ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE

Strengthening the role of the executive nurse director: A qualitative interview study

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Abstract

Aim: To explore the challenges and opportunities facing executive nurse directors in the UK and identify factors to strengthen their role and support more effective nurse leadership.

Design: A qualitative descriptive study using reflexive thematic analysis.

Methods: Semi-structured, telephone interviews were carried out with 15 nurse directors and 9 nominated colleagues.

Results: Participants described a uniquely complex role with a broader scope than any other executive board member. Seven themes were identified: preparation for the role, length of time in role, role expectations, managing complexity, status, being political and influencing. Strengthening factors included successful working relationships with other board colleagues, development of political skills and personal status, coaching and mentoring, working within a supportive team culture and having strong professional networks.

Conclusion: Executive nurse leaders are key to the transmission of nursing values and the delivery of safety and quality in healthcare settings. To strengthen this role, the limiting factors and the recommended shared learning identified here should be recognized and addressed at an individual, organizational and professional level.

Implications for the profession and patient care: Given the pressure on all health systems to retain nurses, the role of executive nurse leaders needs to be seen as an important source of professional leadership and their value in actioning health policy into practice recognized.

Impact: New insights have been provided into the executive nurse director role across the UK. Findings have demonstrated challenges and opportunities to strengthen the executive nurse director role. These include recognition of the need for support, preparation, networking and more realistic expectations of this unique nursing role.

Reporting method: The study adhered to the Consolidated Criteria for Reporting Qualitative Research.

1 | INTRODUCTION

The importance of effective nursing leadership is recognized as key to promoting quality care and patient safety across a range of healthcare settings. The State of the World's Nursing (SoWN) Report (WHO, 2020), released on the eve of the Covid-19 pandemic, highlighted nurses' contribution to achieving the World Health Organization's targets for universal health coverage and sustainable development goals (SDGs) to improve population health and well-being. The report made 'a compelling case' for expanding nursing education, securing a stable workforce and strengthening effective nursing leadership and universal health coverage, quickly followed by the publication of a global nursing and midwifery strategy (SDNM; WHO, 2021). Despite their prominence, the full potential of the nursing workforce is poorly understood and undervalued, and executive nurse leaders face unique challenges in meeting the demands of their role (Horseman et al., 2020; Jones et al., 2016).

2 | BACKGROUND

In the United Kingdom (UK), Executive Nurse Directors (ENDs) are National Health Service (NHS) Executive Board members required by law and, as such, constitute the highest level of professional nursing leadership in the provider sector. The role of all executive directors is to provide strategic and operational leadership, and often also have responsibility for patient safety and quality performance of organizations, including accountability in the event of failure (Monitor, 2013). The UK END role is complex as it provides both strategic and corporate advice to the executive board, while navigating the national political context as well as issues facing local settings, reinforcing nursing values and influencing the culture of the organisation (NHS Improvement, 2019). It is recognized that END roles cover a broader remit and range of responsibilities than any other board member (The Burdett Trust for Nursing and the Kings Fund, 2009). However, little research has been conducted exploring the challenges and opportunities that impact their ability to impact the nursing and broader health agendas in the UK. Prior to undertaking this study, the research team undertook a scoping literature review which confirmed the lack of empirical research on this group, despite the strategic importance of the role (Horseman et al., 2020). These executive nurse leadership roles will differ in scope internationally. However, as illustrated in the study by Kelly et al. (2016), professional responsibility has to be balanced with other factors such as fiscal constraints and workforce shortages. Individuals in these roles sought to protect nursing values despite such challenges.

Recent public inquiries into failings in the quality and safety of hospital care in all UK countries have emphasized the role played by executive nurse leaders, reinforcing their importance (Belfast Health and Social Care Trust, 2019; Chambers et al., 2018; Francis, 2010, 2013; Health Inspectorate Wales and the Wales Audit Office, 2013; MacLean, 2014). Repeated inquiries identifying shortcomings in quality and safety, in conjunction with suboptimal leadership and governance, not only demonstrate a need for stronger nursing voice at executive board level but also have demonstrated the tendency to single out nursing leadership alone for what usually are complex system-wide failures. In contrast, the presence of medical leadership, in the form of medical director executive roles, is considered a positive indicator of quality and effective clinical leadership (Jones et al., 2022; Jones & Fulop, 2021).

Despite recognition that nurses are central to the delivery of high-quality healthcare on a global scale (Crisp et al., 2018), a dichotomy exists between the power and status of nursing (in this case, at executive level) and the level of responsibility assigned to them. Taking the UK END role as an example, little evidence exists about their everyday workplace experiences, preparation for the role or how this role and function are viewed by those sharing executive responsibility (Horseman et al., 2020; Kelly et al., 2016). There are, therefore, lessons to be learned from documenting individual experiences that could offer helpful insights to help strengthen the role of senior nursing leadership at a national and international level (Machell et al., 2009, 2010; Nursing Now, 2019). Similar roles exist in health systems in other countries, albeit with a different scope or range of executive responsibilities, so this is a global nursing concern (WHO, 2020).

It is also important to note that the known stressors of workplace stress, burnout and compassion fatigue that impact clinical staff also manifest in nurse managers, although their incidence in executive-level nurses is not documented (Membrane-Jimenez et al., 2020). We designed this study to address gaps in the evidence based on how to strengthen the END role.

3 | THE STUDY

3.1 | Aim

The aim of this study was to produce empirical evidence identifying contemporary challenges and opportunities facing the END role across the four UK countries. In addition, to provide recommendations for strengthening the role.

3.2 | Research questions

- What are the challenges that impact the END's ability to deliver the nursing and broader health agenda in the UK?
- What opportunities might facilitate ENDs to deliver the nursing and safety/quality agenda effectively in the UK?
- If it is possible to strengthen the END role in the UK, how might this be achieved?

4 | METHODS AND METHODOLOGY

4.1 | Design

We adopted a qualitative approach to explore the experience of ENDs and to give voice to professionals who are important to current health debates, but who are not always heard (Moen, 2006). Brief demographic data were gathered prior to in-depth telephone interviews combining semi-structured and open-ended questions. These were derived from previous experience within the research team, as well as the project steering group (including four END representatives from each country) and previously published research (Jones et al., 2016; Kelly et al., 2016). A conversational interview style was adopted with question prompts to ensure consistency across participants.

4.2 | Study setting and recruitment

The sample of ENDs and nominees was drawn from across UK countries based on the advice and expertise of the advisory group and research team. We took a mixed sampling approach using professional networks, advisory group contacts and social media invitations. Nominees were recommended by the ENDs who particpated.

The study sample included acute and community services in both rural and urban areas. Exclusion criteria included any Health Board or Trust deemed to be in a difficult or sensitive situation such as 'Special Measures'. A sampling grid (Figure 1) was constructed for this purpose (Gentles et al., 2015). The research team included senior academic colleagues from each country who helped to identify and recruit the ENDs and nominees and also undertook the interviews.

4.3 | Data collection and management

Interview data were collected between February and December 2019 following informed consent and professionally transcribed. All interviews were conducted by telephone due to the wide geographical spread of participants and to accommodate their high workload. Participants were given the opportunity to comment on their transcripts to ensure they represented an accurate reflection of their opinions and perceptions, and to help enhance the trustworthiness of the qualitative data. Collaboration between researcher and participant mirrored the equitable research process during which a shared understanding of a sociocultural context is sought (Moen, 2006). Anonymity was prioritized and any identifying information removed from the findings.

To further capture perspectives on the END's role within a shared sociocultural context, each participant was invited to nominate a colleague whom they felt could also comment on their role. This could be a colleague on the same executive board, from another professional disciplines but did not have to be a nurse. The final choice was left open to participants.

Additional documentary evidence related to policy- and country-specific information was also gathered to provide a contemporaneous background and policy context for national- and UK-wide analysis.

4.4 | Policy context

Policy changes in health and social care systems contribute significantly to the complexity and challenges of the END role (Burdett Trust for Nursing and the Kings Fund, 2009). The team recognized
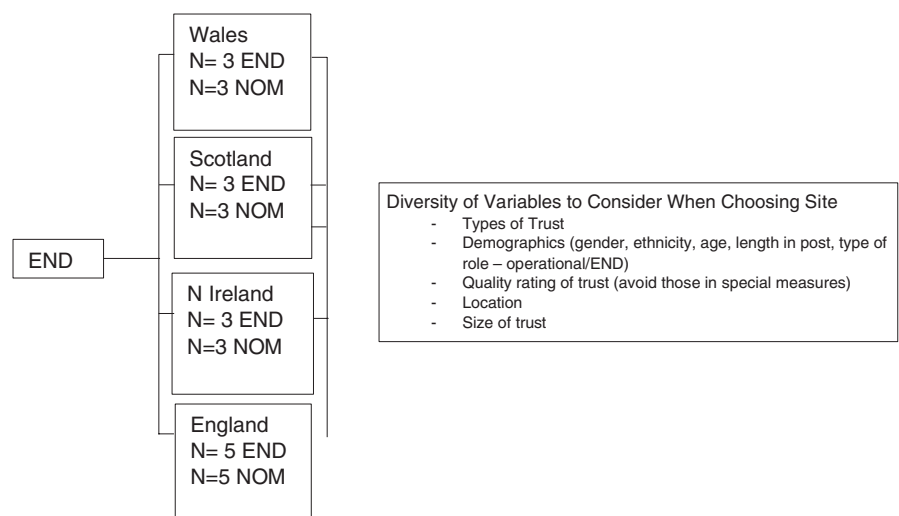

FIGURE 1 Study sampling strategy.

the relevance of this and, as a means of understanding the participants' policy priorities, information was sought on the policy context of each country at the time (File S2). These demonstrate the external national policy factors that impacted the END role, as well as those more immediately relevant to healthcare delivery.

4.5 | Ethical considerations

The questionnaire and interview schedules are available (File S1). Ethical permission was obtained from the Section of Nursing Studies Ethics Research Panel at the University of Edinburgh (reference number STAFF 134). Anonymity was assured using codes in the analysis and reporting stage. Data were stored in password-protected files on the university servers and the team was guided by the principles of research integrity.

4.6 | Data analysis

Following transcription, each transcript was read by members of the research team representing each UK country to develop an overall impression of the data; the content was then analysed using framework analysis (Gale et al., 2013; Srivatsava & Hopwood, 2009). This was to enhance rigour in relation to relevance of findings to the role and the policy context. Significant 'units of meaning' (phrases, sentences and paragraphs) were highlighted, and interpretative codes were created in a table format. Thematic analysis incorporating Braun and Clark (2019) reflexive approach was applied. Themes were merged or added, more detailed elements were identified and interpretations were refined to allow reflection of similarities and divergences of opinion to be recorded (Srivatsava & Hopwood, 2009; Ward et al., 2013).

Critical analysis of qualitative data was undertaken collectively to generate distinct but connected insights that reflected challenges and opportunities of the END role. Connections between everyday working practices, wider policy impact on the role as well as the successes and challenges facing ENDs were examined.

Trustworthiness was enhanced by sharing our findings with members of an advisory group which comprised of ENDs from each of the four UK nations (Koch, 1994). We adhered to COREQ guidelines throughout.

5 | FINDINGS

5.1 | Participant descriptors

We recruited 15 ENDs and 9 Nominees from across the UK (see Table 1) and our approach was shaped by the availability of participants. Despite repeated attempts, the sample fell short of our target numbers outlined in Figure 1. However, we decided not to follow-up potential participants more than twice in recognition of the high

TABLE 1 Demographics of END and nominee participants.

	END (15)	Nominee (9)
Demographics table		
Gender		
Male	1	3
Female	14	6
Age		
40–49	—	1
50–59	12	5
60–65	2	1
Not given	1	2
Ethnicity		
White British	10	6
Black Caribbean	1	—
Black British	—	1
Not given	4	2
UK country		
England	5	2
Northern Ireland	4	3
Scotland	3	3
Wales	3	1
Location		
Urban	5	1
Rural	1	1
Mixed—Urban and Rural	9	6
Not given	—	1

workloads and the challenges in recruiting from what has been described as a 'hard to reach group' (Harris et al., 2008).

The END sample included 1 male and 14 females; 14 were White British, with 1 individual from a Black, Asian and Minority Ethnic (BAME) group. All ENDs were aged 50–65 years. They managed workforce groups ranging from 5000 to almost 25,000 staff members, with between 450 and 2500 hospital beds in organizations that could serve populations of up to 800,000. There was an even spread in terms of years of experience: 4 ENDs had been in post for less than 2 years, 6 for 2–5 years, 2 for 5–10 years and 3 had 10–15 years of experience (Table 2).

The geographical areas covered by nine ENDs were mixed urban and rural, five covered an urban area and only one covered a rural area. It is important to note that the final END sample represented a total of 15 different healthcare providers across the four UK countries.

The nominee group comprised three males and six females, with eight participants stating White British ethnicity and one from a BAME background. All nominees were aged 50–65 years, apart from one who was 40–49 (Table 1). Four of the nominees had worked with the END between 5 and 10 years, three for 10+ years and two for less than 2 years (Table 3). Interestingly, over half the nominees came from a nursing background, see Table 4 for nominee professional context.

TABLE 2 Length of time in END role.

	END, Total length of time as an END	END, Length of time in current post
Up to 1 year	—	1
>1 to 2 years	4	3
>2 to 5 years	3	6
>5 to 10 years	3	2
>10 to 15 years	3	3
>15 years	2	—
	$n=15$	$n=15$

TABLE 3 Nominee professional context.

Nominee role	
Deputy END (including Deputy Chief Nurse safety and quality)	3
Chief Executive	1
Director of People	1
Interim Director acute services	1
Assistant Director safe and effective care	1
Sector Chief Nurse	1
HR Director	1
	$n=9$

TABLE 4 Themes and elements.

	Theme	Elements
1	Preparation for the Role	Few opportunities to prepare for the role Shadowing Coaching and mentoring
2	Length of Time in Role	Experience Networks
3	Role Expectations	Extent and remit of the END role Representing nursing as a profession
4	Managing the Complexity of the End Role	Effective management Administrative support
5	Status	Medical Dominance Professional vulnerability: 'Carrying the can' Visibility and Presence Lines of Power Low Self-Esteem in Nursing
6	Being Political	Being politically astute Being strategic
7	Influence	Influencing beyond the remit of the role Relationship building within the executive team

5.2 | Themes

We identified seven themes and their related elements across interview data from both the ENDs and their nominees (Table 4).

5.3 | Theme 1: Preparation for the role

5.3.1 | Few opportunities to prepare for the role

While leadership training exists, there is no formal pathway of preparation for the END role across all countries and ENDs were appointed from a variety of clinical backgrounds. Some felt that the extent of these roles, and the size and scale of organizations they operated within, could make it difficult for aspiring ENDs to gain relevant experience in more manageable, smaller settings:

> The gap's big, so I think there's less opportunity for senior nurses now to cut their teeth on a smaller organisation that's a bit more manageable and get to grips with at executive level working with the board. END5

Nominees also noted the lack of opportunity to gain experience to prepare for the extent of the END role.

> ...you need to build up a portfolio of experience in leadership in an acute health board in order to prepare you because obviously some of my colleagues who work in smaller organisations...would find it a huge challenge regarding size and complexity of the organisation unless you have experience... NOM9

One participant emphasized the need to understand the role that relationship building plays, as well as self-awareness:

> You need to get them to a place where they're confident, competent, capable persons at whatever level they're at, but they need to start by knowing themselves. Job descriptions are very task oriented they're not written about the complexity of relationships. END2

5.3.2 | Shadowing

Participants emphasized the benefit of shadowing as an aspiring or new END, stating that the opportunity to observe an experienced colleague and/or a senior manager in a different organization or sector, offered insights into how to manage complex challenges and suggested different ways to handle expectations:

> 'I've shadowed some more senior people when I was developing over the years (who) came from a private industry in business and I think that's why my head switches to how I manage my colleagues in a very business orientated way'. END10

> ... I was seven years as deputy to [END name] so I was working for one of the most successful, you know

longest serving Chief Nurses in the country, so I was enabled very cleverly to learn the role..... END1

A nominee further endorsed these views:

> People have the opportunity to come on secondment and shadow, so I think it's important because you know different organisations especially have different complexities. NOM1

Seeing other executive members displaying more power than the END also acted as a motivator. This was not shadowing per se, but did allow the behaviour of other executives to be observed, and responded to:

> I have a set of values and behaviours that I frequently remind myself of and will not deviate from which sometimes puts you in conflict. END1

5.3.3 | Coaching and mentoring

Both nominees and ENDs discussed the benefits of coaching and mentoring, with more experienced participants revealing that they now provide coaching to new and aspiring colleagues. They argued that coaching and mentorship provided a source of independent, unbiased and non-judgemental support, and gave an opportunity to reflect on actions and ensure that they were representing the voice of nursing to best effect:

> 'I have a coach, I would not be able to do this job without a coach because they are the only true independent source that you have, it's a lonely job, everybody has an agenda and therefore, the only true person that you have to assist you is yourself and an objective coach and that sounds quite difficult doesn't it, and it is at times'. END13

In one participant's view, the role of the mentor or coach was: '... to help you explore what you're feeling and what it means to you and what you can do'. END1

The value of shadowing was also emphasized by a nominee:

> People have the opportunity to come on secondment and shadow, so I think it's important because you know different organisations especially have different complexities. NOM 1

5.4 | Theme 2: Length of time in role

The length of time in the role was highlighted by both nominees and ENDs as a key factor in acquiring experience and building networks and confidence.

5.4.1 | Experience

There was agreement among nominees that ENDs would gain valuable experience the longer they were in post, and therefore become more successful and effective:

> I think the longer directors of nursing are in post the better known and more successful they tend to be. NOM6

> People sit up and listen because obviously you know there's been time spent in the role. NOM9

ENDs also recognized benefits of longevity in the role, as well as possible disadvantages, such as becoming complacent:

> Well, I'm the longest standing member of our board which has its advantages and disadvantages really, so I think I'm probably seen a bit like the Queen Mother, I suspect! END5

> There are risks, one is that you are in it too long and become complacent. END11

5.4.2 | Networks

A further element of experience related to the building of effective networks. Having a good support network was seen as essential to success, with more experienced ENDs often having effective networks to draw upon.

Conversely, one nominee recognized that being new in post meant that structures and networks were not yet formed, meaning that it was more difficult to establish themselves in the role:

> I believe the END has made a good attempt to try and establish themselves and without a majorly massive resource around them yet, because I mean their structures haven't fallen in yet behind them. NOM3

All ENDs recognised how important it was to establish support networks:

> Well, my networks are quite supportive as in people who I've worked with, or done a course or a programme with, or in a similar role they will always, you know they will be your cheerleaders yeah, they'll tell you all of the right things to make you feel good. END1

Risks from not establishing networks were also mentioned:

> I remember distinctly saying this one would be my biggest fear, you know I've got no networks. NOM2

5.5 | Theme 3: Role expectations

5.5.1 | Extent and remit of the END role

Role expectations were broadly similar between ENDs and nominees. ENDs placed emphasis on the breadth of their portfolio, and on the size of the role, acknowledging that it took an experienced, well-networked individual to succeed:

> I think there's possibly a bit of an imbalance in the portfolios, I think when you look at us, what's in the portfolios of all the executive directors and the other directors, it feels like sometimes the END portfolio is the largest. END10

The perception that the END portfolio was the largest of all board directors, and was unfairly imbalanced when compared to other directors, was explained by the view that 'anything and everything' could legitimately fall under the 'nurse's remit':

> The sort of nurse mantra that, you know, give it to the nurse, she'll adopt it. END11

This meant the ENDs' portfolio expanded the longer they were in post:

> The longer you stay in the role the more additional things you acquire in the role. END11

Nominees confirmed these perceptions:

> I think actually their portfolio is huge, you know it's a massive job and it's only getting bigger as organisations, especially healthcare organisations, are getting bigger themselves with collaboration and mergers so it's a huge, it's a huge job. NOM1

Unsurprisingly given the above, a strong element in the findings was that the END role was viewed as critical and central to the success of the executive board overall. This meant that ENDs could be asked to play a part in almost all items on the agenda:

> The role is perceived with importance, actually the role works in a triumphant way with our medical director role as well as the chief finance officer role. END1

> By virtue of the portfolio I have, I should be in attendance at every single committee. END15

This view of the remit being so expansive was also shared by nominees:

> So, there's very little you can actually touch in the health board that the nurse director can't legitimately say she or he's got an interest in and I think that view, I know that view, is shared by my executive team. NOM6

It was recognized that ENDs were already expected to cover a wider portfolio and that this was growing as organizations expanded or merged.

5.5.2 | Representing nursing as a profession

An important theme to emerge was that ENDs served as representatives for nurses, as a professional group, at board level. The importance of this professional leadership of nurses across the organization was highly valued and viewed as distinct from direct management of individuals:

> However, you need to be able to translate your professional guidance into everything that nurses do, so we know we do not manage the nurses, it's still about how we lead them from a professional point of view. NOM9

The importance of being seen as nursing role models was a further dimension of professional leadership:

> I think it's important that the person role models the behaviour that we expect from the wider workforce, again so particularly when we think about the culture, cultures, the culture of the organisation and that actually you know the majority of our workforce are nursing, so the person is looked up to as a role model and therefore it's important that that person demonstrates the leadership skills that we would want embodied within our workforce. NOM1

When problems occur in terms of negative organizational culture, there is a need to speak up and promote the role of nursing at board level:

> The culture of the board has not been good and one of the big jobs I have is actually increasing the profile of our nurses and by that, I mean their professional status, their credibility, their ability and their competence. END2

5.6 | Theme 4: Managing the complexity of the END role

5.6.1 | Effective management

While ENDs discussed the many complexities of the role, they also stated that being able to prioritize issues was an important skill in

managing effectively, as was knowing when to delegate and when to take control of an issue:

> You are constantly re-visiting what those priorities are, and I think that's become more challenging. ND13

Effective time management was also emphasized, with some ENDs sharing the view that 'if you want something done, give it to a busy person'. This suggests that the nature of the END role meant that effective time management was key to success. If an END was unable to work in this way, then they would be unlikely to succeed:

> Most Nurse Directors are completers-finishers and get it done, as we've had to be, or we'd not survive. END10

As the role expands, however, so too did the expectations of others:

> The more stuff the END's take on the more the original role can also be diluted. END2

5.6.2 | Administrative support

Lack of administrative support was a practical requirement highlighted. Where there was limited, or no administrative support, ENDs became involved in administrative tasks and were less able to focus on representing nursing and other key priorities. ENDs who had efficient administrative support expressed strong positive views about its value, and stated that they would not be able to function without it:

> I have a very strong business manager and PA without whom I would not be able to function. END12

When administrative support was reduced, this could be a threat to effective functioning:

> Our admin support has been cut back quite dramatically and I think you should never underestimate the value of having had a phenomenal full-time executive PA that's set you up and not leave you to be fiddling about in the paperwork. END10

5.7 | Theme 5: Status

5.7.1 | Medical dominance

ENDs perceived that medical dominance could be a challenge within the executive board, as the medical advice and voice were perceived to override that of nursing:

> You're conscious within the management group of medical dominance. END11

This links with questions of purpose of the END and how they are perceived alongside more dominant professional groups:

> Medicine has always been recognised as an essential part of healthcare and I think nursing less so, you know still definitely the poorer relation in that kind of setting, and there needs to be, and I mean so there is, you have to have a nurse on the board but I think what is not clear or what's not been standardised is what that nurse brings to it and what to expect ... (so) there needs to be this recognition of what exactly the nursing director as an executive brings to the board, how it's recognised. END1

One nominee suggested that ENDs may even play a part in supporting medical dominance by being 'too subservient':

> I think we're still a wee bit too subservient to the medical director or you know to other directors, maybe who've got a lot of responsibility for patient services and things like that. NOM4

As this END inferred, doctors continue to be perceived as being 'in charge':

> I notice that there are still times nationally when it can be perceived that the go to for people can often be doctors rather than nurses or midwives, after a length of time that can "stick in the craw". END12

Also:

> You're conscious of the management group, medical dominance. END2

5.7.2 | Professional vulnerability: 'Carrying the Can'

The pressures inherent within the END role, including the underlying risk of losing one's job, or even professional registration if things go wrong, was also highlighted. This view was based on recent inquiries that had led to ENDs losing not only their job but also their nursing registration, and therefore their ability to practise elsewhere:

> ... (ENDs) carry the can completely for the board rather than the board owning it as a clinical care issue, rather than a professional nursing issue. I think unless we work that through people aren't going to want to become nurse directors because they want to feel supported. END1

Others agreed:

> You know I was aware, well, I was told quite specifically that you know if it all goes wrong your head's the first on the block. END3

> You know myself and the medical director do not only lose our job, but we lose our license to practise whereas other members of the board do their jobs if they would go wrong, and I think that's sometimes forgotten. END13

This theme was also present in nominee interviews:

> I think as a society we have a reduced tolerance for failure and an increased expectation around bullying. Most of the executive nurse directors have responsibility for patient and public protection whether that be around the care environment or whether it's around care protection or vulnerable adults and if things go wrong there has to be someone to blame. Now those things are in the executive nurse's bag, massive pressure for the executive nurses to make sure that they can do the best they can and some of the high-profile failings you touched on, the reality of these executive nurse directors carry some of the riskiest things in their portfolio. NOM6

Failure could be very public, and blame could be assigned to the END for system-wide issues. Participants again reported the value of supportive colleagues and personal resilience to deal with such situations:

> I had to really call on every inner strength I had to get through that time, it was hard. END1

5.7.3 | Visibility and presence

A key expectation of ENDs was maintaining visibility and presence within their organisation. Participants explained that it was difficult to find a balance between being visible on the frontline while also carrying out their executive roles. However, finding time to do this alongside other aspects of the END role was challenging:

> One of the biggest challenges particularly given the size of this organisation is managing to be visible and connected both to the front line and to nurses, midwives, AHPs. END4

Several ENDs used tactics such as 'walking the floor' to maintain visibility within their organisation, and some did so in uniform. This was a tactic to enable ENDs to remain connected and gave staff time to raise current issues:

> I think the thing that I'm most proud of is probably my ambition and that I try very hard to be out there, to be visible, to be accessible and to be approachable. END12

This also reflects the perceived risk of seeming out of touch with 'the detail,' as one participant said:

> The biggest challenge for me personally is that when, as executive nurse I have to be able to present and talk and have a narrative around many issues that I don't always have the detail of. I can't always have all of the detail so that's been my biggest personal challenge END3

5.7.4 | Lines of power

All participants emphasized the importance of relationships and alliances within a successful END role. Relationships were fundamental as they provided access to lines *of* power as well as lines *to* power, thus enabling ENDs to get things done and making their voice and circle of influence stronger:

> The Chief executive decided (not to) replace the nurse director at the board …I was so infuriated that nursing would be discussed through the medical director that I was absolutely determined the medical director would have a very strong voice of nursing. END13

This resulted in the individual deciding to take on the nurse director's role themselves:

> I learnt quickly how I needed to work with people and (it) became clearer about what a board was, and its functionality, and actually the board meetings were the place where people shared information but most of the business was done outside of that. END13

Relationships were not only an important way of accessing and influencing power, but they also provided the END with essential sources of support, advice and sounding boards for problem-solving. Hence, participants described the necessity of attending networking opportunities and the importance of being present at meetings and events:

> The country is run by the people that turn up. So, if you want to influence and you want to shape, you need to be in the room. END10

However, as END13 recognized above 'most of the business' was also done outside of board meetings.

As also discussed in Theme 2, having an established network was essential to success in the role. Relationships helped ENDs to develop a stronger profile within their own organization, making them recognizable as the key voice for nursing:

> I think having those networks and there's no short cut to creating those, but certainly (N) has them but it's a really important part of success at executive level that people know you, you have a profile, you're recognisable so I think that's key. NOM6

5.7.5 | Low self-esteem in nursing

Several nominees suggested that nursing suffered from a form of low self-esteem, even at executive level, so that nursing had also failed to be influential enough at the national platform. Nominees especially called for ENDs to adopt a stronger voice to set the nursing agenda and to be better able to influence political matters:

> I think it is absolutely a pivotal role and you know I think that nurses need to get over their, I don't know, low self-esteem or whatever it is. But to think yeah, I can absolutely do this, I can shape the future. NOM5

> I've seen very little coming out from nationally around the nursing agenda, so I think we've failed, broadly speaking, to influence at a national level. NOM6

5.8 | Theme 6: Being political

5.8.1 | Being politically astute

The importance of ENDs being politically astute was mentioned by two-thirds of the nominees but by only one END. This suggests that political astuteness was observed by others but due to low self-esteem ENDs seemed neither to recognize nor value it in themselves:

> it's really important that we have a strong cadre of politically astute and competent nurses to lead the profession because if we don't, we'll be in trouble. END5

> I think we need to have people that are better at influencing the political matters to make sure that the nursing agenda is fit for purpose to meet the needs of the people we serve. NOM6

The risk of things going wrong is also a significant concern in terms of managing public, as well as organisational, expectations:

The level of media and regulatory scrutiny, yes, given the nature of our services we are rather newsworthy at times so for me that's a big challenge. END2

5.8.2 | Being strategic

Alongside being politically astute, participants explained that ENDs should be able to think and plan strategically, and deliver on the nursing agenda alongside other expectations: This required them to be able to negotiate, influence and navigate complex situations and to ensure that the nursing voice is heard within their organization, and externally:

> As an executive nurse director, I think the first and primary skill that you need to have is the influencing skill to be able to have impacts within a (trust) board. It is critical to get the nursing voice heard …but in order to do that you have to actually be very articulate in what you're trying to explain but you also have to bring the evidence. NOM3

ENDs also recognized that to be effective they needed to choose levels of involvement:

> You work at a strategic level you do all that kind of (frontline) work and then I think one of the challenges for me over the last few years has been extricating myself from being out and about and involved in everything, and choosing what it is I need to be involved in, as opposed to just everything. END4

5.9 | Theme 7: Influence

5.9.1 | Influencing beyond the remit of the role

ENDs needed to influence matters over which they may have little direct control, such as financial and budgetary issues. This can come through the building of relationships and alliances as described above. Nominees suggested that representing nursing as a profession involved them presenting professional guidance in relation to multiple agendas:

> I think you need to be able to negotiate and influence them because you don't actually manage a budget, you don't actually line manage individuals, and you certainly don't line manage others that work in the organisation so you, however, you need to be able to translate your professional guidance into everything that nurses do. So, we know we don't manage the nurses, it's still about how we lead them from a professional point of view. NOM9

Having a role in professional influencing was an important indicator of ENDs' worth and could strengthen their position on the board and beyond. Networking with other ENDs, especially in the sense of presenting a united professional front at a national level, was seen as a key strategy to enable them to succeed:

> The profile of (ENDs) needs to be strengthened … much more front and centre in the national strategic discussions… So, I think there needs to be a much more united front at a national level with the nurse directors and that message needs to come out, and the chief nurses and lead nurses need to set that profile. Otherwise, the danger is we get marginalised by the other priorities which are around demand, capacity for, money, for all that. NOM8

5.9.2 | Relationship building within the executive team

Networking and influence were closely associated with relationship building within the executive team, which was also seen as key to the END's success:

> I think because I went into a quite established exec team who have been together, most of them have been together for a little while, there were just one or two that were new, but you know it's a bit like breaking through a tight team was the greatest challenge. END1

Dealing with differences of opinion was also a necessary skill:

> Well, I have a set of values and behaviours that I frequently remind myself of and will not deviate from which sometimes puts you in conflict. But over the years you learn ways in which you manage that before you get into a board room situation. So, for me it's always about relationships and how you have relationships with the front line and your occupation on the board and everybody in between. END13

Alliances across the board were also key to success:

> But this is all about relationship building and you know developing allies and support structures. NOM7

Finally, the importance of remembering the focus of the role also allowed individual ENDs to feel part of the larger healthcare safety agenda:

> There is something about being able to present well and articulate clearly the point that you want to get

over and to be able to really work in collaboration across health and social care and voluntary sectors. It's a skill and also you know you have to deal with some very, very difficult situations you know, it's the nurse directors who will be the ones who are engaging with the very sad and tragic you know, cases and incidents that can happen, you know, with patients and families, you know we have to deal with the coroners and inquests. You know you are dealing with serious adverse incidents and outcomes and there are some that are very testing to be dealing with, so resilience and having the confidence to deal with those is really important. END2

6 | DISCUSSION

6.1 | Insights

These findings provide insights into the opportunities and challenges faced by individual ENDs and the organizational, professional and personal factors to be used to strengthen effective nurse leadership at board level. Indeed, many of the opportunities and challenges raised were consistent with evidence gaps identified in an earlier scoping review (Horseman et al., 2020). Most notably were the size and extent of the END role, limited influence, lack of preparation for the role and concerns around risks of personal blame for organizational failure.

However, our study reveals new insights into the way that ENDs are expected to play a part in all aspects of the executive agenda. ENDs and their executive colleagues seem to expect them to encompass 'anything and everything' in line with the scope and size of the nursing workforce. Another aspect of this ever-expanding role can be attributed to there being limited personnel to whom tasks or responsibilities can be delegated, including essential administrative support.

With their professional and strategic knowledge and experience ENDs are well-placed, alongside the medical director, to provide the professional insights necessary to guide executive board decision-making and to balance the need for clinical quality with financial and performance targets (Burdett Trust for Nursing and the Kings Fund, 2009, Machell et al., 2009). However, despite similar broad-ranging remits and collaborative working, there are evident contrasts with how END and medical director roles are perceived and valued (Francis, 2013).

In their study of medical directors, Jones and Fulop (2021) noted a paucity of research on doctors working at board level in 'hybrid' roles as managers and professionals. They shadowed one medical director and conducted in-depth interviews with other executive board members including medical directors and ENDs. Because Jones and Fulop (2021) did not report on the END role specifically, our findings go some way to address this gap in knowledge. Their analysis does, however, provide useful theoretical and

empirical comparisons. They draw on the sociological literature (Friedson, 1985; Waring, 2014) to analyse the medical director role in the context of professional and managerial elites. These roles focused on efficiency and management targets, which are more aligned with the END role, conferred lower status and influence than medical directors. Jones and Fulop (2021) also drew on Strauss et al. (1985) original concept of 'articulation' work to characterize the medical director's work as translational, diplomatic and repair-focused, some of which could also be applied to the END role as discussed below.

By shadowing one Medical Director, Jones and Fulop (2021) observed how they used their knowledge of policy and clinical expertise to undertake 'Translation work' which the board's Chair recognized and valued. Our theme of politics and influence can be compared to the observation that the board chair and other board members clearly recognized and valued the medical director's translational role on the board (Jones & Fulop, 2021). The nominees in our study were more likely than the ENDs to observe them as being skilled, politically astute and strategic individuals who effectively influence others and build relationships across the board as well as influence the wider profession. These activities, if better recognised, could be interpreted as the ENDs' 'Translation work' which provides the board with knowledge concerning professional nursing and represents the interests of the nursing workforce. Furthermore, professional guidance and leadership were considered essential to ensure quality and safety of the care provided by nurses

Jones and Fulop (2021) also reported that medical directors also undertook significant amounts of 'diplomatic' work. Clinical credibility was a key component of this diplomacy role which facilitated medical directors' 'repair' work and maintained good relationships between 'rank and file' doctors and management. This finding resonates with our finding of 'visibility and presence', as an example of 'status work', when ENDs 'walked the floor' to remain recognizable to frontline nurses and to appear as effective conduits for concerns to reach the board. However, although ENDs 'walked the floor' to make themselves visible to frontline nurses, not all have clinical involvement on an ongoing basis, unlike most medical counterparts.

This lack of continuous clinical engagement may have contributed to a feeling of low professional self-esteem. This finding resonates with professional vulnerability, an inverted element of 'Status', whereby ENDs felt they were 'Carrying the Can' for organizational failures, resulting in them being scapegoated in formal inquiries and reviews (Francis, 2010, 2013) and removed from their roles as a result. The risk of personal blame and loss of professional registration link further with professional vulnerability and contrasts with medical elites and the perception that medical directors can have only positive impact on an organization's quality (Jones & Fulop, 2021). Low professional esteem was not mentioned as an issue for the medical director by Jones and Fulop (2021), instead, their knowledge of policy and clinical expertise were recognized and greatly valued by the board's Chair. Such views were reinforced in a recent NHS leadership report for England (Department of Health and Social Care (DHSC), 2022) in which the medical profession was encouraged 'to

examine honestly their role in setting cultures, given their unique influence in the workplace dynamic' and 'their authority and influence both in society and the NHS' while many senior nurses were reported as seeing management roles as 'going to the dark side'. This contrast clearly warrants further research.

ENDs, in our study, did not explicitly describe their role in this way although they recognized the need to 'get to grips with executive level working' through shadowing, coaching and mentoring and reported few formal opportunities to prepare them for this. As there may be few clear lines of power for ENDs, coaching and mentoring have the potential to offer safe professional support networks (Machell et al., 2009; Nursing Now, 2019).

Reeves (2008) comments that attention needs to be paid to the traditional relationships between medicine and nursing, described as the 'doctor-nurse game' in seminal research (Stein, 1967; Stein et al., 1990). The 'doctor-nurse game' could explain some of the contrasts between perceptions of ENDs' and medical directors' roles in terms of how they are associated with gender and power. In the original 'doctor-nurse game', predominantly male doctors dominated the division of labour within healthcare, which was complied with by a largely female nurse population. The relative status and value attributed to medical professionals compared with managerial elites in nursing may continue to reflect traditional medical and nursing hierarchies. However, as healthcare becomes subject to increasing financial restraints, this could serve as a trigger for more collaborative leadership models for complex health services, especially when things risk going wrong (Chambers et al., 2018). This optimistic view, however, was not borne out by the recent NHS Leadership report (DHSC, 2022) where medical dominance remains the norm.

The impact of gender and ethnicity to strengthen nursing leadership remains an area for further consideration. National studies suggest women are underrepresented in senior nurse management roles, especially those from ethnic and minority backgrounds (Clayton-Hathway et al., 2020; Launder, 2020; WRES, 2021). An international study of nursing leadership representing the voices of 2400 nurses and nurse midwives in 117 countries revealed that although 70% of the health and social workforce were women, only 25% were senior managers. Stereotypes and discrimination created barriers to progress while, in line with our own study, professional networks and mentoring were recommended as ways to overcome them (Nursing Now, 2019).

Yoder's (2001) sociological analysis is sobering in that she suggests leadership is gendered by its very nature, and played out within a gendered context to impose powerful male stereotypes and professional dominance upon women leaders to limit their effectiveness.

6.2 | Limitations

Limitations include our sample not allowing examination of specific issues affecting nurse executives from ethnic or minority backgrounds, or to examine gendered aspects of senior leadership.

Nearly half of NOMs came from nursing backgrounds and may have been selected as colleagues ENDs felt they could trust.

Although we have not looked at the END role development over time, our sample included ENDs with a range of experience within the role.

Our analysis revealed important dynamics of the workplace culture and the nature of the leadership team, but our findings are limited to ENDs' and nominees' accounts. They do not include other board members or professions. Ethnographic research would help to provide accounts of these roles in action.

7 | CONCLUSION

We have highlighted challenges and opportunities to enable ENDs to view themselves in the more positive light that others already see them. We have also highlighted the challenges faced and identified potential approaches to strengthen and support those taking up similar leadership roles. The challenges for this role are poorly documented, but those that do exist align with the themes identified in our study. Given these challenges, we have highlighted areas, such as race and gender imbalance, that should be considered to support and strengthen the END role and future nursing leadership development in national and international contexts. As moves to reorganise health and social care in the UK continue, the role of nursing leadership across all sectors will require further analysis. The culture and role of the executive board could also provide further areas for exploration of those factors promoting effective nurse leadership at all levels in healthcare systems.

Currently, when COVID-19 has shed new light on the contribution of nursing at the forefront of the global response to the pandemic (Osingada & Porta, 2020, Zipf et al., 2021), there is an opportunity to recognise the value and strengthen executive nursing roles to help address challenges facing all health systems worldwide (WHO, 2021).

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.15699.

DATA AVAILABILITY STATEMENT

The authors are exploring options for de-identified data to be made available via the University of Edinburgh Data repository system.

ETHICAL STATEMENT

Ethical permission was obtained from the Section of Nursing Studies Ethics Research Panel at the University of Edinburgh (Reference number STAFF 134).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.