, therefore, conclusions are drawn from the findings to make a preliminary set of recommendations for leadership educational policy, practice and further research.

Participating ANPs demonstrate their ability to articulate how they practice leadership, although there are differences in how they express and enact leadership. The leadership pyramid reflects three differing leadership approaches that the ANPs employ. Either the ANPs act as role models leading from the peak of the pyramid or as part of the multi-professional team leading with and from the centre of the leadership pyramid. Or the final approach where the ANP leads in direct care-giving episodes and forms the foundation of the leadership pyramid.

The ANPs in this study also view being an outstanding leader as something innate and out of their reach and feel their leadership is challenged by their medical colleagues. This suggests that the ANP remains an enigma to other members of the multi-professional team. We have seen clear examples where the workplace appears to have idealistic views as to what the ANP can achieve, yet do not afford them the resources to do so. The public remains equally perplexed by the role of the ANP with few patients experiencing their care, and there is continued ambiguity surrounding the ANP impact on improved patient's outcomes.

This study did not find the gender associated inequalities in leadership acceptance that was identified in the review of current literature. This may be reflective of the overall sample of participants. It could also reflect a differing view of the ANP as a profession. The ANP role challenges the associated low prestige given to nursing's contribution to health care (Tracey and Nicholl 2007).

The ANPs focused on motivating their teams and demonstrating exemplary leadership practice in how they 'inspire a shared vision', 'enable others to act', 'encourage the heart' and 'model the way' but at times remain reluctant to 'challenge the process'. To allow the ANP role to evolve further and truly demonstrate leadership practice within the multi-professional team, the ANP should feel empowered to challenge the process.

8.1. Recommendations for Educational Policy, Practice and Further Research.

Drawing from the findings, there are several recommendations for future research relating to the leadership practices of the ANP.

One theme reflected throughout this study relates to the changes happening within healthcare and the complexity of the treatments that are offered. At the same time, the development of a larger non-registrant workforce will have significant implications for any nurse leader but perhaps even more so the ANP leader. The importance of the role of the follower has also been considered. Expectations from the leader in this new workforce will differ. What will also differ is what the ANP leader can expect from a very differently skilled workforce. These changes to the structure of the workforce will not only happen in London, and the delivery of healthcare outside of London is no less complex or diverse. However, healthcare provision outside of London can be placed in more rural or potentially less affluent communities.

This study did not observe the ANPs in practice, and this is reflected in many of the published studies that also reflect the views of the ANPs (Ashworth *et al.* 2001, Gerrish *et al.* 2003, Mantzoukis and Watkinson 2006, Carryer *et al.* 2007, Watkins 2011, Higgins 2013). There are ethical challenges to observational studies in healthcare provision; however, this study has described how the ANP enables their team around them. The ANP as a role model is referenced by many of the participants, despite much of their practice being undertaken in isolation. While the role of the ANP is unclear to patients and other members of the multi-professional team, examples of the ANP demonstrating leadership practice would add to the evidence supporting the ANP's impact on improving patient outcomes.

Perhaps the most important overarching theme is how the ANPs expressed their leadership education. Some of the participant ANPs could not recall details from specific leadership education that they had undertaken. In some examples, the ANPs describe it is only once they are appointed into leadership roles that they are enabled to lead. Effective leadership education needs to be undertaken in authentic environments. Applying leadership to real situations through their educational preparation will enable the ANP to become a challenger of process. Leadership education should be an evolving process resulting in an enabled leader and the first recommendation reflects this.

Based on these reflections I offer the following recommendations:

Recommendation One: Leadership Education and Policy

The study identified limitations to leadership education for ANPs. The ANP and other leaders within healthcare provision have described gaining leadership skills once appointed to a leadership position. ANPs need to be encouraged to adopt leadership roles at all stages of their education and professional development. They need to be supported to do this and so leadership education, across all healthcare professionals, must be introduced earlier in their careers and sustained throughout their career progression.

Recommendation Two: Leadership Education and Policy

The development of the ANP's leadership practice in the future was an overarching aim of this study. The culture and climate of the NHS are in constant flux, reflecting health care complexity and political and financial constraints. Identifying leadership approaches and applying or implementing these into practice would be highly desirable. The authentic leader has been educated by application of leadership theory to impact on healthcare practice. Future leadership educational approaches for ANPs must reflect this.

Recommendation Three: Implications for Practice

The provision of healthcare in the UK is changing; the ANP role must respond – this study is imbedded in the healthcare provision delivered in the NHS. The complexity of this healthcare is acknowledged. The changing nature of the healthcare team has also been considered. This will impact on the ANP leadership practice. The ANP leader will work with their team, as a role model and an enabler. Where practice needs to change the ANP leader and their team will challenge process and effect change.

Recommendation Four: Implications for Practice

The role of the ANP has a unique contribution to make to healthcare – they are leaders and this must be demonstrable. Continued reduction in financial support combined with increased demand for the NHS, requires the ANP need to provide evidence that they have had a positive impact on patient outcomes.

The final recommendations have emerged from the process of undertaking this study.

Recommendation Five: Further Research

This study involved a small number of ANPs and data was collected from a single interview. Although by identifying common educational approaches and implementing geographical boundaries it was possible to compare the ANPs there were differences between their expressed views on leadership. A replication of this study, not only comparing the practice of a greater number of ANPs but undertaking a longitudinal study would allow consideration of how the individual ANP views on leadership evolve.

Recommendation Six: Further Research

This study to allow a comparative analysis between the ANP participants placed the geographical boundaries of ANPs who were working in London or Greater London. As a capital city, London offers a diverse and rich culture for health care provision. A future study, reflective of the wide range of interpretation and enactment of the ANP role, could offer comparison between ANPs working in large cities and those working in more rural health provision.

Recommendation Seven: Further Research

It was not possible to observe the ANP participants of the study in their demonstration of leadership, and there are ethical challenges in undertaking this approach to data collection. An action learning research study undertaken throughout the ANP's educational journey and into their practice would not only reflect practice experiences but could align with authentic leadership educational approaches and enable ANP's leadership practice.

Final Thoughts:

Employers in this challenging NHS climate of increased complexity and reduced resources need convincing of the ANPs positive impact on patient outcomes. This can only be achieved by ANPs active involvement in strategical national and international decision making. The ANP cannot wait until their employing organisations are ready for them. The ANP must prepare the organisation. The tools with which they will prepare health care employers are the tools the ANP leader will find amongst their followers.

The ANPs do identify with their nursing identity, but by motivating and empowering their team, they advance the unique nursing contribution to contemporary health care. Rachel describes how she nurtures nurses, ANPs, and fellow professionals within her practice. This analogy reflects not only how to support and enable the ANP, but the support needed to sustain the NHS in the future.

'you can plant a seed on stony ground, and no matter what happens it's not going to do terribly well, but if you plant a seed and you nurture it, you feed it, you give it plenty of compost and feed and all that sort of stuff and you water it on a regular basis, then people will flourish'. (Rachel)

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Appendices:

Appendix 1: Email confirming numbers of RCN accredited ANPs

• ██████████████████████████████████████

    To

• 'anderc1uk@yahoo.co.uk'

Dear Claire

We have records of 354 students from RCN Accredited ANP programmes at London Universities receiving an RCN Accreditation Certificate.

Best wishes

Mary
████████████████ | Customer Service Facilitator | Professional Learning and Development Delivery/Accreditation | Nursing Department
Royal College of Nursing, 20 Cavendish Square, Room 207, London W1G 0RN

Direct line ████████████████
Fax: ████████████████
Email: mary.odonoghue@rcn.org.uk
www.rcn.org.uk/accreditation/

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies. Please consider the environment before printing this email

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From ████████████████ Mary.ODonoghue@RCN.ORG.UK>
To: " ████████████████ anderc1uk@yahoo.co.uk
Sent: Tuesday, 20 October 2015, 11:59
Subject: RE: Numbers of RCN accredited ANP's

Dear Claire

I will need to look back at the info we have for certificates issued over the last 10 years for the London universities and I can give you total what we have. Is it ok to get back to you at the end of the week?

Best wishes

Mary
████████████████ | Customer Service Facilitator | Professional Learning and Development Delivery/Accreditation | Nursing Department

Royal College of Nursing, 20 Cavendish Square, Room 207, London W1G 0RN

Direct line: █████████
Fax: █████████
Email: mary.odonoghue@rcn.org.uk
www.rcn.org.uk/accreditation/

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies. Please consider the environment before printing this email

Appendix 2: Recruitment email

Hi everyone

 My colleague Claire Anderson (Principal Lecturer Post-registration Education Children's Nursing) at London South Bank University is undertaking her Doctoral studies focussing on how the ANP practices leadership. This will generate data through self-report and through observation of their leadership practice.

 The attached participant information sheet and consent form gives some details about the study. The focus is on nursing for this work.

 I hope that you may be able to encourage some of your advanced nursing graduates to contact Claire to volunteer to participate. ████████████████████████████████
████████

 She is hoping to recruit around 10-12 participants in the first instance to agree to be interviewed following which she will ask to observe the same participants in their clinical practice.

 She is hoping to be contacted by volunteers by 31st January 2015.

 Thank you for your support in what should be interesting and valuable research for advanced practice in UK.

Appendix 3: Consent form

CONSENT

I agree to participate in this research project. I am aware that my participation is voluntary and that I am free to withdraw from the study at any time, without fear of penalty. I have retained a personal copy of this letter.

Participant's Name: (Block Capitals) … …………………………….

Participant's Signature: ……… ……………………….

Date: ……………………………….

Email address…… ………………………………

Contact Phone Number………………………………………..

Contact for Further Information
If have any queries about the study please contact the lead researcher -

Claire Anderson
Principal lecturer
London South Bank University
Telephone – ███████████
███████ andersco@lsbu.ac.uk

If you wish to make a complaint about the conduct of the study please contact my Supervisor –

Dr Karen Edge
London Centre for Leadership in Learning
E-mail - k.edge@ioe.ac.uk

A case study analysis of the leadership practices of the advanced nurse practitioner.

The research project

The role of the advanced nurse practitioner (ANP) is that of a registered nurse but differs in that there is an expectation that they will demonstrate leadership skills with not only nursing teams but also the multi-professional team. Therefore this study would focus on how the ANP practices leadership and not only generate data through self-report but through observation of their leadership practice.

The Research team

Claire Anderson - Principal investigator, undertaking this study as part of her Doctorate in Education at the Institute of Education University of London.

Dr Karen Edge - Supervisor, Institute of Education University of London.

Overall research strategy

The research study has two stages
Stage 1: interview
Stage 2: observation.

The interview
You will be sent a participant information sheet and consent form which will have my contact details (email and telephone number). If you agree to participate you will be asked to contact me either by email or telephone and at a time and venue convenient to you the interview will be conducted. Immediately prior to the interview we will go through both the participant information sheet and consent form and sign the latter. The interview will last between 45 to 60 minutes and will be audio recorded. The interview is semi-structured so there will be prepared questions related to the research study questions that will be asked but additional questions may be asked depending on your responses.

You can ask for clarification throughout the interview. The audio recording will be transcribed verbatim and a copy of this will be sent to you for verification. At this stage you may add comments or clarification to the transcript.

You can withdraw consent at any time up until and including your comments on the themes generated from research data collected. If you choose to withdraw consent all audio recordings and transcripts will be destroyed.

The observation
Even if you have consented to being interviewed you have the option to participate only in the interview stage and withdraw consent to participate in the observation stage of data collection.

If you continue to participate in the research study after the interview we will arrange a time convenient to you to observe you in your clinical practice.

This observation will over a period of approximately two working days. The observation will not be continuous but will be undertaken at intervals or during specific actions and interactions that you can identify. For example an observation could be during a ward round or during a multi-professional meeting. The maximum period of continuous observation will be two hours. During the observation 'field' notes will be taken and you may be asked for clarification or explanation of what is being observed.

As other members of your team may be directly or indirectly involved in the observation stage of this study you will be provided with an email to inform them of the purpose of the study. In addition a sign outlining the research study will be placed in the area where the observation is taking place allowing individuals the option to avoid the area or state they do not wish to be included.

Why your participation is important
By taking part in this project you will be contributing to a preliminary study researching leadership practices of ANP's in London. On completion of the research study you will be offered an electronic copy of the report. This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences. If you wish we will identify you as having participated in the project and for this you will be asked to sign an additional consent form.

Privacy and Confidentiality
If you do not wish to be identified your participation in this study will remain confidential. Although the interview will be audio recorded, you are free to turn this off at any point during the interview. Following the interview your audiotape will be transcribed. For the duration of this study all recordings and transcribed material and field notes will be stored in a locked cabinet or password protected computer file and will not be available to any person beyond the research team. You will be assigned a pseudonym immediately on completion of your interview. During my analysis and writing of the research report, your name and that of your employers will not be included on raw data, draft documents and final versions. While we may use quotes from your interview they will not be attributed to you. Only the principal investigator will have access to the raw data and pseudonyms.

A case study analysis of the leadership practices of the advanced nurse practitioner.

The research project

The role of the advanced nurse practitioner (ANP) is that of a registered nurse but differs in that there is an expectation that they will demonstrate leadership skills with not only nursing teams but also the multi-professional team. Therefore this study would focus on how the ANP practices leadership and generate data through self-report of their leadership practice.

The Research team

Claire Anderson - Principal investigator, undertaking this study as part of her Doctorate in Education at the Institute of Education University of London.

Dr Karen Edge - Supervisor, Institute of Education University of London.

Overall research strategy
Semi-structured interview

The interview
You will be sent a participant information sheet and consent form which will have my contact details (email and telephone number). If you agree to participate you will be asked to contact me either by email or telephone and at a time and venue convenient to you the interview will be conducted. Immediately prior to the interview we will go through both the participant information sheet and consent form and sign the latter. The interview will last between 45 to 60 minutes and will be audio recorded. The interview is semi-structured so there will be prepared questions related to the research study questions that will be asked but additional questions may be asked depending on your responses.

You can ask for clarification throughout the interview. The audio recording will be transcribed verbatim and you will be sent a summary of the themes generated from all the interviews and given the opportunity to add further comments.

You can withdraw consent at any time up until and including your comments on the themes generated from research data collected. If you choose to withdraw consent all audio recordings and transcripts will be destroyed.

Why your participation is important
By taking part in this project you will be contributing to a preliminary study researching leadership practices of ANP's in London. On completion of the research study you will be offered an electronic copy of the report. This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences. If you wish we will identify you as

having participated in the project and for this you will be asked to sign an additional consent form.

Privacy and Confidentiality

If you do not wish to be identified your participation in this study will remain confidential. Although the interview will be audio recorded, you are free to turn this off at any point during the interview. Following the interview your audiotape will be transcribed. For the duration of this study all recordings and transcribed material and field notes will be stored in a locked cabinet or password protected computer file and will not be available to any person beyond the research team. You will be assigned a pseudonym immediately on completion of your interview. During my analysis and writing of the research report, your name and that of your employers will not be included on raw data, draft documents and final versions. While we may use quotes from your interview they will not be attributed to you. Only the principal investigator will have access to the raw data and pseudonyms.

Ethics Application Form:

Student Research

All research activity conducted under the auspices of the Institute by staff, students or visitors, where the research involves human participants or the use of data collected from human participants are required to gain ethical approval before starting. *This includes preliminary and pilot studies.* Please answer all relevant questions responses in terms that can be understood by a lay person and note your form may be returned if incomplete.

For further support and guidance please see accompanying guidelines and the Ethics Review Procedures for Student Research http://www.ioe.ac.uk/studentethics/ or contact your supervisor or researchethics@ioe.ac.uk.

Before completing this form you will need to discuss your proposal fully with your Supervisor/s.

Please attach all supporting documents and letters.

For all Psychology students, this form should be completed with reference to the British Psychological Society (BPS) Code of Human Research Ethics and Code of Ethics and Conduct.

Section 1 Project details

a.	Project title	**A case study analysis of the leadership practices of the advanced nurse practitioner.**
b.	Student name and ID number (e.g. ABC12345678)	Claire Anderson
c.	Supervisor/Personal Tutor	Karen Edge
d.	Department	

		PhD/MPhil	EdD
e.	Course category (Tick one)	PhD/MPhil ☐	EdD ☒
		MRes ☐	DEdPsy ☐

		MTeach ☐	MA/MSc ☐
		ITE ☐	
		Diploma (state which) ☐	
		Other (state which) ☐	
f.	Course/module title	Thesis	
g.	**If applicable,** state who the funder is and if funding has been confirmed.		
h.	Intended research start date	November 2014	
i.	Intended research end date	November 2015	
j.	Country fieldwork will be conducted in *If research to be conducted abroad please check www.fco.gov.uk and submit a completed travel risk assessment form (see guidelines). If the FCO advice is against travel this will be **required** before ethical approval can be granted: http://ioe-net.inst.ioe.ac.uk/about/profservices/international/Pages/default.aspx*	United Kingdom	

k.	Has this project been considered by another (external) Research Ethics Committee?	
	Yes ☐	External Committee Name:
	No ☒ ⇨ *go to Section 2*	Date of Approval:

If yes:
 − Submit a copy of the approval letter with this application.
 − Proceed to Section 10 Attachments**.**

Note: Ensure that you check the guidelines carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES) or Social Care Research Ethics Committee (SCREC). In addition, if your research is based in another institution then you may be required to apply to their research ethics committee.

Section 2 Project summary

Research methods (tick all that apply)

Please attach questionnaires, visual methods and schedules for interviews (even in draft form).

☒ Interviews ☐ Focus groups ☐ Questionnaires ☐ Action research ☒ Observation ☐ Literature review	☐ Controlled trial/other intervention study ☐ Use of personal records ☐ Systematic review ⇨ *if only method used go to Section 5.* ☐ Secondary data analysis ⇨ *if secondary analysis used go to Section 6.* ☐ Advisory/consultation/collaborative groups ☐ Other, give details:

Please provide an overview of your research.

<u>Research Purpose and aims</u>

This study focuses on how the a small sample of the ANP's practicing in London define and enact leadership within their professional practice leadership and their perception of the interpersonal and organisational opportunities and challenges in relation to their own leadership. In order to gather robust evidence, this study will not only generate interview data but additionally data generated through observation of ANP leadership practice.

The purpose of the case study undertaken within this research project is to develop a better understanding of how a small sample of ANP's practice leadership. This will be achieved through exploration, employing semi-structured interviews and observing ANP's in practice.

<u>The research questions</u>

How does the ANP understand and interpret the leadership component of their role?

How does the ANP enact the leadership aspect of their role?

What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?

What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?

What personal, interpersonal and organisational and professional support does the ANP need to be able to enact leadership?

Research Design

A case study is a research approach that has been described as having a purpose, approach and a process (Thomas 2011). Specifically the case study approach has been defined as an exploration of a phenomenon within the context in which it exists (Yin 2009). This acknowledges the influence of culture on the views and beliefs of an ANP and that they cannot be seen separately from this. The process of this case study is multiple, that is while each case is an example, the object and focus of the case study is the ANP's leadership practices.

Sampling

In order to qualify for potential selection to participate in the study, participants must have completed a Royal College of Nursing (RCN) accredited ANP educational programme. As the interpretation of the role of the ANP can differ between organisations and between different areas of the United Kingdom and to create a geographical boundary for the case, the ANP's must work in either Central or Greater London. There will be no minimum to the years the ANP's have been in practice but they will be employed in a London NHS Trust. In order to reflect the demographic patterns of the ANP population the sampling approach will work to ensure representative numbers from both genders. However all participation will be voluntary and therefore if only female ANP's volunteer male ANP's participants will not be purposively sought.

Data Collection

The interview is the first stage of data collection interview questions will be derived from a previous study exploring the views of Children's Advanced Nurse Practitioner students on leadership and followership (Anderson 2013), and the current review of the literature, and will include questions including:

What do you think influences your ability to lead the multi-professional team?

How would you describe your leadership style?

The second stage is an observational study of the ANP carrying out their clinical role and it is anticipated that this will be facilitated by an established relationship to encourage a true reflection of their leadership practice.

The two approaches of collecting data therefore although different have inter-dependency; the interview will reveal data that is a reconstruction to the real-life experiences of the participants (Ritchie and Lewis 2003). While the observation of participants actively leading in their ANP roles is a

real-life approach collecting data that often reflects the in-articulated or unspoken data (Mason 2002). It is argued that observation has the function of validation of the data generated from the interviews (Robson 2002).

Data Analysis

In order to organise the data so that it either answers or refutes the research questions of this study a process of pattern recognition of emergent codes and themes will be undertaken. Each set of data from each of the ANP's interviews and observations will be reviewed to identify codes or themes. This research study is however a multiple case study where the focus is on the phenomena of leadership practices of ANP's and each ANP is an example (Thomas 2011). Therefore the analysis of the data will begin by pattern recognition within each case but then augmented or disputed by each subsequent case (Yin 2009). Of equal importance is the generation or 'rival explanation' (Yin 2009 p135) where alternative explanations are offered. For example in this study there is a risk that the ANP's behaviour during the observation or their responses during the interview will be altered by the presence of the researcher or the process of the research.

Reporting, dissemination and use of findings

This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences.

Section 3 Participants

Please answer the following questions giving full details where necessary. Text boxes will expand for your responses.

a.	Will your research involve human participants?	Yes ☒	No ☐ ⇨ *go to Section 4*

b.	Who are the participants (i.e. what sorts of people will be involved)? Tick all that apply.

☐ Early years/pre-school	☐ Unknown – specify below
☐ Ages 5-11	☒ Adults *please specify below*
☐ Ages 12-16	☐ Other – specify below
☐ Young people aged 17-18	

NB: Ensure that you check the **guidelines** (Section 1) carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES).

	In accordance with accepted research governance approval from Research and Development at each ANP's employing Trust will be sought although it is accepted that there may be variation among Trusts, with some allowing the observation to continue unhindered and others requiring higher levels of approval such as National Research Ethics Service. If the individual Trust include this as a requirement NRES approval will be sought in addition to Ethical Approval from Institute of Education prior to conducting any part of the study.
c.	If participants are under the responsibility of others (such as parents, teachers or medical staff) how do you intend to obtain permission to approach the participants to take part in the study? **(Please attach approach letters or details of permission procedures – see Section 9 Attachments.)**
d.	How will participants be recruited (identified and approached)? The participants will be ANP's who have undergone an RCN accredited ANP educational programme. They will not be approached directly but the RCN Advanced Nurse Practitioner Educator Group will act as their gatekeeper and will be asked to approach potential participants. The sampling approach will be purposive in recruiting ANP participants. In each case, the methods employed to gather the data will be a replication of the previous. As this is a preliminary study of the leadership practices of ANP's, eight individual ANP's from NHS employers in London will be selected to participate in the study (Thomas 2011). If fewer than eight participants volunteer it may be necessary to increase the geographical boundary and include ANP's from outside of London. The value of collecting sufficient data will be considered against the potential that ANP's working outside of London practice differently than those who work in London. If more than eight participants volunteer to larger numbers of participants will be considered.
e.	Describe the process you will use to inform participants about what you are doing. The potential participant will be sent a participant information sheet a minimum of one week prior to the interview stage of data collection – please see attached as appendix 1
f.	How will you obtain the consent of participants? Will this be written? How will it be made clear to participants that they may withdraw consent to participate at any time? *See the guidelines for information on opt-in and opt-out procedures. Please note that the*

method of consent should be appropriate to the research and fully explained.

At the same time as they are sent the participant information sheet all participants will be sent a consent form. They will review and sign a consent form (Appendix 2) immediately prior to undertaking the interview. This consent will be to participate in both parts of the study, the interview and the observation but participants will have the option of withdrawing consent at any point up and including when they review the initial generated themes. This will also allow participants to undertake the interview stage of data collection and withdraw without undertaking the observational stage of data collection.

g.	**Studies involving questionnaires:** Will participants be given the option of omitting questions they do not wish to answer? Yes ☐ No ☐
	If **NO** please explain why below and ensure that you cover any ethical issues arising from this in section 8.
h.	**Studies involving observation:** Confirm whether participants will be asked for their informed consent to be observed. Yes ☒ No ☐
	If **NO** read the guidelines (Ethical Issues section) and explain why below and ensure that you cover any ethical issues arising from this in section 8.
i.	Might participants experience anxiety, discomfort or embarrassment as a result of your study? Yes ☒ No ☐
	If **yes** what steps will you take to explain and minimise this? Participants will be informed about the purpose of the study and will have the opportunity to withdraw from the study at any point up until they review initial themes. All principles of ethical research have been considered including not asking participants to undertake anything that you would not undertake ourselves (https://www.bera.ac.uk/wp-content/uploads/2014/02/BERA-Ethical-Guidelines-2011.pdf last accessed 9th October 2014) If **not**, explain how you can be sure that no discomfort or embarrassment will arise?
j.	Will your project involve deliberately misleading participants (deception) in any way? Yes ☐ No ☒

	If **YES** please provide further details below and ensure that you cover any ethical issues arising from this in section 8.	
k.	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)? Yes ⊠ No ☐	
	If **NO** please explain why below and ensure that you cover any ethical issues arising from this in section 8.	
l.	Will participants be given information about the findings of your study? (This could be a brief summary of your findings in general; it is not the same as an individual debriefing.) Yes ⊠ No ☐	
	If **no**, why not?	

Section 4 Security-sensitive material

Only complete if applicable

Security sensitive research includes: commissioned by the military; commissioned under an EU security call;   involves the acquisition of security clearances; concerns terrorist or extreme groups.

a.	Will your project consider or encounter security-sensitive material?	Yes ☐ *	No ⊠
b.	Will you be visiting websites associated with extreme or terrorist organisations?	Yes ☐ *	No ⊠
c.	Will you be storing or transmitting any materials that could be interpreted as promoting or endorsing terrorist acts?	Yes ☐ *	No ⊠

*** Give further details in *Section 8 Ethical Issues***

Section 5 Systematic review of research

a.	Will you be collecting any new data from participants?	Yes ☐ *	No ☐
b.	Will you be analysing any secondary data?	Yes ☐ *	No ☐

* *Give further details in* ***Section 8 Ethical Issues***

If your methods do not involve engagement with participants (e.g. systematic review, literature review) ***and*** *if you have answered* ***No*** *to both questions, please go to* ***Section 10 Attachments.***

Section 6 Secondary data analysis Complete for all secondary analysis

a.	Name of dataset/s			
b.	Owner of dataset/s			
c.	Are the data in the public domain?	Yes ☐ No ☐ *If no, do you have the owner's permission/license?* Yes ☐ No* ☐		
d.	Are the data anonymised?	Yes ☐ No ☐		
		Do you plan to anonymise the data?	Yes ☒	No* ☐
		Do you plan to use individual level data?	Yes* ☐	No ☒
		Will you be linking data to individuals?	Yes* ☐	No ☒
e.	Are the data sensitive ([DPA 1998 definition](#))?		Yes* ☐	No ☒
f.	Will you be conducting analysis within the remit it was originally collected for?		Yes ☒	No* ☐
g.	**If no,** was consent gained from participants for subsequent/future analysis?		Yes ☒	No* ☐
h.	**If no,** was data collected prior to ethics approval process?		Yes ☐	No* ☒

* *Give further details in* ***Section 8 Ethical Issues***

If secondary analysis is only method used ***and*** *no answers with asterisks are ticked, go to* ***Section 9 Attachments.***

Section 7 Data Storage and Security

a.	Confirm that all personal data will be stored and processed in compliance with the Data Protection Act 1998 (DPA 1998). *(See the Guidelines and the Institute's Data Protection & Records Management Policy for more detail.)*	Yes ⊠

b.	Will personal data be processed or be sent outside the European Economic Area?	Yes ☐ *	No ⊠

*** If yes,** please confirm that there are adequate levels of protections in compliance with the DPA 1998 and state wh these arrangements are below.

c.	Who will have access to the data and personal information, including advisory/consultation groups and during transcription? The research team will have access to this data but it will be stored under a pseudonym, that is no personal information will be accessible to anyone other than the principal investigator.

During the research

d.	Where will the data be stored? On a password protected computer file

e.	Will mobile devices such as USB storage and laptops be used? Yes ⊠ * No ☐ *** If yes,** state what mobile devices: audio recording device *** If yes,** will they be encrypted?: Yes

After the research

f.	Where will the data be stored? In a password protected computer file

g.	How long will the data and records by kept for and in what format? Two calendar years following completion o the research study

h.	Will data be archived for use by other researchers? Yes ☐ * No ⊠ ***If yes,** please provide details.

Section 8 Ethical issues

Are there particular features of the proposed work which may raise ethical concerns or add to the complexity of ethical decision making? If so, please outline how you will deal with these.

It is important that you demonstrate your awareness of potential risks or harm that may arise as a result of your research. You should then demonstrate that you have considered ways to minimise

the likelihood and impact of each potential harm that you have identified. Please be as specific as possible in describing the ethical issues you will have to address. Please consider / address ALL issues that may apply.

Ethical concerns may include, but not be limited to, the following areas:

− Methods − Sampling − Recruitment − Gatekeepers − Informed consent − Potentially vulnerable participants − Safeguarding/child protection − Sensitive topics	− International research − Risks to participants and/or researchers − Confidentiality/Anonymity − Disclosures/limits to confidentiality − Data storage and security both during and after the research (including transfer, sharing, encryption, protection) − Reporting − Dissemination and use of findings

Recruitment, gatekeepers and sampling

The participants will be ANP's who have undergone an RCN accredited ANP educational programme. They will not be approached directly but the RCN Advanced Nurse Practitioner Educator Group will act as their gatekeeper and will be asked to approach potential participants.

Informed Consent

The participant will have been sent a participant information sheet and consent form a minimum of one week prior to their interview. The consent form will be reviewed and signed immediately prior to the interview commencing.

Methods, anonymity, confidentiality and limitations to confidentiality

There are two methods employed to collect data in this research study. The interview where the participant will be audio recorded. The recording will be transcribed and all data generated will be assigned a pseudonym. The observation will be of the participant but it will also directly and indirectly involve other members of the multi-professional team. All team members will be identified prior to the observation and emailed details of the process. In addition a sign outlining the research study will be placed in the area where the observation is taking place allowing individuals and this will include patients and non-clinical staff, the option to avoid the area or state they do not wish to be included.

Data storage

All audio recordings will be stored on a password protected audio file. All transcripts, written

observational data and field notes will be stored in a locked cabinet and access to this data will only be available to the principal researcher. Details of allocation of pseudonyms and how this process occurred will be stored separately from any data collected

Reporting, dissemination and use of findings

This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences.

Section 9 Further information

Outline any other information you feel relevant to this submission, using a separate sheet or attachments if necessary.

Section 10 Attachments Please attach the following items to this form, or explain if not attached

a.	Information sheets and other materials to be used to inform potential participants about the research, including approach letters	Yes ☒	No ☐
b.	Consent form	Yes ☒	No ☐
	If applicable:		
c.	The proposal for the project	Yes ☒	No ☐
d.	Approval letter from external Research Ethics Committee	Yes ☐	No ☐
e.	Full risk assessment	Yes ☐	No ☐

Section 11 Declaration

	Yes	No
I have read, understood and will abide by the following set of guidelines.	☒	☐

BPS ☐   BERA ☒   BSA ☐ Other (please state) ☐

	Yes	No
I have discussed the ethical issues relating to my research with my supervisor.	☒	☐
I have attended the appropriate ethics training provided by my course.	☒	☐

I confirm that to the best of my knowledge:

The above information is correct and that this is a full description of the ethics issues that may arise in the course of this project.

Name	Claire Anderson
Date	9th November 2014

Please submit your completed ethics forms to your supervisor.

Notes and references

Revised Ethics Application Form:

Student Research

All research activity conducted under the auspices of the Institute by staff, students or visitors, where the research involves human participants or the use of data collected from human participants are required to gain ethical approval before starting. *This includes preliminary and pilot studies.* Please answer all relevant questions responses in terms that can be understood by a lay person and note your form may be returned if incomplete.

For further support and guidance please see accompanying guidelines and the Ethics Review Procedures for Student Research http://www.ioe.ac.uk/studentethics/ or contact your supervisor or researchethics@ioe.ac.uk.

Before completing this form you will need to discuss your proposal fully with your Supervisor/s.

Please attach all supporting documents and letters.

For all Psychology students, this form should be completed with reference to the British Psychological Society (BPS) Code of Human Research Ethics and Code of Ethics and Conduct.

Section 1 Project details

a.	Project title	**A case study analysis of the leadership practices of the advanced nurse practitioner.**
b.	Student name and ID number (e.g. ABC12345678)	Claire Anderson
c.	Supervisor/Personal Tutor	Karen Edge
d.	Department	
e.	Course category	PhD/MPhil ☐ EdD ☒

(Tick one)	MRes ☐	DEdPsy ☐
	MTeach ☐	MA/MSc ☐
	ITE ☐	
	Diploma (state which) ☐	
	Other (state which) ☐	

f.	Course/module title	Thesis
g.	**If applicable,** state who the funder is and if funding has been confirmed.	
h.	Intended research start date	November 2014
i.	Intended research end date	November 2015
j.	Country fieldwork will be conducted in *If research to be conducted abroad please check www.fco.gov.uk and submit a completed travel risk assessment form (see guidelines). If the FCO advice is against travel this will be **required** before ethical approval can be granted: http://ioe-net.inst.ioe.ac.uk/about/profservices/international/Pages/default.aspx*	United Kingdom

k.	Has this project been considered by another (external) Research Ethics Committee?	
	Yes ☐	External Committee Name:
	No ☒ ⇨ *go to Section 2*	Date of Approval:

If yes:
- − Submit a copy of the approval letter with this application.
- − Proceed to Section 10 Attachments**.**

Note: Ensure that you check the guidelines carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES) or Social Care Research Ethics Committee (SCREC). In addition, if your research is based in another institution then you may be required to apply to their research ethics committee.

Section 2 Project summary

Research methods (tick all that apply)

Please attach questionnaires, visual methods and schedules for interviews (even in draft form).

☒ Interviews
☐ Focus groups
☐ Questionnaires
☐ Action research
☐ Observation
☐ Literature review

☐ Controlled trial/other intervention study
☐ Use of personal records
☐ Systematic review ⇨ *if only method used go to Section 5.*
☐ Secondary data analysis ⇨ *if secondary analysis used go to Section 6.*
☐ Advisory/consultation/collaborative groups
☐ Other, give details:

Please provide an overview of your research.

Research Purpose and aims

This study focuses on how the a small sample of the ANP's practicing in London define and enact leadership within their professional practice leadership and their perception of the interpersonal and organisational opportunities and challenges in relation to their own leadership. In order to gather robust evidence, this study will generate interview data The purpose of the case study undertaken within this research project is to develop a better understanding of how a small sample of ANP's practice leadership. This will be achieved through exploration, employing semi-structured interviews

The research questions

How does the ANP understand and interpret the leadership component of their role?

How does the ANP enact the leadership aspect of their role?

What are the personal, interpersonal and organisational factors that inhibit the ANP in their leadership practice?

What are the personal, interpersonal and organisational factors that enable the ANP in their leadership practice?

What personal, interpersonal and organisational and professional support does the ANP need to be

able to enact leadership?

Research Design

A case study is a research approach that has been described as having a purpose, approach and a process (Thomas 2011). Specifically the case study approach has been defined as an exploration of a phenomenon within the context in which it exists (Yin 2009). This acknowledges the influence of culture on the views and beliefs of an ANP and that they cannot be seen separately from this. The process of this case study is multiple, that is while each case is an example, the object and focus of the case study is the ANP's leadership practices.

Sampling

In order to qualify for potential selection to participate in the study, participants must have completed a Royal College of Nursing (RCN) accredited ANP educational programme. As the interpretation of the role of the ANP can differ between organisations and between different areas of the United Kingdom and to create a geographical boundary for the case, the ANP's must work in either Central or Greater London. There will be no minimum to the years the ANP's have been in practice but they will be employed in a London NHS Trust. In order to reflect the demographic patterns of the ANP population the sampling approach will work to ensure representative numbers from both genders. However all participation will be voluntary and therefore if only female ANP's volunteer male ANP's participants will not be purposively sought.

Data Collection

The interview is the first stage of data collection interview questions will be derived from a previous study exploring the views of Children's Advanced Nurse Practitioner students on leadership and followership (Anderson 2013), and the current review of the literature, and will include questions including:

What do you think influences your ability to lead the multi-professional team?

How would you describe your leadership style?

Data Analysis

In order to organise the data so that it either answers or refutes the research questions of this study a process of pattern recognition of emergent codes and themes will be undertaken. Each set of data from each of the ANP's interviews will be reviewed to identify codes or themes. This research study

is however a multiple case study where the focus is on the phenomena of leadership practices of ANP's and each ANP is an example (Thomas 2011). Therefore the analysis of the data will begin by pattern recognition within each case but then augmented or disputed by each subsequent case (Yin 2009). Of equal importance is the generation or 'rival explanation' (Yin 2009 p135) where alternative explanations are offered. For example in this study there is a risk that the ANP's responses during the interview will be altered by the presence of the researcher or the process of the research.

<u>Reporting, dissemination and use of findings</u>

This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences.

Section 3 Participants

Please answer the following questions giving full details where necessary. Text boxes will expand for your responses.

a.	Will your research involve human participants?	Yes ☒	No ☐ ⇨ *go to Section 4*

b. Who are the participants (i.e. what sorts of people will be involved)? Tick all that apply.

☐ Early years/pre-school	☐ Unknown – specify below
☐ Ages 5-11	☒ Adults *please specify below*
☐ Ages 12-16	☐ Other – specify below
☐ Young people aged 17-18	

NB: Ensure that you check the **guidelines** (Section 1) carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES).

c. If participants are under the responsibility of others (such as parents, teachers or medical staff) how do you intend to obtain permission to approach the participants to take part in the study?

(Please attach approach letters or details of permission procedures – see Section 9 Attachments.)

d.	How will participants be recruited (identified and approached)?
	The participants will be ANP's who have undergone an RCN accredited ANP educational programme. They will not be approached directly but the RCN Advanced Nurse Practitioner Educator Group and or the RCN lead for Professional Learning and Development who will act as their gatekeeper and will be asked to approach potential participants.
	The sampling approach will be purposive in recruiting ANP participants. In each case, the methods employed to gather the data will be a replication of the previous. As this is a preliminary study of the leadership practices of ANP's, eight individual ANP's from NHS employers in London will be selected to participate in the study (Thomas 2011). If fewer than eight participants volunteer it may be necessary to increase the geographical boundary and include ANP's from outside of London. The value of collecting sufficient data will be considered against the potential that ANP's working outside of London practice differently than those who work in London. If more than eight participants volunteer to larger numbers of participants will be considered.
e.	Describe the process you will use to inform participants about what you are doing.
	The potential participant will be sent a participant information sheet a minimum of one week prior to the interview stage of data collection – please see attached as appendix 1
f.	How will you obtain the consent of participants? Will this be written? How will it be made clear to participants that they may withdraw consent to participate at any time?
	See the guidelines for information on opt-in and opt-out procedures. Please note that the method of consent should be appropriate to the research and fully explained.
	At the same time as they are sent the participant information sheet all participants will be sent a consent form. They will review and sign a consent form (Appendix 2) immediately prior to undertaking the interview.
g.	**Studies involving questionnaires:** Will participants be given the option of omitting questions they do not wish to answer?
	Yes ☐ No ☐
	If **NO** please explain why below and ensure that you cover any ethical issues arising from this in section 8.

h.	**Studies involving observation:** Confirm whether participants will be asked for their informed consent to be observed. Yes ☒ No ☐
	If **NO** read the guidelines (Ethical Issues section) and explain why below and ensure that you cover any ethical issues arising from this in section 8.
i.	Might participants experience anxiety, discomfort or embarrassment as a result of your study? Yes ☒ No ☐
	If **yes** what steps will you take to explain and minimise this? Participants will be informed about the purpose of the study and will have the opportunity to withdraw from the study at any point up until they review initial themes. All principles of ethical research have been considered including not asking participants to undertake anything that you would not undertake ourselves (https://www.bera.ac.uk/wp-content/uploads/2014/02/BERA-Ethical-Guidelines-2011.pdf last accessed 9th October 2014) If **not**, explain how you can be sure that no discomfort or embarrassment will arise?
j.	Will your project involve deliberately misleading participants (deception) in any way? Yes ☐ No ☒
	If **YES** please provide further details below and ensure that you cover any ethical issues arising from this in section 8.
k.	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)? Yes ☒ No ☐
	If **NO** please explain why below and ensure that you cover any ethical issues arising from this in section 8.
l.	Will participants be given information about the findings of your study? (This could be a brief summary of your findings in general; it is not the same as an individual debriefing.)

Yes ☒ No ☐

If **no**, why not?

Section 4 Security-sensitive material

Only complete if applicable

Security sensitive research includes: commissioned by the military; commissioned under an EU security call; involves the acquisition of security clearances; concerns terrorist or extreme groups.

a.	Will your project consider or encounter security-sensitive material?	Yes ☐ *	No ☒
b.	Will you be visiting websites associated with extreme or terrorist organisations?	Yes ☐ *	No ☒
c.	Will you be storing or transmitting any materials that could be interpreted as promoting or endorsing terrorist acts?	Yes ☐ *	No ☒

*** Give further details in *Section 8 Ethical Issues***

Section 5 Systematic review of research

Only complete if applicable

c.	Will you be collecting any new data from participants?	Yes ☐ *	No ☐
d.	Will you be analysing any secondary data?	Yes ☐ *	No ☐

*** Give further details in *Section 8 Ethical Issues***

*If your methods do not involve engagement with participants (e.g. systematic review, literature review) **and** if you have answered **No** to both questions, please go to **Section 10 Attachments.***

Section 6 Secondary data analysis Complete for all secondary analysis

a.	Name of dataset/s	
b.	Owner of dataset/s	
c.	Are the data in the public domain?	Yes ☐ No ☐ *If no,* do you have the owner's permission/license? Yes ☐ No* ☐

d.	Are the data anonymised?	Yes ☐ No ☐			
		Do you plan to anonymise the data?	Yes ☒	No* ☐	
		Do you plan to use individual level data?	Yes* ☐	No ☒	
		Will you be linking data to individuals?	Yes* ☐	No ☒	
e.	Are the data sensitive ([DPA 1998 definition](#))?		Yes* ☐	No ☒	
f.	Will you be conducting analysis within the remit it was originally collected for?		Yes ☒	No* ☐	
g.	**If no,** was consent gained from participants for subsequent/future analysis?		Yes ☒	No* ☐	
h.	**If no,** was data collected prior to ethics approval process?		Yes ☐	No* ☒	

***** *Give further details in* **Section 8 Ethical Issues**

If secondary analysis is only method used **and** *no answers with asterisks are ticked, go to* **Section 9 Attachments.**

Section 7 Data Storage and Security

Please ensure that you include all hard and electronic data when completing this section.

a.	Confirm that all personal data will be stored and processed in compliance with the Data Protection Act 1998 (DPA 1998). *(See the Guidelines and the Institute's Data Protection & Records Management Policy for more detail.)*	Yes ☒
b.	Will personal data be processed or be sent outside the European Economic Area?	Yes ☐ * No ☒

***** **If yes,** please confirm that there are adequate levels of protections in compliance with the DPA 1998 and state wh these arrangements are below.

c.	Who will have access to the data and personal information, including advisory/consultation groups and during transcription? The research team will have access to this data but it will be stored under a pseudonym, that is no	

personal information will be accessible to anyone other than the principal investigator.

During the research

d. Where will the data be stored? On a password protected computer file

e. Will mobile devices such as USB storage and laptops be used?   Yes ⊠ * No ☐

If yes, state what mobile devices: audio recording device

If yes, will they be encrypted?: Yes

After the research

f. Where will the data be stored? In a password protected computer file

g. How long will the data and records by kept for and in what format? Two calendar years following completion of the research study

h. Will data be archived for use by other researchers?   Yes ☐ * No ⊠

If yes, please provide details.

Section 8 Ethical issues

Are there particular features of the proposed work which may raise ethical concerns or add to the complexity of ethical decision making? If so, please outline how you will deal with these.

It is important that you demonstrate your awareness of potential risks or harm that may arise as a result of your research. You should then demonstrate that you have considered ways to minimise the likelihood and impact of each potential harm that you have identified. Please be as specific as possible in describing the ethical issues you will have to address. Please consider / address ALL issues that may apply.

Ethical concerns may include, but not be limited to, the following areas:

- Methods
- Sampling
- Recruitment
- Gatekeepers
- Informed consent
- Potentially vulnerable participants
- Safeguarding/child protection
- Sensitive topics

- International research
- Risks to participants and/or researchers
- Confidentiality/Anonymity
- Disclosures/limits to confidentiality
- Data storage and security both during and after the research (including transfer, sharing, encryption, protection)
- Reporting
- Dissemination and use of findings

Recruitment, gatekeepers and sampling

The participants will be ANP's who have undergone an RCN accredited ANP educational programme. They will not be approached directly but the RCN Advanced Nurse Practitioner Educator Group or the RCN lead for Professional Learning and Development will act as their gatekeeper and will be asked to approach potential participants.

Informed Consent

The participant will have been sent a participant information sheet and consent form a minimum of one week prior to their interview. The consent form will be reviewed and signed immediately prior to the interview commencing.

Methods, anonymity, confidentiality and limitations to confidentiality

There are two methods employed to collect data in this research study. The interview where the participant will be audio recorded. The recording will be transcribed and all data generated will be assigned a pseudonym.

Data storage

All audio recordings will be stored on a password protected audio file. All transcripts will be stored in a locked cabinet and access to this data will only be available to the principal researcher. Details of allocation of pseudonyms and how this process occurred will be stored separately from any data collected

Reporting, dissemination and use of findings

This study is in partial completion of a Doctorate in Education and following achieving this award the findings will be submitted to a range of peer reviewed journals and presented at conferences.

Section 9 Further information

Outline any other information you feel relevant to this submission, using a separate sheet or attachments if necessary.

Section 10 Attachments Please attach the following items to this form, or explain if not attached

f.	Information sheets and other materials to be used to inform potential participants about the research, including approach letters	Yes ☒	No ☐
g.	Consent form	Yes ☒	No ☐
	If applicable:		
h.	The proposal for the project	Yes ☒	No ☐
i.	Approval letter from external Research Ethics Committee	Yes ☐	No ☐
j.	Full risk assessment	Yes ☐	No ☐

Section 11 Declaration

	Yes	**No**
I have read, understood and will abide by the following set of guidelines.	☒	☐

BPS ☐	BERA ☒	BSA ☐ Other (please state) ☐

I have discussed the ethical issues relating to my research with my supervisor.	☒	☐
I have attended the appropriate ethics training provided by my course.	☒	☐

I confirm that to the best of my knowledge:

The above information is correct and that this is a full description of the ethics issues that may arise in the course of this project.

Name	Claire Anderson
Date	15th March 2015

Please submit your completed ethics forms to your supervisor.

Notes and references

Appendix 8: Descriptive synthesis of studies

Date	Authors	Country	Main subject	Methods	Results	Limitations
2009	Aduddell et al.	USA	Development of next nurse leaders	Focus surveys	Nurses did not understand the political and financial aspects of leadership	
2001	Alimo-Metcalfe and Lawler	UK	Leadership development outside of the NHS and how it can be applied to the NHS	Postal questionnaires.	Leadership is a 'nebulous concept' p387. Leadership develop can have a negative effect if it 'increases 'cynicism towards the organisation' p402	
2011	Barrow et al.	New Zealand	Early career doctors and nurses as leaders and followers	Semi-structured interviews with follow up questionnaires	Nurses are seen feminine 'carers' and doctors as masculine 'curers' p19. Nurses used 'capillary power' p22. 94% nurses felt that they needed to be a leader while only 55% of doctors felt that nurses needed to be leaders	
2014	Bell et al.	USA	The impact of gender on career progression and inter-professional collaboration	Historical perspective	The ANP by taking on the tasks usually undertaken by doctors they were challenging medical dominance p99. Nursing and social work as professions are feminised as associated with caring while the medical profession being associated with leadership is seen as more masculine	

Date	Authors	Country	Main subject	Methods	Results	Limitations
2012	Bess Griffith	USA	The need to succession plan as there is a risk of nursing shortages particularly nurse leaders and those that are doctorally prepared	International systematic review of literature	Links to nurse leaders and quality of care – not always supported with data Shortage of nurses means reduced quality and reduced nurses with qualification to take on leadership roles – leading to promotion of nurses underprepared for leadership Expert clinicians do not necessarily have the potential to become capable leaders p905	
2010	Brady-Germain and Cummings	Canada	Impact of nurse leadership on nurse performance	Systematic literature review	Nurses prefer leaders who are 'employee-orientated' p434	No studies in non-English speaking countries were included
2014	Brooks and Crawford	USA	Leadership education	Opinion piece	Aging nursing leadership population 81% over 45 years old. 'only 13% of nurses identified themselves as leaders' p669 Describes the potential development of MBA type course	

Date	Authors	Country	Main subject	Methods	Results	Limitations
2011	Brook and Rushforth	UK	The risks of NP's unregulated quasi medical practice Nursing and therefore ANP hard to define Advanced practice is a set of attributes which may be ascribed to any profession p996		The title of NP goes with the post – not the academic award 'the inexperienced are not always aware of what they do not know' Dimond 1995 p65 Professional recognition =status; regulation – protection of the public As there have been no adverse events unlikely to regulate ?ANP's/NP's being over cautious when practicing at the boundaries	
2004	Bryant-Lukosius et al.	Canada	Misuse of APN terminology and differing educational preparation for advanced practice roles	Discussion paper	Advanced Nurse Practitioners as physician replacements. Defining how the APN differs from other nursing roles	
2011 (data collected 2009)	Cameron et al.	Scotland	Community focus Leadership characteristics – credibility, communicating well, goal setting, supporting and promoting team work Quasi family – metaphor of parent- child relationship with leader	Descriptive semi-structured interviews and focus groups Four case studies – two district and two public health groups 54 participants – 17 interviews and six focus groups Framework analysis – a priori: emergent: analytical themes Indexed by two researchers	Band 2 staff reporting considerable autonomy Band 5 did not see themselves as leaders Supporting and people skills seen as important Lack of time and resources inhibit leadership Differences related to grade rather than context	? value of band 2 non-nurses views on leadership

Date	Authors	Country	Main subject	Methods	Results	Limitations
2006	Collinson	UK	Followership		Social identity of leadership, leaders are considered prototypical of the group p180. Position based followers – safety or identity p183	
2014	Constance and Milton	USA	Stewardship and leadership – maintains a unique body of knowledge to nursing	Opinion piece	Stewardship and leadership – maintains a unique body of knowledge to nursing	
2011	Cowden et al.	Canada	Leadership practices and staff nurses intention to stay Shortage of nurses along with increased life expectancy and prevalence of chronic disease leading to inadequate staffing rations undesirable working conditions and lack of nurse autonomy	Systematic review Published English research articles – 23 reviewed all but one were quantitative studies and 19 in Canada or USA	Positive relationship between transformational leadership and staff nurses intention to stay Autocratic leadership had a negative relationship Management by exception – leader actively looks for errors and takes corrective action when errors occur Empowerment, control over practice and shared decision making positive correlation to intention to stay Two approaches to nurse leadership – those that focused on tasks or those that focused on relationships	The studies did not randomly sample or follow up outliers

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Date	Authors	Country	Main subject	Methods	Results	Limitations
2015	Croft at al	UK	Emotional attachment to social and professional group identity	32 nurse managers undergoing a leadership programme were interviewed and observed	Alignment with the identity of nurses which is normal both a subordinate and female gender and so not normally a leader – those (5) that moved on to a purely management role less reliant on this identity 'nurses a group traditionally viewed as subordinate followers rather than leaders' 'Often experience identify conflict and are seen by other professional to lack influence in their new roles' p 116	How many were approached did all participants of programme were invited but did all take part?
2013	Cummings	Canada		Editorial	Mechanism of action by which nursing leaders influence patient outcomes has been in a 'black box' p707	
1996	Davies	UK	Gender and Professions	Discussion paper	Women in order to attain professional status adopt male characteristics p669.	
2014	East et al.	United Kingdom	Survey of all nurses in one Trust who identified themselves as advanced nurses	Electronic survey 323 (10% of nursing workforce) potential 136 responses (42%)	Variation in preparation – only 17% or responses had a Masters degree. Only 3% of nurses time spent on research 3 responses stated they had no training or development needs – 1 because they were about to retire and another as their role was too specialist	Included CNS (68% of responses) in umbrella of advanced nurses – one employed as a band 5 without a degree

Date	Authors	Country	Main subject	Methods	Results	Limitations
					for educational opportunities	Managers identified potential ANP's as Union felt including role title would identify individuals
2003 (data collected 1998 – child study; 2000 adult study)	Engestrom et al.	Finland	Collaborative care collective zones of proximal development Shon reflection in action Negotiated knotworking – no single party to have a dominating position or evade responsibility Co-narrating: making joint decisions: modelling: gaining a voice	Interviews with patient Video of consultations interview with care giver (videoed) Review of medical records and other relevant documents Then two cases reviewed by all MDT - videoed	Re-conceptualising care across professional specialties 'still largely a promise in search of performance' p307 Multi-professional meetings were 'ritualised and formal' p310	Lack of involvement of previous practitioners who had been involved in fragmented care giving
2012	Enterkin et al.	UK	Evaluating a leadership programme for ward leaders	Semi-structured questionnaires	Lack of formal preparation for ward leaders meant they were difficult to recruit – more responsibility with little difference to pay	Action learning sets were challenging for some participants to declare their vulnerability

Date	Authors	Country	Main subject	Methods	Results	Limitations
2009	Evetts	UK	Organizational professional and occupational professional	Discussion paper	Complex professional bureaucracies in hospitals and Universities with professional used to a high degree of autonomy	
2004	Gardner et al.	Australia	Nurse Practitioner Education	Action learning	The nurse practitioner educational requirements were centred on –clinical decision making; assessment and diagnosis; evidence based practice; pharmacology and models of practice	Findings specific to this group and not generalizable. Study dated
2003	Gerrish et al.	UK	Educating nurses at Masters level to create their professional status	18 nurse lecturers from eight UK based Universities were interviewed	Credibility was sought by nurses from both their managers and the medical team p107	Study dated
2013	Giltinane	UK	Leadership styles and theories	Discussion paper	Not only do transactional leaders get the job done they take full accountability in order to leave their followers without the stress of responsibility	
2010	Goodrick and Reay	USA	How the professional role of the nurse has evolved – reflected in the language used in nursing text books	Discourse analysis – reviewing of nursing text books	Professional self is resilient and is associated with the enactment of the professional role p58. 'The new role identity of nursing is not a rejection or contradiction of older identities, but a progeny of it' p74	Differences between US and UK health systems

Date	Authors	Country	Main subject	Methods	Results	Limitations
2014	Goodrick	USA	Transition to nurse educator	On-line survey of a convenience sample of 541 US nurses	Differences between length of time in role and Higher degree	
2014	Günüşen et al.	Turkey	Perception of locus of control and work stress and emotional exhaustion	Questionnaire given to 347 nurses with a 47.5% participation	The less the nurse felt in control combined with work stress led to emotional exhaustion	Only one variable – work stress considered
2015	Halcomb et al.	Australia	Education and leadership – gender influence and structural opposition.	Mixed methods – on-line survey and semi-structured interviews - data collected 2011-2013 – 23 participants	Leadership qualities identified – role model; risk taking; well organised; passionate; approachable; good at negotiating and motivating; team work and acting as a guide – the benefit of applied knowledge	Small number of participants / how many were approached
2013	Hardy et al.	UK	Transformational practice development	Case study material was used as an action orientated practice development	Expectations of the advanced practitioner continue to increase reflecting the complexity of health care	
2009	Hendricks et al.	Australia	Undergraduate leadership education	Pre and post self-assessment questionnaire	Leadership Knowledge; Leadership Skills; Leadership in action	
2014	Higgins et al.	Ireland	Factors influencing the AP's ability to lead	Case study with 23 APs and the multi-professional team working with them	No 'turf wars' between professional groups p899 but APs had no time for leadership activities	
2007	Hurley and Linsley	UK	New leadership models needed in nursing to cope with the complexity in health care	Discussion paper	Nursing work in rigid systems and employ transactional task based leadership. Clinical knowledge empowers nurse leaders. Hierarchy and leadership	Dated paper

Date	Authors	Country	Main subject	Methods	Results	Limitations
2007	Illingworth and Chelvanayagam	UK	Inter-professional education	Discussion paper	'unhelpful protectionism' p122 the team greater than the sum of each individual profession within the team	Dated paper
2014	Kelly et al.	USA	Training and education and leadership practices – need to support during transition from nurse to nurse leader	Survey 512 front-line nurse leaders in 23 hospitals (51% response rate)	'increase in responsibility without increase in authority and lack of leadership education' p159 Three predictors of leadership behaviour – title, training and education	Participants completed the survey during a meeting where researcher was present although had option not to complete. Excluded Chief Nursing Officers
2008	Kennedy.	UK (Wales)	Nurse leadership is not what it was	Commentary	'management is about control, leadership is about change' p944 Leaders feel underprepared and poorly supported	
2014	Keys.	USA	Succession planning for nurse leaders from Generation X who's characteristics include team workers: flexible: not intimidated by authority	Data collected 2011 a replication of a 2005 study. Telephone interviews with 16 nurse managers from organisations across the USA (no more than 2 from one	Lack of opportunity Micro managed Did not realise the enormity of what they were taking on Not influenced by pay The nurse managers appear to have to choose between	Leading questions and also some focus on personal characteristics Study appears to focus

Date	Authors	Country	Main subject	Methods	Results	Limitations
				organisation) – some questions a little leading	work and family and often have to prioritise work	mainly on the barriers which almost contradicts the personal characteristic of Generation X
2011	Laschinger et al.	Canada	Transformational leadership with senior nurses empower middle and first line managers increases quality of care and decreases intent to leave Also uses Kouzes and Posner and cite Kantor (1977, 1993)	Secondary analysis 231 middle managers – 788 front line managers (around 60% response rate)	Senior nurse leadership impacts on middle manager but not front line manager	Secondary analysis - ? dated
2011	MacPhee et al.	Canada	Impact of formal leadership education	27 front line and mid-level nurses were interviewed a year after completing a leadership educational programme	Participants were more confident and adopted transformational leadership styles and initiated change	
2012	McCarthy et al.	Ireland	Team collaboration in mental health	Internal audit Case study	Flexible creative and collaborative leaders create positive relationships across diverse groups	Did not offer anything significant
2012	Neville and Swift	UK (Manchester)	ANP impact on patient outcomes difficult to measure	Critical analysis of the literature	Cost savings can rely on how expensive the ANP is. Impact of ANP in Neonatal transfer team, children's walk in centre, rapid assessment unit	List characteristics of ANP but does not include

Date	Authors	Country	Main subject	Methods	Results	Limitations
					and the management of patients with ENT issues or DVT's	leadership although it is part of their ANP educational programme
2011	Newhouse et al.	USA	Outcomes when Advanced Practice Nurses deliver care	Systematic review	69 studies – 20 RCT and 49 observational studies high level of evidence to support equivalence of outcomes with MDs except for length of time ventilated or length of stay With advanced midwives or CNS's less significant results	Only US studies included as roles and health care differ in USA
2011	Omoike et al.	USA	Most nurse leaders acquire knowledge 'on-the job' p323 Developing a programme 40% on-line and 60% face to face	43 participants (37 completed) in 2 cohorts from 3 hospitals leadership survey pre and post programme- identified which skills or activities participants felt they were more competent at or which they felt were more important	Participants rated themselves more competent in 11 out of 12 categories most important those activities they were directly involved with – suggests that participants are not given the opportunity to practice outside of their sphere although this could be their preference to remain within a practice area they feel confident.	Data collected until 2005 although not published until 2011

Date	Authors	Country	Main subject	Methods	Results	Limitations
2008	O'Brien et al.	USA	Collaboration between nurses and doctors.	Semi structured interviews with five physicians and eight APN's	Doctors seemed unsure as to what the ANP could do p139. Differing approaches to handing over patients and time management. APN's continued to undertake nursing tasks.	Differences between UK and US health care systems and dated paper
2013	O'Neill	USA	Definition of transformational leadership and the importance of emotional intelligence	Opinion piece	Impact on health care of the 'affordable care act' 'highly emotionally intelligent leaders are more likely to advance professionally' p180	
2010	Paterson et al.	Australia	Educating nurses earlier for leadership	Introducing educational programmes for emerging leaders early in their career and developing leaders as they became more experienced	The impact on leadership and positive patient outcomes. 'if nursing leadership is to be effective then such deeply rooted traditions and oppressive leadership modules need to be discarded@ p79	
2011	Patrick et al.	Canada	Structural empowerment enables nurse leadership Challenging the process Inspiring a shared vision Modelling the way Enabling others to act Encouraging the heart – (Kouzes and Posner 1987) Effective leaders ensure that team members have access to whatever resources they	Questionnaire 480 RN's – 46% response rate Nomological network	Positive effect on nurse leadership with structural empowerment No direct effect that is a good nurse manager leader = good RN leader	

Date	Authors	Country	Main subject	Methods	Results	Limitations
			need to get the job done and to participate fully in decisions with the autonomy to act on the decisions they make (p458 Kanter 1977, 1993)			
2012 – accepted 2011	Portoghese et al.	Italy	The role of leadership and communication in relation to change	Non-experimental design with a random sample of 395 nurses Questionnaire given to 703 nurses 437 returned (62%) those incomplete excluded 395 included (states 90% but this is of those returned)	Positive influence on leadership-membership exchange (LMX) and change Organisation is the context of change – employees are the engine of change then leaders are the drivers Mind set in relation to change is either – affective commitment (support the change) – continuance commitment (recognises there are costs associated with failure) and – normative commitment (feels obliged to provide support)	Response rate incorrectly reported
2013	Ross et al.	USA	Transformational leadership – some comment on role of the follower	Survey monkey Professional Nursing Associations nurse leaders 30% (134)of 448	Top 2 transformational leadership practices – enabling others to act and encouraging the heart. With more leadership education they were more likely to challenge the process	Self-assessment with no observation of practice

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Date	Authors	Country	Main subject	Methods	Results	Limitations
2011 (data collected 2009)	Salanova et al.	Portugal	Transformational leadership and how this motivates followers Self-efficacy Social Cognitive Theory	17 supervisors convenience sample (a) 280 nurses (b) questionnaire to two groups a & b Multi-factor leadership questionnaire (Bass and Avolio 1990) Self-efficacy (Bandura 2006)	Transformational leadership style enhances work engagement	Use of self-reports Single site
2012	Shearer and Adams	UK	Evaluating an advanced nursing practice course: student perceptions	Descriptive qualitative/ semi-structured interviews with 14 ANPs	Improved clinical assessment skills Benefits of an educational framework Increased confidence Importance of networking Increased autonomy	Described the ANP nurse as 'nascent' and supported their work with dated references
1986	Spector	USA	Perceived control and job satisfaction	Meta-analysis of 88 studies	'Increased control comes with increased responsibility and often increased workload' p1014 and this is not always a positive experience	Dated study
1988	Spector	USA	Developing a work locus of control scale	Six samples of different workers (numbers ranged from 41 – 496 in each sample and included mental health workers; department store sales assistants; municipal managers	16 items were measured against work locus of control and correlated significantly with many of the items including job satisfaction, commitment and autonomy	Dated study

Date	Authors	Country	Main subject	Methods	Results	Limitations
				and psychology undergraduate students) all given questionnaires		
2014	Stankiewicz et al.	USA	Education and leadership	Electronic survey of Council on Graduate Education for Administration in Nursing 101 participants (55.5% response rate)	Doctorate level nurses are the leaders in nursing	
1968	Stein	USA	The Doctor Nurse Game	Discussion/description paper	The physician is described as omnipotent although really in high state of anxiety through fear of harming the patient. Nurses would recommend actions to the doctor and were unpopular if outspoken	Dated paper but seminal
1990	Stein et al.	USA	The Doctor Nurse Game revisited	Discussion/description paper	The education and empowerment of nursing unbalancing the relationship between doctor and nurse. Although the doctor did not consider the nurse as subordinate by the nurse being liberated the potential was there for the dominating professional to be liberated too p549.	Dated paper but seminal

Date	Authors	Country	Main subject	Methods	Results	Limitations
2007	Tracey and Nicholl	Ireland	How gender influences career progression in nursing	Discussion paper	Three levels of influence, macro-societal; intermediate and organizational; micro-occupational level. The final is assessed by the influence and power the job has p677. Women see their failures as their own while men blame failure eon external factors. Women as 'on-tap' and not 'on-top' p680	Dated study
2014	Waite et al.	USA	Authentic leadership	Developing a leadership educational programme - uses Kouzes and Posner leadership theory but also seven Macy Commitments and students encouraged to develop sense of self	An authentic leader has a deep sense of self where a transformational leader has a sense of purpose	
2011	Watkins	UK/Germany	The influence of Masters education on the professional lives of British and German nurses and the further professionalization of nursing	Qualitative descriptive/ telephone interviews; 9 UK based nurses and 10 Germany based nurses	Personal and professional confidence increasing New roles emerging Multi-professional working enhanced Championing of the profession	

Date	Authors	Country	Main subject	Methods	Results	Limitations
1992	Williams	USA	The Glass Escalator	In-depth interviews with 76 men and 23 women from four different occupations	Men are 'kicked upstairs' p256 however men from non-traditional male professions were seen as not representative of their gender	Dated study
2013	Wong et al.	Canada	Association between nursing leadership and patient outcomes Testing ability to sustain let alone improve patient care Structure- process – outcome Identifies authentic leadership – leader-follower relationship Resonant leadership - attentive to individuals emotions Leader-member exchange – relationship between leader and follower over time	Systematic review update 20 studies – 13 additional from original review	Leadership styles are relationship orientated or task orientated Almost all studies identified Relationship orientated leadership style Four studies showed significant associations between leadership and increased patient satisfaction Strongest association between lack of leadership and medication errors.	Published and English language articles only 15 USA – 4 Canada and 1 Norway Cross sectional and convenience sampling

Appendix 9: Diagrams demonstrating the structure of the NHS, Current, 1974, 1948
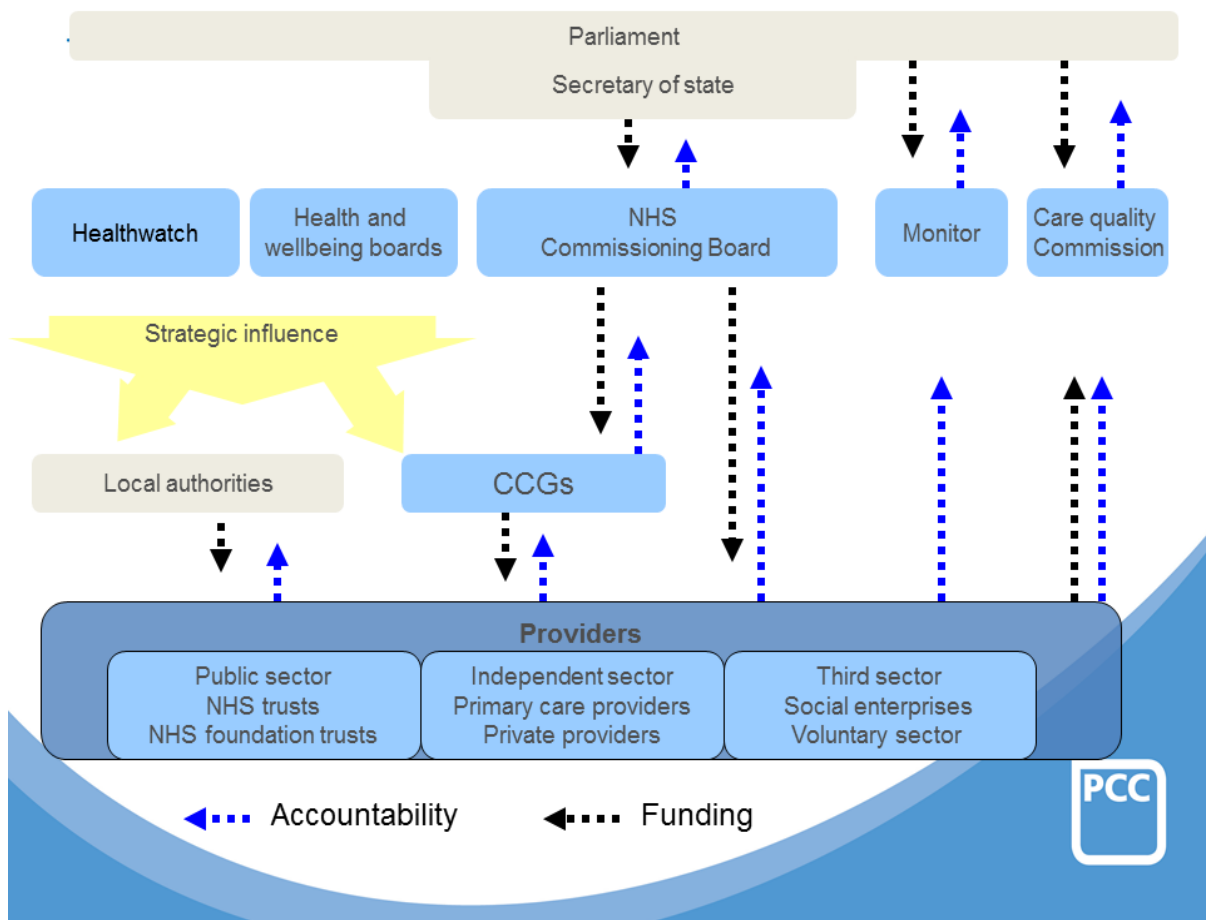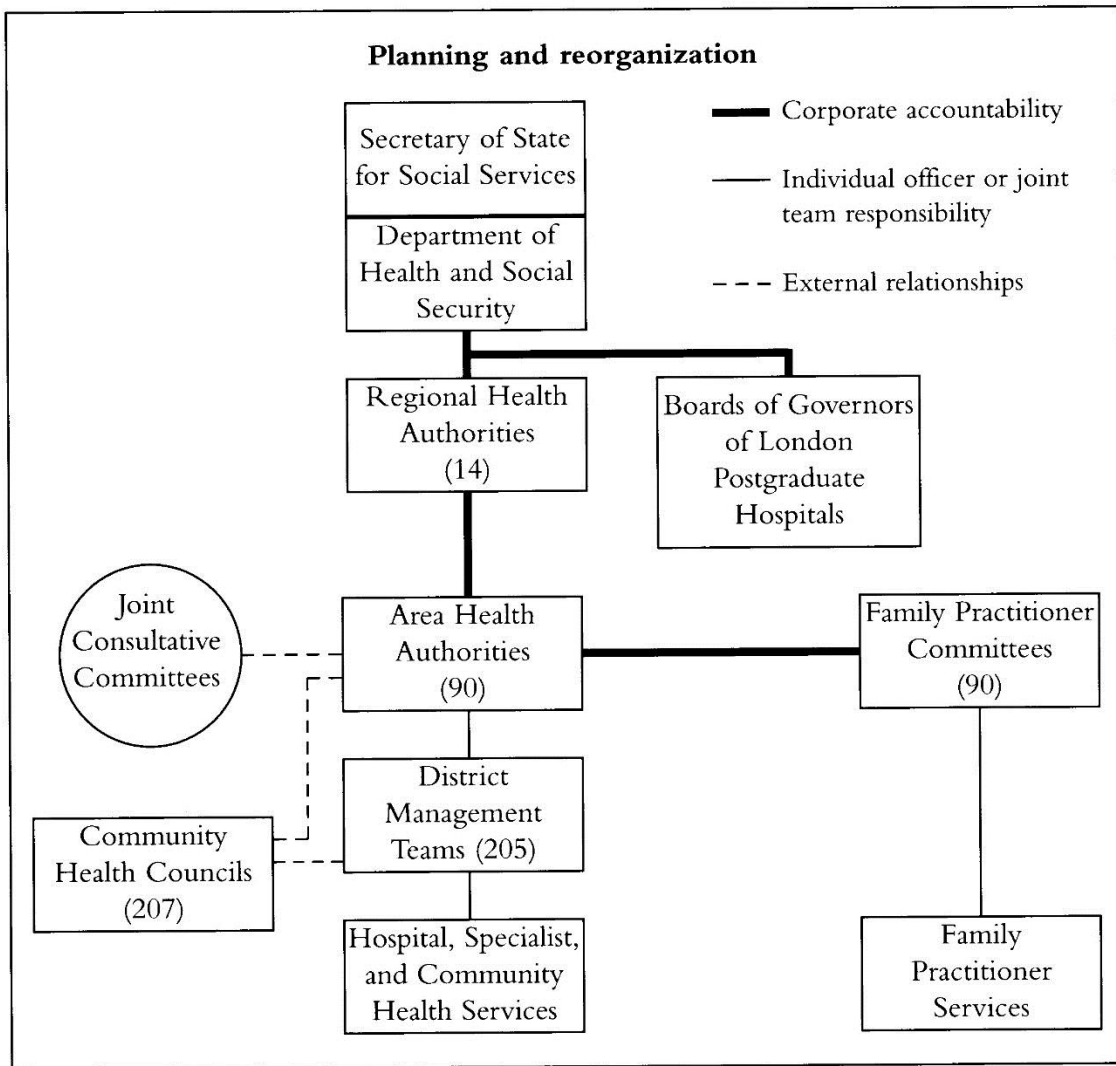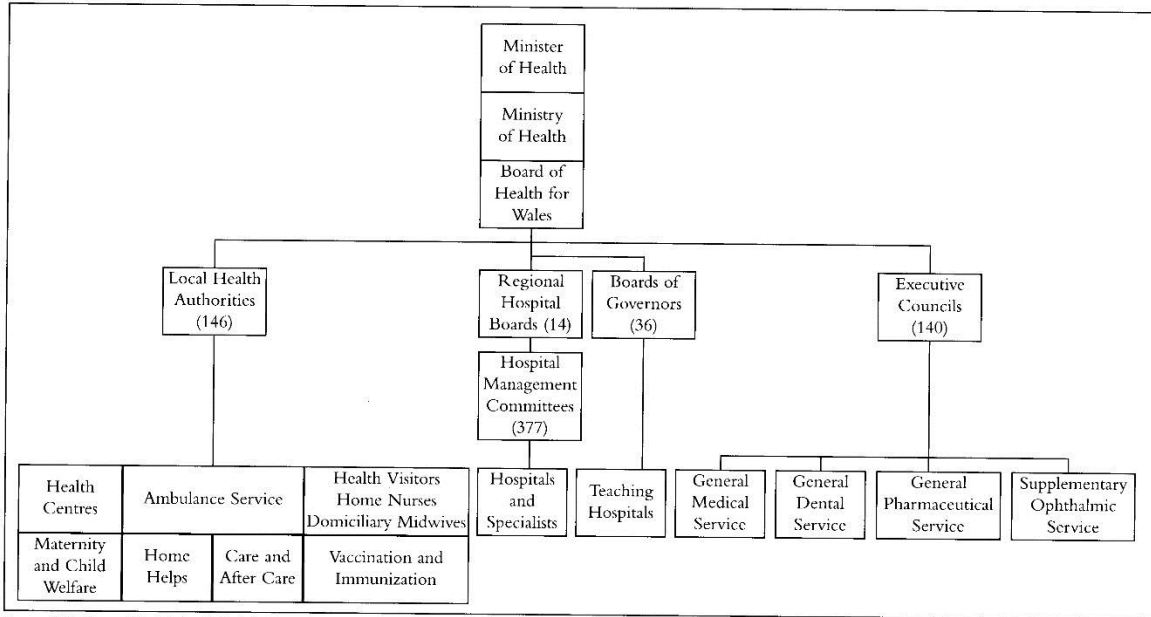
Figure 3 The National Health Service in England, 1974

Planning and reorganization

Secretary of State
for Social Services

Department of
Health and Social
Security

■■■ Corporate accountability

——— Individual officer or joint
team responsibility

– – – External relationships

Regional Health
Authorities
(14)

Boards of Governors
of London
Postgraduate
Hospitals

Joint
Consultative
Committees

Area Health
Authorities
(90)

Family Practitioner
Committees
(90)

Community
Health Councils
(207)

District
Management
Teams (205)

Hospital, Specialist,
and Community
Health Services

Family
Practitioner
Services

Source: C. Webster, The National Health Service: A Political History,
(Oxford, Oxford University Press, 1998), p108.

Figure 2 **The National Health Service in England and Wales, 1948**

Source: C. Webster, The National Health Service. A Political History, (Oxford, Oxford University Press, 1998), p21.