AN EXPLORATION OF NURSE EDUCATION LEADERSHIP AS IDENTIFIED AND EXPERIENCED BY NURSE TEACHERS WORKING IN THE FIELD OF NURSE EDUCATION.

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ABSTRACT

This research is an exploration of nurse education leadership, as identified and experienced by nurse teachers working in a Higher Education (HE) environment. In total 18 nurse teachers were interviewed who formed a whole population sample. The author is identified as a co-worker and part of the community being researched. Semi-structured interviews and field notes were used to triangulate the data and thematic analysis was used to analyse the data. From the findings, the interviewees can be seen to have a strong professional focus and look to their own health and nursing structures to provide leadership. The acceptance of the authority of these institutions and people can be broadly located in a bureaucratic model. Their expectations of people they identified as leaders conforms to a transformational model of leadership, as they identified that leaders were people who had vision, values and influence and of particular importance was the identification of how these individuals made them feel valued. They identified themselves as problematic within the HE environment in which they work and identify being excluded from the collegiate structures and working practices of the university. The findings illuminate problems in the identification and role of nurse education leadership and their position within the university, which this author suggests are areas that need further exploration and have policy implications.

ACKNOWLEDGEMENTS

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CHAPTER 1 INTRODUCTION

The research on leadership in nurse education is unexplored and undeveloped. Dame Elizabeth Fradd, an assistant chief nurse in the Department of Health (DoH), supported this claim when giving a key note speech at an international education in health care conference noting that, '… little published literature was found that was relevant to academic nurse leaders' (Fradd, 2009, p3). This is surprising as effective leadership is identified as central to the success of health education and modernising nursing careers (NAEP, 2007). In addition, despite the fundamental changes that have occurred in nurse education in the United Kingdom (UK) over the last 20 years, the subject of education leadership has attracted little attention. As nurse education has moved from an apprenticeship-style training based in National Health Service (NHS) schools of nursing to a university-based education, major changes have taken place. This move has taken nurse education and nurse teachers into new environments that have different management and leadership structures, with alternative expectations and ways of working. It is important to recognise the context of the move from the NHS to higher education (HE), as the relationship continues to inform and influence nurse education despite its university-based location.

For many within nursing the move from the NHS to universities was welcomed, as this was seen as the successful outcome of years of activity by nursing's leadership whose aim had been to achieve the professional status that other university-educated professionals were understood to have (Bradshaw, 2001). Others have argued (Davis, 2000; Burnard and Chapman, 1990) that this move had nothing to do with the desire of the profession but was part of an ideologically driven policy by the Conservative Government to introduce an internal market into the NHS. In 1989 the Department of Health published Working Paper 10

(DoH, 1989) which dealt with the implementation of this policy in relation to health care education and its funding. The paper outlined that District Health Authorities would no longer be education providers through the funding and management of schools of nursing whilst being simultaneously purchasers of health care. They would become purely purchasers of education: '[monies] … might be transferred to RHA (Regional Health Authorities) and paid to training institutions through contractual arrangements' (DoH, 1989, p19). Although there was never a clear statement of intent in Working Paper 10 that nurse education would specifically enter HE, in 1989 it was announced by the secretary of state that this would occur.

Amongst those involved in planning and overseeing the transition of nurse education to HE there remains a lack of agreement as to the precise reasons why this happened. Burke (2003), when researching why nurse education moved into HE, and why this happened at the time it did found that amongst key individuals involved in implementing the move, opinions varied. Burke (2003) interviewed 70 individuals, nurses and non-nurses, who represented the 'purchasers' and the 'providers', all having been employed at senior levels during this transitional period. Whilst all believed that integration occurred because of a combination of factors, there was division between those who felt it was centrally planned and those who felt it was an accidental outcome of events. Nonetheless, the move occurred and following the transfer of nurse education out of the NHS and into the HE sector, nurse tutors became university lecturers and their employers became the universities, though the funding of the programmes was and continues to come from the DoH. Though supported and promoted by nurse leadership through professional organisations, the move to HE was not universally popular amongst nurses, and Bradshaw (2001) wrote that many nurses felt that their

vocational training was still relevant and should not be replaced by a university-based education.

From a structural perspective the impact of change can be seen locally in the West Midlands; in 1985 there were 18 schools of nursing and midwifery in the region and a total of 412.8 teaching staff were employed. By 1991 there were nine colleges of nursing and midwifery in the region and a total number of 394 nurse/midwife tutors were employed (West Midlands Regional Health Authority, 1991). Figures for 1993 suggest an increase to 700 teaching staff employed in the West Midlands colleges (West Midlands Regional Health Authority, 1993), though nationally the number of nurse teachers fell by 19% between 1993 and 1996 (Hart, 2004). By 1997, in the West Midlands there were six universities with nurse/midwifery training programmes.

The policy to move nurse education into HE, supported by nurse leadership, had a direct impact upon the work experiences of nurses working in education because whilst nurse teachers are located within HE, their education programmes are funded by the Department of Health. As an example of this continued relationship, student places are funded and based upon commissioned numbers. Students do not pay tuition fees and the expectation is that they will work for the NHS upon completion of their programme. In this respect the separation of the purchaser from the provider can be seen to be partial.

In addition to the relationship with the health service, nurse teachers and their programmes have a strong relationship with the nurse regulatory body, the Nursing and Midwifery Council (NMC) which was established by The Nursing and Midwifery Order in 2001 (replacing its predecessor the United Kingdom Central Council (UKCC) and its education wings, the National Boards). The NMC is accountable to parliament through the Privy Council (NMC,

2010). In order for pre-registration programmes to be approved by the NMC, programmes must meet certain 'standards', some of which relate to content and some of which relate to 'resources'. This includes that those who deliver nursing programmes are registered nurses who are clinically up-to-date (NMC, 2011). As can be seen, the changes in the delivery of nurse education over the last 20 years have been significant, now separated from its vocational roots yet still dependent upon funding from the DoH and approval from its professional body, the NMC.

Drake and Heath (2011, p7) wrote that, '... professional doctorates provide opportunities for experienced practitioners ... to work on problems that are of direct relevance to their own professional interests and institutional concerns'. This resonated with my experience: I wanted to explore the contemporary understanding and experience of leadership in nurse education. It is perhaps appropriate here to identify what that experience was, and also identify for the purpose of transparency some autobiographical information, my developing interest in the subject of leadership and my position within the research.

Before working in nurse education I worked as an adult and mental health nurse in staff nurse, sister and senior nurse positions in medical, older adult and forensic psychiatric environments. I left school at 15 with no qualifications and at the age of 21 I was allowed, in the absence of any formal qualifications, to sit an entrance exam to train as a nurse. I trained and worked in several large Victorian institutions on the outskirts of a northern industrial city. The psychiatric hospital I trained and worked in closely conformed to Goffman's (1987) description of the 'total institution' and was the largest 'asylum' in Europe. As a student nurse and a qualified registered nurse I experienced working as part of a team in which there was always a clear hierarchy. Decision making and lines of accountability were closely dependent

upon position within the hierarchy. Behaviour was also influenced and directed by the hierarchy, and even the hospital canteen had designated areas you were allowed sit in, identified by your grade as a nurse. However, within these 'total' institutions, I worked with some individuals who seemed to transcend their environment and these were people I wanted to work with. These 'mentors' were senior to me but were open and approachable and I wanted to work with them and be a good nurse because I wanted their respect. I was fortunate in that they took a personal interest in me, supporting, encouraging and helping me in my career.

Having climbed the nursing hierarchy and become a senior nurse in the NHS I then moved to become a nurse tutor as I wanted to be able to influence and support the nurses of tomorrow. But by moving to be a nurse tutor in a school of nursing I was still a 'nurse' and I still worked for and within the NHS. When I moved to the university I found the word nurse had disappeared from my title; I was a university lecturer and I was no longer in a senior position but in a junior position on a part-time teaching-only contract. This status change did not concern me but I found myself trying to recreate the structured environment and the relationships I was used to. I would arrive promptly in the morning at 8.30 and leave promptly at 5pm. I worked with a more experienced colleague to whom I would 'report'. I soon recognised that this was not required but I still felt I ought to report my daily activities to someone. I was surprised to find that for instance, time off for a dental appointment did not have to be 'made up' and with no specific holiday entitlement I was to negotiate annual leave with my head of school.

I found that I missed the team-working environment I was used to and I felt quite isolated. When we did work together in the university the relationship between staff appeared to be

based on their experience as opposed to their job description, and lines of responsibility seemed unclear. I began to appreciate this way of working but things at the university were, and are, clearly different from working as a nurse in the NHS; initially I was looking for structures and roles that did not exist. I also recognised my position was 'different' from others in the university. I was still a registered nurse and as such had to abide by the Nursing and Midwifery Council (NMC) rules on issues such as codes of conduct, keeping up-to-date with clinical practice and maintaining my annual nurse registration. My salary was funded by the DoH but I was employed by the university. All of these organisations had different structures and ways of working.

I do not look back uncritically to a glorious past but recognise that on a personal level I had benefited from the hierarchical structures in the NHS and I had found senior nurses who I identified as leaders who had influenced my practice and career progression. I recognised that they had guided how I thought and my expectations of leadership and management. But I also recognised that individuals change, as do their environments, and at that time and in those places the expectations, culture and structures of nurse education were different from the current education environment. So my interest in leadership developed from my reflections and recognition that the leadership hierarchies and careers in the health service that existed for nurse tutors no longer existed. This led me to ask, now that we as a profession had entered the university environment and been established in these environments for several years, how did others think about leadership and where did others experience and find leadership within these 'new' environments? These questions are not idle but based upon the belief that the expectations of leadership are based upon how we have experienced and understood leadership, and also that leadership makes a difference to people as individuals and in terms

of achieving professional goals. So with little research to draw upon I wanted to explore the field.

In this unexplored area I decided to investigate leadership from the perspective of those who live, experience and may participate in or take leadership decisions but who do not hold senior positions because their voice is often absent from the research. In arriving at this position I have been influenced by different sources and perspectives. Firstly, from my nursing experience because we include 'service users' in aspects of planning and delivery of health care services and educational programmes, in the belief that service users' experiences and beliefs of health care are as valid as the paid professional 'experts'. I have also been influenced by Gronn (2000) who contests that the term leader adequately represents the work activities of organisations and also Harris's (2002) writing on distributed leadership and school improvement. Harris identified the heroic view of leadership as being located in the head teacher whilst commonly the focus of research and thinking does not recognise the paradigm move to leadership based on the many, rather than the few. A further influence was Gunter, who wrote, '... There are other experiences, stories and lives to be recognised and heard. Such alternatives are evident in the everyday practice of educationalists combined with research that seeks to understand, explain and theorise this context ...' (2001, p139). Whilst recognising the service user involvement in nursing, the work of Gronn (2000), Harris (2002) and Gunter (2001) are located in very different traditions and fields. The recognition that leadership research does not have to be focused on those in senior positions, and that others have experiences that need to be recognised is, I believe an important position to take. These influences informed my decision to locate my research with nurse teachers and not with those who hold senior positions.

I next had to consider where to locate my research. I decided to locate my research in one university, the university in which I work, for the following reasons. Firstly, the organisational, social and cultural differences between universities create different environments and this creates different formal and informal ways of working. This would impact on the experiences and understanding of nurse teachers. Secondly, and more importantly, as I have identified I am a co-worker and am known and share the same working environment as those I interviewed. Had I interviewed nurse teachers in other universities, this dynamic would have been entirely different and the nature of the interviews would have been affected. I therefore took the decision to locate the study in the university where I was known and accepted as a co-worker.

Because of the lack of research in my area of practice, I decided an exploratory approach was appropriate. My position within the research gives me some insight into and understanding of the issues based on a shared professional culture, though others may experience and understand things differently. It is for this reason my research seeks to explore the experience and understanding of leadership with those who work in the field. In the belief that leadership matters, my purpose is to make an early contribution to developing an understanding of nurse education leadership, to contribute to theory and research, and to open the debate on leadership in nurse education.

Research aim:

To explore nurse education leadership as identified and experienced by nurse teachers working in the field of nurse education.

My research questions sought to:

1. Explore the influences and reasons why a nurse chooses to move to nurse education.

2. Identify an understanding of nurse education leadership.

3. Identify where nurse teachers find nurse education leadership and leaders.

4. Explore the experience of working with leaders.

5. Explore the experience of working in the university.

6. Explore how nurse teachers exercise leadership.

For clarification, prior to nurse education's location in universities, the usual title for a teacher of nurses was nurse tutor. Writers whose work has been referred to and the interviewees who were interviewed for this research, have used the titles tutor, academic nurses, nurse educators, lecturers, teachers and nurse teachers and I have left their words unchanged. I have used the term nurse tutor when referring to this teaching role in the historical sense, and thereafter nurse teacher, as this is the term most commonly used now. Finally, the structure of the university where the research was carried can be described as having a collegiate management structure. It comprised five colleges divided into schools. The school in which the research is located runs several health-related education programmes at undergraduate and postgraduate level. When referring to the university's structure, interviewees have used the terms department and school and I have left their words unchanged. However, I have used the term school as this is the title used by the university.

CHAPTER 2 LITERATURE REVIEW

The literature has been explored in three key areas. Firstly, in order to locate and develop an understanding of educational leadership in nurse education a review of the literature and research on leadership and management models developed in the tertiary education field was undertaken. These models provide useful structures from which to explore, locate and develop an understanding of nurse education leadership within an analytic framework. A review of the leadership research and literature in health care has also been undertaken that locates the vocational background in which nurse teachers have experience. Finally, the research and literature that identified the reaction, integration and adaption of nurse tutors into HE has been explored. In the absence of a substantial body of research in which to locate my work, I have identified these areas as useful in exploring and locating influences relevant to nurse education leadership.

Leadership and Management Models in Education

The fields of leadership and management are complex; contested and agreed definitions of these terms within the field of education do not exist. Gronn (2003) wrote that the concept that leaders and managers were not the same has a relatively short history. He wrote that this leader-manager dichotomy can be traced to the demonisation of the manager who was portrayed as restricting the entrepreneurialism of American business in the latter half of the twentieth century. He wrote that this development had its influence in the field of education which he identified as now in decline. However, these distinctions remain evident in the research and literature.

Bush (2009) identified three dimensions that can be used in terms of developing a working understanding of leadership: leadership and influence, leadership and values and leadership and vision. Leadership and influence, he argued can be seen as a central element of the concept of leadership. However, influence may not be restricted to an individual because teams may also have influence. The second dimension, 'leadership and values' does not determine what values leadership may have, but proposes that leadership needs to have firm professional and personal values. Leadership and vision is, he wrote, '... increasingly regarded as an essential component of effective leadership' (2009, p6). These generalisations are, he wrote, essentially normative views for which there is empirical support. Bush (2009) also identified the question of whether school leaders are able to develop specific vision, given the centrality of government prescriptions for curriculum, and this has particular resonance in the field of nurse education.

The different theories of educational management and leadership often overlap and authors may use the same term to denote different practices. Bush (2009) identified a typology of management and leadership models in order to identify how these perspectives and theories might be better understood (see below). I have used this table as it provides a useful structure and guide in locating and integrating management and leadership models.

Table 1 Education management and leadership models (Bush, 2009 p33)

Management Model	Leadership Model
Formal	Managerial
Collegial	Participative
	Transformational
	Interpersonal
Political	Transactional
Subjective	Post-modern
Ambiguity	Contingency
Cultural	Moral
	Instructional

I have identified the formal, collegial, political and subjective models of management as having particular relevance to nurse education leadership because within the literature and research on the health care environment, and HE, their constructs can be identified. The leadership models identified as of relevance are managerial and transformational. I have also included distributed leadership which I have located within the collegial management model.

Formal Models

The formal models of management discussed by Bush (2009) have several common features that include a tendency to treat organisations as systems and give prominence to the official structures of organisations. These official structures can also be understood to share common features such as the tendency to be hierarchical and goal seeking. They also assume managerial decisions are rational, they present the authority of leaders as essentially a product of their official position and there is an emphasis on accountability. Bush (2009) identified that to a greater or lesser degree these features dominate the formal models which can be

further classified as structural models, systems models, bureaucratic models, rational models and hierarchical models. These models provide a useful structure from which to develop an understanding of nurse education within its vocational context.

In particular the bureaucratic model has been identified as of relevance to my study. Bush (2009) identified that the bureaucratic model has several main features: hierarchical authority structures; an emphasis on goal orientation; a division of labour on the basis of experience; behaviour is governed by rules and regulations; there are impersonal relationships between staff and clients and career progression is determined on merit. Though the terms bureaucratic and hierarchy are often used loosely, it has been argued that the hierarchical structures reflect the managerial leadership behaviour seen in nursing structures. Savage wrote:

> ... from the bottom looking up, the main impression is of large numbers of senior people issuing orders which are passed down the line – paralleled by the frequently encountered inability of anyone in the structure to make a decision without referring to someone higher up ... The hierarchical structure has been justified on the grounds that it is necessary for a clear allocation of responsibility and control over other staff … (1985, p.80-81).

Savage (1985), Hugman (1991), Miers (2002) and Murphy (2005) have all identified the hierarchical nature of nursing structures. Savage (1985, p79-80) wrote that; 'The structure of the nursing workforce is most easily likened to a pyramid'. Within the nursing environment, lines of communication and accountability may be to an immediate manager and, ultimately, to the DoH.

The bureaucratic model owes much to the work of Weber (1989) who saw organisations as a hierarchy of paid officials who formed a chain of command. Weber argued that all human action is directed by meaning and that the dominant action in modern industrial society is rational action which involves having a clear goal. Weber also argued that bureaucracy is a

system of control in which individuals within bureaucracies have control over others within a hierarchy. In order to have control then, there must be an acceptance of the legitimacy of that control, which can be located in authority. Weber identified three types of authority (Harling, 1989): authority might be defined as 'charismatic', when people will obey because they regard the leader as having exceptional qualities; as 'traditional authority', when authority is accepted because the person has authority (usually through inheritance) or, as 'rational-legal' authority, when authority is accepted because others accept the legal framework on which their authority is based. Within nursing, authority can be described as 'rational-legal' because authority is conferred by position within the hierarchy, which is attained by incremental promotion based on qualifications, experience and skill.

However, a limitation of Weber's bureaucratic model is the assumption that the decisions made are logical, rational and goal orientated. As has been stated above, the decision to separate nurse education from the NHS was identified in Working Paper 10 (DoH, 1989), but the move to HE for nurse education was not explicitly identified as a goal. Burke (2003, p382) identified that the senior staff involved in the process remained divided as to whether it was planned or accidental, '… It is not clear whether policy was influencing action or action influencing policy'.

For nurse teachers working within HE, the question might be which organisation are they working for? As identified above in Chapter 1, whilst employed by universities, nurse teachers also have professional allegiances that are formally sanctioned through professional regulation by the NMC. In addition, the funding of nursing programmes is provided by Strategic Health Authorities (SHA) who are authorised by the DoH to commission student places. Murray and Aymer (2009) identified these issues when they wrote of tensions created

for professional educators (social workers, nurses, teachers and doctors) in their attempt to meet the imperatives of both HE and their original fields. The formal models describe a landscape familiar to many nurses working and writing in the field and for this reason are of value when exploring the experiences and understanding of nurse education leadership.

Collegial Models

Deem (2001) identified that most British universities claim to be managed through collegiate structures, and for this reason collegial models are of interest to this research. Bush (2009, p64) wrote that 'collegial models include all those theories that emphasize that power and decision making should be shared among some or all of its members'. Several leadership models can be considered as aligned with these structures, including transformational leadership and distributed leadership, and these two models will be explored here.

Northouse (2004) identified that the transformational leader engages with others and creates a vision that has moral overtones. He described transformational leadership as:

> … concerned with emotions, values, ethics, standards and long-term goals, it includes assessing followers' motives, satisfying their needs, and treating them as full human beings. Transformational leadership involves an exceptional form of influence that moves followers to accomplish more than what is usually expected of them. It is a process that often incorporates charismatic and visionary leadership (p169).

This emphasis on the transformational leader having skills in assessing and meeting followers' needs has interest because it recognises the role of followers in the process. The transformational leader needs others to follow, and meeting the followers' needs is part of the process. Day (2003) argued that leadership depends partly on understanding emotional needs, and Gardner and Stough (2002) argued that emotional intelligence must be considered complimentary to transformational leadership behaviours. They argued that the emotional

intelligence of transformational leaders enables them to identify and understand the emotional needs of others, and they are also able to manage both the positive and negative emotions of others and themselves. Palmer et al (2001) argued that the emotional intelligence of effective leaders may account for how they respond to subordinates and how they make them feel at work. There is an assumption within this leadership model that the needs of the follower are congruent with the organisation and that the leader provides a harmonious means by which the goals of the organisation and the follower are met (Bush, 2009). The transformational leader is a concept familiar in nursing and health care leadership research and is associated with vision, charisma and obtaining the commitment of staff and those working with them (Warwick University, 2003; Murphy, 2004; Jooste, 2004). The role of the follower is implicit in this model and Thody (2003, p1) wrote that whilst recognising that the term is problematic: '… Both followership and leadership roles are important to organizational success'.

Thody (2003) found that in comparison to the tens of thousands of sources on leadership, followership attracted little academic attention, and when it did, followership was frequently seen as only having a life that is determined by leadership. She hypothesised that followership has a life of its own and that this 'life' is significant in its effect on leaders, and on other followers. Thody (2003) found that her attempts to gain acceptance of followership as a legitimate field of study met with hostility and humour, yet she argued that followership is a reality in organisations and may, within some organisations, be legally endorsed. She writes that whilst collegiate structures may be considered morally right by practitioners, pressures from external stakeholders enforce hierarchies, and that collegiate structures can be criticised as conflicting with human nature. Thody (2003) makes the argument that there is scope for followership studies within current theoretical models; for instance, 'Gronn's concept of conjoint agency' (Thody, 2003, p4).

Whilst nurse teachers have not been identified in the literature as 'followers', several writers have focused on the experience and impact of leadership decisions; for instance, Congdon and French (1995), Evers (2001) and Deans et al (2003). Other authors have suggested that nursing never makes decisions of its own choosing (Davies, 2000; Hart, 2004; Edwards, 2008) and in this respect nurses and their institutions could be considered as followers. However, Thody's (2003) work is primarily focused on the characteristics of individual followers, and she proposes a typology of followers identified as 'positively effective personality types' such as 'loyalists', and 'negatively effective follower types', such as 'observers' or 'dependents'. The specific roles these personality types might take include, for instance, 'sidekick' for the positively effective follower type, or 'saboteur' for the negatively effective follower type.

Thody's (2003) work challenges the received wisdom that leadership characteristics and behaviours, such as those identified in the transformational leader, are all that matter to achieve success. Her work is focused on individual psychological factors and behaviours, and the effect that these follower types and the roles they enact have on the success or failure of organisations. As such, her work can be identified as conforming to a binary identified by Gronn (2000), who criticised a focus on individual agency as limiting the way leadership is considered and explored.

Distributed leadership has been identified as sharing many of the features of collegiality which Gronn (2002) identified as interdependence, rather than follower dependence. Gronn (2000) identified the concept of distributed leadership as providing an alternative to regarding leadership as either concerned with individual agency, such as the concept of the transformational leader or follower, and with systems and role structures such as those

identified by the formal models. Gronn (2002) argued that there is weakness in the traditional models of leadership where the bifurcation of thinking focuses on the ideal type of leadership, conceptualised as the transformational leader, and that this individualistic view of leadership leads to:

> … individualism [which] may be typified as naïve realism or belief in the power of one, and is grounded in the assumption that "effective leadership by an individual with the skills will find the right path and motivate others to take it … Implicit in this kind of reasoning is a crudely abstracted leader-follower(s) dualism, in which *inter alia*, leaders are superior to followers, followers depend on leaders and leadership consists of doing something to, for and on behalf of others (p319).

Equally, leadership that is focused on the systematic properties of systems and role structures, excluding any sense of individual agency, is based on the same false ontological dualism. Gronn (2002) argued that this dualism fails to recognise the interdependence of these elements. Therefore, he went straight to the heart of the agency-structure interplay and argued that *activity* provided an understanding of agency-structure relations and should be understood as, '… fluid and emergent, rather than a fixed phenomenon' (p324).

Gronn (2003) wrote on what he described as 'communities of practice', and wrote that the well-rehearsed constructs of leader and follower are no longer adequate in explaining the work activities of organisations. He proposed that communities of practice, where there is a fluidity of roles in response to work demands, enable us to develop our understanding of leadership. Gronn (2003) identified that a community of practice could be considered a work formation where there was a de-emphasis on hierarchy and an emphasis on conjoint working. Another feature of these communities of practice involves a sense of common purpose in which a collective identity is instilled. Gronn (2003) recognised that an inherent problem with the concept of communities of practice is that most employees have at least dual points of reference:

> ... they are members of both a community (or communities) of practice as well as occupational communities. Socialisation through recruitment and training into the norms, values, skills and vocabularies of an occupational community (e.g. plumbing, accountancy, teaching) is an equally important source of individual and collective identification and membership (p30).

This has particular resonance with nurse teachers located within a HE environment, who have been socialised in the health care environment and within their professional community, and can therefore be seen to have more than one point of reference.

Harris (2002, p4) also argued that leadership practice is a distributed entity mediated through human interaction, and that collaboration is at the heart of distributed leadership:

> … distributed leadership is characterised as a form of collective leadership in which teachers develop expertise by working collaboratively. This distributed view of leadership requires us to 'de-centre' the leader (Gronn, 2002) and to subscribe to the view that leadership resides not solely in the individual at the top, but in every person at entry level who in one way or another, acts as a leader … this is dangerous ground because it challenges the conventional dualism of leader and led and of leader and follower …

Distributed leadership, Harris argued, can happen though spontaneous collaboration, intuitive relations or institutionalised practices and that the focus is on how leadership practice is distributed, not that everyone leads. Harris and Spillane (2008) writing on schools, identified that distributed leadership acknowledges the work of all individuals who contribute, and that the idea of the singular heroic leader is at last being replaced by an interest in teams rather than individuals. This approach places greater emphasis on other people in the organisation, including teachers, support staff and students. They argued, however, that the term is in danger of being a 'catch all' concept because a number of related leadership concepts which describe, for instance, devolved leadership, create conceptual confusion. They argued that distributed leadership is an analytical frame, and this frame galvanises attention on leadership as practice, rather than leadership as role.

Within the HE sector collegial models have been identified as having been adopted by most universities with extensive committees, professional autonomy and distributed leadership, and are identified as the model of leadership that most claim. Bolden et al (2009) identified that whilst most studies on leadership in HE conclude that leadership is widely distributed, the term can shroud issues of power. They identified that HE institutions are not generally suited to 'top down' leadership and that the desire for collegiality remains deep-seated. Their study sought to explore the reality and manner in which leadership is perceived and enacted at different levels within HE. The study involved interviewing staff at 12 universities, including vice chancellors and heads of department, who were identified as middle-level managers. These heads of department formed the majority of interviewees and were identified by the authors as being in key roles within their universities:

> …we are particularly interested in leadership at the school/department level as this is the main operational unit of universities, the primary source of future senior academic leaders and the main point of interface between leadership of the institution and leadership of the academic discipline … We were interested in how leadership is experienced at this level and how it interacts with other parts of the organization (Bolden et al, 2009, p261).

The respondents identified distributed leadership as fitting into broad classifications that the authors locate as being originally identified by MacBeath et al (2004):

1. Formal, for instance devolving budgets;

2. Pragmatic, for instance, negotiating division of responsibilities;

3. Strategic, bringing in outsiders with key skills;

4. Incremental progressive, opportunities for skill development;

5. Opportunistic, people taking on extra responsibilities and

6. Cultural, when leadership is assumed and shared for instance in the development of collaborative bids.

They concluded by arguing that:

> … As a description of leadership practice the concept of distributed leadership offers little more clarity than 'leadership' alone. As an analytic framework it is a more promising concept, drawing attention to broader contextual, temporal and social dimensions of leadership that may be missed through a more individualistic and decontextualized perspective ... Fundamentally, though we argue that distributed leadership is most influential through its rhetorical value whereby it can be used to shape perceptions of identify, participation and influence but can equally shroud the underlying dynamics of power within universities (Bolden et al, 2009, p274).

This study, whilst significant, might be criticised for excluding staff below middle management levels. Whilst recognising that leadership practice may be distributed and that not everyone leads, it is unclear what positions and contributions those below the level of head of department hold.

Bolden (2011) identified that the literature and interest in distributed leadership have grown in the preceding ten years, particularly in the UK, in school-based work. A number of other related leadership concepts were identified, in particular democratic, shared, emergent and collective. However, he also identified that concepts of distributed leadership incorporate the ideas that leadership is not necessarily widely shared or distributed, and that more critical accounts are needed that challenge and explore the concept and meaning of distributed leadership. Harris and Spillane (2008) also warned against the dangers of conceptual confusion and conceptual overlap, and that distributed leadership's chief concern should be how leadership is distributed. Gronn (2008) considers that in reviewing the empirical and conceptual significance of distributed leadership, it currently retains value in contributing to a better understanding of the work of organisations. He further argues that leadership's

distributed status now needs to be considered as aligned to power and influence. He argued that leadership as a separate vehicle of analysis lacks justification.

However, some have challenged the acceptance that HE has moved to distributed leadership, and whilst Deem's (2001) study was concluded prior to the work of Bolden et al (2009), she examined the extent to which 'New Managerialism', derived from research on reforms to the NHS, was perceived to have permeated HE and wrote that, 'the efficiency model, "doing more for less", backed up by funding policies and league tables, was perceived as having significantly permeated higher education' (Deem, 2001, p3).

Deem's study included focus group discussions with academics, manager academics and administrators, followed by semi-structured interviews and the selection of a small number of institutions for detailed study. Her study identified that HE displays hybridised forms of managerialism, but that, unlike the NHS where big organisational changes have taken place, universities have developed within their existing structures. Miers (2002, p217) welcomed this move and identified that 'New Managerialism' provided opportunities for nurse education in HE as:

> The university sector of the twenty first century is very different from the 1960's and 1970's, the period during which many of the leaders of higher education gained their own university education ... Fortunately, for nursing… the challenges that leaders of higher education are having to face – changes in funding mechanisms as well as the surveillance of research and quality – all facilitate a more flexible model of what it means to be educated.

Miers (2002) regarded a move away from what can be described as collegiality in universities as a positive move for nurse academics because the changes remove the cultural barriers that perpetuated a denigration of the practical nurse.

Bryman's (2009) report, 'Effective Leadership in Higher Education' found that whilst there existed literature on what leaders in HE did, there was little on leadership and effectiveness. Also, many writers did not use the term leadership in a consistent way, with the terms management and administration also being used. In relation to evidence of collegiality, the report identified that the term frequently surfaces, though is rarely defined, and is identified as in decline with the rise of managerialism within the university sector. However, in a series of interviews conducted as part of the report carried out with leadership researchers drawing on their experience in HE, they identified that consultative behaviour was associated with effectiveness.

Collegiate models of management and the concepts of the transformational leader and distributed leadership are of relevance to my study. The concept of the transformational leader is both normative and evidenced in the nursing and health care literature. Distributed leadership, it is argued, is evident in British universities; though, there is evidence that the term distributed does not mean that all decisions are distributed, or that power is absent from the arrangement. There is also disagreement in the research as to the extent to which distributed leadership is a reality, or whether what can be described as new managerialism is evident. These models provide structure for exploring and developing an understanding of nurse education leadership in the university environment from the perspective of those who work within its structures.

Political Models

The political models described by Bush (2009) are also of interest because it has been argued by some authors (Davis, 2000; Burnard and Chapman, 1990) that the move to HE by nurse education concurred with the ideology of the then Conservative government, which sought to

bring an internal market to the public sector, and that separation of the purchaser (NHS) from the provider (HE) was the main motive behind the move to HE. In this respect overt political processes can be seen at a macro level. However, Bush (2009, p89) identified that most political models identify operation at a micro level within organisations. The political models of management provide a critical approach to understanding the structures of educational organisations. Within the political models identified by Bush (2009, p89), a central definition is that:

> Political models assume that in organizations policy and decisions emerge through the process of negotiation and bargaining. Interest groups develop and form alliances in pursuit of particular policy objectives. Conflict is viewed as a natural phenomenon and power accrues to dominant coalitions rather than being the preserve of formal leaders.

Hoyle (1999, p213) asked 'What can the study of micro politics contribute to the practice of leadership?' He stated that this question is based on the assumption that there is a precise set of social processes which can be termed micro politics, that there is a distinctive field of enquiry called micro politics and that the outcomes of such an enquiry can be of use to leadership practice.

Bush (2009) identified that there are many sources of power but that in broad terms a distinction can be made between authority and influence. Authority involves a legal right to make decisions; influence represents the ability to affect decisions. Power might be considered to have six sources: positional power, authority of expertise, personal power, control of rewards, coercive power and control of resources. Sources of power that have been identified by Bush (2009) as being relevant to schools and colleges are, 1) positional power – where the official post holder holds most power and in using this definition some parallels can be seen with the hierarchical model discussed earlier; 2) authority of expertise – where conflict can arise between the formal leader and the expert (for instance a subject expert); 3)

personal power – where individuals who have charismatic personalities gain power; 4) control of rewards – the person who perhaps gives references or allocates work and 5) coercive power – the ability to constrain, block to interfere or to punish.

Within the nursing literature, power is identified as an important component of a nurse's position, although it is not usually referred to within institutions or sub-groups. Power is usually conceived of as nurses positioning themselves to make change and improve patient care, and in this respect is not a critical tool of analysis (Masterson and Maslin-Prothero, 1999). However, some authors have written from a critical perspective using concepts of power and oppression to explore the nurses' position. Lorentzon and Bryant (1997) identified social class and gender to explain nurses' development and position historically. Whitehead (2010, p22) argued that nursing is oppressed by its socioeconomic position and by other occupational class groups, such as medicine and professional management, and that it is fiction that it is an equal partner with these groups. She also argued that nursing is oppressed through gender:

> Consequently, nurses are oppressed in the same way as other working class professions as part of the economic and social structure of society. It is this oppressed position that leads them to be constantly pilloried for achieving more advanced academic qualifications and that a move to graduate status for nurses will expose its oppressed position for what it is.

Hart (2004), in his book 'Nurses and Politics' wrote that two terms became prominent in the nursing literature in the late 1990s, the first being nurses' power and the second, leadership. He asked if leadership is related to power, then where does leadership in nursing come from? He wrote that nurses might expect to see nurses who had become members of parliament (MP's) as being in a position to provide leadership; though, he notes that most nurses regard those nurses that have become MPs as being out of touch and of not valuing nurses. Hart

(2004, p182) also criticised the NMC for not providing leadership: '… Not a body that most nurses in practice would be looking to for inspiration and examples of practical leadership'.

He also wrote that the appointment in 1999 of a new Chief Nurse for England, Scotland and Wales (a civil service post) was not on 'anyone's shortlist for the vacancy', and asked if 'leadership and nurse power, are not to be found on the national stage, where will they be found?' (Hart, 2004, pp181-182). He concluded by writing that, 'When the issue of leadership, as opposed to management, is explored in a nursing or health service context, it has to be remembered that the overall thrust and direction will always come from government' (Hart, 2004, p195).

Hart's (2004) analysis is primarily concerned with the position of nurses within society and the NHS, and in this respect, he has identified power and politics at a macro level. He wrote of tensions existing and of nurse leaders adopting a conciliatory, naïve political approach that has sometimes sold nurses short. He argued that nurses should form new networks and fight for their rights, and that at the macro level politics might be identified. However, whilst Hart's work is not based on research he addresses many important issues and provides a critical account of the political context of nursing today. Writing as a nurse, Hart is one of only a few nurses who have critiqued nursing using the concepts of power and politics.

Within the educational field, Bush (2009) described Baldridge's model as a 'classic model'. Baldridge (1971) identified five stages in the policy process: 1) the social structure where there is a configuration of social groups; 2) interest articulation; 3) the legislative stage; 4) formulation of policy and finally, 5) the execution of policy. This process is not straightforward, and the ultimate success or failure of interest groups depends upon their

resources of power. This framework provides a useful tool for understanding the process of policy development and implementation of nurse education.

From reading the literature concerning the proposal and eventual policy to transfer nurse education from NHS schools of nursing into HE, different interest groups can be identified, in particular the statutory bodies of nursing and the professional organisation, the Royal College of Nursing (RCN) (Davis and Beach, 2000). Other interested parties include the government through its interest in providing a workforce to undertake the work of nursing. In terms of its application at the micro level, institutions' (such as schools and colleges) internal sub-systems can be identified. Although, as discussed above, there is little nursing research which looks at leadership within a power framework, Edwards (2008, p132) addresses the impact on government policy and on the subordination of academic freedom in relation to nursing curriculum design: 'Institutional leaders are seen as conduits of government policy and the content of the field is beginning to be defined by government agencies rather than within the field itself'.

Bush (2009) wrote that there are two central facets of leadership within political areas. Leaders are the key participants in the process of bargaining and negotiation. Leaders have their own values, interests and policy objectives which they seek to advance as appropriate. For instance, head teachers have substantial reserves of power which they may deploy in their own or their institution's interests. The leadership models that he locates as being most closely aligned within the power model is that of transactional leader. The transactional leader can be identified as being part of an exchange process, exchange being established between different members of the organisation. For instance, where exchange is in the form of promotion, if the member of the organisation has provided some benefit the leader can reward

them (Northouse, 2004). The limitations of political models are their immersion in the language of power, conflict and manipulation (Bush, 2009). Political models stress the influence of interest groups on decision making, the assumption being that organisations are fragmented into groups that pursue their own interest. Further criticisms might be that there is too much emphasis placed on conflict and neglect of professional collaboration leading to agreed outcomes.

Glen (1990, p1335) wrote that whilst evident, the concept of power in nurse education is not in its lexicon:

> From my own experience of working in colleges of nursing, … Nurse Teachers (tutors) tend to think they are alien, or even superior to considerations of power as a crucial and inherent aspect of social relations: social relations both within colleges of nursing and between schools and the wider social context ... [however] Power relations are not simply chosen by Nurse Teachers (tutors) but made more or less necessary by the organisational structures under which they come together.

Mulholland (1995, p 446) argued that, 'The failure of nursing and nurse educationalists to confront power as a feature of their relations with each other and their clients is closely related to their failure to recognise the inextricable relationship between knowledge and power'.

Hewison (1994) provides a framework for use as an analytic guide in the study of nursing politics and suggests that power can be identified at three levels. Firstly 'interpersonal power' that is activity that concerns relationships with patients, colleagues and power, in negotiation and interaction. Secondly, 'organisational power' that is concerned with dominant groups and coalitions, institutional policies, power of the institution and organisational hierarchy. Thirdly, 'external power' that is national/governmental policies and political action to influence

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policy. This typology of power provides a framework in which to locate and understand the impact and interrelationship of power at different levels.

Masterson and Maslin-Prothero (1999) wrote that power and politics are a legitimate part of nursing knowledge and that the move to HE has allowed for the introduction of ideas and methods of inquiry from such disciplines as sociology, to influence the development of nursing knowledge. This move away from medicine as its traditional source of knowledge has allowed for the development of critical skills from which to examine the organisational context in which nurses work. They also wrote that the move to HE was seen as 'empowering' and as a societal recognition of the value of nursing. However, nurses found themselves marginalised and devalued:

> Nurse Educators have been reviled in the academic press, and by many of their new academic colleagues for their lack of research and publication experience. In addition, the centralization that resulted from the reorganisation led to massive early retirements and redundancies. And despite being located in universities, the development of educational purchasing consortia composed of service representatives has once again increased the service over the shape and content of the education provided (Masterson and Maslin-Prothero,1999, p227).

They also wrote that leadership may have been seen as lacking in nursing because of the people attracted, and perhaps specifically recruited, to the profession. Whilst not a homogenous group, they tend to be submissive, lacking in initiative and obedient: '… yet if nurses feel uncomfortable with notions of power and politics it is not surprising that they shy away from assuming leadership skills and responsibilities' (Masterson and Maslin-Prothero, 1999, p228).

Concepts of power are identified within the nursing literature and, where identified as related to nurse education, control over curriculum content has been identified as a focus (Edwards, 2008; Masterson and Maslin-Prothero, 1999). Power is also identified at the macro level

(Hart, 2004) as is the lack of power of nurses as a group. Perhaps, significantly, there was also a perception of lack of cohesiveness amongst nurses as a professional group which, within a power model dichotomy, would lead to a lack of 'interest group' action. However, because the identification of power is evident within the nursing and education leadership literature, this model provides a useful structure for understanding nurse education. As Bush identified and Baldridge et al (1978, p43-44) wrote,

> This political model is not a substitute for the bureaucratic or collegial models of academic decision making. In a very real sense each of these address a separate set of problems and they often provide complementary interpretations. The political model also has many strengths ...

Subjective Models

The subjective model identifies the individual within the organisation. Subjective models are concerned with the meaning that individuals place on events and, therefore, phenomenology in often used as its methodological approach to enquiry. The meanings people place on events are central and the goals of individuals are seen as important, not the goals of the institution. Gronn (1999) used biographical methods of enquiry to explore and conceptualise leadership pathways. He identified that the leadership career can be described as passing through four stages. Firstly, 'formation' when experiences from childhood and adulthood are influential; 'accession' when preparation and positioning for leadership roles takes place; 'incumbency' when the leader experiences leadership and matures in that role; and 'divestiture' when the leader disengages from the leadership role. Gronn (1999) recognises that this approach has to be understood within the historical, cultural and social setting in which the career takes place, but in doing so he allows for agency to be exercised within the context of the environment.

Ribbin's work (1997) explores the values and attitudes of leaders and considers what took them to leadership positions. His work provides an exploration of the complexities of individuals within organisations and can be seen, in part, as belonging in this approach. Criticisms of this approach, as Bush (2009) has identified, include that whilst the organisation that individuals work within is assumed, the structure of those organisations is taken to have no more meaning than those who work in it. Nonetheless, this model of leadership is of interest because within my research I am seeking to explore the experiences of individuals. This focus on the individual is at the heart of the interpretative approach but its limitation in its pure form is to ignore certain issues such as the organisations within which people work.

There is not a body of research that has explored leadership within UK nurse education, despite the recognition of the importance of leadership in achieving the ambitions of the profession (Deans, 2003). It is evident from the literature and research that there are aspects of nurse leadership that can be located within existing frameworks and these provide structures for exploring and understanding complex situations. However, I do not seek to impose nor am I seeking to evaluate the existence of specific ways of working and it is for this reason that I have identified a number of management and leadership models as I seek to explore how the experiences of others might be understood.

Leadership in the Health Care Environment

Leadership is considered central in the delivery of high quality health care. However, it is not within the scope of this literature review to explore fully the leadership literature and research within the health care environment, only to provide an overview of some key influences. It is also important to recognise that nurse teachers who have left the NHS to take up teaching posts will have arrived from an environment where the talk and expectations of leadership

have a significant presence. Also, nurse teachers retain close professional relationships with the NHS.

There is a substantial interest in leadership within the NHS and it is identified as a key facet of delivering high quality care. The NHS Plan (DoH 2000, p96) identified that 'Delivering the plan's radical change programme will require first class leaders at all levels'. In 2003 the Office for Public Management identified that the nation's health will depend on leaders influencing areas of health and health provision including influencing education policies. The 'Darzi Review' (DoH, 2008) identified the need for NHS staff to lead, and identified that clinicians were expected to provide leadership. A National Leadership Council was established in 2009 as a subcommittee of the NHS Management Board in recognition that:

> Outstanding leadership is strongly associated with high-performing organisations, good outcomes and a culture of safety and quality. The NLC's role is to support and develop world-class leadership which puts the quality of patient care at the heart of everything the NHS does (National Leadership Council, 2011).

The Council emphasise the personal qualities that are required of leaders which include self-awareness, acting with integrity, working ethically, communicating effectively and managing their emotions. These personal qualities are identified as important in delivering the NHS strategy.

There is also a substantial body of literature on leadership in nursing in the health care environment. However, this division is simplistic because most authors recognise the complexity of the organisations in which they work and the importance of interdisciplinary working. Literature and research into the nurse leadership role frequently place the nurse within the multidisciplinary team and identify the contribution of nurses. McCallin (2003, p365) argued that interdisciplinary models of leadership have emerged in an attempt to,

> … Modify existing theories of leadership that have been vague, and continue to be poorly understood, despite considerable effort to explicate knowledge over several decades. Interdisciplinary leadership has emerged from traditional models of leadership that are outdated in the health reform environment.

However Murphy (2005, p128) argued that historical influences, in particular the lasting legacy of Florence Nightingale's autocratic leadership style, still permeate contemporary nursing practice, though often from a mixed perspective: 'These are mirrored in organizational philosophies, transactional and autocratic leadership styles and disempowered staff'.

Leadership within the health care environment literature shares, in common with other disciplinary leadership study areas, no agreed single definition of leadership (Ford, 2005). But, however leadership is conceptualised or defined the focus is largely on the process and actions needed to improve clinicians as leaders, or on how to improve care through effective leadership, rather than on the structures that support leaders. Leadership texts and training programmes written for nurses and health care workers often focus on competencies and traits that leaders must possess and exhibit. A substantial number of training programmes exist that focus on the development of the skills needed by a leader. Edmonstone and Western (2002) identified the range of leadership development programmes to meet the NHS's needs. These included centrally-funded national programmes such as the nursing and advanced health practitioner programmes and self-financing national programmes such as those offered by the Kings Fund. Other programmes are provided at regional and employer levels. Leadership programmes were also accessed, for example when individuals attended or registered for university programmes. Werrett et al (2002) reviewed the impact of the 'Leading Empowered Organisations Programme' in the West Midlands, and whilst participants found the

programme useful, they were unable to identify examples of how the programme impacted on their delivery of care in the clinical environment.

Hewison and Griffiths (2004) identified that whilst leadership is crucial, it should not be seen in isolation from the wider environment. They reviewed the evidence concerning leadership development programmes within nursing and concluded that leadership is only one element of the changes that need to occur in health care: '… too much emphasis on leadership without an equal concern for transforming the organisation nurses and other health personnel work in may result in leadership being added to the list of transient management "fads" which have characterised health care in recent years' (Hewison and Griffiths, 2004, p464). Ford (2005) identified that within the NHS leadership training focuses on 15 qualities that the leader must aspire to which include personal qualities such as self-belief, self-awareness and personal integrity. This focus on heroic qualities leads to leadership being seen as an organisational panacea and fails to take account of individual's identities, experiences and power relations.

There have been a number of systematic reviews of leadership within the NHS and public sector environment. Some recent reviews of contemporary leadership have been carried out that have encompassed nursing leadership within general public sector leadership reviews. The Performance and Innovation Unit (2001), which is part of the Cabinet Office, carried out a literature review of changes and trends in leadership thinking and the implications for public sector staff. The review used data from schools, local authorities and the NHS. Whilst the review has no profession-specific focus, the one example given for nursing relates to cutting patient waiting times, where the focus again was on 'getting the job done'. This review identified that with higher demands and greater public expectations there was a need to

develop better and more effective ways of working. They also identified many examples of excellent practice and that within the current system there was,

> … little shared understanding of the qualities required for effective leadership in today's public services … that Leadership theory is riven by conflicting interpretations, in a full spectrum from those who emphasise the primary importance of personal qualities to those who say that systems are all important (The Performance and Innovation Unit, 2001, p4).

Warwick University's 'Systematic Review of Leadership Development' (2003) identified the need for clear and explicit approaches to leadership and leadership development in the NHS, the public and private sector. Their conclusions from the literature include ensuring that leadership development is consistent with the model of leadership identified as needed by not, '... developing transactional leaders, when the organisation needs transformational leaders' (Warwick University, 2003, p10).

The Henley Management College's literature review (commissioned by the NHS Leadership Centre) considered the evidence for the contribution leadership development for professional groups makes in driving organisations forward (Williams, 2004). Their findings were that there is evidence that professional groups can be effective in driving organisations forward but that leadership development needs to be both work and programme based, and must also take into account organisational culture. Leadership development must happen at a team, as well as at an individual level and that transactional and transformational leadership skills need to be developed.

The Health Foundation Review of Research's 'Leading Improvement Effectively' (Ovretveit, 2009) focused on 'What do healthcare leaders need to do to stimulate and sustain successful improvements to their services?' In a wide ranging review that acknowledged that there are few empirical studies of leading improvement, and that there is a need for such studies, the

report is presented as identifying the type and level of senior leadership needed and the factors that help and hinder leaders. The report's findings into nurse leadership stated that they could not find any research of sufficient standard, and found no, '… Systematic empirical studies into nurse leadership for improving that could be used to formulate evidence based actions for different nurse leaders' (Ovretveit, 2009, p38). They did, however, identify one personal account by a nurse that, drawing on transformation concepts, described practical steps taken to improve care by building high expectations, setting small achievable goals, encouraging staff to make changes and celebrating success. The report's recommendations include further research in order to answer the question, 'What do healthcare leaders do?'

Whilst no clear definition of leadership exists, the model of transformational leadership is popular within the literature. The focus on leadership within the NHS is clearly located in improving services; however, Hewison and Griffiths (2004) question the orthodoxy of identifying leadership as the only element within the health care environment in need of improvement and change. Health Service research on leadership has been prolific with studies focussing on improving services. Although no preferred leadership model has been identified the concept of the transformational leader is evident in some of the literature.

Preparing to Move and Adapting to Higher Education

The move of NHS nurse tutors away from familiar structures to universities was not universally popular and Bradshaw (2001, p185) wrote that,

> Although the plans and proposals of the professional leadership chimed with the culture, they were not welcomed by many grass roots nurses, for whom the vocational tradition was still very relevant. Nevertheless, disagreement was ignored and the apprenticeship training was replaced by a new educational system, designed to increase the status of nursing as an independent self-regulated profession.

The literature was reviewed for the period 1986–1992, looking for nurse tutor reaction to the proposals. Little appears to have been published on what nurse tutors thought about the proposals. This lack of education staff's response to proposed change had been noted before by Flemming (1985), who wrote that in response to the 1985 RCN report, when presented by Harry Judge to a meeting of 380 nurse tutors, there was almost no response, the room was silent with just one question asked. Flemming (1985, p55) wrote, '… discussion can do little harm to the profession. What can harm it is a lack of discussion'.

As a result of this move, nurse tutors were to become employed by universities; with this came a new working environment, culture and new management structures. In addition there were new terms and conditions of employment, though many staff had their NHS terms and conditions of employment protected by The Transfer of Undertakings (Protection of Employment) Regulations (TUPE) (Department for Business Innovation and Skills http://www.berr.gov.uk/) and, for instance, many remain in the NHS pension scheme. It should be noted that whilst none of the literature identifies the following point, many nurse teachers entered schools, departments or other faculties that were not headed by nurses. Some nursing departments became part of established medical schools; others were located within, for example, social work schools. Whilst nurses may have become part of senior management teams, they did not always become head of school. In this respect the goal of nurses being led by nurses that the original 'professionalisers' had sought was not attained, and it might be argued that a compromised position was achieved. By virtue of entering this new environment there had been an expectation that a nurse's status would be improved. The move to HE had been promoted from within the profession as a means to improve the status of nursing, but the literature evaluating or discussing whether this has in anyway been achieved is sparse.

Gibbs and Rush (1987) wrote that they carried out their study in response to not being able to find any literature on the experience or reaction of education staff involved in the proposed move to HE. It had been recommended that nurse tutors should all be graduates, but in Gibbs and Rush's (1987) sample of 115 nurse tutors, just 46 (40%) had degrees or were studying for them. Of the 69 nurse tutors who did not have degrees or were not studying for them, three-quarters of the women respondents thought it was not unrealistic, but that it would be difficult to study for a degree. Of the men, half thought it would be realistic. Of the same sample, when asked if their preference for the future of nurse education was in colleges of health, universities/polytechnics, 'institutes' or schools of nursing there was strong support for colleges of health. How nurse tutors viewed the prospect of moving to HE reveals that areas of concern included the issue of ensuring that nursing did not lose touch with clinical practice and falling victim to 'academic drift' (Gibbs and Rush, 1987), a finding that is supported by Glen (1995). Articles in the professional journals during this period were mostly concerned with curriculum development, for example Cave (1994) and Cook (1991), wrote on ensuring that a theory-practice gaps did not occur, and that changes to the curriculum also provided leadership opportunities for the nurse tutors. Also of concern was how tutors would be supported in their new roles.

Clifford (1995) carried out research using a questionnaire identifying the reasons nurse teachers entered nurse education. This research was carried out just prior to the integration into HE. Her findings were that 22% had a desire to teach, 53% had enjoyed teaching in a previous job, 35% wished to influence or improve care, 46% named career progression and 18% because of frustration in a previous role including that teaching would mean better working hours' or that it was a 'better option than management'. She notes that a number

recognised that research skills would be important in HE but were given a low priority and that this would be a major challenge.

Camiah (1997) described the changes in the role and work of nurse tutors brought about by the proposed education changes. A case study approach was adopted using interviews as a method of data collection. Content analysis was used to analyse the data. She found that a minority of tutors felt threatened and apprehensive about the move to HE, and that most felt that their role would alter to reflect the change brought about by the HE environment. For instance, styles of teaching would change with more student-focused learning. She found that many nurse tutors claimed that they had to report to two or more senior managers and that this put them under many pressures. This may, she argued, be a consequence of rapid reorganisation of nursing schools. She further concludes that nurse tutors may be inadequately prepared for their new roles, given the haste with which nursing schools prepared for the approval of new HE courses.

Knight (1998) reported on data collected between 1992 and 1994 and described the 'lived' experience of nurse tutors who faced changes to the nurse curriculum and integration into HE institutions. His data was gathered using interviews and was informed by grounded theory. He described nurse tutors as having a grief response. He identified some as being 'waiters' or 'movers', as a coping mechanism in their reaction to change. Although all the teaching staff agreed with the Project 2000 changes for nurse education, they also felt unhappy and threatened by the process and the changes that had occurred as a result of the implementation.

Carlisle et al (1996) carried out research on the changes in the role of nurse teachers following the formation of links with HE. Their study was carried out between 1991 and 1994 and used several methods of data collection, including a modified Delphi survey and telephone

interviews with nurses, health service managers and HE lecturers. Over 95% thought that linking with HE was desirable in terms of giving nurse teachers increased academic status, but it was not seen as probable (46.9%) that they would have equal academic status to other HE lecturers. Teaching large groups, maintaining, and giving support to students were also identified as areas of particular concern. The authors concluded that the requirement to be a 'jack of all trades' may dominate with the consequence that excellence will not prevail in either teaching, research or practice:

> The competing responsibilities of teaching theory and practice of nursing, facilitating the development of clinical skills in Project 2000 students, on-going pressure for higher degree status, and added responsibility to conduct research and publish may well be an unrealistic goal to expect of every Nurse Teacher (Carlisle et al,1996, p769).

More recent research that has sought to evaluate the impact of the move to HE has been conducted by Deans et al, (2003, p147) who wrote that,

> Leadership and credibility of nurse academics is fundamental to achieving the goal of improving the status of nursing yet the previous decade has produced little or no research on the relationship between the progress toward the stated goals and the role and function of nurse academics.

The Deans et al (2003) study can be described as descriptive, with a focus on how nurse academics viewed their work and their place within HE. The study used a questionnaire and the results were given as descriptive statistics. Their study comprised a 50% randomised sample of universities selected from the 60 HE institutions that provided both pre-registration and post-registration nurse education. A questionnaire was sent to 1612 individual nurse academics including different academic levels from lecturer practitioner to dean. The return rate was 543 (33%).

The questionnaire requested demographic data, information regarding the subject's career as a registered nurse and academic career. It also included a list of 28 items which respondents were asked to rate on a five-point scale, 1 (highly unlikely) to 5 (highly likely) concerning whether specific changes in nursing education were likely to occur, and whether it was a preference that they did occur. The information regarding the academic career of respondents identified a mean score of four years employed as an academic in their faculty or university school of nursing. Respondents were asked to identify their qualifications and 35% were identified as having a bachelor's degree as their highest level of academic qualification, 60% had a master's degree and 5% had a doctorate. In terms of predictions and preferences for the future of nurse education, the results demonstrate some discrepancy between these two positions. For instance, in response to the statement 'Nursing will be fully accepted by other academics as a discipline in its own right', a mean prediction of 2.77 was given and a mean preference of 4.36. An example of predictions being higher than preferences includes 'The research assessment exercise will cause nurse academics to prioritise their research over teaching', to which a mean prediction of 3.68 was given and a mean preference of 2.20. Where discrepancy between prediction and preference was found, the authors considered this as a 'finding of concern', as this generally meant disquiet amongst nurse academics.

The main findings of the study indicate that although advances have been made, a number of nurse academics had concerns regarding the development of nursing as a discipline and parity of status with other academic disciplines. Workload and resources were also areas of concern and there was also a perception of lack of cohesiveness amongst nurses as a professional group. Nurse academics in this study thought that, despite the end of the hospital-based apprentice models of education, workforce requirements rather than disciplinary development were expected to drive the nurse curriculum by the year 2008. In addition, the authors noted

that respondents predicted that hospitals would become responsible for the education of nurses at post-registration level and they write, '... This prediction has the potential to undermine the development of nursing as a profession unless some collaborative programmes between health agencies and universities can be initiated ...' (Deans et al, 2003 p153).

The Deans et al (2003) work identified similar themes to those highlighted by the RCN report 'Charting the Challenge for Nurse Lecturers in Higher Education' (Evers, 2001). The report surveyed and analysed the concerns of nurse teachers in HE. Focus groups identified nine key issues which were then used to devise a survey tool. The issues covered were contractual status and conditions, workload, job security, clinical time, integration and status, role, student support, morale and union representation. The questionnaire was sent to every nurse who held joint RCN and Association of University Teachers (AUT) membership (approximately 1,600) and through the RCN education forum newsletter. A total of 703 questionnaires were returned. It was estimated that nationally a total of 5,000 nurse lecturers were employed at this time (RCN 1997), though the precise number was not known as centralised data does not exist. The data was analysed both qualitatively and quantitatively.

The findings identified workload, role and clinical time as high priorities, and concern was expressed over the extended teaching year, multiple student intakes and conflicting demands from HE, the United Kingdom Central Council (UKCC) (nursing's regulatory predecessor of the NMC) and the NHS. Respondents also identified pressures of work leading to health problems such as stress. Role conflicts with different stake holders including HE, the NHS and the UKCC caused problems and the need to undertake multiple roles, resulted in less time for personal development, scholarly activity, personal time, annual leave and weekends. It was a belief that clinical time was not valued in HE and the maintenance of competence and

clinical credibility was difficult. Student support, morale, integration and status were identified as medium priority issues. The findings of the study suggest that respondents felt that HE was not organised to meet the needs of a more diverse student group as opposed to those of more traditional students, and that HE facilities were not always available to support students on extended year programmes. Lecturers felt undervalued and discriminated against, and some felt like second class citizens. Respondents also identified that research was accorded greater status than teaching, but that teaching was the first and extremely demanding priority for many nurse teachers.

Integrating two cultures, HE and NHS posed many problems. Contractual status and conditions, job security and union representation were identified as low priority issues; however, they still posed problems with some staff reporting that terms and conditions looked satisfactory on paper but that the reality was often different. Respondents believed that redundancy was being used as a threat to those who were having difficulty coping with the demands of their workload, and that older, part time and ethnic minority staff felt particularly insecure. This study therefore raised a number of concerns, and the author identified the lack of research concerned with the 'survivors' of the change process that integration into HE brought to nurse tutors:

> Academic nurses appear to be focussing their research endeavours on the educational *process* rather than the educational infrastructure in which they find themselves located. This issue itself poses some interesting and important research questions which need urgent exploration if nursing is to fully utilise and secure its place within the academic institutions, in addition to ensuring that the educational environment for future generations of nurses is healthy and robust (Evers, 2001, p9).

Murray and Aymer (2009) compared the practices of social work educators in England with that of nurse, teaching and doctor educators running professional courses. They identified that since social work became established in HE it had 'struggled to find its place within the

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academy' (Murray and Aymer, 2009, p81). They identified close parallels between social work, teaching and nursing in regard to regulation, registration and adherence to a code of practice or conduct. Their work focused on how educators experienced their role within HE and concluded that teacher educators, social workers, nurse educators and, to a lesser extent, medical educators find similar conflicts between commitment to the development of the profession and the demands of the academic institutions. Their study used Bourdieu's concept of fields within the social space of education and conceptualised educators as second order practitioners because of being one removed from their original field. They found that the different professional groups had similar missions: teaching in HE, research or scholarship, contribution to professional fields and service to the university, underpinning professional practice. Other similarities included engagement in complex pedagogies, struggling to engage in valid research and perceptions that their departments had low status within HE institutions.

Meeting both professional and HE imperatives created tensions. Their study highlighted the complexities of having to meet multi layered accountability mechanisms in their work. Other issues highlighted in the study were struggles to engage in research, especially where common tensions existed in combining engagement in research worthy of the Research Assessment Exercise (RAE) with high quality teaching. Published work which was not RAE-submissible because it had a 'professional focus' was also highlighted as problematic. From the practitioners perspective, work published in professional journals reached more practitioner staff and therefore had an impact on practice which was of value. The authors argued that professional courses must be afforded the same government priority in terms of policy development as professional courses:

> … [professional courses] are an integral part of the HE sector's contribution to the economic, cultural welfare of the nation. But we would suggest that the tensions which

this study has indicated may indicate a lack of joined up thinking between policy makers and universities about the value and importance placed on professional courses, and the national needs for high quality professional preparation (Murray and Aymer, 2009, p93).

The studies described above have identified how individual educators have perceived their roles within HE. But whilst Deans et al (2003) referred to the importance of leadership in nurse education there is no overt identification of leadership as an operationalised concept within the research. Evers (2001) identified the impact of leadership decisions upon the working lives of nurse academics who have 'survived' the integration into HE. But because the work was commissioned by the RCN its intention was to utilise the information to develop strategies for the RCN to support lecturers. Deans et al (2003) identified that amongst the nurse academics questioned there was strong commitment to the advancement of the discipline, identifying that disunity amongst nurses must be resolved in order that advancement of the nursing knowledge base and dissemination of that knowledge is permitted to flourish. Whilst neither study sought to focus on educational leadership, their work has relevance as both pieces of work identified the lived reality of leadership decisions. Murray and Aymer (2009) identified the failings of policy makers and universities to provide joined-up thinking in the provision of professional courses.

Whilst there has been little research into the position of nursing in HE, there have been a number of authors who have given critical opinion and commentaries. Thompson and Watson (2008, p1) wrote that academic nursing seems to have lost its way:

> Many nurses, and others involved in nurse education, appear neither to understand the purpose of universities, nor to recognise the importance of scholarship. It could be argued that the wholesale move of nursing into the higher education sector in the UK was premature; that many nurses now in universities are on unfamiliar territory without a map.

They wrote that this situation was, in part, a result of changes in HE, in particular the expansion of universities but also, '… an anti-intellectual ethos pervading nursing and anything perceived to be intellectual is criticised as elitist ... the last thing people in positions of authority or power over nurse education would appear to want is questioning, confident and assertive nurses' (Thompson and Watson 2008, p1-2). The authors argued that because of failure to recognise the importance of scholarly work, there has been a lack of people developing research skills at a time when there has also been an expansion of university nursing departments. This has led to a vacuum of academic leadership, with under qualified and inexperienced staff being appointed to chairs. They conclude by arguing that it would be a tragedy if the struggle to gain academic acceptance in universities evaporated.

Miers (2002) identified cultural factors that contribute to problems in nurses gaining equal status in universities. She argued that historically, because nurses did not require academic qualifications beyond GCE 'O' levels, the more academically successful girls did not consider entering nursing, resulting in caring courses having low status. Nurses, clearly aware of this distinction, celebrated the practical nature of their skills and their caring role in order to gain some status, bringing them a sense of responsibility and respectability. However, within nursing this led to an anti-intellectualism movement which can be viewed as a defensive reaction against a culture that defines practical activity as inferior to abstract thinking skills. Miers (2002) referring to Friere's (1996) work on pedagogy and oppression, argued that this can be viewed as an act of rebellion against the oppressor. However, this then allows the oppressor to label the oppressed as unintelligent and unthinking. Dialogue, she argued, is essential for both the oppressor and oppressed in order to gain freedom from negative and subjecting myths:

> Historically, nursing's own culture, embedded in hierarchical forms of management and in ritualistic patterns of nursing practice, has often inhibited dialogue, through dominating nursing recruits. In the past nurse education has been seen as denying nurses the opportunity to recognize and examine the structural and cultural context of their own struggles (Miers, 2002, p217).

However, Miers (2002) also identified that there is reason for optimism for nurse education as the culture of universities is changing. She identified that the Quality Assurance Agency's endorsement of learning outcomes and the identification of employment-related transferable skills, help link cognitive attributes with employment skills and opportunities. Many of the challenges that leaders in HE face in meeting these student needs, alongside the changes to funding mechanisms, the surveillance of research and teaching quality, create a more flexible model of what it means to be educated. Nurses can take advantage of this cultural change. Ball (2003) takes an opposing view on this measurement of performativity, and wrote that whilst some may see opportunity, for others it creates tensions as the commodification of knowledge and professional judgement is subordinated.

Edwards (2008, p131) wrote in an editorial of the merger of schools and colleges of nursing into universities, '... that in many cases the National Health Service corporate mentality prevails in the face of weak competition from older more traditional ideals of academic freedom, and a minimum of managerial restraint'. In raising the issue of leadership she described bureaucracies, subservience and subordination and wrote that nurse leaders within HE are suffering from 'bastard leadership' (Edwards, 2008, p132). She argued that the efforts of central government and the nursing professional bodies had been unremitting in their continued erosion of the nurse teachers' autonomy, professional status and claims. These bodies, along with the Quality Assurance Agency (QAA) benchmarks, Framework for HE Knowledge and Skills Framework and National Service Frameworks have created leaders who are conduits of government policy, rather than leaders who define educational direction

themselves. This stifling culture, she argued, had a detrimental effect upon academic staff and students: 'This stifling de-motivating, subservient educational system fails to produce a creative and flexible workforce' (Edwards 2008, p132).

Research concerning the move into another organisation's culture and the adaption of new ways of working was carried out by Congdon and French (1995). This work focused on the challenge faced by nurse educators leaving the culture of the NHS and integrating with the culture of tertiary education. They developed their study based on the concepts of collegiality developed by Hargreaves (1994) who made a distinction between collaboration and contrived collegiality. Congdon and French (1995) argued that the challenge required of nurse educators was the adoption of traditions normally associated with university culture which they identified as collaborative collegiality when moving from what they identified as environments of contrived collegiality. They argued that university cultures were characterised by 'collaborative collegiality', defined as spontaneous, voluntary, development-orientated, pervasive across time and space and unpredictable. Non university cultures were characterised by contrived collegiality defined as administratively regulated, compulsory, implementation-orientated, fixed in time and space and predictable. Nurse tutors, they argued, were facing a transition from contrived collegiality to collaborative collegiality. Using a case study approach they videoed interviews with five lecturers working in a HE institution and thematically analysed the content. Four major themes were identified from the interviews: 1) ingroupism; 2) nursing the students; 3) nurse academics are different and 4) power relationships.

The conditions that were found to enhance the development of collegiality within 'ingroupism' included a shared homogenous background, a shared educational philosophy

and shared aims and purposes by voluntarily collaborating. The 'nursing the students' theme identified that nursing lecturers felt responsible for their students' learning and how, as nurse tutors, they had felt possessive towards their students – they referred to 'my students'. This behaviour was identified as more appropriate to nurse tutors in colleges of nursing than lecturers in HE which advocates independent learning and student autonomy. They also identified that the respondents felt that 'nurse educators are different' because they considered themselves caring in their teaching and supervision of students and they tended to put their own interests secondary to those of the students. The final theme, 'power relationships', emerged from data related to expectations of leadership and the different styles associated with the health service and tertiary education.

The group identified that, under the process of change, the group appeared to have taken collective responsibility, and that the leader acted as co-ordinator, similar to that of 'lead teacher'. Their leader's belief and trust in them was an important factor in their high level of commitment and three respondents said they felt empowered to make major decisions, regardless of their acceptance by the institution. However, tensions were noted by the respondents when the leader was compromised and had to accept decisions that went against his better judgement. There also appeared to be non-egalitarian 'terms of membership of the group' with an unwritten pecking order. A new member of staff expressed difficulty in settling into the group: 'I was accepted but I was still an outsider for quite some time … It was just the settling in ... now I know my place within the group, I'll give my all to it' (Congdon and French, 1995, p 455).

In conclusion, the authors write that nurse tutors who nurses were coming from autocratic environments face problematic issues in terms of adaption to university culture. As collegial

relationships determine a different set of power relationships, the adaption required of the nurse educator also requires a personal change strategy for what is essentially a career move. Resources should be spent not only on structural level integration but also at a personal level.

The research on nursing's integration into HE is sparse, and what is available highlights concerns over the acceptability of nurse tutors and their discipline in HE and the conflicting demands in meeting professional and academic requirements. In these areas, it has been identified that nurses share these concerns with other vocational subject academics. Commentators have identified tensions within the nursing profession, in particular an anti-intellectualism that has led to an under development of nurse academics skills. Whilst some authors argued that progress has been achieved, there appears to be little evidence that nurse education as a group feels satisfied. Nursing has been described as autocratic and it has been identified by Congdon and French (1995) that nurse tutors from these autocratic environments would face difficulties in adjusting to university environments which are based on collegiate principles. When leaving the NHS, nurse tutors expressed concern over losing touch with practice and whether they would achieve equal academic status with HE lecturers. Most of the research carried out with nurse teachers on making the move to HE was carried out at a professionally turbulent time as the integration of nursing into HE occurred between 1989 and 1996 and as such may represent the anxieties of that period.

Chapter Summary

Models of leadership that have been developed in the tertiary field of education have been identified and explored with reference made to literature in the field of nursing. These models provide useful frameworks for exploring nurse education leadership. The research on leadership in the health service and nursing literature has also been explored identifying that

leadership is largely focused on the process and actions of individuals needed to improve the skills of clinicians as leaders. Finally the literature on nurse teachers and their reactions and adjustments to HE have been identified. My research questions have arisen from my reading of the research and literature and from my position as a practitioner who has identified that nurse education leadership is unexplored territory.

CHAPTER 3 RESEARCH STRATEGY

My research aim was to explore nurse education leadership as identified and experienced by nurse teachers working in the field of nurse education, and in this chapter I will discuss and identify how this aim was achieved. I identify the wider philosophical frameworks of research and locate my own philosophical position. I identify that my methodological approach is influenced by phenomenology in the North American tradition, described by Caelli (2000) as being different from traditional phenomenology in that it includes the thoughts and interpretations of experience by interviewees. A total population sample of 18 nurse teachers was interviewed using semi-structured interviews. Field notes including autobiographical insights were recorded and used to triangulate the data. I have addressed the issues of reliability and validity within the study and in particular have considered my position as a co-worker within these constructs. I have identified thematic analysis as the means of analysing the data and I have also identified how the research was managed.

Knowledge and Philosophical Frameworks

Gunter and Ribbins (2002) wrote that different kinds of research questions require the use of different forms of enquiry and logic. In order to identify where the intellectual work of this research would be located, I looked at the knowledge framework they developed in which they identified five knowledge domains within education leadership research. These they identified as,

> 1. Conceptual research, which is concerned with issues of ontology, epistemology and conceptual clarity;

2. Critical research, which is concerned with the emancipation of leaders and followers for social justice;

3. Humanistic research that seeks to gather and theorize from the experience and biographies of leaders and those being led;

4. Evaluative research that seeks to abstract and measure the impact of leadership at different levels and

5. Instrumental research that seeks to provide leaders and others with effective strategies and tactics in order to meet organisational goals.

I have located my work as being closely associated with humanistic research because my research is concerned with the leadership experiences and the biographies of those who are not in formal leadership positions.

Ontology and Epistemology

Whilst many researchers do not identify their philosophical assumptions about the social world, I consider this an important distinction to make. There are broadly two positions the researcher can take, that of objectivist/positivist, or subjectivist/interpretative, and these positions will influence what they consider is a valid topic to research and how the research is carried out. The objectivist/positivist position can be understood to mean following the logic of demonstration (Gunter et al, 2008), whilst the subjectivist/interpretative position can be understood to mean following the logic of discovery (Gunter et al, 2008). These approaches to research can be understood to be founded upon ontological and epistemology assumptions.

Ontology is concerned with the nature of being. From an ontological position, the researcher must consider how they themselves conceive social reality. Cohen et al (2011) identified that it is important to consider our assumptions about the social world. They wrote that the researcher should consider whether they believe that social reality is external to individuals or

is a product of individual consciousness: 'Is it a given "out there" in the world, or is it created by one's own mind?' (Cohen et al, 2011, p5). These two polar positions can be identified as objectivist/positivist and subjectivist/interpretative. The objectivist/positive position is founded on the belief that reality and truth are external to the individual and that the scientific method is best suited to understanding and uncovering the processes of human behaviour. At the other end of the continuum is the belief that reality and truth is purely the product of the individual.

Epistemology can be defined as a general set of assumptions about the best ways of enquiring into the nature of the world and how knowledge is produced and constructed. (Cohen et al 2011). It is important that the researcher ensures that the epistemological approach is consistent with their ontological approach, although this is often not made explicit by researchers. The objectivist/positive perspective claims that the methods of natural science are appropriate for social enquiry because human behaviour is governed by natural laws. The objectivist/positive position is usually adopted by those carrying out quantitative research and numerical analysis is used. The subjective/interpretative tradition seeks to explore the social reality of interviewees in order to understand meaning. Researchers taking this position use qualitative approaches to their research and analysis as they seek to explore and interpret, not measure or test. Many researchers adopt a position in the mid-ground between the objective/subjective, choosing to recognise that there is a reality out there but that it does not predetermine all human action, and that individuals will interpret events and situations from their own constructs of understanding. Watling and James (2011) wrote, 'The qualitative researcher, especially one working within such an epistemological framework, is likely to be searching for understanding rather than facts: for interpretations rather than measurement: for values rather than information (p355).

My own position is that there are 'external truths' in the social world and that within our communities we share many common experiences and understandings. However, as individuals we have different perspectives and beliefs about those external truths, based on our own social and cultural experiences. Therefore, in order to understand the experiences of individuals it is necessary to ask them, not test them. A subjective/interpretative approach has therefore been identified as appropriate to my research. I have identified my intellectual position within these frameworks; I believe there is a material world that provides constructs and that we interpret that world within our own understanding. In order to enquire how others understand and experience that world we must allow them to speak for themselves. I have located my work as humanistic within the knowledge framework identified by Gunter and Ribbins (2002).

Methodology

My methodology approach has been influenced by North American phenomenology which was identified and described by Denscombe (203, p104-5) as being linked to,

> … The disciplines of sociology, psychology, education, business studies and health studies … This kind of phenomenology is less concerned with revealing the essence of experience, and more concerned with describing the ways in which humans give meaning to their experiences. Here lies the defining characteristic of the North American approach: *its concern with the ways people interpret social phenomena.*

Caelli (2000) wrote on the use of phenomenology (North American tradition) in nursing research and identified that that, '... descriptions of experience, rather than being primordial, may also include the thoughts and interpretations of the experience that occurred ...' (p369).

Caelli (2000) argued that the North American phenomenological tradition recognises that culture and tradition have an impact on how people view the world, and that to remove

cultural and inherited understandings is not possible. In this respect North American phenomenology does not concur with what Cohen et al (2011) described as interpretative approaches, at risk from being 'hermetically sealed from the world outside' (p21), as those working in this tradition are not seeking universal or unchanging truths but recognise the influence of their environment.

The issue of cultural understandings is important because as a co-worker I share those same cultural understandings. I have, in Chapter 1, identified autobiographical detail and influences that informed my research interest. Drake and Heath (2011) identified that students on professional doctorates frequently research areas of practice and institutional concerns after several years of working with the issues, and this places them in positions that may not be methodologically aligned with conventional research approaches. My own position as a nurse teacher means I work in the same environment and belong to the same professional group as those I am interviewing, but my thoughts and interpretations of experiences may be 'my reality'. So whilst my position may give me insights, my insights may be different from those I interview. My field notes (see below) provide 'my reality' and the interview data (see below) provides those that I interviews' reality. These two approaches through triangulation will be used to identify a shared reality as I look for common themes arising from the data.

Research Methods

When considering research methods it is important that there is fidelity between the research aims, the methodology and the methods used in gathering data. I have identified interviews and field notes which include autobiographical insights as my methods of data collection. I have also discussed my position as a co-worker within the process of data collection.

Interviews

Kvall and Brinkman (2009) wrote that if you want to understand how people understand their world and their lives, why not talk to them? The interview used in qualitative research can be seen as central for knowledge production as the researcher 'attempts to understand the world from the subjects' point of view' (Kvall and Brinkman, 2009, p1). The interview, used as a method for data collection, can be conducted in a highly structured manner to being completely unstructured, with many interviews falling somewhere between these two extremes (Bell, 2002). Cohen et al (2011) identified that interviews should be fit for purpose, with structured interviews being better suited to research that seeks to gain comparable data and unstructured interviews being suited to studies that seek individuals' views of the world. Ribbins (2011) wrote, 'The fundamental objective of qualitative interviewing is to provide a framework within which respondents can express their views in their own terms' (p209).

I identified that semi-structured interviews would be appropriate to my research because as a co-worker I had some insights into the issues to be addressed and the questions to be asked. But it was also important that the interviewees would be able to respond to the questions from their own experience and framework of understanding. The semi-structured interview ensures that the same questions are asked of interviewees, but also allows for flexibility, with probing or changing the order of questions during the interview (see Appendix 1, Question Schedule). Ribbins (2011) wrote of his experience of being pragmatic when interviewing and not interrupting the interviewee if they jumped to a later question, as interrupting may be disruptive, be annoying and reduce the interviewee's willingness to speak freely. This style of interview he wrote, 'Substantially reduces the possibility of interviewer bias and increases the comprehensiveness and comparability of interviewee response' (p 210).

Advice to researchers conducting interviews also frequently focuses on the influence the researcher may have on the interview. Holliday (2002) wrote that,

> … the relationship between the researcher and the participant is an issue which inevitably pervades all aspects … Any form of researcher presence is considered contamination by positivistic quantitative researchers … Within a progressive qualitative research paradigm, however … it is recognized that the presence and influence of the researcher is unavoidable, and indeed a resource, which must be capitalized on (p145).

As I was interviewing co-workers to whom I was already known, I considered myself a resource in the sense that I was known to the interviewees and not an 'outsider'. Coar and Sim (2006) wrote about interviewing fellow health professionals and stated that, 'As an insider, the interviewer can gain potentially rich insights by capitalizing on a shared culture and a common stock of technical knowledge, as well as feelings of collegial trust …' (p255).

Drake and Heath (2011) also identified several areas where the co-worker researcher may benefit. These include established relationships and collegial connections, though simultaneously these may also present a challenge if relationships with colleagues are contentious. However, the limitations of interviewing co-workers must also be considered. Coar and Sim (2006) identified that colleagues may feel professionally vulnerable in terms of their knowledge base. Unlike Coar and Sim, I was not interviewing colleagues on their professional knowledge base but on their experiences, so I considered this less problematic as this would not be interpreted as a 'test' of their professional knowledge.

Hockey (1993) discussed the potential problems that can arise from researching peers in familiar settings. He wrote that the advantages of researching in familiar settings include the lack of culture shock and disorientation, and also the possibility of enhanced rapport and communication. In addition, the ability to gauge honesty and accuracy of responses is noted.

The advantages of interviewing peers include those of interviewing in familiar settings but also that certain problems are apparent. Where, as in many traditional research settings, researcher and subjects are for the most part anonymous to each other, the opposite is true when interviewing peers. He wrote that it is important that the researcher recognises the element of friendship that exists and decides whether to play the role of researcher, friend or a combination of the two. The interview was not an informal 'chat', and I believe that during the interviews, because I was using a semi- structured question schedule, I did play the role of the interviewer at the same time recognising the element of friendship that existed between us as co-workers. This friendship and familiarity is reflected in the field notes where I recorded, for instance, that people seemed relaxed during the interview. In summary, Hockey's (1993) potential problems can be identified as listed below, and I have outlined how I have responded to these problems in the management of my research.

Table 2 Interviewing peers - problem areas and response (adapted from McGrath, 2004)

Problem area	My response
Intimate knowledge	I used semi-structured interview but asked questions in a conversational manner. Because of the relatively short period of time each interview took I found it relatively easy not to 'join in'
Filtering process	The information was honestly asked for and I can only assume the answers were honestly given, though it must be acknowledged that any interview situation is 'filtered'. I felt a sense of genuineness during the interviews and recorded this impression in the field notes I kept.
Peer assessment	I piloted the interview, but was self-aware in terms of the quality of questions and, in honesty I was concerned that I might be criticised. I felt my peers were supportive during the process and I did not, for instance, detect any negative body language. People seemed pleased to be asked many of the questions and pleased to have their opinions and experiences listened to.
Status differences	All interviewees had the same status as me. Other work-related status differences would be hard to identify. See comment above re challenge to 'interviewer status'.
Personal hostility	I was not aware of any personal hostility or history of hostility. No one declined to be interviewed or 'forgot' the appointment. Most interviewees stayed to chat informally once the digital recorder was switched off.
Discipline hostility	None noted. We all belong to the same discipline. Most interviewees are qualified teachers or studying for teaching qualifications and so regarded my interest in education leadership as an extension of 'our' interest in education.
Confidentiality	In the analysis I have taken particular steps to remove identifying features.

In terms of ensuring the interviews were efficiently conducted, I was aware that I needed to ensure that certain technical matters were addressed before starting the interviews. I had decided to audio record the interviews using a digital recorder because this provided a permanent record of what was said and was therefore more reliable than relying on memory or hastily written notes. Silverman (2001) identified that recorded interviews also preserve the sequence of talk and the utterances around; this is important in understanding what was said. I tested the recorder making sure that it was working properly and that speech was audible before I started the interviews. I was also aware that, as an interviewer, I needed to be conscious of my non-verbal behaviour when conducting an interview, in the recognition that enthusiastic nodding or frowning may encourage or discourage the interviewee (Green and Thorogood, 2009). I also recognised other skills as being important; for instance, probing the interviewee for more information but also to be comfortable with silences.

Despite being known to the interviewees the topic of nurse education leadership is not one that I had previously discussed with my co-workers, so I considered it important to abide by these rules regarding conducting interviews in order to allow the interviewee the freedom to share their experiences. I was conscious that interviewees may wish to identify experiences that I had not asked about. I asked at the end of each interview if the interviewee had anything else they wanted to tell me about or anything they wished to clarify. These questions were asked of all interviewees. Finally after I had transcribed each interview, I returned the transcript to the interviewee for them to change or clarify points.

Field Notes

The use of field notes as a means of data collection was identified as an appropriate method of data collection. Cohen et al (2011) wrote, 'The interview is a flexible tool for data collection, enabling multisensory channels to be used: verbal, non-verbal, spoken and heard' (p409).

In this respect, whilst the interviews were conducted the interview environment allowed me the opportunity to observe, and immediately following the interview to make field notes, based upon a reflective style. I recorded biographical information about the interviewees, what I heard and observed, and my reflective observations based upon whether I felt I had influenced what was said. I also recorded any 'autobiographical insights' and my reflection on what was said. Below I have given an abridged example of my field notes taken from one of the interviews I conducted.

The Interview (65 minutes) date xxx and time xxx., biographical detail

Interviewee 1. The interview took place in my office – offered alternatives but said he was ok with my office. Male, age 46. We've had a good working relationship for 5 years, worked at a statutory university before taking current post 5 years ago. Ten years' experience working in HE. Hospital-based trained.

Listening and Observed

Before the interview started he joked about saying the 'right thing' and that he'd never been on any sort of leadership or management courses – reassured that there were no right or wrong answers. Talked slowly with deliberation. Non-verbal body language – elbows on chair arms, hands interlinked thumbs being 'twiddled'. Looked relaxed and reflective.

I maintained open posture body language, nodded and smiled in order to encourage – mindful to do this to all responses so as not to give the impression of selective approval. Used paraphrasing to clarify.

Reflective Observation - what I 'felt and reflective thoughts and my experience.'

The interview felt 'professional' but comfortable with no tensions between us. Was he really worried about saying the right thing? Is 'saying the right thing' in front of me important to him? Unlikely, we have a good working relationship as equals and we frequently share information and work. This definitely wasn't a conversation as at no point was I asked my opinion. Answered many questions with 'I think' and had to be probed on the origin of his belief – had this happened to him to think this instance i.e. whether 'I think' was based on experience. When experiences were given following the prompt the examples were often clinical. Very clinically focused in his answers, though the examples also related to education opportunities such as a ward sister who had been a good teacher – 'she was inspirational a real leader'. My own experience of leaders has been of people who helped/encouraged me, not people who had been good teachers. Probed specifically on experiences of leadership in nurse education, did not mention national leaders and could not really identify any people he considered leaders, but that the NMC regulatory role 'was necessary'. Not particularly critical but reflective. The university was 'out there' not within his main frame of reference.

Figure 1 Field notes framework

As a co-worker keeping field notes provided the opportunity for locating myself within the data and acknowledging my role within the research.

Reliability, Validity and Trustworthiness.

Kvale and Brinkman (2009) wrote that some qualitative researchers dismiss the concepts of reliability and validity as being oppressive positivist concepts and others have argued (Silverman, 2001; Boudah, 2011; Bush, 2011) that for subjectivist/interpretative qualitative research, terms such as authenticity and trustworthiness are more appropriate. I have considered these issues with reference to my own work and I have also explored these concepts with reference to my own position as a co-worker within the research. The concept of reliability can be understood to mean that it is: '... essentially a synonym for dependability, consistency and replicability' (Cohen et al 2011, p199).

Kvale and Brinkman (2009) identified that reliability pertains to trustworthiness of the research findings. Pertinent to my research and conducting interviews, this can be understood to mean that if interviewed by another researcher, the interviewee would give the same answers to the same questions, or that when reviewing transcripts from interviews, others would identify the same issues. When using structured interviews this level of replicability may be achievable (Cohen et al, 2011); however, when using semi-structured interviews Kvale and Brinkman (2009) argued that a strong emphasis on reliability may be counteractive. For instance, the semi-structured interview often used in subjectivist/interpretative research allows the interviewer to follow their own style and to prompt for clarity when detail is sought. Kvale and Brinkman (2009) also argued that by following hunches, a greater authenticity is arrived at. This may be particularly apparent with co-worker research as identified by Coar and Sim (2006), who argued that insider status provided advantage and the opportunity for capitalising on a shared culture and a common stock of technical knowledge. Therefore, the researcher is in a position to ask more pertinent

questions when detail is required and a greater authenticity is achieved. This advantage held by the insider conducting research is not replicable by another researcher.

My use of field notes, which included my observations, reflections and autobiographical insights, were specific not only to the interview but also unique in being based upon my experiences and understanding as a co-worker of those I was interviewing. They, therefore, also do not meet definitions of reliability that include replicability. Research that relies on a more subjective/interpretative perspective, using qualitative methods of data collection, cannot and does not aim to achieve replicability because the findings are unique to the individuals taking part in the research. Cohen et al (2011) wrote that the term reliability is often contested and that terms such as dependability and trustworthiness are more appropriate to subjectivist/interpretative work. The aim therefore, is to achieve a level where trust and confidence in the research can be established. In order to do this I have been honest in locating myself within the frame of the research and in this I have been open in identifying my own interest and influences within the research (see Chapter 1). I have identified above how, when conducting interviews, I dealt with any potential problem areas and my own position and contribution to the research data. In making my position clear, I make the claim that trustworthiness can be seen to have been achieved.

Validity can be understood to be concerned with whether the research 'accurately describes the phenomena it is intended to describe' (Bush, 2011 p97). Cohen et al (2011, p179) wrote that whilst the concept of validity was based on the view '... that the instrument measures what it purports to measure', validity is a requirement for both quantitative and qualitative/naturalistic research. They identified different types of validity, with external validity being concerned with the extent to which the findings can be generalised to a wider

population and suited to quantitative research, and internal validity commonly sought by qualitative researchers as they, 'seek to represent the phenomenon being investigated' (Cohen et al 2011, p181). In essence, validity pertains to truth and the main concern of internal validity is that of bias and the work having little value. Moyles (2011) wrote of observer bias in relation to leader/managers researching their own institution. He identified that there is no such thing as value-free data-gathering for reasons including selective encoding and selective memory. I recognise that my position as a co-worker presents particular challenges when considering validity and bias.

Drake and Heath (2011) wrote that for practitioner researchers, 'The overall challenge seems to be to come to terms with how to devise practitioner research that investigates experience, understands and describes in such a way so as to be recognisably worthwhile ...' (p38). They argued that the practitioner can never achieve a level of validity identified from a more traditional researcher position and that as a co-worker conducting research it is not possible to claim any distance. They identified the need for developing: '... a means of stimulating reflectivity ... as an important aspect of 'self-triangulation' of their interpretation of their data (p20).

In my field notes (see above) I have identified how I recorded my reflective thoughts and observations and considered my relationship with each interviewee within a written framework. I also took advice from the literature (Bush, 20011; Silverman 2001) where triangulation of data was identified as an appropriate form of validation. In order to use my field notes alongside the interview data I identified triangulation as an appropriate way to achieve confidence that my research findings can claim accuracy in describing the issues identified.

Triangulation

In order to achieve an acceptable level of trustworthiness and accuracy, I have identified the use of triangulation. Triangulation is identified by Bush (2011) as a means by which the accuracy of information or phenomena can be cross checked. My use of interviews and field notes conforms with triangulation between methods which Cohen et al (2011) defined as the use of two or more methods of data collection. This, they argued, provides benefit over exclusively relying on one form of data collection which may distort reality. By using two methods of data collection I was able provide mutual validation between the results. I have identified below that I have used data from across the interviews and field notes ensuring that the data was drawn from the range of data collected and did not rely disproportionally on either a single interview or my field notes. This approach allowed for improving validity by checking the data across the two different sources.

Table 3 Contribution of interviewees to data

Interviewee	Quotations used
1	13
2	7
3	7
4	8
5	7
6	7
7	7
8	10
9	7
10	7
11	9
12	9
13	7
14	11
15	10
16	10
17	10
18	11
Field Notes including autobiographical information	26 references –though only one reference may have been made in the findings under a theme or issue which may summarised several entries from the field notes.

Thematic Data Analysis

In order to determine how to analyse my data I referred to the literature and identified thematic analysis as being the appropriate way to analyse my data from both the interviews

and my field notes. There are different approaches to analysing data; Gibbs (2007, p2) wrote that there is disagreement amongst researchers as to how the data is transformed. Some researchers, he wrote, are concerned with the processes of sorting and retrieving data, other researchers, '… Emphasize that analysis involves interpretation and that it is imaginative and speculative'. Richie and Lewis (2003, p200) wrote that, '… There are no clearly agreed rules or procedures for analysing qualitative data. Approaches to analysis vary in terms of basic epistemological assumptions about the nature of qualitative enquiry …'.

My inexperience as a researcher had led me to assume that I would be able to analyse interviews and my field notes in a systematic way. However, I quickly noticed that this was not how interviewees responded to questions. During the interview, they frequently moved between topics and also sometimes provided answers to questions I had anticipated asking but had not yet had the opportunity to ask. Movement between experiences, understanding and talking in the abstract frequently occurred. However, I was reassured by Denscombe (2003) who wrote that this is a common experience of researchers. I also recognised that this is to be welcomed because it indicates that the questions were asked within the spirit of subjective/interpretative research, allowing the interviewee freedom to interpret the questions as relevant to their experience. However, this still left me with the task of deciding how I could organise the data.

Denscombe (2003) wrote that at the beginning the choices of which words, events or ideas are put into which category is not crucial as the categories are subject to a continual process of refinement during the research. He also wrote that as the analysis progresses new things will emerge as relevant or new insights. This advice was useful as I found that as I read the transcripts, main themes did start to emerge. These themes appeared in response to certain

questions but also at other times during the interview because people gave answers based on their own experiences and understandings, and other issues arose that I had not anticipated. Furthermore, the interviews did not follow a straight path and interviewees referred back to points made earlier in the interview, providing new and further exploration and explanation.

Green and Thorogood (2009) identified the importance of the comparative process when developing themes by which the different accounts are gathered, compared and then located in a theme. So in addition, my field notes and the detail they contained were used to build the themes. I developed a thematic grid. Interviewees were identified by number across the top as was the main theme identified as a 'main theme'. Within this main theme, sub-themes emerged and I noted these in the side column. I have identified these sub-themes as 'issues'. These issues recognise that interviewees had different experiences and understandings but that their comments could be located within a broader 'main theme'. For instance, a main theme identified as 'the experience of working with leaders', and an 'issue' was 'how leaders made people feel'.

In addition, my field notes that were written following each interview provided my observations and reflections and biographical information that was examined and used as data in order to triangulate and support the findings. Interviewees and field notes were identified by numbers 1 to 18 and, if an interviewee made a comment on an issue, the transcription line reference was given next to their identifying number, for instance (Interviewee 13-Line 278). This allowed me to locate the issue in the transcribed interview. (See Appendix 2 for the thematic grid which illustrates how the themes were constructed). In terms of using the data, I have tried to ensure the interviewees were allowed to speak for themselves by providing extensive quotations within the identified themes arising from the interviews. However,

though quotations have been used verbatim, it has been necessary to insert punctuation, make some grammatical changes and, for the sake of clarity, remove speech fillers such as 'ums' and 'ers'. Reference will not be made in the analysis where this has occurred but is being acknowledged here.

Data Collection

It is important to recognise that all forms of research can fail to produce reliable data unless appropriate preparation, planning and adequate management take place (Bell, 2002). In this section I have identified how I managed the collection of my research.

Access

My position as a nurse teacher within the school where I was conducting the research, provided me with easy physical access to the interviewees and I did not have to negotiate entry. I offered the interviewees a choice of venues for the interview but all stated that my office would be a good place for the interview to take place. Because some interviewees shared an office and I do not, this provided a private place for the interviews. During the interviews a 'do not disturb' notice was placed on the door and the office phone switched off. As a co-worker not a manager of the interviewees, when I asked if they would be interviewed, they were not under any pressure to agree and all appeared happy to be interviewed. All appointments were kept, with some people phoning to check times and not one 'forgot'. No one erected 'access barriers' in terms of being too busy or by not returning phone calls. I believe that the willingness of my co-workers to be interviewed indicated that the research did not pose any sort of conflict for them. Access was achieved in both a physical and social sense.

Ethics

At the time I commenced the thesis and during my data collection, there was no requirement for students to submit their proposal to a student ethics committee. The advice given to students (University of Birmingham, 2004) was to use the guidelines identified by the British Educational Research Association (BERA). The guidelines state that interviewees should be treated with respect and be informed as to the purpose of the research and any likely publication of the findings. That openness should characterise the relationship between researchers and interviewees, and that researchers should be mindful of cultural, religious, gender and other significant differences within the research population in the planning, conducting and reporting of their research.

The BERA guidelines were followed, and the concept and principles of informed consent was utilised (Cohen et al, 2011). The potential interviewees were approached directly in person and asked if they were prepared to be interviewed. All interviewees were aware that their co-operation was voluntary and that should they change their mind they could withdraw at any time. I also assured them of anonymity. Because I was known to the interviewees, this approach, as opposed to a formal letter, seemed both appropriate and practical. The interviewees were aware that they were contributing data for my thesis and any possible publications arising from the research. Before the interview commenced, interviewees were asked to sign a consent form acknowledging that they understood and agreed to this proposal, and that all identifying characteristics would be removed (see Appendix 3 for sample consent form). Interviewees were assured that they would be given a copy of the transcribed interview and that they could change or withdraw information if they, for instance, felt uncomfortable with anything they had said. Generally, interviewees asked no questions, in fact most agreed

to be interviewed before I'd even mentioned anonymity. However, during the interviews two of the interviewees said, 'this is confidential isn't it?' and reassurance was given.

A further issue I took into consideration was the principle of 'do the interviewee no harm', which I extended to 'do the school/university no harm'. This study did not set out to be an evaluative study of either the university or school where the interviewees worked, and interviewees were assured that this was not the case. They were assured that I was interested in their experiences and what they had to say on nurse education leadership. If that boundary had been crossed during the interview process and, for instance, interviewees started naming and criticising colleagues or managers in the university, then a decision would have been made as to the appropriateness of the information within the research aims, and, if used, any identifying features of either party removed. In the event this did not happen. The principles of ethical trust can be seen to have been applied.

Sampling

Cohen et al (2001) identified that research is judged not only on the appropriateness of methodology and instrumentation but on the suitability of the sampling strategy. They write that this, '... assumes that a sample is actually required; there may be occasions on which the researcher can access the whole population rather than a sample' (p143). My interviewees represent what can be described as a whole population sample and in total 18 nurse teachers were interviewed. The research was carried out in a single location and this group represented the total number of nurse teachers with one exception, one member of staff went on long-term sick leave shortly after agreeing to be interviewed.

The sample characteristics of the interviews include that there were 10 men and 8 women in the group. Whilst nursing is a female dominated occupation with the latest figures available

indicating that 89.29% of nurses are women (NMC, 2008) the number of men in education and management posts has always been disproportionate (Masterson and Maslin-Prothero, 1999). However, the figure remains high despite this recognition. Seventeen of the interviewees were full time members of staff and one was part time. All were registered nurses and all had worked as clinical nurses on qualifying as nurses. As I identified in Chapter 1, I was employed on a 'teaching only contract' and this was the case with four of those being interviewed who also had applied and been appointed to teaching only contract jobs.

Table 4 Staff employment contracts

Teaching only contract	4
Full academic contract	14

The majority of the interviewees had undertaken their initial nurse education and registration as student nurses in a hospital-based school of nursing though all had subsequently obtained HE qualifications from universities. Two had undertaken their initial nursing education in a university.

Table 5 Location of interviewees' initial nurse training/education

Hospital-based school of nursing	16
University	2

The interviewees had worked in clinical nursing for between 3 and 29 years with an average length of 13.8 years. They had worked in nurse education for between 1 and 32 years, with an average length of 9.7 years. The average age when taking a first job in nurse education was

38.7. This average age of 38.7 years, compares to an age range of between 26 and 30 years in all academics groups (Higher Education Statistics Agency, 2010). The age range of staff was 38 to 62 with an average age of 44.6 years.

Table 6 Age and length of time working in nurse education

Length of time in clinical nursing	3–29 years
Mean	13.8
Length of time in nurse education post	1–32 years
Mean	9.7
Age when first entering nurse education	29–47 years
Mean	38.7
Current age range	38–62 years
Mean	44.4

Their pathways to their current posts were varied. Of the 18 interviewees, 11 interviewees had experience of working as nurse teachers at other 'new' universities, and one interviewee had had a teaching post in the NHS in a staff development teaching role prior to becoming employed in HE. Two interviewees had been employed in NHS research posts before moving to work in HE in nurse teaching posts, and four had moved into the university they were currently working in from clinical posts.

Table 7 Employment prior to current post

Worked at statutory universities before current post	11
NHS teaching post	1
NHS research post	2
Moved from clinical post	4

This information describes the sample characteristics and has been referred as appropriate in the findings and discussion chapters.

Pilot Interview

The first interview I conducted was as a pilot interview. I was reasonably confident with my interview questions but recognised the importance of piloting the interview so as to ensure the questions had meaning to others. The importance of piloting is identified by Fogelman and Comber (2011) so as to remove inappropriate or poorly worded questions. During the interview I noticed that the interviewee had made little reference to the university. I had not anticipated this because I had assumed that when giving answers the university would be referred to, perhaps to illustrate an experience. I therefore inserted a specific question concerning his experiences within the university, and decided to include this question in all subsequent interviews. I was generally happy with the way the interview went but noticed when listening to the recording that I made a lot of 'verbal sounds', 'ums' in particular. I also noticed that I seemed uncomfortable with silences and rushed to fill the gap with a question. I recognised that a longer silence might have encouraged further information. In future

interviews, I consciously made changes to my technique and allowed longer silences before prompting or moving to the next question.

Transcription

Eighteen interviews were conducted ranging in length from 45 minutes to 1 hour 15 minutes, with a mean of 46 minutes. I transcribed the interviews as soon as possible after each interview. Transcribing interviews is time consuming and can be expensive if an outside agency is used. I did consider employing a professional to transcribe the tapes but decided to do the work myself because it allowed for a closer scrutiny of what was said. I also found that this started the process of developing familiarity with the data.

Data Protection

Interviewees were made aware that the data would be stored anonymously on my secure workplace server and erased from the digital recorder. This applied to the voice recording and the transcript of the interviews. Data on my workplace server is backed up every 24 hours, so is both safe and secure. Paper print outs were kept to a minimum and kept in a locked office drawer.

Chapter Summary

In this chapter I have identified my philosophical position. I have identified that my work is mostly subjective/interpretative and is influenced by North American phenomenology in its methodological approach whilst recognising that as a co-worker researcher my position and shared professional culture takes me outside a normal methodological position. I have also addressed issues of insider bias and I how I managed this within the research setting. I have demonstrated how there is fidelity between my subjective/interpretive philosophical position

and the methods used to collect and analyse data. I believe my research strategy was appropriate to the aim of searching for experience and understanding within the field of nurse education leadership.

CHAPTER 4 RESEARCH FINDINGS

The research findings have been presented thematically. Each theme has been subdivided into issues which were identified as being relevant to the theme. Quotes have been used to illustrate these issues. It has been my intention to present these issues as honestly as possible, using the words of the interviewees through which their experiences and understandings have been identified and located. Whilst the themes that have been identified arose mostly from the responses given to specific questions, at times interviewees spoke about issues identified as relevant to themes at different points in the interviews by, for instance, referring back to comments they had made earlier in the interview. Therefore, data has been extracted from the interviews in their entirety and organised as appropriate within the identified themes. Extracts from my field notes have been included and identified in italics to demonstrate triangulation. The below figure identifies the themes which provide a focus for exploring how nurse education leadership is identified and experienced by those working in the field.
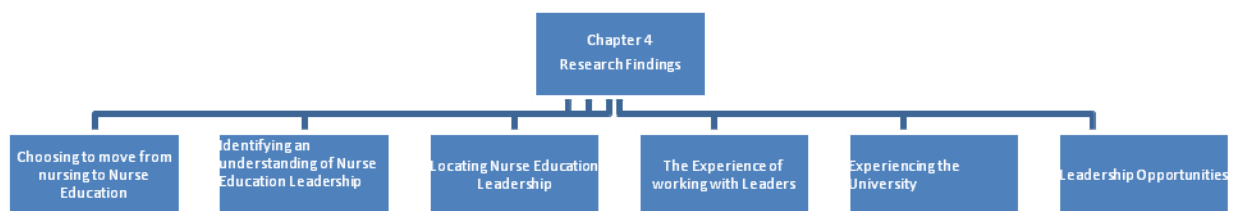

Figure 2 Identification of themes

Theme 1: Choosing to Move to Nurse Education

The interviewees were asked why they had chosen to move to nurse education. All of the interviewees gave more than one reason for choosing to make this move. The issues related to this theme are presented below.

Career progression

For most interviewees, the first reason given as to why they had wanted to become a nurse teacher was that it seemed a natural progression based upon an assessment of their development and experience and having considered the alternatives:

> … So my natural step (was) to move into nurse education … I thought this is natural, this is a natural step to take … (Interviewee 1 lines16-20).

> … I'd done some management ... over all I needed a change so that's why I decided I kind of thought nurse education would probably suit me better than management (Interviewee 7 lines13-18).

> ... and I think I sort of naturally progressed down that line really, in nursing you can either go down the education or the management route or the clinical specialist route and you know those are the kind of ways of climbing the ladder … and education was just the thing that appealed to me most really (Interviewee 11 lines12-16).

> … so it seemed a logical extension to my career … I'd gone as far as I could clinically, I needed to think of the next stage of development and education seemed like the most preferable way forward (Interviewee 14 lines 29-30).

For these interviewees the move to HE was seen as a progression in their career, with some having dismissed other areas, such as management or becoming a nurse specialist. Interviewee 11 (above) identified that a move to 'education was a way of climbing the ladder'. Other interviewees also identified that a wish for progression, along with promotion, was part of the reason they applied for a teaching position:

> … As career development. So, in terms of promotion, and more autonomy, more responsibility (Interviewee 10 lines 22-23).

Two of the interviewees identified they had been in research posts within the NHS prior to being employed in nurse education, and had become involved in nurse education because of being in those posts. In this respect they 'naturally progressed' from their posts into nurse education, and share this in common with those that 'naturally progressed' from clinical work to nurse education. Two interviewees described an easy flow between the jobs:

> ... I just sort of started doing some hourly teaching and then I got a permanent position here ... (Interviewee 13 Lines 21-22).

> So I applied for a research job … It seemed to all flow very easily … and then the school of nursing was linked to the research unit I worked with and asked if I wanted to do … teaching for two days a week ... so I had to have an interview but it was all fairly sort of informal ... so I started working there for two days a week (Interviewee 8 lines 11-19).

My field notes record that moving into an education post for many was identified as '*natural progression*' in their careers after they had had '*considerable clinical experience*'. Most moved from clinical posts but two had been working in NHS research posts and they too identified that it as career progression. Following interviews 13 and 8, my field notes recorded that for these interviewees the move to education had been a *gradual drift* rather than a planned move or early ambition; these two interviewees had both undertaken their initial nurse education in a university. Four interviewees were men and two were women so there does not appear to be any significant gender differences noted in terms of how they talked about their move to nurse education. The length of time spent in clinical practice varied from 3 years (Interviewee 8) to 29 years (Interviewee 7) so the decision to make the move to education also came at different points in the interviewee's career.

Preferred teaching and student contact

Three of the interviewees identified that they had wanted to be teachers for a long time; they

talked as if they had instinctively known they wanted to teach:

> I think it was one of my dreams as a child to become a teacher (Interviewee 4 line 9).

> I've always wanted to be a teacher … just always, and once I went into nursing I just knew ... I just knew I wanted to go into nurse education (Interviewee 9 lines 9-10).

> I've been interested in teaching since I qualified as a nurse … (Interviewee 18 lines11-12).

The identification of preferring teaching and student contact was identified by the above

interviewees who were all on full academic contracts. Interviewee 4 identified wanting to be a

teacher before he had wanted to be a nurse. Many other interviewees also said that when they

had been working as clinical nurses they had enjoyed working with and teaching students who

were on clinical placement with them. Hence moving to a nurse teaching role had appealed,

following these experiences:

> Well I was a keen teacher on the ward (Interviewee 15 line14).

> … then I was a staff nurse and worked as a charge nurse and I enjoyed being with the students (Interviewee 17 lines15-16).

I had teaching skills

For some the move was based upon their assessment that they already had the skills and

experience for a job in nurse education because of the work they were already doing:

> … The job I had at the time involved lots of teaching … and I felt I had the skills to make that move (Interviewee 1 line18-20).

... so I think I was a clinician probably for about 11/12 years and then ... started to do some training (teaching) in nurse education ... and very much enjoyed that, and then … thought that it might be good to sort of do that more full time. So I, found an advert in the Guardian Newspaper in 2000 and applied ... and so ... then made the shift then from being a clinical nurse specialist to a nurse educator (Interviewee 5 lines 21-24).

… and once I was in that role and realised that I enjoyed, sort of, organising courses and teaching qualified staff in house ... very different of course to higher education, but, really that was the stepping stone of me thinking, well, maybe I would like a career in nurse education (Interviewee 6 line16-19).

These interviewees identified teaching skills as being important when moving to a post in nurse education because these skills gave them something to offer students:

I always thought that I had things to offer students as well and I remember as a clinical member of staff, acting on several occasions as a mentor, I could see that students were really happy with what they were taking from me, so I thought that, that's possibly, I think, be something to do in the future to become a nurse educator (Interviewee 4 lines 13-17).

I thought that maybe that way I could help to influence the 'nurses of tomorrow (Interviewee 18 lines 31- 33).

Enjoying working with students and enjoying teaching was identified by both the interviewees on teaching only contracts and full academic contracts and by male and female respondents.

Only one interviewee identified that their experience of being taught and having had a role model acted as inspiration for them:

… we had an excellent nurse tutor who effectively sort of was responsible for the vast majority of our ... of our three year training and I actually found him a very inspirational teacher, he seemed to know an awful lot about lots of things really ... but it always sort of, certainly sort of wetted my appetite which is the fact that, you know, at some point I felt like that's what I wanted to ... what I wanted to do (Interviewee 5 lines 12-13).

Though not always a positive experience, the impact of previous educators (nurse tutors/teachers) and mentors (clinically-based nurses acting as mentors to students when out in clinical practice) had an impact on the decision to become a nurse teacher:

> I had some very good mentorship experiences and some very bad ones. And some good experiences of nurse educators and some very bad ones and I just thought that I'd be ... happy ... being a teacher (Interviewee 18 lines 12-13).

For many, the enjoyment of being with students and in teaching acted as an impetus to be a nurse teacher. In my field notes after most interviews I have noted that *'patient contact and care has been replaced by student contact and teaching'*.

I prepared myself

For some, the recognition that they would like to move into a nurse education post involved identifying that they needed to prepare themselves academically for this move. In this respect, the move was not a natural progression but one that they worked towards purposefully. Several interviewees spoke of how, having decided they wanted to work in nurse education, they gained educational qualifications in preparation:

> I decided I wanted to go into nurse education so that's when I went and did my degree and then ultimately my masters (Interviewee 3 lines15-16).

> … So my focus was developing my education really, into going into education (Interviewee 9 line 11).

> I always wanted to get out of the wards … I'd just got my PhD, like the week before I was coming across for my interview to be a lecturer here (Interviewee 15 lines 45-46).

My field notes record that several interviewees including interviewees three and nine gained master's degrees in education. This preparation included interviewees on full academic contracts, for instance interviewees 15 and 9, and teaching only contracts, for instance

interviewee 3. However, for two interviewees the move into their first education post had not required any preparation, or indeed even an interview. One explained:

> So, I went to the School of Nursing and asked what I needed to do to become a nurse teacher and to my surprise they said, well, we'll send you on the course. Within the year it was ... to my surprise, not 'go away and get a bit more experience' or whatever. So, I went and did a teacher training course, went back to the School of Nursing and became a nurse teacher ... I didn't have to apply; it was within the gift of the Director of Nurse Education who they seconded (Interviewee 17 lines 16-24).

Following this interview I had noted in my field notes that interviewee 17 had started his nurse teaching career 25 years before and his experience would not have been '*uncommon at that time*'. I also recorded in my field notes that the move was identified as a '*personal decision*', interviewees did not mention others in terms of support or mentorship, my own move into education had been encouraged and supported by my manager.

To escape

Some staff identified that their wanting to be a nurse teacher was also to escape from the pressures of the clinical environment, in some instances because of difficult situations with colleagues and managers:

> ... basically I was in this team which wasn't really going very well and really when I look back I was bullied. It was quite nasty really (Interviewee 12 lines19-20).

> I had got a job within a trust … and this was a clinical job but I realised that I had great problems dealing with the manager at this job (Interviewee 14 lines 11-13).

> It was because I was fed up of the clinical job that I was doing because I was going round in circles with it and not making any ... making what I thought I could make of it, so I escaped into nurse education ... (Interviewee 18 lines 15-18).

Others identified wanting to escape the pressures and the realities of working with patients/clients as reasons for moving into education because this was considered less stressful than clinical work:

> Because I knew that it would be a (clinical) job that was very stressful and I couldn't envisage doing it forever (Interviewee 10 lines 16-20).

> I have to admit that when I was behind the curtains cleaning up a patient who was incontinent and (it made me ill) … so I really wanted to get out of the ward (Interviewee 15 lines 18-19).

> And working in a university seemed to be first of all a much cushy option than that, and I believe it is. There are no more psychological stresses and strains associated with doing caring and health and welfare work (Interviewee 16 lines 14-16).

My field notes record 'no barriers' following interviewees 10, 12, 14, 15 and 16 and I had noted under 'listening and observed' that their answers seemed '*genuine*'. In particular I noted after interviewee 12 that he was '*able to display such honesty because I am known to him*'. I felt such honest comments would not have been shared with an outsider.

For one interviewee, moving to nurse education was an 'escape' but not through disillusionment or dislike of clinical work:

> … I was in clinical practice and I was really, really thoroughly enjoying it but I did have a back injury (Interviewee 8 lines 10-11).

The emotional labour of caring work and the stress of working with colleagues who were bullying, or perceived as causing problems, were reasons given for moving to nurse education. However, this might also be seen as escaping from, or avoiding the physical demands of the job. Wanting to escape from the clinical environment to a teaching post was identified by interviewees of both genders who had spent various lengths of time in clinical

practice. The desire to escape does not appear determined by any specific characteristics of the interviewees but is based on individual experience.

To accommodate life style

A move into an education post for nurses would mean fixed hours and days of work, no shifts, nights or weekend work. Only one (male) interviewee identified that this had been a consideration:

> I was working clinically, doing a lot of on call, got a very young family ... (Interviewee 1 lines12-13).

However, one (female) interviewee identified the loss of shift work was a concern because of the loss of the anti-social hours payments:

> I was worried about losing my special duty payments certainly (Interviewee 6 lines 13-44).

To engage with intellectual work

Three interviewees mentioned wanting to be involved with intellectual work or engagement with research as a reason for entering nurse education in a HE setting:

> I just felt that I, you know, I'd sort of potentially, I was bright and I felt I could go and teach really. So that is why I went to nurse education (Interviewee 15 lines 23-24).

> … It just seemed there was potential for me to play with ideas and think about ideas and relate those to practice and to research and those sorts of things (Interviewee 16 lines 21-22).

> And I thought that sounded far more attractive and I thought if I could combine the research, which I'm really passionate about, with the teaching (Interviewee 18 lines 21-23).

These comments were made by one female and two male interviewees; all had undertaken their initial training in NHS schools of nursing and were now employed on full academic contracts at the university. My field notes record under 'reflective observation' after interview 16 took place that whilst he had stated that working in a university would be a 'cushy number' he was also '*one of only a few who had identified wanting to engage with research*' which he regarded as requiring less emotional commitment.

All of the interviewees gave more than one reason for choosing to make the move from nursing to nurse education. In terms of career progression, the interviewees made the decision at different points in their careers ranging from after three years to after 29 years of clinical work. Preferring student contact and identifying that they had teaching skills was a reason given by the range of interviewees and this is identified by interviewees on full academic and teaching only contracts. Teaching and student contact was identified as a principal reason for moving from clinical work and took precedence over other academic activities. The location of interviewee's initial nurse training does not appear to have shaped their attitudes significantly as wherever their initial training took place they identified a desire to work with students. The two who had undertaken their initial nurse education in a university did identify that they did not plan their career and had rather drifted into a university post, but they also identified a preference for working with students. In relation to employment immediately prior to their current post, while several identified wanting to escape clinical practice, this was identified as their original reason for moving to nurse education not necessarily to their current post. The group's desire to work with students and engage in teaching appears a shared feature that transcends the differences between the interviewees. This information provides some background and context, and also locates some of the reasoning and influences of this group of nurses who chose to leave clinical nursing work to work in nurse education.

Theme 2: Identifying an Understanding of Nurse Education Leadership

This theme and the issues identified were drawn from questions related to what experience and understanding the interviewees had of leadership in nurse education. The issues related to this theme are presented below.

A leader is a person with vision

The first theme identified was that leaders are people who have special qualities though this was often identified in the abstract:

> Leadership means someone I respect and look up to and (see) as a role model ... I'd like to be as good as them ... (Interviewee 3 line 43).

> ... there is somebody there to guide you ... probably to create some dreams for the future (Interviewee 4 lines 51-54).

> … for me, leadership is about a person. About a person who has ideas, values, beliefs, goals (Interviewee 9 line 60).

> Well, ideally it's about someone inspirational. That would be my idea of leadership. Someone who is inspiring and who you would want to sort of follow or listen to (Interviewee 10 lines 98-100).

> I think it's just people who have vision and lots and lots of ideas and energy to put ideas into action cause I think it's that ability to see ahead, see a long way ahead and yet have lots of ideas about what they want to do and where they want to go you know it can be … its having that forward vision … I've always admired people who can do that really, really think ahead and think widely and have all sorts of amazing ideas about what to do and where they want to go (Interviewee 11 lines 251-256).

For these interviewees the personal qualities of the leader were identified as important; these people had exceptional personal qualities often based on values and morals.

Leadership is about vision

Several interviewees identified that leadership was about providing vision and motivation:

> Leadership in education is … To provide you with some insight about what it is best to do and to provide you with some ... probably to create some dreams for the future. About how to achieve some of your dreams in education for the future (Interviewee 4 lines 50-55).

> Leadership is about taking a lead on how we take (an) ... agenda forward ... (Interviewee 6 lines 44-45).

> Well for me, leadership should be inspirational, about inspiring people, about having a strategy, a plan, somewhere where we want to go, having a vision and actually taking you to that vision, a goal (Interviewee 8 lines 70-72).

> … Leadership is about mission, it's about organising people … yes primarily it's about motivating people to do the job properly (Interviewee 14 lines 51-52).

> For me leadership is about being visionary, you know, and looking into the future and, and saying where are we going in nurse education and can we do things better and maybe making certain predictions based on you know sort of current developments and future expectations. You know, that's about leadership (Interviewee 15 lines 52-56).

> What's important and in a way and bringing people on board, involving people and having a vision about ... about what nurse education's about really (Interviewee 17 lines 71-73).

My field notes note that for these interviewees, leadership was talked about in the abstract and was identified as providing vision, being visionary and motivating others. I also record in my field notes (interviewee 1, 8 and 9) that their '*eye contact drifted from me to a point in the distance as though they were trying to locate something abstract to them'*. These interviewees talked about their understanding of leadership in terms of what leadership *should be,* with some relating leadership to nurse education, though not all made this link. Leadership here can also be seen to be concerned with process in terms of 'getting people on board' and

identifying what it is people are aiming at. The characteristics of a leader being associated with vision were identified by all staff and no distinction based on the interviewee's characteristics is apparent.

Management is getting the job done

Interviewees frequently chose to contrast leadership with management. Management was generally identified as something that was done in order to ensure systems were in place that enabled work to be carried out:

> A manager is, I believe, is someone who manages, looks after, develops a team they might not be a good leader but they might be a good manager, they might get a team rolling … (Interviewee 3 lines 45-47).

> It's somebody who is able to look at the micro skills of the particular subject and then be able to take the component and subsume it into a much broader system ... (Interviewee 5 lines 103-105).

> I suppose management, one always thinks of traditional, what we know as nurses, how we are managed as nurses in the NHS. So often in a very kind of ... one thinks of an autocratic top down style of ... and delegating to people that's I suppose rightly or wrongly when somebody mentions management to me that's what I think of (Interviewee 7 lines 47-50).

> It's almost about sort of managing what you have, what has been given to you. So it's not necessarily about being too interventionist and being too proactive and you know wanting to change this and wanting to change that. That's how I observed it in nurse education and the NHS (Interviewee 15 lines 60-63).

> I think that management is the day-to-day, making sure that there are enough people to fulfil the roles, course administration, support of students, and making sure the staff have responsibilities of equity and fairness and all that sort of thing across the responsibilities. That people fulfil their role and obligations. And management goes beyond, beyond the institution and the delivery of the course within the institution, it goes towards placements and ensuring that placements are correct and having systems in place which are to do with the quality of the placements, feedback, preparation and support of students in placement (Interviewee 17 lines 62-69).

One interviewee identified power as being a key component of management:

> ... Management, as I've experienced it within the NHS, but even in this university to an extent, can be about power ... so management I feel um, I think very critically, (Interviewee 16 lines 58-60).

Leadership and management are different but both of value

Management and leadership were also identified by some interviewees as both necessary and, at times, interdependent. Several interviewees identified this and the comments below illustrate this understanding:

> … You've got to have the ability, the organisational skills, and the people skills to make it happen. I think ideas, ideas are cheap and easy you know, bright people think things, they come up with new ways of doing things, alternatives I suppose by virtue of the fact that people work in academic institutions they're often questioning and can come up with ideas but if you haven't got those fundamental skills to put those ideas into a package that other people can understand, that other people can subscribe to, that other people want to take forward, then it becomes a very difficult task (Interviewee 1 lines 332-340).

> I think they're both important, they're both important ... but I think you often ... I think in good departments, you need both and I think in my experience, what happens is the fact that you either get one that either sort of pushes forward from a leadership perspective but ends up not having a programme that's sort of maybe academically robust or you have some that are just so bogged down in the micro management of a programme, that actually it doesn't have that, you know, clinical sharpness (Interviewee 5 lines 110-116).

> … I think you cannot get away without having a *good* management structure, but equally you need some sort of leader. You need some sort of leader to help to direct you, to pull everyone together. A manager isn't necessarily (going) to do that. But you can't get away without having management without leadership. You need some sort of leadership. You need both. You should have both (Interviewee 9 lines 79-84).

> I wouldn't say one is more important than the other. I think you have to have the two. I mean, occasionally you get the expert person who is both an excellent leader and an excellent manager, but even if you have the two the two parts need to work simultaneously (Interviewee 14 lines 61-64).

One respondent identified that occasionally a person is found who has both leadership and management skills but, as with most respondents, whilst both roles are seen to be important it would seem that they expect different people to hold different roles, one as a leader, the other as a manager. The importance of leadership and management working together was identified by these interviewees, suggesting that both roles have important parts to play, but also they were not mutually exclusive because effective working requires both. However, one interviewee felt that whilst they were both important, without leadership you might encounter difficulties:

> ... so I guess in a kind of hierarchical way in the way that I'm saying leadership is more an umbrella term ... that would make leadership much more perhaps hierarchy than management, because you can manage things, but if you manage them without leadership you're in a lot of, you'll often get into a lot of trouble. Might be alright for a little while, and then when you hit up against problems, then that's when you know, that you suddenly realise that the leadership isn't there and you get problems. Whereas you can have a leadership role, not be managerially responsible for the day-to-day running of the service I suppose, or education programme (Interviewee 12 lines 68-76).

Here leadership is identified as senior in terms of hierarchy but is also seen as having a role in ensuring problems do not develop. The importance of leadership and management working together was identified by the range of interviewees and characteristics such as place of initial training or education and length of time in nurse education, gender or contract type does not appear significant.

Problems defining education leadership

Not all interviewees were certain that they had any understanding of education leadership:

> It's a difficult thing to think about leadership in education ... (Interviewee 4 line 55).

> I would say that I am still trying to figure that out (Interviewee 2 line 52).

Another interviewee identified a problem in trying to define education leadership within her work environment:

> So … and I don't know if this is because this is such a research intensive university that the sort of education leadership element of things is not given as much, sort of, attention (Interviewee 10 lines 69-73).

Though only one respondent, interviewee ten who held a teaching only contract, explicitly separated education leadership as being something problematic in a research university, in this context it illustrates another theme that will be returned to later in this chapter when the theme 'experiencing the university' is addressed.

Most interviewees can be seen to have an understanding of leadership and management which are generally considered to be different but both of value; this view was expressed by interviewees regardless of the different characteristics of the group. The responses given were fairly uniform, for instance male and female interviewees and those on full academic or teaching only contracts identified their understanding of leadership as being concerned with vision and management, being concerned with getting the job done and both being of value. Few of the interviewees focused on nurse education leadership but leadership in more general terms.

Theme 3: Locating Nurse Education Leadership

This theme developed from the research question that sought to identify where the interviewees looked for education leadership. The issues related to this theme are presented below.

Strategic leadership

One interviewee identified the difficulty in locating a single source of leadership for nurse education, identifying that different groups might provide leadership:

> I think with nursing education, I think it's a bit complicated because it is not only the education we provide at the university, but it's ... we have to adhere to requirements from the Nursing and Midwifery Council, so there are different areas, obviously there are the local NHS Trusts as well and we provide their requirements for the future (Interviewee 4 lines 87-91).

Some interviewees clearly identified leadership as being in part from government and government departments:

> Nationally … leadership it's from ... the health authorities (Interviewee 3 line 80). So I think government policy drives … nurse education (Interviewee 8 lines 101-2). Health Authorities, government ... (Interviewee 13 lines 72-73).

My field notes record '*accepted as fact*' (interviewee 3), '*That's how it is*' (Interviewee 8) and '*no resistance*' (Interviewee 13). However, all interviewees (including those above) identified the nurse professional body, the NMC, as a source of education leadership. Some comments focused on the curriculum delivery aspect of nurse education:

> I guess it would be like the NMC … and they obviously still want to be very, very involved in nurse education and their involvement seems to get more and more pronounced as time goes by to be honest (Interviewee 11 lines 150-152).

> The influences on education and the curriculum ... are really from the NMC. I think the NMC … whatever it says about guidance for curriculum it says ... in effect what they publish is a syllabus and it's all encompassing. So you've got to do what they say, so leadership is coming from the professional body as far as I can see (Interviewee 17 lines 194-198).

However, when identifying the NMC as providing education leadership, most did so critically:

It's dedicated by the NMC, I don't know if that's leadership ... the dictates from the NMC, you know, how many hours you've got to do, which skills you've got to teach, and you know, to some extent, I think we've gone from training to education and I think back on the road to training, so you know, you wonder where the "education" is sometimes. When you have got all these things that are dictated, that you have got to do ... (Interviewee 6 lines 63-72).

I suppose the NMC is setting standards for the profession and it is leading the profession's standards but I wouldn't really see it as leading education in the best way really ... So although I think the NMC does drive a lot of what we do, I think there's a little bit of resentment because we do sometimes feel like puppets to another group that's dictating what we have to do (Interviewee 8 lines 112-125).

I see the pressure from the NMC as being an annoyance. No one embraces the controlling orders from the NMC as desirable. People want more autonomy ... (Interviewee 14 lines 68-71).

… but I don't know that there's clear visions as to where nurse education should be going ... [what] comes out of the Nursing Midwifery Council, seems … very bureaucratic (Interviewee 12 lines 88-89).

The other thing is that the NMC doesn't engage with us locally, except in a punitive way, it seems. I know it's not supposed to be in a punitive way but we try to achieve 'outstanding' and 'good' from our visits with them by jumping through hoops ... So I think if we see them as people who can punish us ... whilst I think that is a function of a management structure, I don't see it as a function of a leader, a leadership organisation (Interviewee 18 lines 142-153).

Many interviewees, despite being critical of the NMC felt that the NMC's role was needed

and had an important function:

I think the NMC clearly has set ideas, set policies about what nurse education will involve, and these are quite prescriptive which limits the freedom of institutions and individual academics to move forward. I suppose in one way that's good because it stops mavericks going off at a tangent but also its quite restrictive as I think sometimes people have good ideas but they can't put them into practice because there are such rigid ideas about what a nursing course will be like ... restrictions on how long the course is and restrictions on what you include (Interviewee 1 lines 91-97).

On a national level the NMC seem to have a kind of bureaucratic authority which I'm sceptical about as well because I think the NMC is largely pre-occupied with risk aversion rather than developing kinds of nursing education. They have a role to play I

suppose in checking what we do, but largely my experience of what they have to say is, is time consuming, they kind of, they tend to hide around notions of quality (Interviewee 16 lines 93-99).

Only one interviewee gave uncritical support to the role of the NMC:

I think that it's very important that we have statutory bodies. I think that is incredibly important. At the end of the day, I think what is interesting is that they give us a framework from which to hang our information, which we teach every day, and that's absolutely fine (Interviewee 9 lines 95-98).

Others identified that the NMC failed to provide leadership for the profession and not only on educational matters, one interviewee said that,

I think it is weak, I think if you take organisations like the NMC ... I don't think the NMC personally is a good leader for nurses, I think it takes too long with decisions, it's you know ... I just don't see it as a profession that leads from the front whereas I think that other ... other professions seem to do that much, much better really (Interviewee 5 lines 166-170).

In my field notes under 'reflective observation' when the NMC was first identified by interviewee 1 (and all subsequent interviewees) as providing a leadership role I'd noted '*surprised by the NMC being identified, its role is regulation*'. Whilst the interviewees identified this regulatory role and were critical, there was still anticipation that the NMC would provide educational leadership. All interviewees identified that the NMC provided leadership.

Leaders found in the school

Whilst the NMC and the NHS were identified as providing leadership at a strategic level, others felt that that engagement with leadership directives depended on where you were in your career. Whilst the NHS and the NMC might set policy, senior colleagues would interpret this policy and provide leadership:

I think ... I suppose leadership could come from organisations like, for example, the NMC ... but it doesn't. I think ... I think it depends at what stage of your career you are at and how engaged you are in the politics as to where your leadership comes from. And for me, personally, leadership comes from within the organisation and quite close to where I'm sitting. So my leadership would come from my colleagues and senior staff ... I think leadership ... I think ... we get guidance and information from places like the NMC, the NHS and the health authorities, but it isn't particularly influential to me ... but I see other people engage with it. And those are the people I would look to for leadership because ... they understand the implications of it better than I do right now ... (Interviewee 18 lines 105-119).

Interviewee 18 above identified that leadership for her would be provided by people who were more accessible than the NMC or the NHS and others concurred with this:

Leadership to me should come from either senior lecturers or the ones above, directly above us, not in the whole university itself, but in our profession, directly above us (Interviewee 3 lines 53-55).

I guess [I look for leadership in nurse education] … from the people who have the more experience really from the professors, the senior lecturers that sort of thing, people who've been in the system a long time, people who have lots of experience, people who can pass on that … and I think we look to people within this building for our leadership and you don't necessarily think about going outside so there is a wider college structure you know and we have a head of college and a head of school but I think it's going to take a while for people to see those as a part of our structure. Certainly from my point of view ... leadership ... come[s] from within that unit and I wouldn't necessarily think of going outside of that structure for leadership (Interviewee 11 lines 123-142).

The interviewees looked also for leadership from senior professional (nursing) colleagues and this included the range of characteristics of the group, for instance interviewee 18 is female and on a full academic contract and interviewee 11 is male and on a teaching only contract. It is interesting to note that some interviewees, either explicitly or implicitly, reject the university as a source of leadership choosing instead to look to those within their professional group.

Do we need leaders?

Three interviews expressed reservations about whether nurse teachers can or should be led:

> I think everybody is equal and I don't like that differentiation of hierarchies, so I don't see people as *more* senior ... I am probably ... the only person that would be *led* [only] when I'm willing to be ... (Interviewee 2 lines 81-92).

> We can lead … from good practice from our own individual experiences we're all very experienced senior people here but also knowing how to disseminate ... it is as important I think to share with one another what we do and how we do it ... (Interviewee 7 lines 86-89).

> ...where people don't want to follow a leader, and academics some of them are kind of the worst, it's like herding cats, they don't want to do anything, they don't want to go anywhere (Interviewee 12 line 405).

The above comments identify three different perspectives. The first, that nurse teachers can be difficult to lead; the second agreeing with the first, in the sense that they are identifying that they are only led when willing to be led; and the third, that nurse teachers should be left to provide their own leadership from within their own community because for experienced and senior people, leadership may not be needed. Following interviewing interviewee seven, my field notes record, under reflective observation, that within the context of what he is saying he, '*… is referring to people being very experienced and senior within a nursing framework'*.

In terms of finding nurse education leadership, all those interviewed identified strategic organisations such as the NHS and the NMC as providing leadership for nurse education and therefore no distinction based on the group's characteristics can be identified. Senior nursing colleagues and those with more experience were also identified as a source of leadership, though some questioned the need for leaders.

Theme 4: The Experience of Working with Leaders

This theme has been based on the research question that sought to explore the experience of working with leaders. The issues related to this theme are presented below.

Being honest, genuine and passionate – having values

A quality that interviewees identified in leaders that they had worked with was a sense that these people were 'genuine' and had high standards, in essence they had values. The following quotes illustrate the importance of these qualities:

> I mean it's refreshing if you come across someone like that someone who really is professional, has high standards, and is very clear about what they're doing and is motivated to do what they're doing well ... They're more successful than someone who is not as genuine, someone who whose, whose almost like someone who is playing the game, they've read the book, know what they're supposed to do but people see through it, they're savvy enough to see through it (Interviewee 1 lines 266-274).

> Good principles, that's ... [what] I would associate with leadership … (Interviewee 2 line 145).

> People who can draw the line of where it is to work, and where it is not to work, and they can always tell you and direct you, possibly in the right direction. They are people who are not afraid to say how things are and express their ... views (Interviewee 4 lines 153-156).

> I think, I think you know you can think back, right back to when you were a student nurse in your younger days when people made a huge impression on you and, and you see that in our present students when they've had fantastic placements because their mentor has been really inspiring or really facilitative, really helpful, really passionate about what they do, all those kind of qualities play a part … (Interviewee 7 lines 170 - 175).

The qualities of being genuine, having principles and having a real passion for what they were doing, were identified as important qualities for leaders by all interviewees. These qualities can be seen as leaders having values which when conveyed to others are inspirational.

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People who helped me and others

Some interviewees had experience of working with leaders who had helped them develop their career or to become better teachers:

> There are characters that I have worked with at university that have created a different ambition in me, inspired me, pointed me in directions and led me to think differently … You know, to lead you to think differently, or act differently, or to get more out of you, that sort of ability (Interviewee 2 lines 131-146).

> … I've worked with some people who are really good at that, who come in and say "you ought to be doing more of this" and "do this or that because you're very good at that bit" (Interviewee 12 lines 363-367).

> ... he brought the staff on, he didn't have all the best staff or the most qualified, but he looked at who he had and he sat down with people, found out what they wanted to achieve, looked at how he could support it, what was realistic. People didn't get everything they wanted, but he was supportive in helping people achieve certain things (Interviewee 13 lines 290-294).

> ... She called her secretary and she said can you fill in this chitty for this man to be given the money, she paid for the books and the

> orientate the curriculum to the way students learn … (Interviewee 17 lines 119-125).

Being able to give attention to the needs of others by supporting and facilitating people to develop themselves is identified as a key quality of leaders and this was highlighted by the range of staff I interviewed. My field notes after interviews 2, 12, 13, 15, 16 and 17 all record '*these people helped m*e *– not self-serving'*. I had also recorded that I could identify '*being helped to develop – I can still remember who helped me*' from my experience in the clinical field. My field notes following interviews with 12, 15, 16 and 17 noted that these incidents happened '*many years ago – experienced teaching staff*'.

How leaders made people feel

Another issue that arose in many of the interviews was how leaders made the interviewees

feel positive about their work and about themselves:

> They are people who are open, and they are people who make you feel that you are
> comfortable when you are with them (Interviewee 4 lines 149-150).

> One of the best educational leaders I worked with was a guy in … who was just, was
> very astute, very knowledgeable ... The other reason why I liked him was because ...
> he was also a very good people person, you know, he was very much sort of an
> empowering type of, nurse educator that... that really sort of inspired people … but
> also really ... [he] seemed to value people as individuals ... and yeah, I think as a
> leadership role, I think both of those things are ... both of those things I think are
> important, it's that sort of ... also the personal, you know, the personal bits
> (Interviewee 5 lines 289-302).

> I'd not had that sense of somebody having confidence in me to do something
> anywhere else (Interviewee 8 line 339).

> My experience of being with leaders, they help you to feel *really* part of an important
> team (Interviewee 9 line 188).

Being made to feel confident about their work abilities was identified by several of the

interviewees and was often facilitated by leaders who made people feel that they were

available and approachable:

> … approachable you don't have to be someone who sits in the office and doesn't go
> around or move from the office, doesn't talk to anyone else apart from people of the
> general level they're on (Interviewee 3 lines 184-187)

> They are people who are open, and they are people who make you feel that you are
> comfortable when you are with them ... These are the qualities that I think that I have
> met and thought that they were leaders (Interviewee 4 lines 150-153).

> … He treated people as individuals, he was interested, he was a human being, he
> didn't have a facade, he's just person (Interviewee 8 line 200).

They're not just sitting on ... sitting on a pedestal and looking down at everyone (Interviewee 13 line 278).

It tends to be those people who listen to the ideas of their staff and it tends to be those people who don't see themselves as separate from the main working body of their staff who tend to be the better leaders … (Interviewee 14 lines 177-179)

… Who can emphasise to staff what's important to do and also listen to staff concerns (Interviewee 14 line 198).

Making people feel valued and comfortable was often attributed to having good people and communication skills:

They find it easy to communicate with people … (Interviewee 1 line 215).

… People who are good communicators (Interviewee 3 line 188).

… good communicator' (Interviewee 13 line 280).

[she] ... was a very good clinical nurse on the wards and so on and had such good interpersonal communication … [she had] various people eating out of her hands (Interviewee 15 lines 280-282).

… inspiration, communication (Interviewee 17 line 148).

The importance of being a skilled communicator contributes to making people feel valued. This skill made the interviewees feel that they were valued members of a team. Because these people were skilled communicators, the interviewees felt these were people who were approachable, available and made people feel comfortable. My field notes record after these interviewees '*how important being made to feel listened to and valued is*'.

Leadership is not a job title

Four people identified that leadership came from people in authority but this was expanded to

assert that people in authority did not automatically have leadership qualities. The following

illustrates this issue:

> … because sometimes you see people in leadership or management roles and you're not entirely sure how they got there because they don't necessarily have the qualities you'd expect from in that position ... (Interviewee 11 lines 278-280).

> … and they might lack essential leadership qualities such as vision, that's frustrating when there are people in the positions of authority who don't have the vision and don't seem to have the skills of leadership (Interviewee 12 lines 452-453).

Another issue that began to emerge as I read the interviews was that leaders and leadership

were not only identified as a role connected to seniority. I have mentioned this above when

interviewees referred to finding leadership in more experienced staff. However, below

interviewees can be found to talk of the experience of working with people who were not in

formal leadership roles and why they were identified as leaders. Leadership was identified by

many of the interviewees as being apparent in 'junior' staff or staff on the same grade as

themselves:

> ... good leaders aren't necessarily people in positions of power … but they have such a voice that they can significantly hinder any potential change ... it's a case of sometimes the people in power need to be with you and sometimes it can be people who don't particularly have positions of responsibility but have quite a powerful voice, you see this quite a lot in practice you go forward to, before you instigate a change in the clinical area and you think it would be the nurses, the senior nurses are pivotal but then you find out it's the unqualified staff who have been there for 20 years who have a voice, a loud voice, an important voice who determine if that change becomes effective or not. So they can sabotage [the change] ... (Interviewee 1 lines 401-409).

> ... they are very good at team working, communication and making people motivated. (Interviewee 3 lines 372-373).

That's a good question … I mean one of the ... one of the best nurse … [leaders] I ever worked with was an enrolled nurse and I remember I was working with him in a … unit and he was fantastic … He was never ambitious, he loved being an SEN, you know ... and not have to do the conversion ... But as an example, no he wasn't, he wasn't hierarchical … (Interviewee 5 lines 307-312).

… people can show good leadership skills who can emphasise to staff what's important to do and also listen to staff concerns, motivate staff and act in a leadership capacity, even though their position and pay doesn't (Interviewee 14 lines 198-201).

Here, leadership can be seen to be identified as being based on personal qualities, not on formal position but emphasising personal qualities and skills as important.

You could 'spot them'

Several interviewees identified that leadership characteristics could be spotted in people, sometimes early in their career:

I've seen it at all levels to be honest but they're probably the people you'd identify, they'd probably get to leadership or management levels if they wanted to but no I've seen people in at every level really and probably sometimes they've had more vision than people you've seen in leadership roles … but I've seen plenty of people at the shop floor level, if you like, that have that sort of vision and that sort of drive and you know you think eventually they're going places at some point in the future, if they wanted to (Interviewee 11 lines 274-282).

I think you can find good leaders in lower situations and I think therefore people who appoint people to high positions, you should be looking at people to see how they operate, whether they show leadership qualities lower down, because if they do then they are likely to continue and to lead in a higher position (Interviewee 15 lines 403-407).

... I think I've met as many people who are peers as those who are in a position of authority, if you have the right skills. Sometimes they might not necessarily have the right experience yet, but you can see that's where they are going (Interviewee 18 lines 376-379).

These people may not yet be in formal positions of leadership though it is thought that they would or should be eventually. My field notes record after the interviews quoted above under

'reflective observation' that these interviewees were quite *'passionate'* in their responses and *'felt strongly that leadership could be "spotted"'* and was a personal quality that individuals displayed. I also recorded '*spotted in the clinical environment – no reference to education environment*'. That you could spot leaders was identified by interviewees with a range of experience and other characteristics, for instance interviewee 15 is male on a full academic contract and had over 30 years' education experience, and interviewee 11 is male on a teaching only contract with 1 years experience in nurse education. Interviewee 18 is female on a full academic contract with 10 years' experience in a nurse education post.

Leaders and the experience of working with leaders were positively identified and an important feature of leadership was identified as how they made you 'feel'. These qualities were identified by all of the interviewees and no distinction between the group's characteristics can be detected. It is also of interest to note that the characteristics, such as gender, of those they identified were also rarely referred to, for instance interviewee 11, 15 and 19 all refer to 'people' who were leaders without any defining characteristics. The qualities of leadership were identified by some of the interviewees as being more to do with the individual than the post they held.

Theme 5: Experiencing the University

As identified above, questions concerning the experience of working in the university had been included following the pilot interview in order to focus on the interviewees' current experience of leadership within the university. The issues related to this theme are presented below.

Adjusting

Some interviewees spoke of their move to the university, and how they felt 'unmanaged':

> ... There's nobody managing anybody. Maybe that's a good thing, maybe that's a deliberate decision … maybe that's why we've got the structures we have, fairly loose, you know, we haven't got people breathing down our necks and I think that's a good thing. I think it's a ... but I think it's been okay, maybe it does encourage it, yeah, flat hierarchy ... gives people freedom to do things (Interviewee 8 lines 480-493).

> … one thing I noticed when I did came here was the fact that the management structure was extremely flat, you know in the NHS its very hierarchical and you know, it's all you have, your line manager and someone above that and it's all very well defined, whereas when you come here is very much flatter and less defined approach … so you're very much left on your own if you like and that's one of the things I found quite surprising and quite hard to deal with in a way almost like running your own business isn't it? This is your work load, but you know with no one checking up on you or anything and no one clocking you on or off so it's entirely up to you to sort it out and get it done and almost when you'd like to do it really that did take some getting used to ... (Interviewee 11 lines 41-53).

In my field notes under reflective observation I wrote that '*I can identify with this experience as when I too moved to the university I also found I took some time in adjusting to its structures*'. The experience of becoming part of what has been identified in the literature as a collegiate structure is identified here as causing feelings of being 'unmanaged' though this is not experienced as unpleasant but needed adjusting to. My field notes record '*collegiate trust*' and '*the view is different looking up than down*'. The period of adjusting seems to be specific to the university and not dependent on the characteristics of the interviewee. For instance, interviewee eight was female on a full academic contract, had previously worked at a statutory university and had undertaken her nurse education at a university. Interviewee 11 was male on a teaching only contract, had moved to the university from a clinical post and had trained as a nurse in an NHS school of nursing.

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Unwelcome

Several identified not feeling comfortable in the university and some related personal stories

of being made to feel unwelcome, based on their belief that being a nurse teacher was at the

route of the rejection:

> … [it's] difficult when it's about respect isn't it? … You put yourself forward for things, which then central university ignore … and you think if I wasn't a nurse would you be ignoring the fact that I've volunteered for that? ... [I] never heard a dickybird back about that and I just think, if I was a medic, you know? (Interviewee 12 lines 257-269).

> We're not seen as of the same status, so we're not really welcome ... but we're ok to be invited onto say admissions committees, admin stuff (Interviewee 3 lines 200-201).

Another reported a more insidious rejection of nurse teachers:

> So I hear gossip and notions about nursing in other parts of the university, which is often derogatory, it's as if we're less able to, particularly less able to write, less able to do research (Interviewee 16 lines 160-162).

The discipline of nursing was identified as posing a problem which made it unwelcome in the

university:

> I do think nursing has the potential to feel uncomfortable in the higher education setting' (Interviewee 7 lines 132-133).

> Some of the negatives for nursing in the uni, there's still a tendency on the part of some people to see nursing as a semi-profession and not being as credible as say medicine and law and so on. Credibility of academic and professional disciplines within universities are sort of based on how much research money you've brought in. It's going to be difficult for nursing in this university because we are not bringing in huge amounts of research money (Interviewee 6 lines 269-275).

> I think it's something that's still struggling to define itself as an academic subject you know, I guess when you compare it to a lot of other subjects around the university it's probably considered a bit of a you know, wishy washy subject it doesn't generate

millions of pounds worth of high profile research like the Medical School or some of the other departments around here (Interviewee 11 lines 175-179).

I think there's always been a tension between nursing and the other schools ... because these other schools and faculties or subject units, whatever you choose to call them, they are, they are ancient and well established in universities by teaching and research, nursing is relatively new and I think a lot of nurses are still very nervous and perceive that they're not being looked at as favourably as the other more established faculties if you like ... So they're established, they've got very high and powerful, strong research profiles, we have weak research profiles … In a university like *******, red brick, who probably in the distant past looked down their noses at nurses, I don't think nurses are so comfortable (Interviewee 15 lines 153-173).

Others explained their discomfort using the language of power in explaining barriers:

But I don't know if nurse education sits comfortably with others within the university setting, especially say now, with our position within the school with … medicine and dentistry, you know ... if we sort of look at the dominance of medics and ... I don't want to say subservient but the lesser role of a nurse is seen as ... Nurses can be seen as handmaidens (Interviewee 10 lines 223-228).

I was talking to someone ... [and he thought] medicine was a profession, and possibly physiotherapy is a profession, but nursing wasn't ... and it was because this individual strongly believed that the subordination of nursing, intellectually but also structurally within the NHS and within universities was inevitable (Interviewee 16 lines 167-170).

These comments of discomfort were widely made and are not specific to the characteristics of the interviewees. For instance interviewee 16 is male, on a full academic contract, trained in an NHS school of nursing and has many years of experience in nurse education having moved to his current post from a statutory university. Interviewee 10 is female, on a teaching only contract and had moved from clinical practice to work at the university in her first teaching post three years previously. She had also trained in an NHS school of nursing.

The way these interviewees describe their feelings of discomfort was shared by many and generally explained by locating the discomfort in discipline hostility. In my field notes I had recorded under reflective observation that there was a '*genuineness*' in what interviewees said

to me as the researcher which they would not have shared if I had not been a co-worker; there was an expectation that I would understand their position and what they were saying. After several interviews, in particular after interviewees 12 and 16, I had written that there was a '*frustration and anger towards the university*' in how we have been treated. After interviewee 10, I had written that '*the reality of the ambition of the profession to gain a university education for nurses hasn't been comfortably experienced*'.

We have other responsibilities

Others identified the structure of nursing courses with half the year spent in university and the other half spent in practice, as well as a longer academic year, as problematic for staff:

> ... it's very difficult for nursing to fit into research focused universities ... in that it's quite a challenge to be research focused as a nurse academic and fulfil all the commitments you have in terms of teaching, in terms of supporting students in practice, in terms of the administration that's expected of you and to be clinically up to date (by the NMC) across a full range of topics … (Interviewee 1 lines 154-159).

> But we do not have the standard lecturer workload – of doing research for three months in the summer. Having the time to concentrate on our own work just doesn't happen in our working environment. We're very much caught up in our students having a compressed course and we have less time for our own academic research as a result of that (Interviewee 14 lines 158-163).

Having other responsibilities related to supporting students was identified by several as reasons for not 'fitting in' to a research university.

Nurses are the problem – we're different, caring

Not all interviewees identified that 'not fitting in' was simply due to the demands on a nurse teacher's time. Others identified the personal qualities of a nurse as posing a problem in a university environment:

I think it's a characteristic of nursing … Because ... I think nursing as a profession attracts a certain type of person. Not one certain type of person but *a* person that would have a certain spectrum of ... qualities, attitudes and things like that ... I think a sort of core. One of the core things that people have when they come into the profession ... is they want to look after other people (Interviewee 10 lines 257-262).

What I like about quite a lot of people who work here is they're quite kind really in my experience. They're quite caring, they're quite considerate. Their humanistic, or…some people as individuals they're influenced by Christian beliefs and others by post-feminist beliefs, that sort of thing, and their behaviour towards other human beings often is, in my experience, is quite caring. And in an entrepreneurial research-lead university like this I don't think those kind of behaviours, those kind of activities and those kind of values are highly valued, because I think it's competition in order to recruit staff; do we have successful bids? Which is really highly valued, so encourages nurse teachers who want to be successful, in my view, to behave badly (Interviewee 16 lines 121-130).

Here the interviewees identify the caring nature of nurses as making it difficult for nurse teachers to fit into the requirements of a university and as these two interviewees have been previously identified above, they represent a range of the group's characteristics.

It's our fault, we lack confidence

Some interviewees identified a lack of personal and professional confidence:

... it's a young, a very young profession in higher education and I think it beats itself up quite a lot that maybe we're not ... you know, maybe we haven't in *certain* areas not as accomplished more established as other disciplines, that have been here for a hundred years, but I think that's unrealistic anyway ... (Interviewee 2 lines 253-257).

I think one of the things, I suppose that our own confidence in our own abilities because we're kind of … nurses, that other people see that and say "ah well that's nurses"... and that ties in to what they add to their perception and that's if we were to be confident about our own scholarship and said well actually we've got quite a lot of good things, there would be a PR job there I suppose (Interviewee 12 lines 324-330).

In this university I think ... we are ... we refer to ourselves as lower down the pecking order ... and we use terminology that places us in an almost subservient position to medicine, for example, or some of the other bigger disciplines … Even by saying that we're sort of acknowledging that we are *not* quite as important as somebody else and

it's not just a problem of nursing as part of a university but it's a problem of nursing as a profession (Interviewee 18 lines 163-174).

Having identified that they do not fit in to university life, some located blame for this on a lack of professional confidence.

We're also weak

Some identified weaknesses that might be identified as due to power imbalances:

> I'm not sure whether that restriction is a felt restriction or an actual restriction whether people just believe the restrictions and whether those restrictions really are really there, I'm not sure. There can be a power imbalance which affects the way, if you're a smaller group within a larger group and that can make it difficult to put forward some of the initiatives … I mean even such simple things as to where you're located and the resources that are at, at your disposal, access to equipment, ownership of your own funding (Interviewee 1 lines185-191).

> Yeah, with our relationship to medicine helps us particularly in that, there's a subservient relationship, or traditionally a kind of view of subservience relationship to medicine, so that being co-located with the Med School I think makes that quite difficult (Interviewee 12 line 324).

A weakness due to lack of power is identified as being caused by nurses' historic relationship with medicine, and also by being a smaller group in relation to medicine within the university structures. Both of the above respondents were male on full academic contracts.

What should be?

Others did not identify whether nurse education was comfortable within the university, but rather that it *should* be:

> In my opinion, I think nurses have to be educated at university and I don't know how comfortable that is ... I think that if we need to accept nursing … as a discipline like other disciples which are providing education within the university and if we want to see nurses at the same level as the rest of the health professionals, I think … nurse education, should be offered at university (Interviewee 4 lines 121-6).

... I've always been a great believer that nurse education needs to be at degree level ... I have some concerns... (Interviewee 5 lines 195-196).

I don't see why nursing shouldn't have the advantage of a university education (Interviewee 6 lines 161-164).

... if you can call nursing a discipline ... I don't see any reason why it can't fit into the university. Medicine can fit into the university. If dentistry can, if social work can I don't see why nurses can't be educated to degree level and to participate at a higher level with cognitive skills, you know with analysis, synthesis all those sorts of things as well (Interviewee 17 lines 283-287).

What became apparent was that those that had worked in 'new' universities identified that fitting into a research university was problematic, and that nurses were better off within the new universities. The following statements were made by interviewees, all of whom had worked in statutory, post 1992 universities:

I think it depends on the university, I mean here, I don't think it's comfortable at all … Because I think nursing feels quite intimidated and threatened because we feel like a small piece in this huge machine over there whereas at the other university I was at, you know, nursing, within the health faculty, was just massive, we were like the big earner. We had status because, you know, we were, in part, an income stream and people were very confident about the position ... (Interviewee 8 lines 157-165).

I just think that some of the new universities perceive nurse education ... well, whether they perceive it because nursing brings all the money ... but I still think it's still perceived as more prestigious ... than in the old universities, the traditional universities … A lot more status in the newer universities than in the traditional universities (Interviewee 9 lines 150-58).

I think [in] the old universities, pre 1992 ... [nursing] doesn't fit in very well, particularly this university. This university has got expectations … about what it's about really. Whereas in a post '92 institution, the polytechnics which in some respects were more ... more geared towards, they still are more geared towards educational activity, and nursing fits in better, or seems to fit in better (Interviewee 17 lines 331-335).

I think in the newer university, nursing is in a very different position than it is in this university (Interviewee 18 line 162).

The comments above might be understood to suggest that the interviewees support and believe nurse education should be university based, but that some universities are more comfortable places than others.

We're in the right place

Though the majority identified discomfort in the university setting, two interviewees did not concur with these views:

> I think if you are attached to a hospital [school of nursing] you would just feel out of a bit ... out on a limb really. Insular ... But no I like ... I think it's nice being part of the wider ... bigger thing ... (Interviewee 13 lines 142-144).

> I feel we're exactly in the right place … (Interviewee 14 line 118).

However, interviewees 13 and 14 would appear the exception in holding this view and I have noted in the field notes under reflective observation that interviewee 14 had '*trained in a hospital*' and interviewee 13 in a '*university*' so the characteristics of the interviewees does not appear significant in this instance.

The interviewees' responses can be seen to be generally based on a feeling of discomfort, though this is not universally felt. Interviewees have different explanations for this discomfort which is not based on opposition to nurse education being located in universities, more the reality of their specific experience. I have located the pertinent characteristics of the interviewees and have identified that similar responses can be identified; the key characteristics of the interviewees does not appear to have a significant impact on how they identify their experiences.

Theme 6: Leadership Opportunities

This theme explores how interviewees identified their own leadership roles and opportunities. The issues related to this theme are presented below.

Leadership opportunities

Some interviewees identified that opportunities generally existed for people to become involved and take a leadership role:

> I think I have the opportunity to develop things to take things forward to be party to innovation … I think … certainly the opportunity to, at all sorts of levels, to get involved and to lead things forward and I think people are looking for people willing to do that, I think the opportunities are definitely there in nurse education (Interviewee 1 lines 296-302).

> In my current post, yeah, yeah ... mainly teaching stuff ... (Interviewee 12 line 473).

> I think I've had the opportunity to try and improve, you know, to try and influence the way that things are done (Interviewee 18 lines 397-398).

One interviewee felt that leadership opportunities existed for those willing to take them:

> If [you are] very motivated you can certainly lead things forward if you're willing to get involved ... (Interviewee 1 lines 303-304).

My field notes recorded after interview 1, 12 and 18 under 'listen and heard' that the interviewees were uncomfortable and '*non-verbal discomfort' was* expressed when identifying the leadership opportunities they had taken. Claiming for yourself a leadership role seemed to present some interviewees with a feeling of discomfort. Another interviewee felt discomfort at being thought of as a leader, though identified taking a leadership role:

> I always feel very uncomfortable being perceived as a leader, I always find I'm ... yeah, a bit embarrassed about all that really although, you know, there are things I'm

very proud of, I mean what we've done in ... for example. I'm very proud ... that's taken a lot of leadership (Interviewee 5 lines 351-354).

Whilst not in formal senior leadership positions these interviewees see that their role and the work environment allows them, or provides them with the opportunity to lead. They do not refer to taking leadership as a requirement of their role, more that the opportunities exist for people to take a leadership role if they choose to do so.

Several interviewees specifically identified leadership opportunities through teaching and student contact:

I'd like to think that I lead, that I lead the students through the module ... that I would like to think that I sort of inspire them. I don't know if I do (Interviewee 10 lines 440-442).

'I guess I'm leading that module aren't I? I'm module leader. So I'm driving that forward, I'm trying to put everything in place to make it run as smoothly as possible (Interviewee 13 lines 258-258).

I suppose you're doing that (leadership) with students to an extent (Interviewee 16 line 245).

Leadership here is described as part of the role of a nurse teachers in terms of leading a module, and one interviewee identified inspiring students in the process. These interviewees were male and female, included those on full academic and teaching only contracts and ranged from those who were relatively new to their posts to those who were very experienced.

Leadership with peers

Two interviewees identified that working with peers provided opportunities to use leadership skills:

… These kind of small leaderships where you're doing projects and you're making sure things work properly and, you know, you might change things. So I suppose I'm working with other people collaboratively and maybe we might be setting examples to other people ... [perhaps] we're leading really… but it's not big leadership (Interviewee 8 lines 410-414).

... to some extent about writing research with my peers ... so there's a responsibility there in as much as I think what we will be doing [and] looking at bids and publications and that sort of thing … (Interviewee 16 lines 250-253).

Here leadership can be seen as using personal initiative in situations that arise when working with peers.

Leadership in the profession

Only one of the interviewees identified taking a leadership role within the wider professional community in which he held a leadership position:

And we had a re-launch of the *** Nurse Education Group in June at *** university, and that was really well attended, there's a lot of enthusiasm for people to kind of get re-started, and the Royal College of Nursing is offering to work with us. (Interviewee 12 lines 214-217).

Limitations and blocks to leadership

Some interviewees felt they had had limited opportunities to exercise leadership and also that opportunity was restricted in terms of what was possible within their role and the school structure. There were limitations and boundaries to what was possible:

… The management team is a finite number of people. It's not everybody is it? So, I think there is purpose ... purposeful exclusion and purposeful inclusion (Interviewee 2 lines 212-215).

Some the only leadership role that I really have is a voice as part of the … team and the responsibility of ... leader but both of those have very limited scope in terms of what I can effectively lead people to do (Interviewee 14 lines 232-5).

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… Because there is a ceiling effect, I think, in this unit. And I think decisions are made by the College ... (Interviewee 18 lines 450-501).

Barriers to taking a leadership role are related here to organisational structures in which the interviewees work. My field notes support these comments and record that opportunity to move outside the school is limited and team working is within the school. These barriers were identified by male and female interviewees on full academic and teaching only contracts.

Having the right skills

One interviewee felt that the possession of the right skills was also important in order to be a successful leader:

> I wouldn't necessarily say I'm a natural born leader so it wouldn't be something for me to naturally migrate towards, so for me to enact change takes a lot of conscious thinking and, and, and questioning and reflection ... you've got to be the right person … can be somebody who wants, who thinks they've got all the ideas … but if you don't have the leadership skills and you just have ideas of what you think is the way forward, then it won't happen. There are too many people who see through or there are too many obstacles can be put in your way so I think to lead you've got to be … aware of the culture in which you work, the restrictions that are put in place and be realistic about what you hope to achieve ... (Interviewee 1 lines 297-317).

Some interviewees felt that they did not have the right skills to be a leader:

> So I think it has something to do with my characteristics as a person that I haven't actually tried to take a leading role ... I like to be quite knowledgeable before I take a step ... (Interviewee 4 lines 174-177).

> I know I'm not a manager. And I know I don't have the ... possibly the qualities to be a manager of people and therefore the opportunities for leadership are not as high if you are not in a position of authority (Interviewee 17 lines184-186).

This position was not necessarily viewed negatively; one interviewee felt they were working at the right level and with the right level of responsibility:

> That's always been the level I've been comfortable with, like I say I've never had any desire to manage a ward or anything like that or have my own department it's never really interested me (Interviewee 11 lines 341-343).

Here the interviewee is identifying responsibilities that are associated with leadership. Another identified that using leadership skills was a choice, and she had chosen not to use them:

> I think sometimes I could probably exercise leadership and management and contribute in that way to the organisation. Quite often I choose not to (Interviewee 2 lines 201-202).

Interviewees can be seen here to locate their own experience of leadership opportunities, and male and female interviewees on full academic and teaching only contracts identified this issue. The length of time in a teaching post also ranged from relatively inexperienced to experienced. When leadership is identified, it is mostly education-focused activities and dependent on having the right skills but it is also identified by some as being a matter of choice whether one chooses to take a leadership role or not. In terms of the characteristics of the group, there appears to be no significant differences based on their characteristics. For example, male and female respondents seem reluctant to identify themselves as leaders or to identify leadership roles. Likewise, contract type, length of time working in nurse education or their previous experience does not appear significant.

Chapter Summary

These themes and issues arose from a thematic analysis of the interviews and field notes. As might be anticipated when using a semi-structured interview, responses are varied and many different perspectives have been identified, providing rich data to discuss in Chapter 5.

CHAPTER 5 DISCUSSION

This chapter returns to the original research questions, and discussion takes place with reference to the literature discussed in Chapter 2 and the research findings presented in Chapter 4.

Question 1. Explore the Influences and Reasons Why a Nurse Chooses to Move to Nurse Education

My first research question sought to explore the influences and reasons why the interviewees chose to move to nurse education and this has been addressed in Theme 1. Professional pathways have been identified in the 'subjective models' literature on leadership as being identified as stages or phases. Ribbins (1997) took this humanistic approach in his work on leadership biographies. Gronn (1999) identified leadership careers within a framework of formation, accession, incumbency and divestiture, and this provides a framework for understanding the career paths of those who have achieved leadership positions. The interviewees were not in formal leadership positions within the university, but the formation of their wish to move from clinical nursing to nurse education and how they actualised this move can draw from this perspective as it identifies stages through which career progression can be located. My questions sought to identify what their influences were and how these influences contributed to their decision to move to nurse education. Gronn (1999) also identified that a careers approach had to be seen within the cultural, social and historical setting, and it is within this framework that choices that were made must be understood.

The first issue identified illustrates the importance of these factors because when the interviewees spoke of the reasons they chose to move to nurse education from clinical

nursing, they identified that this was to make progress in their career. The identification that moving to education would provide a means to progress their career was identified by several as a way to gain promotion, and this was identified by male and female interviewees equally and was not dependent upon their age, the length of time they had worked in nurse education or their employment contract. Historically, when nurse tutors were still employed within the NHS, the position and grade of nurse tutor was commensurate with senior nurse management posts. As I have identified in my autobiographical information and reflected on in my field notes, this is the journey I took. Therefore, within nursing's own structures and traditions becoming a nurse tutor involved progression to a senior nursing post. Of the 16 interviewees who trained in NHS schools of nursing, their experience of nurse education would have been at the time it was located within these traditions. The two interviewees who undertook their initial nurse education in a university also identified career progression and promotion as amongst the reasons they chose to move to nurse education.

That the interviewees would understand nurse education in these terms must be considered to be based upon the cultural, social and historical traditions and practices of nursing, which includes the expectation that you cannot teach nursing until you have considerable experience of working clinically as a nurse, and this I have noted in my field notes. This has also been identified in Table 3.5 where it can be seen that this group made the move to nurse education at an average age of 37.8, and that the decision to move to nurse education had been made after many years of practice as clinical nurses. Against this clinical background, most interviewees can also be identified as taking active steps in identifying what they must do to make this change by 'preparing themselves' for the move to education. For them, to progress in their careers and gain promotion was an important consideration when they made active

choices. It is against this social, cultural and historical background that the interviewees can be seen to make choices.

The formation of the decision to move to nurse education for most, came directly from their experiences while working as clinical nurses and this can has been identified in my theme, 'choosing to move to nurse education' starting with the issue identified as 'preferred teaching and student contact'. Whilst working as clinical nurses they had contact with student nurses doing clinical placements and they enjoyed this aspect of their role. This experience helped them decide that they wanted to make the move to an education post. For instance, 'I was a keen teacher on the ward' (Interviewee 15), illustrates how interviewees' interest in an education post was formed by their experience of teaching students in the clinical environment. Some interviewees identified knowing quite early on in their career that they wanted to teach but most of the interviewees identified that having the experience of working with students was central in their decision making. This interest was not nurtured by others though, and in only one instance did an interviewee identify that a 'significant person' had helped him in making the decision to move to nurse education. He identified that an inspirational teacher he had met whilst a student had made him feel that that was what he wanted to do. Mentors or significant people who had an influence on their decision, or who supported them and enabled them to enter nurse education were not mentioned.

Ribbins (1997) clearly identified the significance of mentors in shaping head teachers' career direction but only one interviewee identified a positive role model from his student days, and they were not a mentor in the sense of formerly helping him develop his career. My own experience, reflected upon in my field notes, acknowledged that I had worked with people I identified as mentors who had supported me in terms of encouraging and enabling me to

move to an education role. These people had made a significant difference in my career but this experience was not identified by the interviewees. However, whilst this experience was not located by the interviewees in response to questions concerning their move to education, the impact of leaders 'helping you reach your goals' was identified as an attribute of leadership and will be returned to later in this chapter.

Gronn (1999) identified that as leaders enter a period of accession, an element of self-belief is required. The interviewees can be seen to have this self-belief when they identified the issue 'I had teaching skills'. This self-belief was supported and endorsed for some by the identification that students appreciated what they had to offer. For instance, interviewee four said, 'I could see that students were really happy with what they were taking from me ...'. In this respect their self-belief is supported by the perceptions of others. This identification of wanting to give something to students and enjoying being able to do so, is important to the interviewees and can be seen to contribute to their self-belief as being caring. Given that nursing is often portrayed as a caring profession (Miers, 2002), being caring can be seen to be reinforced by public image. This too is identified by Gronn (1990) in terms of a stage in the accession process where a sense of internalised self-belief as a nurse who can teach, supported by others, equips them to move forward and progress in their careers into nurse education.

In terms of making this move happen, several of the interviewees recognised that they would need further qualifications and they prepared themselves by gaining these additional qualifications including degrees, postgraduate degrees and some took teaching qualifications. This process generally involved part-time study and might be viewed as positioning themselves as credible candidates for an education post (Gronn, 1999). For others the move was not planned and several talked in terms of the move being a 'natural progression', so they

did not identify taking any steps to prepare themselves. In terms of conceptualising the careers of leaders, Ribbins (1997) identified that not all leaders plan their careers and in this respect the careers of nurse teachers might also be understood to contain an element of serendipity.

For all of the interviewees there were several reasons and influences as to why they chose nurse education and these do not fit neatly into a linear career pathway. Coar and Sim (2006) identified that collegiate trust can exist when interviewing colleagues, and my field notes record that I felt 'no barriers'. My position as a co-worker allowed for honesty and perhaps an anticipation that I would have an understanding when interviewees talked of their reasons for moving to an education post which I have identified as 'to escape'. Several identified that 'escape' was a motive and that working in education was seen as a more comfortable environment away from the emotional stress of clinical work or from the stress of working with certain colleagues and managers. One interviewee (interviewee 16) explicitly said that the university seemed a cushy option, with the emotional labour of clinical work being considered harder than the work of education. Interviewees referred to escape in terms of escaping from being bullied or from working with difficult managers. They are not identifying escape from nursing, however, just from the difficult situations they found themselves in. A further 'honest' response came from one interviewee who identified that the regular hours would help him accommodate his family's needs. These might be considered some of the invisible reasons that individuals may have for making career choices. By invisible I mean the private reasons people have for making career choices that are not always shared publicly when giving a career history.

Most of the reasons given for choosing to move to nurse education were closely resonant with Clifford's (1995) work that identified enjoying teaching, career progression and frustration in

previous roles, including the opportunity to work regular hours, as reasons to become a nurse teacher. She also identified that research was considered a low priority amongst the nurse teachers she surveyed. This would appear to still be the case, despite several years of nursing being integrated into the HE sector. Just three of the interviewees identified wanting to engage with intellectual work, and of these three one had moved from a clinical post into the university, one from an NHS research post and the third from a statutory university. All three of the interviewees were employed on full academic contracts. The other 11 interviewees on full academic contracts did not give this as a reason from moving to an education post. Thompson and Watson (2008) criticised nurses involved in nurse education as appearing neither to understand the purpose of universities nor to recognise the importance of scholarship. With the exception of these three interviewees, scholarship is not identified as a reason for, or influence on, their decision to move to nurse education. The influence of their formation stage, that of clinical practise, and the experience of working with students can be seen to have had a greater influence.

The original question set out to explore the influences and reasons why a nurse should choose to move to nurse education. As Gronn (1999) identified, the cultural, social and historical setting must be considered when taking a careers approach and the interviewees' nursing culture and traditions can be identified as influences that contribute to the reasons they chose to move to nurse education. As individuals they chose to move to nurse education because they identified that they enjoyed the contact they had had with students in the clinical areas, and they had teaching skills from which the students would benefit. Most identified preparing themselves to make the move by studying for additional qualifications. These decisions seem to have been based upon their own initiative as they do not identify others within this process. They also identify the 'invisible' reasons for their choices but, most significantly, they

identify the frameworks that they relate to are nursing frameworks. They are not leaving nursing, but progressing as nurses. When considering the interviewees' gender, age, length of time working in nurse education and their employment contract, there does not appear to be any significant differences based upon these criteria, and the issues identified in the findings span the sample's characteristics. There is no evidence of a competing reality and the identifying reality can be seen as nurses progressing their careers in nursing. Whilst Gronn's (1999) work is concerned with the journey to leadership, these interviewees describe a career which is still in progress and is located within their own nursing culture and traditions, and where they have been able to make active decisions about their own progress.

Question 2. Identify an Understanding of Nurse Education Leadership

In Chapter 2 I had identified different models of leadership in tertiary education and the research and language of leadership in the NHS and nursing literature. These models, developed in fields related to my study, provide frameworks from which to begin to develop an understanding of where the interviewee's experiences and understanding might be located. What is understood by nurse education leadership was addressed in Theme 2 and several issues were identified within the theme. However, in response to my questions, and as I recorded in my field notes, the interviewees' body language and expressions suggested this was a concept they would have to think about. Some of the interviewees, for instance interviewees four and two, were clear that they found it difficult to identify what their understanding of leadership in nurse education was. As a result of this uncertainty and despite my probing, many of the interviewees did not specifically focus on nurse education leadership and, despite asking for experiences, I found that interviewees generally talked in the abstract about leaders and leadership. Interviewee eight can be seen to illustrate this issue when she said that '... leadership *should* be inspirational ...'. However, whilst many answered in the

abstract about nurse education leadership, they did talk about what leadership meant to them in more general terms.

The interviewees understanding of leadership can be seen to be in the first instance as located in the qualities of individuals. The first issue I identified from the interviews was that a leader was considered to be a person with vision. Some of the interviewees identified that the leader's vision could be their vision as well. For instance, interviewee four talked of leaders 'providing you with ... some dreams for the future'. This shared vision could inspire people, and the interviewees identified that because of this inspiration people could be motivated and influenced to achieve that vision. In response to my first question concerning choosing to move to nurse education, I had identified that interviewees had not identified individuals who had inspired or influenced them, but here they identified how leaders *could* inspire people. Terms such as 'visionary' and 'inspirational' were used by all the interviewees to describe leaders and these were always spoken of as good qualities. Leaders were always described in positive terms by the interviewees. Leaders were not identified with leading in an inadvisable direction, and none of the interviewees identified that the leader's vision conflicted with their own interests or goals. Several of the interviewees identified that a leader's vision was based on values, for instance, interviewee nine who said that a leader '... is a person who has ideas, values, beliefs and goals'. The interviewees can be seen to be identifying leadership in normative terms in that they are identifying what leaders should be. The interviewees are not seeking to explain why a leader is these things or the structures that leaders work within. They are identifying what for them leadership should be.

That leaders have vision, influence and values has been identified by Bush (2009) as the three dimensions of leadership that may be of use in developing a definition of leadership, and the

interviewees can be seen to have identified these components from within their understanding. These components of leadership may be identified within the different leadership models but the interviewees' understanding can be seen to be closely aligned to the idea that leadership is enacted by individuals and conforms to the concept of the transformational leader. Northouse (2004), identified the transformational leader as a person who creates a vision that has moral overtones. Northouse (2004) also identified that the transformational leader is able to influence others to achieve more than what is usually expected of them. This definition of the transformational leader can be seen to match the interviewee's understanding of leaders.

In Chapter 2, I had identified that in the education leadership research and literature interest had moved from the actions of individuals to more inclusive concepts of leadership including distributed leadership. For example, Harris and Spillane (2008) identified that distributed leadership is concerned with process and not the actions of individuals. However, the interviewees' understanding of leadership is that it is a quality and responsibility of individuals. What was also clear in the issues identified from the interviews, was that they did not identify their own role as one of a leader. The qualities they identified leaders as having placed leaders in an elevated position. Interviewees identified that leaders could '... guide you ...' (Interviewee 4), they could be, '... someone to respect and look up to ... I'd like to be as good as them ...' (Interviewee 3), and they could be '... admired ...' (Interviewee 11). By identifying leaders as being different from themselves, they are validating the leadership position and identifying themselves as someone who is not a leader.

Interviewees can be seen to be identifying with what Gronn (2000) referred to as a binary, as if these are the qualities of leaders, then others must be identified by other qualities, such as those of followers. Followership has been identified by Thody (2003) as having an

independent existence from leadership and she also suggested 'followers' can be located by their characteristics that she identified as personality types. The interviewee's talk of being inspired to follow the leader, reaching goals and looking up to leaders and this might be seen to equate to the 'positively effective follower type' personality. Masterson and Maslin-Prothero (1999) have also argued that nurses have a 'personality type' which identifies them as obedient. To identify them as personality types locates them permanently as followers and this may be a simplification of their actual understanding and experiences. It would also be hard to conclude from this evidence that the interviewees are 'personality types' and alternative explanations might be looked for in terms of how their expectation of leaders has been shaped through their experience, socialisation and culture within nursing and the NHS, where the concept of the transformational leader is promoted as the ideal in driving change (Warwick University, 2003; National Leadership Council, 2011). The interviewees frequently located their answers in the abstract and as stated above this may reflect normative views concerning leaders not their actual experience.

I had not asked the interviewees to identify what their understanding of management was but all of the interviewees referred to management usually to provide contrast when talking about leadership. When talking of management they referred to their actual experience, and this was frequently their experience of management whilst working in the NHS as clinical nurses. For instance, interviewee seven said, '... management ... what we know as nurses, how we were managed in the NHS ... an autocratic top-down style ...'. These experiences can and should be seen as influential in informing the understanding of the interviewees. The interviewees were clear that managers and leaders have different roles to play, and this introduces a further binary with a distinction made between managers and leaders.

Gronn (2003) wrote that the demonising of management had first developed in the US business world and was driven by the belief that managers were too cautious to introduce fundamental change where a route and branch change had been required. He argued that the separation in the literature between leaders and managers introduced a binary which has been pervasive. The descriptions of what managers do identified by the interviews supports the idea of a binary as they identified managers as different from leaders. Whilst leaders were understood to have vision, influence and values, managers were talked of by the interviewees in conservative terms and were considered to be managing the status quo, dealing with day-to-day issues and making sure systems ran efficiently. Interviewee 15 said that, '... it's sort of managing what you have, what has been given to you ... that's what I've observed in nurse education and the NHS'. Managers were therefore not considered to be sharing in leadership but enacting leadership decisions. Management was not generally described as being part of a system but as a role carried out by individuals whose job it was to process and enact leadership decisions. Their descriptions of managers as being focused on the actual implementation of 'getting the job done' can be seen to have some of the features of the transactional leader which in health care is rarely defined but closely linked with the practice of management (National Leadership Council, 2011).

Northouse (2004) identified that the transactional leader is not concerned with the individualised needs of subordinates and the interviewees' descriptions of management confirm this as they describe managers as focusing on the job that needs to be done. However the transactional leader is also identified with the exchange of things of value; for example, promotion can be given to good employees whereas the interviewees focus on the role of the manager in terms of their responsibility to ensure tasks are carried out. Most interviewees identify that managers have a legitimate responsibility for 'getting the job done'. Only one

interviewee identified any tension in what he considered management was concerned with, and he said that in his experience both in the NHS and the university management (and leadership) was about power.

Whilst the interviewees contrast leadership with management and see clear differences, many do not regard managers or the roles that managers perform as less important than leaders or what leaders do. Most of the interviewees regarded leadership and management roles as interdependent, stating that both roles were important. It was suggested that putting ideas into practice and managing effectively might require different skills from those of leadership but was just as important. For example, interviewee one said that, '... ideas are cheap ... but if you haven't got the skills to put those ideas into a package ... then it becomes a very difficult task.' Whilst many of the interviewees did not explicitly identify that the leader had positional authority, there is the suggestion that they are at the apex of a hierarchical structure because they take a lead. Their views of how leaders and managers work together suggests a coherence and integrity of working. That the leader gives the vision which the manager ensures is put into practice and this is accepted and worked towards by everyone suggests an acceptance of practices that can be located within the bureaucratic model of operation as Weber (1989) identified; that is that organisations work on the basis of rational action which involves having a clear goal. However, the interviewees mostly focus on the individual's role rather than on systems and this is how they identify their understanding of leadership and management.

It was unclear what most interviewees consider leaders are doing when they are not providing vision, as leaders and managers were not generally considered to be the same people. Leithwood and Jantzi (2009) wrote that most models of transformational leadership are

flawed because of the lack of focus on transactional practices. Whilst some of the interviewees did identify that occasionally leaders and managers can be the same people they mostly identified that the qualities of leaders are person specific as opposed to role specific. For them, leaders are transformational, managers are transactional.

In terms of addressing the aim of identifying what understanding the interviewees had of nurse education leadership, there was uncertainty concerning nurse education leadership as a distinct entity and my field notes support the claim. Their understanding of leadership is that they equate leadership with vision, influence and values but most do not locate this specifically in the context of nurse education. They identify leadership qualities as being located in individuals and their descriptions conform to transformational leader types. As a group they contrast leadership with management which is also principally identified as being the role of individuals and transactional practice. These roles are seen as of equal importance though there is a suggestion that managers come after leaders in the hierarchy. When the interviewees do refer to management systems, these can be identified as conforming to a bureaucratic model with a hierarchical structure. Their own role was identified by their admiration for leaders and a concordance with organisational goals. Their main point of reference is the health service and when probed about their experiences they also located their experiences to when working clinically in the NHS and these influences remain important to them as to how they understand leadership. However, it must be acknowledged that they often spoke in the abstract and these ideas may be understood as normative as the language of transformational and transactional leadership is common in the health service literature. With reference to the sample's characteristics, their understanding of leadership and management does not appear to be shaped by their characteristics. I found that the interviewees had a

shared understanding of the roles of leaders and managers and they all shared a difficulty in identifying nurse education leadership.

Question 3. Identify Where Nurse Teachers Find Nurse Education Leadership and Leaders

My third research question sought to identify where the interviewees found nurse education leaders and leadership, and their response was identified within Theme 3. Though I have identified that the interviewees found it difficult to provide an explanation of what their understanding of nurse education leadership was, they had no difficulty identifying sources of leadership for nurse education. However, this was identified as problematic, for instance, interviewee four said, '... I think it's a bit complicated ... it's not only the university ... we have to adhere to the requirements of the Nursing and Midwifery Council ... and the local NHS Trusts ... because we provide their requirements for the future'. This was succinctly put, as these three sources of leadership were, in varying degrees, identified by all the interviewees. Having identified that the interviewees considered the components of leadership to be concerned with vision, influence and values, when asked to identify who or where they found leadership from, several interviewees' first response was to identify government and government agencies, such as the DoH, as providing leadership. This was identified in terms of, '... government policy ... driving nurse education...', as identified by interviewee eight, for example. Those who identified government agencies represented the span of interviewees in terms of their characteristics.

Leadership by a government agency cannot be identified within the leadership models but within the formal management models identified by Bush (2009) and in particular the bureaucratic model (Weber, 1989). Within the bureaucratic model there is an identified

hierarchical authority structure which, in this instance might be seen as the interviewees' identification of these government agencies as being at the top of the structure. Other features of the bureaucratic model include that organisational tasks are distributed and goal orientated, and here the interviewees might be seen to be performing these roles when it is identified that, '... we provide their requirements for the future...' as stated by interviewee four. This acceptance that others, external to the profession, have the authority to set an agenda which is adhered to supports the argument that nursing never makes decisions of its own choosing, as argued by Rafferty (1996), Davies (2000) and Hart (2004). Edwards (2008) also supports this argument and wrote that in this area 'these agencies' must be seen as providing strategic leadership in directing nurse education and that, '… the content of the field is beginning to be defined by government agencies rather than within the field itself' (p132).

By identifying government agencies outside of nursing as providing leadership and direction, this might also be seen as demonstrating an acceptance of the power that the 'purchaser' has over the 'provider' of nursing programmes, which includes the commissioning of student numbers (Davis, 2000; Burnard and Chapman, 1990). As nursing programmes are linked to the NHS and the students are being prepared for working in the health service, the content of the programme is influenced by NHS needs. In my field notes I had recorded comments such as 'these matters are accepted as fact', and there was no sense of professional indignation as expressed by Edwards (2008) above. The acceptance of the ideology that nurse teachers are preparing students to meet the NHS's organisational needs is not contested. It might also be argued that the interviewees' understanding reflects the vocational nature of their programmes and indeed, if the students were not educated on programmes that met the NHS needs, it is inconceivable that the programmes would be funded by the DoH. These interviewees might

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be seen to accept that NHS needs and the power it exerts through funding takes precedence over their professional autonomy.

Whilst some interviewees identified government agencies as their first response to my question, they also identified, as did all interviewees, that the nurse professional body, the NMC, also provided nurse education leadership. Leadership was identified in this instance as being focused on providing and directing the content of the education programme delivered. The NMC is a regulatory body which, in addition to its other functions, 'sets standards of education, training, conduct and performance, so that nurses can deliver high quality health care consistently throughout their career' (NMC, 2011). That all interviewees identified the NMC as providing leadership is also at odds with the previously identified understanding that leadership is about individuals providing vision, influence and values. It is hard to see consistency between the identification of the leadership qualities of individuals, as previously identified, with a regulatory organisation that monitors the quality of education standards. Some of the interviewees were hesitant in identifying what the NMC did as leadership, or if it was leading education in the best way but, despite this uncertainty, as a body it was identified by all of the interviewees as being a source of leadership for nurse education. My field notes noted my own curiosity at it being identified with leadership in this context, and indeed as Hart (2004, p182) wrote, the NMC was, '… Not a body that most nurses in practice would be looking to for inspiration and examples of practical leadership'.

However, having identified the NMC as a source of leadership most interviewees were in fact extremely critical of the way it imposed aspects of curriculum and monitored educational programmes. The NMC was criticised by the interviewees for being controlling, for being bureaucratic, for being punitive and for making us 'feel like puppets' (Interviewee 8). The

control over the content of the curriculum was a particular focus of criticism because this was considered to hinder the interviewees from educating students and of returning education back to training. These criticisms have been made previously by Masterson and Maslin-Prothero (1999) and Edwards (2008) who argued that the concept of power can be identified in terms of control over curriculum content. Edwards (2008) argued that government agencies and the nurse professional body, the NMC, have been unremitting in their erosion of teachers' autonomy and that the NHS corporate mentality exists in the face of weak academic opposition. Targets and performativity has been described by Ball (2003) as a vehicle for changing academic work, with professional judgement being subordinated. However, Miers (2002) identified that the change in culture in HE with the Quality Assurance Agency's endorsement of a learning outcomes approach (an approach long endorsed in nurse education) in higher education, created a more flexible model of what it means to be educated, and that this should to be viewed positively by nurse educators.

Clearly the interviewees, with one exception, who supported the role of the NMC without reservation, do not like the surveillance of the NMC and, unlike Miers (2002), do not regard surveillance of teaching quality or control over elements of the curriculum as a positive. Yet, whilst highly critical of the NMC, most also accept the legitimacy of its role. Comments such as that of interviewee one, who said of the NMC that, despite being prescriptive and limiting academic freedom, the control it exerted was in some ways good because it stopped mavericks going off at a tangent, and can be seen as accepting the legitimacy of the role that the NMC plays. Within the bureaucratic model control is regarded as legitimate because of the acceptance of what is seen as rational-legal authority (Weber, 1989). Whilst the interviewees are critical, most do not challenge the authority that the NMC has over what they do and teach but accept that it has a legitimate role to play. This acceptance might also reflect

their recognition that the NMC was established by The Nursing and Midwifery Order, 2001, and is accountable to parliament through the Privy Council, so is accountable to external agencies and does in fact have legal authority. The NMC can be seen to take its place in the hierarchy after other government agencies. The interviewees, whilst mostly critical, demonstrated an acceptance of the legitimacy of their authority. For instance interviewee 16 said that, 'They [the NMC] have a role to play, I suppose checking what we do...'. From their perspective and based on their experience, government agencies and the NMC are identified as sources of legitimate leadership.

It might also be noted that the NMC is a nursing body and, as a group, the interviewees demonstrate a strong professional allegiance to their professional group but might also be considered critical insiders. When scripts were returned to the interviewees, two commented that they recognised they had contradicted themselves when identifying leadership with positive characteristics, and then identifying leadership from the NMC as bureaucratic and controlling. However, they asked that the scripts be left unchanged. Denscombe (2008, p101) wrote that it is important to accept aspects of experience that appear self-contradictory and that the researcher should not act as an editor or, '… impose some artificial order on the thoughts of those being studied by trying to remedy any apparent logical inconsistencies'. Whilst the interviewees accept the legitimacy of these organisations in providing what they identify as leadership, they are really identifying the structures that nurse education works within; when they talk about leaders they identify a source closer to home.

The third source of leadership that the interviewees identified was within the university, not the wider organisation of the university but people who worked within their school. Their actual source of leadership was locally accessible and could be found from senior nurse

colleagues. In terms of finding leaders, several interviewees identified that they looked to senior colleagues because they had more experience. Experience can be seen as making leaders and their advice more credible. For instance, interviewee 18 identified that these more experienced people would be able to interpret policy or understand the implications of the policy, and thus provide information to her. Amongst most of the interviewees there was an expectation that senior nurse colleagues (identified by the interviewees as senior lecturers and professors) in their school would provide leadership. This can be seen as an acceptance that leadership is hierarchical, that communication is passed downwards and that leaders are people who can provide direction, which seems again to suggest an acceptance of a bureaucratic model. In addition, the expectation that senior nurse colleagues have more experience can also be seen to concur with the bureaucratic model in that they demonstrate the expectation that experience is a criterion for promotion (Bush, 2009). This identification can be identified as rational-legal authority (Weber, 1989); that is the belief that promotion is rational and based on qualities such as the experience of the employee. Looking at the characteristics of those that identified experience as of importance, they were mostly interviewees who were relatively new to their posts, with interviewees who had been in their roles longer not identifying this as a criterion for leadership.

Those who identified leaders from within the school described what they expected from these leaders as being similar in function to how they previously described managers. For instance interviewee 18 who identified that these people could interpret NMC and NHS policy for her. It is significant that the source of the people who filled this role was only to be found from within their own nursing community because possible leaders from the wider university were rejected by many of the interviewees who specifically said they would not look outside of

nursing for leadership. This sense of professional identity can be seen to exclude others outside of their own professional community.

Commitment to the profession has been identified by Gronn (2003) when he identified that most employees are members of 'communities of practice' as well as occupational communities. Whilst recognising that communities of practice refers to, for instance, semi-informal or self-leading work teams, it can be seen that in this instance they certainly form a leadership perspective, and that this group of interviewees maintain a strong sense of occupational community that excludes others from their community. Because Weber's (1989) work on bureaucracies focuses on the needs of one organisation and does not identify the competing interests of professional groups (Harling, 1989), it would seem that the interviewees' responses can be seen to be broadly located within this definition of a bureaucratic framework. That this group of interviewees look to health and professional structures and senior nurse colleagues for leadership, and in some cases explicitly reject those outside of these communities of practice, demonstrates they retain a strong commitment to their original professional field. The retention of these ties can be seen by their acceptance of leadership from those that control the funding, direct and monitor the content of their programmes, and their identification of nurses in senior academic positions within their community as leaders.

There were a few voices of dissent from the views held by most. For instance, interviewee two said that she did not like the differentiation of hierarchies and did not see people as more senior. Interviewee 12 identified that academics were probably difficult to lead. One of the more experienced in terms of the years he had been working as a nurse, interviewee seven identified that as we were all experienced people, sharing our individual experiences was

important and that we could all lead. All three had, however, previously identified the NMC as a source of leadership, so again perhaps Denscombe's (2003) advice regarding not imposing artificial order on people's thoughts is important.

To return to the original question of where nurse teachers find nurse education leadership and leaders, the interviewees can be seen to locate leadership and leaders in three locations. They identify the DoH, the NMC and senior nurse colleagues within the university. I have identified that these three sources of leadership and leaders can be located within the bureaucratic model and, in particular, their authority is accepted as legitimate. That large organisations might be considered bureaucracies is not in itself surprising. But what is unusual about nurse education is how two different organisations, the DoH and the NMC, and those that work in the university as senior nurse academics, have been identified as providing leadership. Whilst the interviewees are critical of their professional body, the NMC, the authority of these three sources of leadership can be seen as being accepted by the interviewees and they do not identify tensions between them. This can be seen by the identification that their vocational 'community of practice', that is the health service and nursing, provides their leadership.

Weber's criteria for the bureaucratic model do not recognise the competing interests of professionals, so it is perhaps more accurate to claim that this finding can be broadly located in a bureaucratic model. The university does not appear to permeate into their community by providing leaders or leadership, and was by some interviewees explicitly rejected. Though there were some different opinions concerning leadership within the school, the interviewees share a strong and shared health and professional focus which can be seen to transcend these differences. When considering the interviewees' gender, age, the length of time they have

worked in nurse education and their employment contract, there does not appear to be any significant differences based upon these criteria, and the issues identified in the findings span the sample's characteristics. There is no evidence of a competing reality and the identifying reality can be seen as nursing focussed.

Question 4. Explore the Experience of Working with Leaders

My fourth question was concerned with exploring the experience of working with leaders. I have identified above that the interviewees locate leadership within a bureaucratic model with authority identified as a core feature. Within the bureaucratic model one of the criteria is that that relationships are impersonal (Weber, 1989). The interviewees' responses to questions exploring their experiences of working with leaders demonstrate how they, as a group, actually place a high value on the relationship they have with people they identified as leaders. This relationship was identified as having a significant personal impact on them. The interviewees can be seen to identify that a key component of the impact that leaders had had on them was based on the belief that leaders were people who were honest, genuine and passionate about what they did, and that these qualities were value based. These qualities were, in part, what made them leaders. Interviewees also identified feelings of trust towards these people because they were identified as people with personal integrity. Personal integrity has been identified by Northouse (2004) as a key component of leadership. The interviewees identified that leaders can be seen to demonstrated their integrity through acts of consideration by, for instance, giving help which was not identified by the interviewees as self-serving.

Jooste (2004) identified how the clinical nurse leader should enable others to act, celebrate and cheer accomplishments, and several of the interviewees identified such leadership behaviour. For instance, interviewee 15 was helped to pay for books, whilst others identified

being helped to develop their professional skills through being encouraged. Interviewee 12 spoke of how leaders offered encouragement to people who were identified as being good at certain things and were encouraged to do more. In my field notes under reflective observation, I noted that this had been an experience I had shared in the clinical environment in that I felt I was being helped to develop my career and how, many years on I can still remember these people. For others, help was identified as enabling, such as interviewee 16 who identified that he had wanted to be able to write and someone enabled him through support to do this. A common element was that the actions of these leaders was seen as lacking in self-interest because the leaders actions were not understood as being part of an exchange process, such as has been identified within the transactional leadership model or transformational model (Northouse, 2004).

The field of emotional intelligence is perhaps more widely explored in the field of organisational psychology but it has also been identified as being linked with, and a component of, the transformational model of leadership (Palmer, 2001; Gardner and Stough, 2002). The transformational leader is one who builds confidence in others in order for them to achieve goals, and can be regarded as someone who meets the needs of others in exchange for their performance (Gardner and Stough, 2002). This description of the transformational leader sits comfortably with how the interviewees identify the experience of working with leaders except that they do not identify any exchange taking place. These acts of consideration can be seen as acts that demonstrated to the interviewees that they were valued as individuals and this is what was seen as of great importance. Someone taking an interest in them, and helping them, was identified as creating confidence. I had written in my field notes following several of these anecdotes that being helped could not be a common occurrence as some of the anecdotes occurred many years before the interviews took place, and often early in the

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interviewee's career. For instance, interviewee 17, one of the more experienced nurse teachers interviewed, identified that the only person who stood out for him as a leader was someone he met at the beginning of his nurse teaching career and who had helped him be a better teacher.

Even amongst the less experienced interviewees, being made to feel confident about what they were doing was rare. For instance, interviewee eight said that 'I'd not had that sense of somebody having confidence in me to do something anywhere else'. Interviewees identified that this sense of confidence was also due to feeling they could speak to these people and be listened to and not be looked down on. Interviewee 14 said that, 'they didn't see themselves as separate from the main working body of staff' interviewees also talked of how leaders had made them feel part of a team. Northouse (2004) identified that the transformational leader often inspires trust and respect from followers and provides a supportive climate in which to listen to the individual needs of followers.

Their talk of leaders was of people who did not create barriers within hierarchies, and it was felt by the interviewees that they were approachable. The interviewees identified that this was often because these leaders had good communication skills which were used to make people feel comfortable. Interviewees can be seen here to be identifying what can be seen as the influence that leaders have had on them. Influence is an identified characteristic of leadership (Bush, 2009) and the interviewees identify that these leaders have helped them on a personal level, influencing how they felt about themselves and their abilities. This in turn had a positive impact on how they did their job. However, there is no suggestion from the interviewees that they are in any way critical of this strategy. All of the interviewees identified the emotional impact of leaders and no distinctions could be found based on the sample's characteristics.

Whilst all of the interviewees talked of their experience of working with leaders in terms that can be located as transformational, several of the interviewees also stated that leaders did not always have leadership qualities and leaders were not always in leadership positions. Interviewee 11 identified that he had often been surprised that some people were in senior positions because they lacked the qualities he would have expected to find in people in those situations. A further interesting issue identified by some was that having previously identified that leaders were people who were senior experienced people, several of the interviewees identified that leadership could be exercised by junior staff. I had noted in my field notes, under reflective observations, following the interviews where this issue was identified. These individuals were seen to transcend their environment because all of the examples were from the clinical environment which the interviewees had previously identified using terms such as autocratic, hierarchical and bureaucratic. These people were identified as leaders because of their influence, not because of their status. For instance, interviewee three identified unqualified staff in the clinical environment and that '... good leaders aren't necessarily in positions of power ...'. However, he then referred to these people being able to sabotage events, which would suggest that they are able to use power which can be located as coercive power (Bush, 2009), even though their positional power in terms of their job within a hierarchal structure was low. Interviewee 14 also referred to staff that showed good leadership skills because they listened and motivated others, even though they were not in formal leadership positions. These people might be seen to use personal power (Bush, 2009).

Some of the interviewees spoke of 'spotting' future leaders. These were people who were considered to be showing leadership qualities although still in junior positions. All the interviewees who spoke about spotting future leaders felt that with more experience, and if they made the choice to do so, these people would get to a higher position. My field notes

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record that these people were all 'spotted' in the clinical environment and that promotion would be within the NHS. They might be seen here to demonstrate a belief that staff will make progress on merit and that the system will promote them once they have more experience. This acceptance can be seen to conform to Weber's (1989) rational-legal authority though they themselves present their understanding as being focused on the personal qualities of the individual and of choice.

The personal qualities of leaders was given a high premium by the interviewees, to the extent that for some it could override status and position in the organisations that the interviewees have experience of working in. The limitation of focusing on the individual has been identified in the literature (Gronn, 2002; Hewison and Griffiths, 2004; Ford, 2005; Harris and Spillane, 2009; Hewison, 2009) and above, but these interviewees do in fact focus on the personal qualities of individuals, not the systems that they work within or the contribution of others.

To return to the original aim, that of exploring the experience of working with leaders. The influence of leaders through the emotional impact they had on the interviewees is a significant factor, and in particular interviewees valued leaders who had good interpersonal skills and made people feel valued. Feeling valued created confidence in the interviewees and they do not identify that an exchange process takes place but view the help they have had from leaders as being based on the leader having personal integrity. This view of leaders was shared by all interviewees. When considering the interviewees' gender, age, and the length of time they have worked in nurse education and their employment contract, there does not appear to be any significant differences based upon these criteria, and the experience of working with leaders identified in the findings span the sample's characteristics.

Question 5. Explore the Experience of Working in the University

My next theme arose from question five, which set out to explore the experience of working in the university. During the pilot interview I had identified that this question had to be specifically asked because little reference had been made to leadership or leaders from the university, and this observation remained valid when conducting the interviews. When asked about their experience of working in the university, several of the interviewees who had moved from NHS posts and the new universities, identified having to adjust. These interviewees can be seen to be moving from what was described by interviewee 11 and supported by the research and literature (Congden and French, 1995; Murphy, 2005) as a very hierarchal environment, to an environment with very different leadership and management traditions. Deem (2001) had described the desire in HE institutions for collegiality which includes academic freedom and consultation and is not considered suited to top-down leadership.

The interviewees described how their first experiences were based on their observation of how flat the structures seemed at the university, and this was experienced and described as being 'unmanaged'. Interviewee 11 identified that he found coming from an environment where '... it's very hierarchical ... where you have your line manager and someone above that ...' to feeling that you were '... left on your own' which he found surprising and hard to deal with. I had written in my field notes under reflective observation that I could identify and confirm that this was similar to my own experience when I moved from the NHS and first started work at the university. However, recognising that there was a different structure was not experienced as a bad thing, and interviewee eight identified that this flat structure provided people with a freedom that enabled people to 'do things'. She also added though, that she was not certain if being 'unmanaged' was a deliberate decision or not. Interviewee

eight was not the only interviewee who seemed unclear on this point, and during this period of adjustment the experience was described as not being managed or, as interviewee 11 said of his experience, '[its] ... almost like running your own business ... '. These observations made by people who are not in formal leadership positions but who work within the university's collegiate structures and practices, provide a different perspective from those who have traditionally contributed to the research in this area. My field notes record that the view 'looking up' is different from looking down. The lived experience of the environment created by collegiate structures and practices was experienced as being unmanaged and needing time to adjust to.

The second issue identified from the data was a feeling of being unwelcome. However, the focus of this feeling was not identified as being due to working in a new environment and adjusting to that environment, but rather their experience of being a nurse teacher in the university. The collegiate structure of the university was not experienced as collegiate in the familial sense, and most of the interviewees talked of feeling unwelcome in the university. Feeling unwelcome was mostly based on their experience of rejection or on the perception of how nursing, as an academic discipline, was regarded negatively in the university. These explanations demonstrate that the interviewees identified themselves as a group or community within the university.

Congdon and French (1995) identified 'ingroupism' as a means by which nurse educators adjust to university life based on their shared background and Gronn (2003) identified communities of practice. Here the interviewees can be seen to consider themselves as a group identified by those outside of the group, often in derogatory terms. For instance, interviewee 16 said that, 'I hear gossip ... about *nursing* in other parts of the university which is often

derogatory, it's as if *we're* less able...'. They identified that as an academic discipline nursing was understood to lack respect and that this contributed to feelings of being unwelcome, and the actuality of being rejected. My field notes record that during this stage of the interview I felt openness in their responses which they were able to share with me as a co-worker (and a member of the community). For instance, when the interviewees talked and shared their experience of personal rejection after they had volunteered their experience outside of the school. Interviewee 12 had put himself forward for such a role and his application had been ignored: '... and you think if I wasn't a nurse would you be ignoring the fact that I'd volunteered for that? He identified this as demonstrating a lack of respect. Interviewee 3 identified that in some areas we were allowed to be part of the less prestigious collegiate structures, 'we're not really welcome ... but we're ok to be invited onto say, admissions committees, admin stuff...'.

Those that looked for broad explanations identified that nursing, as a subject group, posed problems and that this was due to reasons such as not being an established academic discipline and lacking the status of more established disciplines within the university with strong research profiles. The interviewees identified that they are judged on their weak research output and, in addition to being a new academic discipline, they identified that they had other responsibilities as nurse teachers which placed demands on their time. For instance, interviewee one said that because of the need to support students in practice, and the expectation that you are clinically up-to-date (by the NMC), it was a challenge to be research-focused. Other demands were also identified, including the demands of a curriculum which covered a longer academic year than the standard academic degrees. The interviewees had previously identified that their reason for moving to nurse education had been, in part, because of enjoying student contact and here they can be seen to be prioritising this over the

other demands of the university. They can also be seen to be having to prioritise the professional demands placed on them by the NMC.

Murray and Aymer (2009) also identified that teacher educators, social work educators, nurse educators and, to a lesser extent, medical educators, struggled to engage in valid research and also with perceptions that their departments had low status within HE institutions. They too identified that their time is spent engaged with students and that this is because the demands of their professional groups and of professional practice is time consuming. Carlisle et al (1996) also identified the competing responsibilities of the nurse teacher and wrote that, 'The competing responsibilities of teaching theory and practice of nursing, facilitating the development of clinical skills ... [in] students ... and [the] added responsibility to conduct research and publish may well be an unrealistic goal to expect of every nurse teacher' (1996, p769).

In addition to meeting professional demands, the interviewees also identified the personal characteristics of nurses as an explanation for not fitting in at the university. These differences included being too nice and wanting to care for people. This issue was identified by male and female interviewees equally. Others blamed nurses teachers' subservient behaviour within the university. For instance, interviewee 18 said, '... I think ... we refer to ourselves as lower down the pecking order ... we use terminology that places us in an almost subservient position ...'. They felt that nurses were themselves to blame, either because they are too caring and lacked academic edge, or that poor self-esteem amongst nurse teachers was the source of the problem. Congdon and French, (1995) identified similar findings in relation to their 'nurses are different' theme when they described nurse teacher interviewees as believing that they were more caring than other academics in their teaching and supervision of students. They

believed that they also put their own interests secondary to those of the students. The majority of interviewees talked of feeling like second class citizens and refer to having less status than other more traditional academic subjects. Deans (2003) also identified that some nurse lecturers felt like second class citizens within HE, and this is reflected in the way these interviewees talk about their own experiences within the university. This second class status is as if they consider the rest of the university as a homogenous group of 'real academics' and themselves as outside of this structure – 'we're different' perhaps best describes how they explain their position.

Glen (1990) had identified that power was not in a nurse teacher's lexicon, saying that in his experience they 'tend to think they are alien, or even superior to considerations of power as a crucial and inherent aspect of social relations: social relations both within colleges of nursing and between schools and the wider social context'. Whilst few interviewees used the word power, the relationships they describe can be seen to be based on power and two of the interviewees made direct reference to their exclusion being about power. Interviewees 10 and 16 identified power as being a component of their exclusion and nursing being in a subordinate position. This, they suggest, has its historic precedence from the NHS and refers to their relationships with medicine having followed them into the university, and into the college that they work. Bush (2009) identified that power has many sources but that a broad distinction can be made between authority and influence; authority having a legal basis, and influence having an ability to affect decisions. As discussed above, the interviewees accept authority from legal sources, such as government departments, the NMC and senior colleagues. However, when the interviewees talk of power in this context it can be seen to be more closely associated with influence which they identify they do not have whilst others in the university do. When interviewee 12 referred to the subservient relationship of nursing to

medicine within the university, it is seen as a relationship based on influence, although they do not expand on what the basis or origin of that influence is, other than 'historical'.

Bolden (2011), in looking at power and influence in distributed leadership (a concept closely related and identified above as of relevance to collegiate structures), suggests that that much current theory and research takes insufficient consideration of the dynamics of power. In terms of power and influence the interviewees clearly see themselves as a group as having little of either when compared to other groups in the collegiate structures. It is interesting to note that the move to HE had been supported by many within the nursing leadership as a means to seek independence from the domination of medicine and the argument that nurses, if educated in universities, would put themselves on an equal footing with other university educated staff (Bradshaw, 2001). It would seem that most of the interviewees do not feel that they, as nurse teachers, are on an equal footing.

Several of the interviewees talked in terms of what should happen 'if nursing is to be accepted', or that they did not understand why it was not accepted in the university. Many identified that being accepted depended on *which* university and that 'new' universities might be, or in their experience had been, more comfortable places to be. Of the 18 interviewees 11 had worked previously in statutory universities and all of the interviewees who had had this experience identified that statutory universities were more comfortable places for nurse education to be located. In the statutory universities they identified that nursing, because of the universities' greater focus on teaching, the often large numbers of nursing students and the money that this brings to the university, placed them in a better position. Interviewee eight said, '... at the other university ... nursing ... was just massive; we were like the big earner ... we had status ... and people were very confident about the position [of nursing] ... ' In this

instance power is being identified as positional power (Bush, 2009). Their focus here can be seen as having power based on their resources, whereas in their current position that power is absent and they perceive themselves as excluded.

Having established previously that the interviewees place a high premium on being valued it might be fair to conclude that for many, the experience within the university is that this need is not being met. Whilst access has been achieved there seems to be a culture of low self-confidence and esteem based on their experience within the university. Feelings of rejection by the university may provide some explanation as to why the interviewees do not look to the university for leadership. Instead they look to those within their own 'community of practice', from individuals who make them feel valued, or from nursing's professional body, the NMC. In contrast two of the interviewees, when asked about being in the university, their experiences and responses provided stark contrast. Both identified that 'we' are in exactly the right place. The sample's characteristics does not appear to have an impact on their understanding because one was male, the other female. One was a university educated nurse, the other a hospital trained nurse.

To return to the question, the experience of working in the university is identified as firstly requiring a period of adjustment to a working environment that is understood as having flat structures and a lack of hierarchy; this is not identified in itself as problematic. The university is perceived as an unwelcoming place, a place that does not value nursing as an academic discipline, or themselves as members of the academic community. This would suggest that the collegiate and distributed working practices outside of the school are not extended to those within the school, and that some staff have experience of being specifically rejected when they have made attempts to join the 'community'. They identify themselves as different from

traditional academics which they attribute to having professional commitments surrounding the education of students and the demands of the profession. For some this is also understood using the language of power and they understand their position as less powerful than other academic disciplines. However, they do not identify feeling unwelcome in other statutory universities, meaning their experience is specific to where they currently work. Comfort in statutory universities is identified as discipline acceptance and has been identified as based on positional power in terms of the size of nursing departments at other universities. When considering the interviewees' gender, age, the length of time they have worked in nurse education and their employment contract, there does not appear to be any significant differences based upon these criteria, and the experience of working in the university identified in the findings span the sample's characteristics. I have suggested that their professional allegiances remain strong and are their main source of identity in the face of this perceived unwelcome environment.

Question 6. Explore How Nurse Teachers Exercise Leadership

My final question aimed to explore the opportunities and experiences the interviewees had of exercising leadership in their roles within the university and within their professional community. Bolden et al (2009) identified that in response to the challenges that universities face, distributed leadership is increasingly espoused. Whilst distributed leadership is not necessarily widely shared or democratic (Bolden, 2011), my interest was to explore how 'on the shop floor' this was experienced, and what opportunities did interviewees have to engage with leadership. In addition Harris and Spillane (2008) identified that distributed leadership acknowledges the work of all individuals. The interviewees also demonstrated strong professional allegiances, and therefore may also have identified leadership opportunities taken outside of the university in their professional roles.

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Distributed leadership classifications, developed by MacBeath et al (2004), were found to be recognisable within the HE sector (Bolden, 2009). These include formal, pragmatic, strategic, incremental and opportunistic. Several of the interviewees identified that opportunities were available to them within their role as nurse teachers and that these opportunities were available to people who were willing to take them. Several interviewees identified that their leadership opportunities were to be found in terms of their module management. For instance, interviewee 13 identified that as a module leader she took a lead in ensuring it ran smoothly. In this respect distributed leadership was described as incremental by MacBeath et al (2004) and described by Bolden et al (2009) as, ' … progressive opportunities for experience and responsibilities, such as sitting on and chairing committees; leading modules, programmes and projects; serving as a deputy' (p262).

This role also provides the opportunity to take a leadership role with students. For example, interviewee 10 talked of being able to inspire students. Other opportunities existed for the interviewees that might be located as cultural opportunities. Two of the interviewees identified that when working with peers doing projects or when writing bids or papers, these opportunities existed. These can be seen to conform to MacBeath et al's (2004) description of cultural leadership opportunities: '... leadership is assumed and shared organically such as in the development of collaborative research bids' (Bolden et al, 2004, p262). This type of collaborative working has similarities with that identified by Gronn (2002) as institutional practice, and can be seen to be the way institutions, through their organisational structures, enable people to work together. In this respect the interviewees can be seen to be working in a collegiate manner as they talk about working with colleagues in what can further be described as within a collaborative culture. However, the interviewees do not identify the formal

structures that enable them to work and take a lead in these areas but more that the situation and opportunity allows them to take a lead with colleagues.

In terms of leadership opportunities within their professional community only one of the interviewees (Interviewee 12) identified a leadership role in the form of a formal position he held within a professional interest group. This can be identified as opportunistic within the MacBeath (2004) framework. Others referred to groups that they were members of, but not of taking a leadership role.

I had noted in my field notes that several of the interviewees seemed uncomfortable in identifying that they had taken leadership roles. I had also reflected in my field notes that this might be because interviewees had previously described leaders as people being in possession of exceptional skills, and to then identify having taken a leadership role might be considered to reflect having an inflated image of themselves and their abilities. Interviewee five actually identified that he felt uncomfortable at being perceived as a leader. Gronn (2002) wrote that the problem of the acceptance of a transformational leader, who has all the skills needed to inspire others and to motivate them, is that it then locates others as followers. This might of course be analysed as the interviewees conforming to identifying themselves as 'followers', and some of the interviewees identified that they did not consider they had the right skills or personality to be a leader. Interviewee four said that he felt that not taking a leadership role had something to do with his personality. Interviewee one talked of not being '... a natural born leader ...'.

In reviewing the interview data alongside my field notes, I noted that those who did identify leaders as people with exceptional abilities and reluctance to claim leadership for themselves, were mostly the same people. Interviewee five said that '... I always feel uncomfortable being

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perceived as a leader .... a bit embarrassed really ...'. Most of the interviewees did not appear to locate themselves in the position of follower but identified that their opportunities were only for 'small leadership'. They identified that their leadership opportunities were modest. For instance, interviewee eight, when referring to doing projects or bids, described these opportunities as a 'kind of small leadership'. These opportunities did not conform to their previously expressed understanding of what leadership and leaders are.

The distributed leadership classifications developed by MacBeath et al (2004) do not imply progression but limitations and blocks to leadership opportunities and activities were identified by the interviewees. They did not identify opportunities outside of their school environment or opportunities to take part in these other types of distributed activities. They had, however, previously identified being excluded from the wider university, with the exception of being on, for example, admissions groups. Here they identify further restrictions within their own school. The interviewees identified this was because of structural restrictions, such as the management team consisted of a finite number of people and that there was a ceiling effect which restricted what people could do in terms of leadership. Exclusion and inclusion was identified by interviewee two as purposeful and that leadership opportunities were restricted to a few chosen people. Some felt that their position left them with very limited leadership opportunities, suggesting that the structures within the university created barriers to leadership opportunities and my field notes support this claim. For example, interviewee 18 identified that there was a ceiling effect in this unit (school) and decisions were made at college level.

To return to the original question, of all my questions this subject area seemed the hardest for the interviewees to answer and produced the briefest of responses. Opportunities were largely

identified as limited to their immediate environment and some of the staff identify that they are limited in what they can do because of the management structure. Several were reluctant to claim any leadership for themselves and I have suggested that this may be because of previously expressed understanding of leaders and leadership reflecting exceptional people with exceptional qualities. Their own opportunities are therefore understood as 'small leadership'. When considering the interviewees' gender, age, the length of time they have worked in nurse education and their employment contract, there does not appear to be any significant differences based upon these criteria, and their own leadership opportunities identified in the findings span the sample's characteristics.

Chapter Summary and Recommendations

This EdD thesis started with the claim that leadership in nurse education is unexplored and undeveloped. The aim of the research was to explore how nurse teachers identified and experienced nurse education leadership, with the intention of making an early contribution to the field. I located myself within the study and I have identified the importance of leadership in shaping my own career. As a student on a professional doctorate this was an area that had direct interest and relevance to my practice as a nurse teacher. I located my research with those who are not in formal leadership positions because their voice is often absent from the picture, and yet they have experiences and things to say that should be recognised. In the absence of research to draw upon, an exploratory study using subjective/interpretative methodology was considered appropriate. Watling and James (2011) wrote, 'The qualitative researcher ... is likely to be searching for understanding rather than facts: for interpretations rather than measurement: for values rather than information' (p355).

As is common in qualitative studies I have tried to create order from often different perspectives, and I have used the interviews and my field notes in triangulating the evidence and constructing the themes in order to establish validity. To reiterate the main findings, the decision to move to nurse education can be seen to be largely based on enjoyment of the teacher role and the desire to progress in a nursing career. In the absence of a clear understanding of nurse education leadership, nurse teachers' NHS and their nursing background informs their understanding of the role of leaders and leadership, which can broadly be located within the bureaucratic model. However, within this system the interviewees identified leaders by identifying that they are people who have the qualities of vision, influence and values, and in particular they place a high premium on being valued as individuals by these people. As a group within the university they identified themselves as different from other academic groups because of their commitment to students and their profession, which impacts on their ability to engage with research. They believe this contributes to their lack of perceived value and power in the university, feeling that as nurses they are excluded and unwelcome. Some consider that as an academic discipline, both nursing and they as individuals are responsible for this treatment. This experience was identified as being specific to the university where they currently work and was not an experience that those that had worked in other universities had experienced.

The nurse teachers' own leadership opportunities can be identified within their school, working with students and colleagues, but most do not identify opportunities, either within the wider university or within their own professional role as nurses. Their experiences as nurses and strong commitment to the profession, overrides the characteristics of the group and is central to their identity. This might be considered unusual in that factors such as the interviewees' gender seem not to have an influence on their understanding or experience of

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leadership. Whether this is a characteristic specific to those that were interviewed or whether the identify of being a nurse always overrides these characteristics, needs further exploration. It is interesting to note that when talking of their experiences of working with leaders they did not refer to characteristics of the leader either and leaders are referred to in neutral terms, unless a specific anecdote was used to illustrate their experience.

From the data I am left with an understanding of how important the formative clinical background of this group of nurse teachers and myself as a co-worker remains, as it was a frequent point of reference during the interviews and in my field notes. I would suggest that whilst some of the findings may be limited to the experience of those taking part in the research, this continued influence on nurse teachers working in universities is likely to be recognised by others working in the field and may also cause conflict for them. In addition the lack of clarity concerning leadership in nurse education may also resonant with others in the profession.

As with any research there are limitations to acknowledge. Firstly, the small size of the sample and the single location might be considered to be limitations. This was a small-scale exploratory study in a single university, and as such its findings may not be generalisable, although nurse teachers in other universities may find the study of value in reviewing their own position. My position as a co-worker might also be considered by some a limitation but my position was congruent with the methodology chosen as I share the same cultural background as a nurse with those I interviewed. As a co-worker I have been in a privileged position of collegiate trust and I have been honest in locating my position within the research. In this, I believe I have been honest and truthful and that the work demonstrates an authenticity because of my position.

Whilst my intention had been to explore for understanding, there are clear implications for policy and practice at a national and local level. The identification of the NHS by the interviewees as providing leadership represents a recognition that the operational needs of the NHS influences nurse education. The recently formed Health Education England (HEE http://healtheducationengland.dh.gov.uk/), a new national leadership organisation confirms that the Department of Health has responsibility for setting education and training outcomes for health workers. Health Education England works with the NMC in achieving policy goals, including improving nurse education. These structures will continue to provide the framework in which nurse education operates, the challenge is in ensuring that there is leadership and direction from the NMC on how nurses can contribute and influence the direction of nurse education at this strategic level.

It is clear from the interviewees that despite being critical of the NMC there is an expectation that education leadership will come from within the nurse professional body and historically this has been the case. Whether the NMC as a regulatory body in its current form is equipped or mandated to provide leadership in this area needs to be debated. In order for nurse education to develop leaders it needs to have structures in which leaders can operate and as the NMC in its current structure does not support this need, it may be more appropriate for the NMC's education role to be split from its regulatory role. The NMC is currently undergoing a government-led strategic review concerning its activities (http://www.nmc-uk.org/Press-and-media/Latest-news/NMC-welcomes-strategic-review/) and debate is occurring as to the future role of the NMC.

As nurse teachers at a university level, interviewees can be seen to be identifying that meeting the demands of the profession, not the university, contributes to their feeling that they are

different from other academics. However, it is not only the professional focus of the nurse teacher role that sets them apart from others in the university, and interviewees identify that they feel looked down on and excluded from the university. Being left outside of collegiate working practices where there are different working expectations and traditions can be seen to contribute to their reliance on their own professional structures and experiences. Further questions that need to be asked, specific to the location of this research, include what is the relationship and contribution of the university to nurse education and to those that work within its school. Being valued was identified as a key component of leadership and one that is not evident in their current environment. Further exploration and research should focus on how professional demands are met by others involved in professional education programmes such as teachers and social work educators within the university.

There are a number of challenges that face nurse education at this current time and without effective leadership at both a strategic and local level those challenges will go unmet. Nurse education leadership needs to find its voice in order to contribute to the future of nurse education at a national and local level.

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APPENDIX 1

Question Schedule

An exploration of nurse education leadership as identified and experienced by nurse teachers working in the field of nurse education.

Background data

How old are you?

How many years have you/did you work in clinical nursing/nurse education?

Where were you working before this post?

Influences

Why did you choose to move to nurse education?

Probe – source of motivation if identified, any previous experience relevant, any influential figures etc.)

What is your understanding of nurse education leadership?

Can you give me an example from your *experience*?

Probes – in your experience how is leadership and management different in nurse education?

- Which do you consider the most important? (if appropriate)

Where have you or do you find nurse education leadership and leaders?

Can you give me an example from your experience?

Probes - how important do you see these agencies/people in providing leadership in nurse education

Tell me about nurse education leaders you've worked with

Can you give me an example from your experience?

Probes - what have you learnt from leaders you have worked with?

- What made them a 'leader'?

- Tell me about their qualities and skills

Tell me about your experience of working in the university

How comfortable is nursing in the university?

Can you give me any examples from your experience?

Probes - what differences did you notice between here and where you'd worked before?

How have you exercised leadership?

Can you give me any examples from your experience?

Probes - university or professional?

- How did this happen?

- Who made it happen?

- What barriers or opportunities were there?

Is there anything else you'd like talk about or tell me about that I haven't asked you?

Thematic Grid

Interviewee	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Main Theme: The Experience of working with leaders																		
Issue: How leaders made people feel	215	131	184-187+188	150-153 +149-150	289-302			200 +339	188				278 + 280	177-179 +198	367 +280-282		148	
Field Notes																		
Gender	M	F	F	M	M	F	M	F	F	F	M	M	F	M	M	M	M	F
Contract Type	FC	F	TC	F	F	F	F	F	TC	F	TC	F	TC	F	F	F	F	F
Initial training	H	H	H	H	H	H	H	U	H	H	H	H	U	H	H	H	H	H
Length of experience in clinical/education	12/10	10/8	25/5	15/6	12/8	25/11	29/5	3/10	15/17	10/7	20/1	12/9	5/8	15/6	8/32	16/9	5/15	12/8
Previous experience Other University Research NHS Teaching	OU	OU	OU	OU	OU	OU	C	R	OU	C	NHS T	OU	C	C	OU	OU	OU	R
Listening and Observed		✔		✔				✔							✔			
Reflective Observation	✔	✔	✔	✔	✔			✔	✔				✔	✔	✔		✔	

APPENDIX 3

Consent Form

Thank you for agreeing to be interviewed and take part in my research which comprises part of an Education Doctorate being undertaken at the University of Birmingham. My research is concerned with nurse education leadership and it is anticipated that the interview will take approximately one hour.

……………………………………………………………………………………….

I understand that by taking part in this interview the information I supply will be used as part of the Education Doctorate and any linked publications being undertaken by Alison Coates. I also understand that the British Educational Research Association (2004) rules on ethics will be applied and any identifying features will be removed from the completed work.

Signed…………………………………………..

Date…………………………………………….