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THE INFLUENCE OF WORK EXPERIENCE ON LEADERSHIP STYLES: A GROUNDED THEORY STUDY OF MANAGERS IN THE NHS.

M. STEPHENSON

MPhil

April 2021

THE INFLUENCE OF WORK EXPERIENCE ON LEADERSHIP STYLES: A GROUNDED THEORY STUDY OF MANAGERS IN THE NHS.

MICHAEL STEPHENSON

A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the degree of Master of Philosophy.

Research undertaken in the Faculty of Health and Life Sciences, Northumbria University.

April 2021

Abstract

Leadership is essential to the continued transformation of the NHS, but for middle managers leadership is challenging at a time of increasing pressure and complexity in NHS England. There is a lack of evidence to understand the impact of previous work experience on the leadership development of managers recruited from diverse employment pathways. This thesis investigated how previous work experience influenced the leadership style of NHS managers.

A grounded theory constructivist and interpretivist perspective was used to investigate leadership in NHS managers. The sample comprised of 12 Band 8 Agenda for Change (AfC) Managers recruited with diverse previous work experience. Participants included, nurses, midwives, dieticians, audiologists, managers lacking a health care professional background, and a chaplain. Interviews were used to generate data, and the cyclical approach of the constant comparative analysis and theoretical sampling ensured theoretical saturation of the emerging categories was achieved.

The categories generated recognise uncertainty and role conflict in managerial staff, a result of role identity, a preferred image, and frustrations within participants' roles. The importance of transferable skills from previous roles to build managerial capabilities, and the changes in participants approach to leadership indicate that previous work experience in an organisation lacking a clear managerial identity leads to managerial uncertainty.

The knowledge generated recognises the importance of previous roles, to complement a focus on future development. The theory of a unified management approach provides a structure to inform the development of NHS managers, regardless of previous roles and experience. The theory combines core aspects of a leadership and management training framework, with an informal managerial forum to support managers, regardless of previous roles and experience to construct one managerial identity.

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Acknowledgements

Throughout this Journey I have been thankful for the support and encouragement from many people, too many to name in person. However, I would like to acknowledge and thank the following.

Dr Sarah Annesley for her encouragement and support during this journey, along with Dr Alison Machin and Dr Tony Machin for their support. I would also thank Dr Nicola Ring and Dr Belinda Dewar for their comments and feedback as external examiners in this re-submission.

Northumbria University for the time and resources to undertake this programme while in a full time academic role.

The support and guidance from County Durham and Darlington NHS Foundation Trust, and Northumbria Healthcare NHS Trust was gratefully appreciated. I thank the participants from both organisations for their time and flexibility.

Authors Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas, and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 9th December 2015, and County Durham and Darlington NHS Foundation Trust on 15th April 2016, and Northumbria Healthcare NHS Trust on 9th June 2017.

I declare that the Word Count for this thesis is 46,672 words.

Name: Michael Stephenson

Signature

Date- June 24th, 2020

Amendments- April 16th 2021

Chapter One- Introduction and background

Introduction

This thesis will focus on NHS leadership development and training, including the role of NHS middle managers to understand the influence of leadership in ongoing NHS reform. In particular, the importance of previous work experience to inform leadership development. This is an important issue in managerial effectiveness, as conventional approaches to managerial development consider managers in current roles. This research considers the impact of previous roles on identity, competence, and membership of professional/social worlds. The findings from this research inform managerial development in a time of continued managerial reform in the NHS.

NHS management in Context

NHS England was established in 2013 and is responsible for coordinating the provision of health services in England. Through NHS England, the government mandates the provision of health care. As an example, the Five Year Forward View and the next steps on the five year forward view (NHS England 2014a, 2017b) ensure ongoing re-design of health care and its delivery to reduce barriers in care provision. In 2015, as part of the Five Year Forward View, NHS organisations were invited to register as one of thirteen vanguard sites to lead on new care models (NHS England 2015a). Trust two in this research is one of the thirteen sites.

NHS managers occupy a pivotal role in an evolving NHS, to ensure services are not only delivered, but adaptable to ensure organisational success. It is essential for NHS organisations to achieve long term success and develop effective leaders to deliver ongoing reform (Department for Business Innovation and skills 2012). The literature review chapter will focus on leadership and the role of managers to understand how leadership is essential in this ongoing reform.

This thesis will focus on the leadership role of middle level managers (Band 8 Agenda for Change (AfC)) at a time of increasing pressure and complexity in NHS England, and not in the devolved regions (NHS England 2017a).

Managers are responsible for delivering patient focused services, within financial constraints (Bailey 2018). The NHS is patient focused, and managers who operate in this arena may previously have worked as health care practitioners. However, the contextual focus of this thesis centres on the leadership roles and responsibilities of managers. It will not explore the patient focused quality agenda, equally as important, but not aligned with the research aim of understanding NHS managers approach to leadership.

At the time of data collection in February 2016, the Health and Social Care Act (DoH 2012) was undergoing further reforms following a conservative government overall majority in May 2015. The NHS consists of over 8,300 separate organisations employing 1.3 million staff seeing over a million patients every 36 hours (DoH 2016). The Health and Social Care Act disbanded Primary Care Trusts (PCT's) and gave responsibility to purchasing health care to 211 newly formed clinical commissioning groups (CCG's). NHS England established Health Watch and Health Watch England to drive patient and public involvement and creating Public Health England (PHE). The Health and Social Care Act also extending the powers of the National Institute for Health and Care Excellence (NICE) to develop guidance and set quality standards for social care. Competition for NHS funding was extended by allowing independent, charity and third-sector healthcare providers bid for NHS contracts, giving greater choice and control to patients to choose their care (NHS England 2014b). The care quality commission (CQC) continued as the independent regulator for health and social care in England (The Kings Fund 2014a).

This chapter summarises the role of (Band 8 AfC) managers in the NHS at the start of the research process in February 2016. Following this, unanswered questions from practice which led to the research question and motivation for undertaking the research are presented, providing the research rationale and background. The conceptual framework is then introduced, before a detailed evaluation in chapter 3 is undertaken. The chapter concludes with an overview of each chapter within this thesis.

The research commenced following the publication of the Health and Social Care Act (2012) introducing clinical commissioning groups, the research period

also covers the introduction of the Five-year forward view and the next steps (NHS England 2014, 2017b) which aim to reduce the barriers between health and social care. The shift is also seen in independent publications, such as The Kings Fund (2018b) recognising NHS leaders must learn to use explicit methodology to achieve system changes in health, changes that lead to a changing recruitment strategy.

Role and responsibilities of the Directorate Manager

The term Directorate Manager was used in both NHS Trust one and two, and will be used in this thesis, however, in many NHS Trusts the terms Service Manage and Operational Manager are also adopted. The Directorate manager is responsible for liaising with clinical staff and health care professionals, interacting with the public, managing complaints, and anticipating and resolving service delivery issues, recruiting, and retaining a workforce to meet the service need, deliver services in line with local and national targets and outcomes, and responding to patient complaints (Health Education England 2017). Directorate managers act as the essential link between strategic mangers and clinical staff, translating the organisations strategic and financial plans. A role, Kelliher and Parry (2015) believes often places them under pressure which may result in experiencing high levels of stress.

There is no national agreed job description or personal specifications for a directorate manager’s position, job descriptions are based on organisational needs. However, the impact of NHS reforms with a focus on efficiency and productivity has influenced recruitment, recognising the need for managers with business and leadership skills to support clinical care within financial constraints.

Personal experiences which have informed choice of topic

From 2009 to 2011 I was a directorate manager (2009-2011), I was accountable for the care children receive in the North East of England across three acute hospital sites. As children access services in many hospital departments (operating theatres, out-patients, pharmacy, radiology etc.) My role was organisation wide and I was frequently asked for advice and guidance to understand the implications for children in service reforms.

During these conversations, it became apparent that not all managers had previous experience of working as health care practitioners. When asked to discuss a service re-design and offer advice, I would acknowledge the idea was of sound business and financial strength but had practical issues for clinicians that would threaten its delivery. A lack of clinical experience limited some managers' ability to see the practical complexities and limitations on practitioners and children. As a result, I began to question what the ideal skill, knowledge, training, and background would be for an NHS manager. Would one employment approach and associated previous work experience prepare an individual for the role of directorate manager over another?

My interest in this area is best illustrated by the opinion expressed by a neonatal consultant at a seminar I attended in 2017, to discuss the regional commissioning changes proposed for midwifery and neonatal services. It mirrors the question I was considering.

> *20/09/2017- Northern Neonatal conference:*
>
> *"Neonatal staff becoming managers will have a better idea of what we need"*

The quote was not part of the prepared presentation, but in answer to a delegate's question. It supports the notion that individuals have a pre-conceived understanding of what previous work experience is preferred, to prepare an individual to lead, in this case a clinical service.

My belief at this time matched the speakers. That to effectively manage a clinical service, a manager would require a knowledge and understanding of the clinical roles and their application in practice. I assumed without this knowledge and clinical experience; a manager could not appreciate the impact of their decisions on the clinical environment. They may have compelling reasons to implement changes from a business viewpoint, without recognising the difficulty of implementing these in practice. For this reason, I believed staff valued a manager that shared their experience, knowledge and background, a belief leading to an interest in prototypical behaviours discussed throughout the thesis. A personal 10-year career plan to gain an operational manager role was

based on this belief. Successfully gaining promotion to a senior clinical role in child health, prior to transitioning into child health management.

The complexities of managing in today's NHS and leading clinical teams through change, leaves the question of understanding the influence of previous work experience difficult to answer. My personal experience has informed this research question through a need to understand if NHS managers responsible for delivering clinical services should preferably hold a professional qualification, if so, must their clinical experience match the service and staff they lead? Alternatively, can managers with no clinical experience and qualifications manage and lead clinical staff and services; are experiences from previous work experience transferrable to health care? Will the approach taken by managers with clinical experience and health care professional registration, be different to those lacking clinical experience and registration?

The gap in understanding the research addresses is to understand the influence of previous work experience on managers' approach to leadership from an NHS manager's perspective.

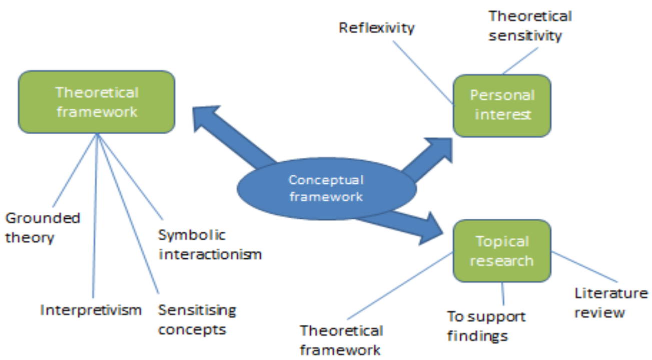
Conceptual Framework

To inform my understanding of the research topic a conceptual framework has been developed. A conceptual framework intends to satisfy the reader of the studies importance (Ravitch and Riggan 2012). Consisting of three primary elements; personal interest, topical research, and the theoretical framework, through which a critical lens is offered to view my research. This results in an overall theory that relates to the researcher's epistemology, their individual approach to constructing knowledge.

Throughout this thesis justification is given for reasoned and informed choices made to explore the research question, and to justify the approach to data collection, analysis, and interpretation of the data. Moreover, as a conceptual analysis differs from theoretical analysis with its inclusion of personal interests and motivations (Ravitch and Riggan 2012), the origins of this research will be explored, recognising the importance of theoretical sensitivity and reflexivity throughout. Finally, the influence of existing theoretical frameworks as sensitising

concepts will be acknowledged. These are, Bridges “transitional model” (1995), Benner’s (2001) theory of “novice to expert”, and the concept of “social worlds” (Koveshnikov and Ehrnrooth 2016).

Figure 1: The conceptual framework



Refinement and development of the research question

The research question asks:

> *How does previous work experience influence the leadership style of NHS managers?*

This research asks participants to consider their approach to leadership in both current and previous posts, to consider how previous experience influences leadership style in their current role and acknowledge the influence of previous work experiences on current performance. To understand how managers perceive the influence of previous work experience, and answer the research question, the importance of symbolic interactionism and interpretivism to this research design is explicit in chapter four, the research design.

Overview of the thesis

Chapter Two- Literature Review

The literature review sets the context for the thesis to understand what is known about leadership and management in the UK NHS. The review begins by detailing an evolving search strategy, prior to recognising the political re-structuring that has moved the NHS towards a business and management

model of operation since the publication of the Griffiths report in 1983; this includes a chronological summary of NHS policies pertinent to leadership and managerial development. The review continues with a focus on leadership as an overall approach, before differentiating approaches to leadership and management. The final section reviews the evolution of leadership development programmes, concluding with an overview of the recruitment pathways available to NHS organisations.

Chapter Three- The conceptual framework

The conceptual framework begins with revisiting the research question; it then presents my approach to constructing knowledge, recognising constructivism and interpretivism as the ontological approaches to generate knowledge. The epistemological approach of symbolic interactionism to support knowledge generation is then presented. This chapter introduces the evolution of grounded theory and its progression leading to several approaches (Glaser and Strauss 1967, Strauss and Corbin 1990, Strauss and Corbin 1998) before identifying Charmaz's (2014) constructivist approach to constructing knowledge as the approach employed in this research. The chapter concludes by introducing the sensitising concepts role to look at the data in new ways and inform the final substantive theory.

Chapter Four- Research methods

How the research was undertaken, emphasising the importance of the structured constant comparative approach to grounded theory research, including the cyclical approach to participant selection, the use of theoretical sampling to identify participants, data collection and the use of semi-structured interviews. Interviews transcribed verbatim and line by line coding to build initial categories. The chapter concludes by recognising the importance of reflexivity to the research process, before concluding with a summary of the ethical procedures to scrutinise the research.

Chapter Five- Presentation of findings

The purpose of this chapter is to restate the importance of theoretical sampling to generate the findings presented in this thesis. Four interrelated categories are identified, one of which serving as a core category linking the other three.

The emergent grounded theory linked to this interrelationship is introduced with formative discussion. Direct participant quotes are used to ground the emerging concepts.

Chapter Six- Discussion of the findings

This chapter begins with a theoretical discussion relating to the core themes, followed by revisiting the conceptual framework and value of the sensitising concepts. Later, a summary positions the key findings in relation to the literature. The chapter concludes introducing the emergent grounded theory and its application to managerial development.

Chapter Seven- Emergent theory and implications

In this chapter, the emergent grounded theory of a unified management approach is presented. The four constituents of NHS clinical priorities, human resources, business capabilities and leadership that form the leadership and management framework central to the theory are presented. The approach is then compared to an international approach with similar objectives. To conclude, this chapter acknowledges the value of the model, with three examples given to demonstrate how the model's flexibility can support the development of managers with diverse working experience.

Chapter Eight- Recommendations and conclusions.

The purpose of this chapter is to conclude the thesis. It begins by revisiting the research question and objectives in relation to the research findings, followed by understanding the implications for central policy, education, and practice. Recommendations based on the findings are offered, prior to unanswered questions and future research opportunities presented.

Chapter Two- Leadership; a literature Review

Introduction

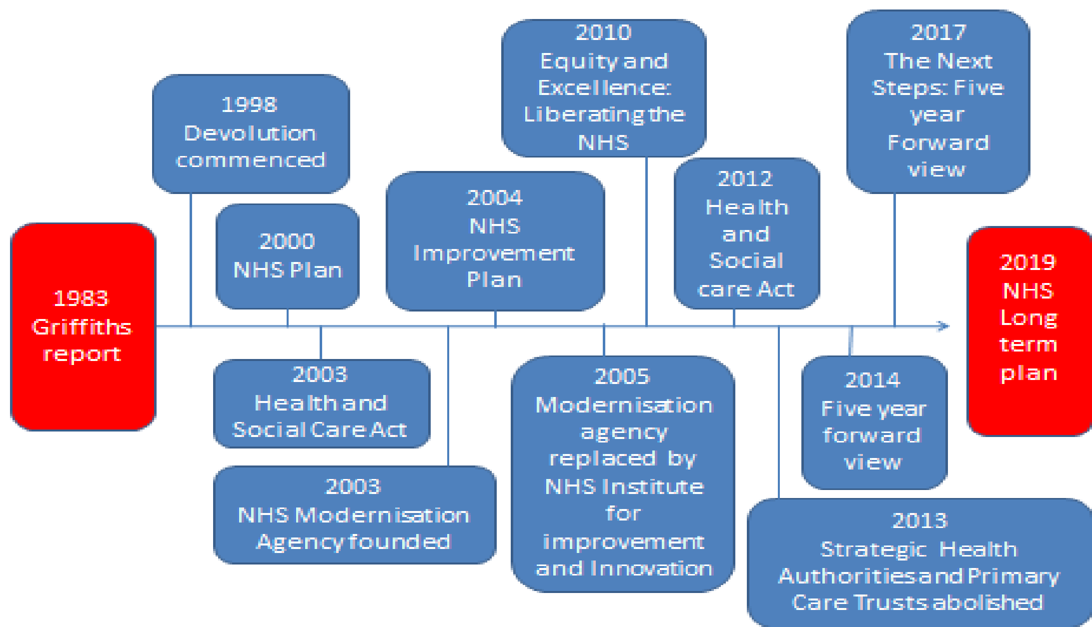
This chapter synthesises the literature on leadership to provide context for the study. The significance of political influences and a succession of modernisation initiatives, and their impact to managerial recruitment and development is also acknowledged. Following this, a change in transformational leadership from a taught competency based approach, focusing on leaders' individual behaviours, to a capability approach recognising the impact of context and social relationships to leaders' behaviours is given. An evaluation of the predominant methods of recruiting NHS managers is then introduced. The chapter ends with an appraisal of the three sensitising concepts utilised within the conceptual framework.

Literature search

The point at which a literature review should take place is a contentious issue. The approaches taken since Glaser and Strauss's seminal publication in 1967 when they recognised no-one enters research lacking pre-existing knowledge of the subject area, have changed. Glaser (1992) subsequently advocated no engagement with the literature prior to the emerging theory becoming clear. Whereas Strauss later recognised the value of a literature review in the early stages of the research. The approach adopted in this research by Charmaz (2014), is influenced by Glaser, permitting an early search in the literature.

This literature search focused on leadership within the NHS. Figure 2 recognises a new approach to NHS management in1983 with the publication of the Griffiths report. However, the NHS Plan (2000) is used as the reviews starting point, to reflect modernisation in the 21st Century.

Figure 2: Chronology of significant NHS England modernisation from the year 2000



My literature search was undertaken in three phases:

- Phase 1. An initial review to understand the principal theories influencing the NHS, beginning in the nineteenth century (2014-2015)
- Phase 2. Further refinement focusing on the modernisation from 2000 onward (2015-2016)
- Phase 3- A targeted review alongside data collection to understand the emerging data (2017-2020)

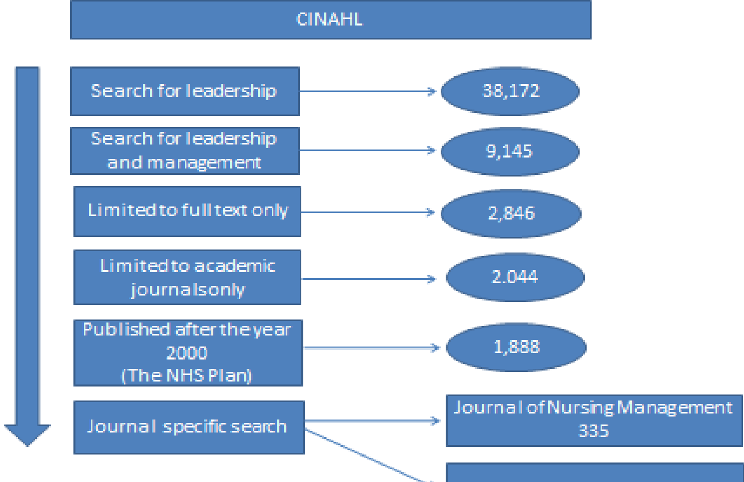
Phase one began when writing the research proposal and ethics submission. It was a generic search to understand NHS leadership and the principal theories underpinning leadership in health care. A preliminary look at the role of the directorate manager was also included.

Key words in the initial literature search included, directorate manager, leadership, NHS leadership, clinical leadership, management, middle manager, and NHS management. Searches were restricted to peer review articles and English language only. Literature excluded in phase one comprised leadership not associated with the NHS and leadership specific to the medical profession.

Initial searches included Medline, PubMed, CINAHL and Northumbria University library portal. Searches were initially confined to peer review research articles. However, reference lists within these publications revealed the importance of local and national policy guidance. This led to searching NHS England, Department of Health (DoH), devolved health boards in Scotland, Wales and Northern Ireland, the Leadership Academy and The Kings Fund. Literature was printed and a colour coded system used to highlight areas of interest. Useful resources were allocated to individual folders with headings that included *middle manager, clinical leadership, NHS leadership models etc*. These folders were developed over time as the review continued through phases 2 and 3. Alongside this, a search for methodological literature was undertaken. Seminal texts, from the initial Glaser and Strauss (1967) publication in grounded theory were procured from an online bookstore.

Phase one of the literature search focused on leadership and management within a health care setting. As a result, relevant journals such as the Journal of Nursing Management and Nursing Management were searched in detail. These journals were chosen as authors commonly returned in literature searches, such as Alistair Hewison, frequently published in these journals. A manual search of these journals revealed articles not found with key words in the inclusion list. Figure 3 summarises an initial search within CINAHL for these publications.

Figure 3: Journal specific literature search (Phase 1).



Phase 2 of the literature search began when data collection commenced in June 2016 with Participant 1 (P1) During phase 2 the emerging categories recognised the significance of the social aspects of leadership and the importance of managerial identity. As with phase 1, peer reviewed research was initially the focus. However, the impact of subjective influences like uniforms and clinical hierarchies led to looking at publications based on reflection and personal observations.

In early 2017, phase 3 commenced as the constant comparative analysis continued, the importance of transition, knowledge and social worlds emerged. As a result, the literature was further explored, identifying the sensitising concepts introduced later in this chapter.

The literature review and research question inform the structure of this chapter. Subheadings reflect the significant themes in the literature pertinent to the research question. Reflexivity was an important consideration while conducting the search to ensure the literature review was an honest representation of the literature. I had preconceived ideas during my time in NHS management, ideas that were in part responsible for my interest in the study, assumptions that I held to be true and accurate. Reflexivity ensured I was aware of these interests and assumptions. Charmaz (2014) states, it is the researcher that must be reflexive about what they bring to the study, what they see and how they see it.

The role of the literature review

In a constructivist approach to research, the researcher possesses professional knowledge relevant to their study, engaging with the literature is one approach to sensitise the researcher to this pre-existing knowledge. According to Charmaz (2014), knowledge is informed by experience, intuition, reflection, and research through reading literature. Despite criticisms that engaging with the literature may influence the researcher's approach, it is now accepted by influential grounded theorists such as Charmaz (2014) and Strauss and Corbin (1990, 1998), that there is value in conducting a literature search as a way of thinking afresh when theorising. A concept known as theoretical sensitivity.

Historical overview of NHS policy changes

In 2018, the NHS celebrated its 70th birthday. At the time of its foundation in 1948, the NHS was unique in offering comprehensive health care funded from general taxation, free at the point of use (Webster 2002). Recently, local sustainability and transformation plans focused on productivity and efficiency required to maintain financial balance and tackle unwarranted variation and waste. In line with this focus, the summary of the changes below is specific to managerial development.

In the 1980's, the NHS in England adopted, an internal market approach, when a split between purchasers and providers of health care was introduced, mirroring the approach of private organisations. A process Hewison (2004: 340) acknowledged as "*managerialism*". It aimed to strengthen the role of efficient care providers and motivate weaker providers to improve or withdraw from the market (Contandriopoulos et al 2001). The Griffiths Report (1983) marked the introduction of materialism that was fundamental to managerial development, focusing on NHS organisational dynamics and not structure (Klein 2013). Griffith's focus on managers was essential to efficiency gains, suggesting managers could be recruited from outside the NHS. Prior to Griffiths the NHS adopted an administrative approach, where administrators supported clinicians to deliver services (Hewison 2003). Post-Griffiths, a new style of general management saw the influence of the dominating internal market, known as new public management (NPM) (Kelliher and Parry 2015), this freed public sector managers to behave like their private sector counterparts.

The Royal College of Nursing (RCN) opposed Griffith's recommendations, fearing nurses would be overlooked for management positions, as they would no longer be guaranteed to be managed by a member of their own profession (Hewison and Morrell 2014, Klein 2013). A change successfully resisted by medical staff to ensure they could only be managed by medical practitioners. (Dopson and Waddington 1996). However, as part of *working for patients* (DoH 1989) consultant contracts were introduced giving managers more control over medical staff workloads.

In 1997 Tony Blair's labour government was elected with a mandate to deliver politics in a *"third way"*. The NHS Plan (2000) restructured the NHS, removing the conservatives' internal market, while the purchaser/provider split remained. In 1998 the UK government passed the Scotland Act (1998); the Northern Ireland Act (1998); and the Government of Wales Act (1998) to establish national assemblies and devolve central powers. These have since been superseded by the Government of Wales Act (2006), the Scotland Act (2016) and Wales Act (2017) (The Cabinet office 2018). A National Audit office (2012) review since devolution, has seen the commissioners and providers of health services reintegrated in Scotland and Wales, whereas the role of competition has increased in England.

Alongside devolution of health services in Scotland, Wales and to a lesser extent Northern Ireland, the Health and Social Care Act (2003) introduced NHS Trust status. In *liberating the NHS*, the DoH (2010) established the NHS commissioning board to support regional and national commissioning negotiations. In the five year forward view, DoH (2014) and the next steps to the view (NHS England. (2017b) commissioners and local authorities are given greater power to reconfigure care services. NHS Improvement (2016: 4) state *"Only through a system-wide set of changes will the NHS be sure of being able to deliver the right care, in the right place, with optimal value"* To ensure changes are delivered, the reports emphasise the need for effective leadership across all health and social care boundaries.

In the most recent English health policy, The NHS Long Term Plan (NHS England 2019) continues to call for effective leadership to support quality health care and ensure organisational performance, recognising the need to establish a pipeline of highly skilled leaders. Specific to this research, The NHS Plan (NHS England 2019) not only recognises the need to increase the number of NHS graduate management trainee positions, but to also provide career support and guidance to health care staff identified as future leaders.

What is Leadership?

This section presents the literature around Leadership and focuses on understanding the leadership approaches taken by NHS managers; this may

lead to confusion as leadership as a concept is not a coherent or static experience but an emergent, fluid, discursive and negotiated process (Tourish 2014). The Kings Fund (2015: 2) recognise a key challenge faced by NHS organisations is to establish a culture of *“continuously improving high quality, safe and compassionate health care”.* Unfortunately, defining leadership required to deliver on this is problematic, as what constitutes good leadership, and a good leader is challenging (Millward and Bryan 2005).

Leadership as a concept is difficult to define, there are as many as sixty-five different classification systems that attempt to define the dimensions of leadership (Northouse 2013). Leadership is often seen as an umbrella term to describe the multitude of theories and behaviours possessed by the majority and utilised by the few (Bennis and Nannus 2007). Schedlitzki and Edwards (2014) believe one definition has yet to be agreed in the leadership discourse. A possible explanation is that definitions reflect changing fads, academic trends, and political changes (Bennis and Nannus 2007).

Defining, and researching leadership in the NHS is complex, its meaning changes depending on individual’s roles and responsibilities. NHS Leaders interact with colleagues throughout the organisation, in both clinical and corporate contexts. For some, this complexity means leadership cannot, and should not be defined. Owen (2011: xvi) contends leadership is inundated with small words with big meanings like *“vision”* and *“values”* and *“integrity”.* While Prosser (2015) rejects the need for authors to define their entire field of enquiry, into a few well-chosen words.

Despite this confusion, the operational definition I will use in this thesis is given below and in table 1. I have chosen this definition as I am interested in understanding what informs the behaviours and attitudes of leaders, recognising the importance of the clinical context, alongside organisational needs. In doing so, it combines the influential approach favoured in clinical care, alongside more directive approaches utilised at organisational levels.

Operational definition of leadership:

> *"Leadership is conceptualized as a multidimensional process of influence…. and includes behaviours and activities of managers that exert direct and indirect influence on individuals, their environment, and organizational infrastructures" (Gifford et al 2007: 128)*

Table 1 demonstrates the opposing views in the literature to define leadership, acknowledging leadership as a process focused on influence and inspiration (Parkin 2012).

Table 1: Leadership definitions to demonstrate the lack of agreed meaning

Leadership definition	Author	Academic perspective
"Leadership is discovering the route ahead and encouraging and personality permitting, inspiring others to follow"	Stewart (1989. 3)	UK. Social philosopher with a doctorate in management studies. Founding director of the Oxford Health Care Management Institute.
"The legitimacy of leadership rests on the trust placed in the leader and on the leaders perceived competence and integrity"	Sadler, P (2003: 172)	UK. Academic and fellow of the international academy of management and board member of the international leadership association.
"Leadership isn't about achieving more targets or improving bottom line figures. Leadership begins by having the courage to become all you can be"	Owen et al (2004. 13)	UK. Previous head of Leadership Services for the Police in England, Wales and N Ireland Chief Executive Officer at the Institute of Leadership.
"Good leaders recognise the complexity of leadership, and combine it with their experience to lead in a way that works for them and their teams"	Hewison (2004. 112)	UK. Health care academic Senior Lecturer, Research Lead for Nursing.
"Leadership is a process whereby an individual influences a group of individuals to achieve a common goal"	Northouse (2006. 3)	USA. Professor of communication.
"leadership is conceptualized as a multidimensional process	(Gifford et al 2007: 128)	At the time of publication, a Doctoral Student, University of Ottawa,

of influence to enable nurses to use research evidence in clinical practice, and includes behaviours and activities of managers that exert direct and indirect influence on individuals, their environment, and organizational infrastructures”		Faculty of Health Sciences.
“Leaders are expected to be visionary, determined, forward thinking innovative and charismatic sort of people”	Kenny et al 2011: 84)	UK. Sociologists with interests in Organizational and political studies.
Leadership in its simplest terms suggests “in order to be a leader you have to have followers”	Jones and Bennett (2012: 2).	UK. Higher education academics focus on leadership.
Leaders “must possess a strong didactic educational background, be focused on taking care of people and resources simultaneously, and also be confident in his or her own abilities”	Ledlow and Coppola (2014: 5)	US. Academics in public and allied health science.
“Shared leadership… requires a shift away from traditional ways of leadership where leadership is assumed by one person….there is a need to make more use of leadership behaviours and underpinning abilities and expertise of different team members”	Willcock (2018: 104)	UK. Nursing higher education academic

Contrasting management vs leadership

Management is described as a focus on process and rules to bring order to chaos through structured policies and monitoring (Kotter 1990, Gopee and Galloway (2014), a role seen as functional to determine the most effective methods of working, to provide suitable working conditions and equipment. Managers are interested in how things are implemented, while leaders focus on

what inspires people (Dawson and Andriopoulos 2017). The operational definition chosen for this thesis recognises management as a coordinating process designed to improve efficiency.

Operational definition of management

> *"Management can be described as a team of appropriately qualified individuals who engage in multiple activities aimed at achieving the goals of the organisation effectively and efficiently" (Gopee and Galloway 2009: 29)*

This contrast reflects the challenge in public sector organisations requiring managers to lead public services, while ensuring efficiency. Gill (2013) finds this problematic as unlike leaders in private sector organisations, public sector leaders hold high levels of accountability yet less authority, requiring a more engaging and collaborative approach.

Understanding the process of leadership and management.

Leadership and management are accepted as the opposite sides of one coin, neither is a replacement or superior to the other, but organisations need both to succeed (Grint 2010). To differentiate the two, comparisons are offered such as management is associated with climbing the ladder of success, while leadership asks if the ladder is leaning against the right wall (Covey 2004). Managers are people who do things right, while leaders are people who do the right thing (Bennis and Nanus 2007). Although Gill (2013: 17) questions the need to separate the roles, suggesting the need for managers who are leaders, and leaders who manage, effectively, one individual who can do both and *"do the right things right".* What is clear is an overlap exists. Managers exerting personal influence behave as leaders; while leaders planning, staffing, and organising duties are involved in management (Northouse 2013, Millward and Bryan 2005). Despite this complexity, both leadership and management share characteristics and attributes. Indeed, leadership alone will not deliver change; it should not be the "*panacea"* to remedy organisations ills (Hewison and Griffiths 2004). Northouse (2013) declares leadership and management as mutually supportive; an organisation with strong management and poor leadership will be

bureaucratic, whereas strong leadership without management may result in misdirected or meaningless change.

The complexity of health care is the opposing needs of leaders and managers within the same organisation. Indeed, it is difficult to imagine anything other than a purely business approach prevailing when managers are encouraged to innovate within regulatory and administrative boundaries (Millward and Bryan 2005). Therefore, the confusion of who manages, leads, or both, is distracting (Kippist and Fitzgerald 2009). Such distraction, Gatenby et al (2015) believes leaves middle managers caught in the unenviable position of delivering organisational objectives, while maintaining a culture driving excellence in patient care. Some of the confusion distinguishing leadership and management in health care, and the difficulties faced by individuals recruited from a variety of professional and non-professional backgrounds, while working between the needs of clinicians and strategic managers, led to the inclusion of the sensitising concepts later in this chapter. They help to understand how this confusion compels some managers to rely on the support provided by social worlds, as they transition from expert clinicians in clinical practice, to developing the skills and capabilities as managers.

Carlstrom (2012: 92) refers to middle management positions as "*hybrid roles*", a term to communicate the added managerial responsibilities given to clinical managers when management hierarchies were flattened. Today's middle managers are positioned in a hierarchy between upper management and staff. Directives cascade down from upper management, while ideas, demands, and reactions to organisational initiatives are communicated up from staff. To add to this confusion, Tunc and Kutanis (2009) and Jones (2005) suggest the titles given to managers can leave managers conflicted. Suggesting ambiguous titles lead to uncertainty about what managers should accomplish in their roles.

A leadership identity may seem desirable, but for many managers encouraged to adopt a leadership approach, its idealised and intangible form may oppose their management identity (Carroll and Levy 2008). This focus is significant when considering the breadth of NHS leadership. NHS organisational success relies on meeting targets within financial constraints. A failure to do so, would

lead to a call for more money, or fewer desirable results would be achieved (Nichol 2012), another significant factor is the autonomy of individual NHS organisations (Goddard and Mannion 2006). While central control and targets prevail, decentralisation remains a dominant theme, to create opportunities for leaders to support local innovation and entrepreneurship. Such apposing demands of control and autonomy make it difficult to apply one definition of leadership to individuals in the NHS.

A focus on patient care generates an inverted power structure, where autonomous clinicians have greater power and influence in day to day patient decision making, over appointed managerial staff (Nichol 2012). One possible explanation why a manager promoted from clinical role, may continue to look for identity and support in social worlds aligned with their profession or clinical speciality. Such leaders rely on respect and admiration known as personal power (Sullivan and Garland 2010), whereas appointed leaders rely on hierarchical power to punish or reward followers (Walshe and Smith 2011). White (2012) believes this shift in power base is one reason middle managers fail to be effective when promoted from emergent to appointed positions. While Kippist and Fitzgerald (2009: 643) suggest the contextual change from "*the practice of health*" to *"the business of health"* explains why some effective clinical leaders, are ineffective when moved from clinical roles, to managerial roles.

Leadership in healthcare

The focus of this research is managerial leadership, by this I mean a focus on the influencing role of managers to engage and motivate teams. As a concept this is not new. Yukl (1989: 251) in an article titled *managerial leadership* stressed the need for managers to empower staff to develop a sense of ownership for what goes on in their organizations, emphasising "*power sharing, mutual trust, and participative decision making"*.

Jones and Bennett (2012: 2) in the leadership definitions in table 1, state "*in order to be a leader you have to have followers*". It is important to recognise not all individuals aspire to be leaders, and for leaders to be effective the capabilities of those delivering a leader's vision are of equal importance, and so

a mutually beneficial relationship exists between leaders and followers (McKimm and Phillips 2009, (Reicher et al. 2005). The Kings Fund (2011a: 7) suggest leaders must recognise the limits of their knowledge, as they will ultimately fail unless they rely upon their followers to compensate for their own *“ignorance and impotence*”. Therefore, Owen et al (2004) believe a key consideration for leaders is to recognise the capabilities in their followers, to allow followers to fill any gaps in the leader’s knowledge or skills.

In a review of leadership theory, The Kings Fund (2015) concluded transformational and transactional leadership theories were most influential in guiding health care leadership research. However, there also exist, several theories and approaches that attempt to classify successful leadership. The variety makes it unrealistic to summarise each in detail. Therefore, only theories that apply directly to contemporary healthcare modernisation and transformation plans will be summarised in chronological order. As will be clear, according to Jones and Bennett (2012) the emphasis changes over time to reflect society’s expectations of leaders.

An overview of leadership theories and approaches

Great man and trait theories

Originating in the 1840’s, *great man theory* believed leaders were born, not made. If you were not born with essential characteristics or traits you could not learn them. However, from the 1930’s, trait theory believed leaders could be effective if they studied the personalities of such great men and women in history. By emulating them, individuals could themselves become great (Sadler 2003). Perceived traits included decisiveness, assertiveness, dominance, self-control, and intelligence. As an approach this was considered outdated in the 1960’s. Unfortunately, the legacy of great man theory is not forgotten. The Kings Fund (2011b) reminds the NHS not to rely on any one great individual, regardless of gender, to lead NHS organisations to success.

Contingency and situational theories

In the1960’s the focus moved from leaders’ traits, to leaders’ behaviours, what leaders do, and how they react in different situations. Leadership behaviour was not simply copied, like a trait, but observed, understood, and taught to others

(Clegg et al 2012). Critics of behavioural leadership question if we expect too much from leaders, focusing on them as a *quick fix* for organisations problems, ignoring the context and external influences that may limit their effectiveness (Hewison 2009) and overlooking how leaders change behaviours in different situations (Yukl 1994, Schedlitzki and Edwards 2014). Situational and contingency leadership relates to a leader's ability to adapt their approach depending on the situation. The two theories are commonly presented as one, as the situation is central to both. However, while situational leaders can adapt their behaviour to be effective in a variety of situations, contingent leaders cannot, contingent leaders are only effective in situations that align with their singular approach. The significance of situational influences leads Peretomode (2012) to suggest, a leader may emerge in one situation as a leader, but find they are unable to cope, let alone lead in a different situation.

Behavioural theory

Behavioural theory gained popularity as critics suggested contingency and situational models were simply updated trait models, where leaders were taught specific responses to a range of given situations, focusing on individual capabilities. Alternatively, behavioural theory considers what leaders do and how they behave (Northouse 2013). Behavioural theory refers to the ways in which leaders undertake their functions, how they behave is also used to refer to their "*leadership style" (*Gopee and Galloway 2014: 71). Behavioural approach is important for this research as it suggests a leader's education and training instil a learned set of behaviours that dictate their actions.

Transactional and Transformational leadership

The Griffiths report (1983) was a turning point in health care. Griffiths argued the NHS did not need reorganisation; it needed cultural change, a change led by newly appointed managers, a change recognising the continued value of transactional leadership. Transactional leaders motivate employees by satisfying a need for something they value, such as finance or promotion (Sadler 2003 and Jacobsen and Anderson 2016). For this reason, a transactional approach, for some, should not be aligned with leadership, as it is nothing more than a managerial approach, based on reward for compliance, and punishment for deviation (Adair 2009 and Hewison 2004). Alternatively,

Marques (2015) and Kumar (2013) believe transactional approaches remain useful to leaders, as they contribute to organisational effectiveness using processes and procedures. Critics of a transactional approach to health care site external motivation as their main concern. For this reason, Belle (2013) and Clarke et al (2014) suggest it is difficult to reward performance in public sectors such as health care with financial incentives.

The perceived limitations of transactional leadership offer justification for pursuing a transformational approach in health care, focusing on beliefs, attitudes and values that supersede self and organisational interests (Belle 2013, Alimo-Metcalfe and Alban-Metcalfe 2006). Plesk and Greenhalgh (2001) suggest transformational leadership are relevant to complex and complicated environments in constant reform, such as health care. Kumar (2013) believes improvements in health care can only be achieved if professionals believe through transformational leadership that they own the change. Transformational leaders combine the values and desires of followers into common goals that align with organisational strategic objectives (Gopee and Galloway 2014). The impact like a domino effect, as the positive and motivating effects of the leader cascade throughout the followers (Bass et al 1987). Although, to suggest transformational leadership operates in isolation is naïve. Bass and Riggio (2006) in their *full range of leadership model* recognise a combination of both theories as an ideal approach. Hutchinson and Jackson (2013) suggest critics of transformational leadership warn the focus may be the characteristics and behaviours of leaders, and not close examination of their integrity, permitting transformational leaders to use their influence to deliver personal agendas.

Collective, collaborative, and connective leadership

Criticisms that a transformational approach may focus on the personalities of charismatic leaders without questioning their integrity or avoidant behaviours (Hutchinson and Jackson 2006) led to a more collective and less individualistic approach. Transformational leaders remain essential; however, their role was to ensure staff looked beyond their immediate role and responsibilities, to consider their collective role alongside colleagues throughout the organisation (The Kings Fund 2014b). Leaders within organisations control information and

resources; they influence others through their actions (Schneider and Barbera 2014). As a result, developing positive cultures through their actions.

Leadership, an individual transformation

An increasing number of leadership approaches do not align with those presented in table 2. Of these, Fuda (2014) most influences my understanding on leadership in a modern NHS. Fuda encourages leaders to look at their leadership in a very personal way, arguing that to transform the leader's impact, the leader themselves must first be transformed, the starting point to change the team or organisation is personal change. It is a personal journey that will only be successful if the leader invests time in changing themselves, not attending a course to be told what the ideal leader should do. In agreement, Goleman et al (2011) proposes leadership is based on emotional intelligence, requiring self-awareness and an understanding of their emotional impact on others.

Table 2 provides an overview of the leadership theories discussed. The information is a summary of the texts used to inform this chapter. The dates are an approximation from many sources, which further demonstrates the complexity of an evolving concept over time.

Table 2: leadership theory chronology

Date.	Theory.	Summary.	Influence on NHS leadership development programmes.
1840-1930	Great man	Individuals were born to be leaders. Leadership traits were intrinsic and therefore leaders could not be made.	Pre-1948 when NHS established. However, they remain relevant as NHS organisations are warned not to rely on heroic individuals to save them.
1930-1960	Trait	Duplicating the characteristics and traits of leaders allows others to become leaders. Traits focused on mental and physical abilities	
1960-1980	Contingency and situational	Contingency and situational leadership are commonly mistaken as the same	Initial leadership programmes focused on key generic skills that

		approach, as the environment (situation) is central to both. However, while situation leaders can adapt their approach to a changing environment, contingency leaders cannot.	leaders could apply in a variety of situations. This competency approach taught leaders to react in a predictable way to a given situation.
1940-1980	Behavioural (also known as style)	In reaction to trait theory, behavioural looks beyond physical and mental abilities, to consider the behaviours and actions of leaders.	A focus on predictable reactions continued. However, key generic skills were complimented with a consideration of the individual's behaviour.
1970-present	Transactional	1970 onward recognises a post-industrial shift in the UK. From manufacturing to service provision. Alongside cost control and efficiency, meeting customer expectations was of equal importance. Managerial continued to influence a relational approach with the continued use of transactional leadership	Specific programmes continue to offer development for strategic NHS leaders. Alongside developing the individual behaviours, they focus on strategic development and organisational growth.
1970-present	Transformational	A shared vision of leadership, leaders instil a shared vision of success and empower and enable followers to achieve their full potential	A move away from a generic competency approach, to a capability approach. Development programmes recognised the importance of social relationships and their specific contexts
2010 and ongoing	Collective, collaborative, and connective leadership	Leadership responsibility is distributed throughout the organisation;	Focus is no longer developing a transformational leader, but to

		leadership is every employee's responsibility. Leader's role is to establish coalitions where the cultural norm expects employees to connect and collectively deliver change.	establish a culture that delivers transformational change.

What is Clinical leadership?

The UK Department of Health states clinical leaders inspire, motivate, and promote the values of the NHS with a consistent focus on patient needs (DoH 2007). Cook and Leathard (2004) and Chavez and Yoder (2014) suggest a clinical leaders' expertise is embodied in direct patient care, it is not the result of formal authority, but a desire to deliver a shared clinical objective. Summarising the attributes of clinical leaders, Stanley and Stanley (2018) found clinical competence, a focus on excellent clinical care, supportive, and a motivator of others essential characteristics. Suggesting clinical leaders are not found in offices removed from clinical areas. To reinforce the need for clinical expertise, Stanley et al (2007) found managers with a level of control were rarely viewed as clinical leaders.

The NHS leadership academy (2011a) emphasises that the responsibility of all practising clinicians, is to contribute to the leadership process and to develop and empower the leadership capacity of colleagues. The importance of empowerment aligns clinical leadership with transformational leadership. Clinical leadership is therefore seen as the essential link between effective management, patient safety, and improved quality of care. Clinical leadership as an approach focuses on practical and technical skills specific to clinical environments (Mannix et al 2013). Similarly, Hewison (2010) recognises the NHS in the twenty first century has become an ever more labour intensive environment. Therefore, the NHS must view staff as a resource to achieve improved quality of care alongside financial savings. Storey and Holti (2013) emphasise clinical leaders act as the linchpin for effective communication in

their environment, interpreting the collective threats and opportunities within the organisation.

Professional identity and prototypical leadership

This section considers the influence of professional identity and prototypical characteristics on a manager's leadership approach.

Professional identity describes how people define themselves through their work and is influenced by their unique role in health care practice and team member trust (Best and Williams 2018). One area of importance identified by Pratt et al (2006) to inform professional identity, is previous work experience. Petriglieri (2011) and Morales and Lambert (2013) recognise identity as a source of threat if the individual's identity is inconsistent with their professional identity, conflict results when organisational and professional priorities clash (Simpson et al 2002, Rai 2016).

Similarly, Reed (2001) found an individual's role in an organisation is an ongoing process, modified by how they perceive the purpose of their role. This finding may help to explain why Hay (2014) suggests the uncertainties experienced by managers are generic, with common themes existing among many participants.

For some, identity is central to who they want to be, their role in the organisation may change, but their identity remains consistent (Watson 2008). This is an important consideration for staff moving from professional roles to managerial roles, as Bolton (2005) found the hesitation to change identity hindered individuals from accepting their managerial role, feeling constrained by social pressures to maintain a professional identity. In agreement, Tansley and Tietze (2013) hold the view that staff transitioning into senior roles must reconstruct their professional identity to conform to the organisational norm. While Pratt and Rafaeli (1997) stress individuals need to reconcile identity conflicts that arise between two or more work identities to progress from one to another. Sigel (2001) believes identity has a stabilising effect on individuals, and any sudden social dislocation can have a devastating effect and shatter the individual's stability. The sensitising concept of Bridges "*transitional theory*" (1995) helps to understand the impact of this conflict. If a managerial identity is resisted, it can

leave managers in the neutral zone as they resist losing their professional identity.

Davies (2013) suggests health care managers lacking a professional identity recognise the need to acquire clinical acceptance and demonstrate a shared purpose, as a lack of professional identity limits credibility among clinical staff. To compensate for a lack of professional identity, Aycan et al (2014) suggests managers work alongside clinical teams to acquire knowledge in a new cultural context. Knowledge that can be used to construct a basis for a different form of legitimacy (Schedlitzki and Edwards 2014).

One influence on professional identity is the unique characteristics of individuals who share an identity within a group, characteristics known as prototypical. Leaders with prototypical characteristics like their teams are trusted to pursue an agenda in the team's best interest, as they are viewed as one of them (Van Knippenberg 2011, Van Dijke and De Cremer 2009). Leaders with a shared professional identity or clinical history may be viewed as prototypical for these reasons only. However, if externally appointed leaders demonstrate a commitment to support the teams' ideals and beliefs, despite never being truly prototypical, they can also be trusted to act in the team's best interests. (Giessner et al 2009). A limitation of prototypical leaders' relationship with team members is individuals within the group can manipulate the leaders' actions. Van Dijke and De Cremer (2009) warn if group members redefine what is prototypical, leaders are compelled to accept the new norm, if they do not, they may no longer be viewed as representing the team's interests and lose support.

Current research on leadership in healthcare.

Research, underpinned by a sound qualitative empirical base, was integral to phase 3 of the literature search. The research studies below underpin the importance of context and the researcher's prior knowledge to the constant comparative analysis. Research specific to the Police service also recognise the influence of legitimacy attained in working at an operational level, like the values seen in clinical leadership.

Nielsen et al (2008) used a cross-sectional design to evaluate the responses from a questionnaire competed by Four hundred and forty seven staff caring for older people in Denmark. They concluded a transformational leadership style was closely associated with followers' working conditions, job satisfaction and well-being, identifying an association between leadership behaviour and employee wellbeing. Furunes et al (2018) support this finding, in a qualitative descriptive study of twelve experienced registered nurses to understand the reasons why experienced nurses intend to remain in their jobs. They suggest enhancing retention; leaders should provide a health promoting work environment that ensures productivity, autonomy, and skill development.

To identify the attributes of effective clinical nurse leaders. Cook (2001) adopted a grounded theory research approach, using two research techniques: observation and interview to understand the importance of transformational leadership to clinical leadership, and subsequent follower satisfaction was made. Importantly, the research stressed the value of the constant comparative analysis, when returning to the literature to identify emerging concepts within clinical leadership, with limited published research. However, Cook (2001: 36) also stressed that *"generalisation cannot be made with a high degree of confidence"* due to the specific and unique contextual influences within the research site. A consideration discussed in the conceptual framework.

Intazari and Pauleen (2018) in a grounded theory study interviewed thirty seven managers and senior executives about their perspectives on the concept of wisdom in the business context and its role in management decision-making. Their findings recognise the decisions leaders make are not simply the result of managers applying a specific set of abilities to a given situation. Through a process of continuous reflection, self-awareness and cognitive-emotional mastery, leader's knowledge, values, beliefs and experiences are recognised as essential in decision making. They support a continued engagement with the literature focusing on wisdom to clarify the emerging data, but not define it, as sensitising concepts support this thesis. In agreement with Cook (2001) they recognise the context specific approach of grounded theory as a limitation to generalisability, wisdom in managerial decisions was influenced in their research by gender, age, culture, and education within a defined population.

Lysek (2016) conducted a grounded theory study of forty seven employees in a Swedish industrial company to reveal the *"true processes"* around leadership that existed within the organisation. The data revealed managers had concerns regarding staff engagement and commitment to the organisation, concerns that threatened the organisations success. Lysek's (2016: 27) core variable was termed "*collective inclusioning"*. Collective inclusioning is what leaders did to include everyone in their vision and mission. Lysek recognised that although the study was conducted in a Swedish electronic company, *collective inclusion* could be applied to any organisational setting. Its emphasis on a visionary and engaging leader has similarities to transformational leadership in the NHS.

Day et al (2014), examined the characteristics of influential *superheroes* in public health. Using a grounded theory approach, they conducted twelve semi-structured interviews to identify five leadership *talents* for public health. These were: mentoring-nurturing, shaping-organizing, networking-connecting, knowing-interpreting, and advocating-impacting. Their findings reveal shared values, developing relationships and credibility earned through a commitment to their profession were their predominant abilities. Findings that support the significance of social identity and prototypical characteristics, as the *superhero* qualities identified by followers, mirrored their own values. The findings also support the move away from leadership development programmes designed to strengthen weaknesses identified through psychometric testing. Alternatively, as Fuda (2014) advocates, to focus on individual talents related to thoughts and feeling, as well as behaviour, supporting the focus of current programmes.

Grover et al (2014) adopted a grounded theory approach to conduct forty one face-to-face, in-depth individual interviews with employees across a variety of occupations from the white-collar sector to explore the interactions between leaders and followers trust in a variety of *white-collar occupations* including retail, industry, and the public sector. They believe an interpretive grounded theory approach was imperative to appreciate types of trust violations, how followers react to such violations, and how leaders attempt to repair relationships with followers. Findings conclude leaders' behaviour leads to a recoverable loss of trust for minor errors in judgement; however, trust is irreversibly lost when followers feel threatened or exploited. Grover et al (2014:

700) associated their findings with the concept of *“destructive leadership”* where the leaders’ behaviour can harm or intends to harm the organisation or their followers.

To demonstrate the breadth of research in health care, a qualitative study by Paquin et al (2018) interviewed twenty seven physicians involved in paediatric crisis management. They concluded a lack of clarity over leadership roles could result in errors and poor patient outcomes. Although this research was conducted in healthcare, there are many similarities in the research aiming to understand how public-sector organisations are managed and led during complex and changing times (Jones 2018). A recent focus on leadership in the Police service (The College of Policing (2015), PEEL (2018)) identifies a lack of succession planning and understanding of the leadership styles and skills of the workforce. The research summarised below reveals leaders in the police service, face similar struggles to those in the NHS.

Hoggett et al (2018) used data from a national police survey of over twelve thousand police officers to understand their views on direct entry and existing police leadership. They found police leadership to be dominated by a focus on individual idiosyncratic leader traits, characteristics, and behaviours, with transactional and charismatic leadership the two common approaches. They used an online survey to question serving police officers, looking at a range of issues facing the police service in England and Wales, but specifically the issue of direct entry to superintendent level and fast track promotion through the ranks. Findings revealed experience was viewed as vital for legitimacy and operational competence, with officers lacking experience subject to a lack of credibility, respect, and trust. A lack of front line police experiences also led to poor decision makers who did not have the experience to understand the implications of their decisions.

Tourish (2014) approached the study of Police leadership from a social constructionist perspective to understand the influence of rank. The findings confirm rank as an accepted powerful and legitimate leadership tool in the Police service. Tourish developed a model of situated authority, recognising

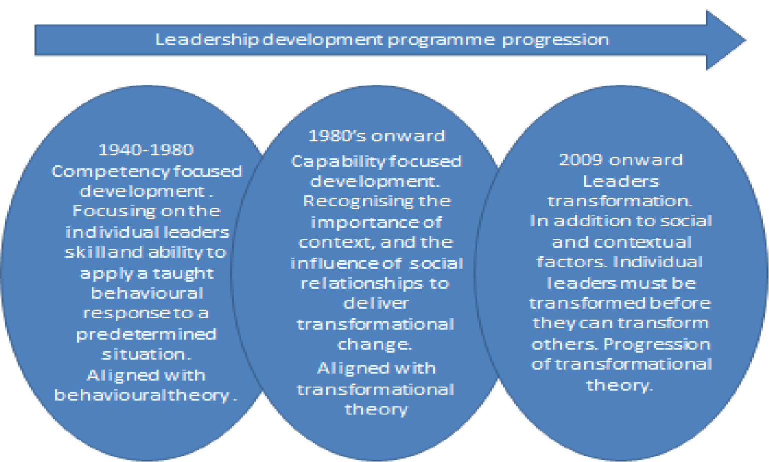
rank is used as a hierarchical form of power in restricted instances, mainly times of emergency and in the public domain.

The approach to leadership in the NHS.

Leadership development has been a key policy concern since the NHS plan (2000: 86) called for, *“the development of first class leaders at all levels of the service”.* A need confirmed by research undertaken by Kippist and Fitzgerald (2009) who found a lack of development in organisational training impedes leaders’ impact and contribution to organisational strategy.

This section summarises NHS leadership development programmes. Initially, from a competency based skills approach, to an ongoing capability approach recognising the importance of contextual social relationships.

Figure 4: The changing approach to leadership development programmes



The competency approach

Initially, leadership development programmes focused on skills development, to acquire knowledge and competence in a specific activity (Jones and Bennett 2012, Hewison and Morrell 2014). Leaders were taught through lecturers, role play, case studies and adapting behaviours a set of generic skills to apply to their role, offering leaders the *know how* to use later (DuBrin 2010). Mumford et al (2000) believed the continued use of taught skills permitted leaders to demonstrate intelligence in their decision making. The skills model offered a multi-faceted structure for individuals to follow, by not focusing on individuals

inherit traits; it was easily adopted as a blanket approach to leadership development.

A blanket approach did not consider individual's previous experience; the generic approach applied a set of universal capabilities regardless of experience. This approach was forward facing and applied a blanket approach to instil a core set of skills, failing to recognise leadership as a social process to build social capital (Edmonstone 2013, Bekas 2014). Indeed, as far back as 1955 it was suggested that leadership was based on human and conception skills, not technical (Katz and Kahn 1978, Hewison and Morrell 2014). This thesis recognises this omission and aims to understand the value of previous work experience to managers' approach to leadership development.

The capability approach

To recognise the social and contextual influences in the NHS, several generic leadership frameworks were produced. These programmes encourage staff to recognise their strengths, weaknesses, belief systems and prejudices, while working alongside others to collaborate and share leadership opportunities (NHS Leadership Academy 2011a, NHS Leadership Academy 2013, and NHS Improving Quality 2013). As transformational leadership shares many of the models approaches, it was chosen to underpin leadership development programmes. At the time of this shift, NHS managers were predominantly recruited from professional staff within the organisation. The shift to focusing on capability, alongside a transformational leadership approach mirrors the social working practices of clinical staff in patient focused environments, an influence of previous experience this research aims to understand.

Critics of this underpinning transformational approach question its application at a time of increasing complexity, financial restraints, and reform (Hutchinson and Jackson 2013). Believing the healthcare leadership model does not reflect the changing approach to health care and value managerial excellence. The capability approach coincided with the publication of the Griffiths report (1983). This may explain a focus on organisational profitability, success, and continued influence of management theory (Storey and Holti 2013). A further criticism is referenced as the *honeymoon period* (Goleman et al 2011). During this time the

enthusiasm, motivation, and energy from participating in such programmes fades away within six months, buried on a return to work by targets, demands and day to day communication. For this reason, recognising the continued support of participants following a programme is vital (Hewison and Griffiths 2004). A further limitation offered by Alimo-Metcalfe and Alban-Metcalfe (2006), is a focus on middle managers, while excluding senior manager development.

Recruiting NHS Managers

So far, this section has considered the position of managers in the NHS, development programmes they may undertake, and the predominant leadership approaches they may adopt. However, the focus of this thesis is the influence of previous work experience. It is therefore necessary to consider the common routes individuals may take to NHS management posts. Three routes to NHS management can be identified these are: professional hierarchical progression, NHS graduate Management scheme and recruiting managers from outside the NHS. The three pathways echo The Kings Fund (2012) belief that service specific knowledge, improvement know how, and change management are essential to effective leadership.

Professional hierarchical progression

In effective organisations good leaders are grown (Drotter 2010). Organisations that view staff as assets to be developed recognise staff development as a crucial part of management (Hewison and Dodwell 1994). In return, Khoreva and Vaiman (2015) maintain, staff who receive training and development feel obliged to reciprocate the investment by remaining with the organisation, removing the need to look elsewhere.

Leaders grown within organisations understand the organisations processes and culture, sharing a set of embedded values (Hewison 2001). Indeed, Adair (2007) suggests, while strategic leaders could be recruited from outside the organisation without specialised, technical, or professional knowledge, staff at team and middle management levels should be developed from within.

NHS Graduate Management Scheme

The graduate management training scheme aims to inspire a new generation of managers to work in the NHS (Musgrave 2014). To transform the NHS into an

efficient, successful, and professional care service (NHS graduates 2018). The scheme is essential to the success of NHS Trusts, positively impacting the hiring and retaining of graduates, to sustain an edge over market rivals (Human Resource Management International Digest 2017). The apprenticeship approach of the graduate management training scheme, allows trainees to work alongside substantive colleagues, contributing to day to day workloads, developing a specific set of skills for one of four predetermined roles. Of the four, Boddy (2008) recognises general management is particularly relevant to this thesis as it focuses on performance and delivering part of the organisations function. Hewison (2004) considers the post graduate element, allowing trainees to critically examine the scientific basis for their decisions, an essential element of evidence based management.

Recruiting managers from outside the NHS

NHS organisations may place greater emphasis on managerial knowledge and success, over professional experience, and knowledge. Consequently, individuals with proven management experience may be preferred over existing clinical staff. A strategy Thompson and Flynn (2014: 86) describe as *"inter sector senior leader transitions"*. At an organisational level this is acceptable, as senior managers do not require clinical knowledge to make decisions that others will make for them. Credible managerial experience may seem a preferred option based on previous success. However, Gill (2013) believes business and public sectors have unique differences that must be considered, differences such as values and norms in health care are dissimilar to private organisations (Thompson and Flynn 2014). Gill (2013) believes such opposing attitudes and approaches of employees largely explain the differences in leaders' attributes and characteristics between the two sectors.

The Department for Innovation Business and skills (2012) reports UK managers are significantly under qualified compared to their equivalent in advanced economies, with only one in five holding a management related qualification. Subsequently, with a business focused approach, and a lack of managerial qualifications. NHS organisations now seek managers with demonstrable skills in the private sector. Despite this approach, Khoreva and Vaiman (2015) warn

that recruiting external staff will not remove the need for ongoing development, as externally appointed managers lack important service specific knowledge.

The discussion in this chapter has focused on the chronological development of leadership specific to the NHS, providing examples of how grounded theory has contributed to understanding leadership in general and within the NHS. The following section identifies the sensitising concepts that guided data analysis, providing a theoretical lens to understand the emerging concepts.

Theories and models of relevance in the literature as sensitising concepts.

The importance of Bridges *transitional theory* (1995), Benner's (2001) *Novice to expert* theory and the concept of *social world* (Koveshnikov and Ehrnrooth 2016) to the conceptual framework are outlined in chapter three. However, within this literature review, reference has been made to links with the three sensitising concepts. The introductory chapter explained an interest in social worlds following a review of *communities of practice* in a previous post graduate assignment. I recognised a similar need in participants to maintain links with colleagues sharing a common goal or professional registration. I also had knowledge of Bridges Transitional theory from delivering a post graduate level leadership module. Despite Bridges model referring to manufacturing, the elements within the model, in particular individuals stuck in the neutral zone, had similarities to the participants personal transitions. These transitions often involved acquiring new capabilities and knowledge or losing previous capabilities due to a removal from clinical roles. For these reasons, the sensitising concepts were important to phase 2 and 3 of the literature searches. The following section summarises their development and influence in the literature and explains their importance to understanding the emerging data.

Bridges "managing transitions framework"

The theoretical insights of William Bridges, an American Professor of English, helped individuals better manage their daily lives, placing him in the American tradition of pragmatic philosophy (Bridges 1995). Bridges transitional framework focuses on change from the perspective of the individual moving through the change process (depicted in Figure 5). Bridges recognised existing models of

change concentrated on situational aspects, such as the new site, team, and building. This focus misses the psychological process individuals go through to come to terms with change, a process known as transition.

The importance of Bridges model to leadership and this thesis is that it recognises that individuals evolve during periods of transition and enter a neutral zone, like the transition faced by many participants, where old habits and ways of working are replaced by new practices, requiring new skills and a modified approach to work. Bridges model is not specific to health care; however, it is applicable to individuals transitioning through organisational change, in this case a change in role. As the individual category chapters will demonstrate, Bridges model provided a frame of reference to understand the participants' anxieties in adapting to a new role and responsibilities; the three stages offered a theoretical lens to focus the emerging data. Bridges model also maintained reflexivity, as the model offered a point of reference to return to.

Figure 5: Bridges Transitional model. (Adapted from Hayes 2014)

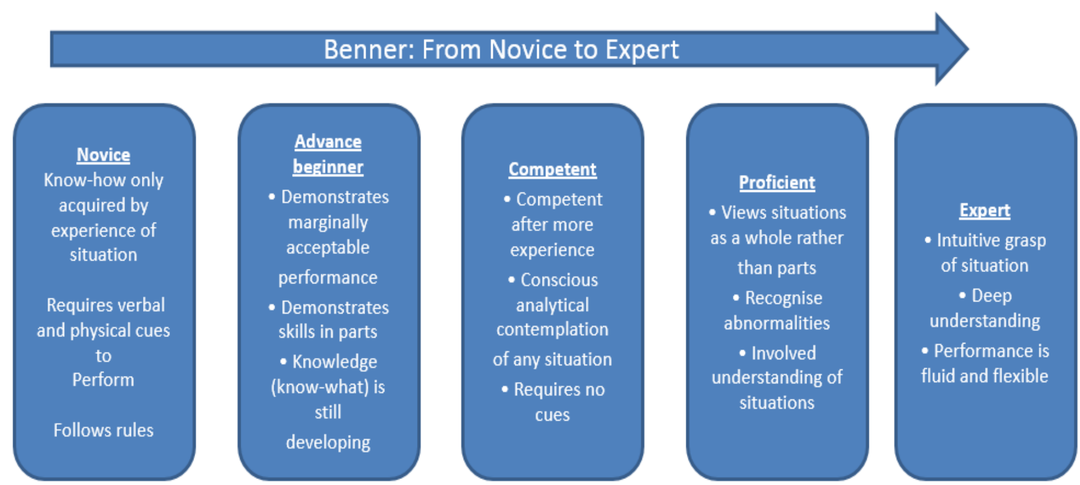
Benner's theory of "novice to expert"

Benner (2001) applied the concept of *know that* and *know how* to nursing practice. A concept recognising nurses may *know how* to perform in clinical roles (practical skills), without the *know that* (theory based knowledge). Benner asserts novice nurses apply theoretical knowledge to practice without question. Throughout a clinical career their dependence on theoretical knowledge lessens. Replaced instead by a body of knowledge opposed to direct theory, which is tacit and case specific at expert level (Fook and Gardner 2013). The expert no longer relies on analytical rules and guidance used as a novice to inform action. Instead, they rely on an intuitive grasp of each situation. An

intuition that may no longer be relevant when individuals move from clinical to managerial roles.

Like Bridges, Benner's model is a linear transitional model; albeit one that focuses on clinical knowledge, not organisation change. Benner's value as a sensitising concept is to appreciate the influence of knowledge and experience acquired in previous roles. Intuitive *know how* from previous roles may be ineffective in new roles and contexts, requiring leaders to acquire new *know that* knowledge, a journey potentially moving them from a position of clinical expert, to managerial novice.

Figure 6: Benner's theory of novice to expert (Adapted from Quick 2016. 225)



Social Worlds

Social world theory describes social worlds as groups of individuals that merge into areas of interest; membership of a social group allows individuals to meet others who share the same interest (Unruh 1979, 1980). Social worlds allow an understanding of the existence of social identities in complex situations (Guala and Hindriks 2014). Social patterns contained within social worlds, such as health care professionals and support services, produce shared identities and viewpoints, forming the basis for individual and collective actions and norms (Ostrom 2000). To understand the perception and interactions of individuals in organisations, you need to look beyond individuals as individuals, and instead look at how social interactions are a combination of individual's identity in social groups (Haslam 2004). Gieryn (1995) believes it also provides individuals with legitimacy through agreed and defined standards and boundaries within the

group. Such standards and boundaries may be lost in new roles, with a new social world, adding to any anxieties experienced during transition.

Mengiste and Aanestad (2013) believe social worlds are rooted in symbolic interactionism, as they assume meaning can only be constructed among individuals with a shared language and commitment. Within health care, professional groups use social worlds to maintain an enhanced social status and a sense of self-esteem. From a leadership perspective Kenny et al (2011: 74) suggest occupations establish social worlds to uphold a set of norms and values, to not only define "*who I am",* but also, *"who I am not".*

Miles (2001) suggests social life is nothing if not complex, with all sorts of power relationships that influence how we behave on a daily basis. In a study by Borland (2018) to understand the positive experiences related with social experiences. They found females find same-sex social interactions to be more rewarding than males and can predict better mental health outcomes. Specific to health care, Hinze and 'Am (2004, 103) suggest social worlds in health are a "rigid hierarchy of authority and power" In a study conducted by Carol (2011) this power was centred around masculinity. Carol determined women only get promoted into leadership positions in health when they adopt male-like social practices, such as being more dominant (Hodroj 2015). Murphy (2001) believes the social worlds of health care professionals, where many participants in this research are promoted from, can therefore offer collaboration, mutual respect, and replace a sense of powerlessness with one of achievement.

Clarke and Friese (2007) adopt the concept of *social worlds* in their version of grounded theory to recognise social worlds are fluid, where managers move across boundaries, interacting with many social worlds daily throughout their careers. This research aims to understand the influence of previous work experience, moving from one role and associated social world to another may be significant. If so, social worlds provide a lens to recognise the impact of this interchange. This view is essential, as individuals view themselves and their alignment with a social group contingent on their perceived *fit* (Haslam 2004). Therefore, if an individual's *fit* with a group was based on professional identity

or clinical speciality, aligning with a managerial group may be problematic if they hold an opposing view to health care delivery.

Conclusion to chapter

In this chapter leadership has been defined with difficulty as a contested term, one that shares many similarities with management. Importantly, while the literature informs this research, it does not dictate its theoretical development. The literature review summarises leadership development to understand the principal theories in use, and development programmes designed to apply the theories to a health care context. The literature review demonstrates reflexivity through an ongoing interaction with the literature, evidenced using sensitising concepts. The following chapter presents the conceptual framework and methodological approaches that underpin and structure this research.

Chapter Three- The Conceptual Framework

Introduction

This chapter provides a critical overview of how the research was undertaken, explaining the underpinning conceptual framework. Initially, constructivism and interpretivism are introduced as the ontological approaches to generate knowledge. The epistemological approach of symbolic interactionism to investigate knowledge is then presented. Furthermore, to acknowledge Ravitch and Riggan's (2012) assertion that personal interests and pre-existing knowledge and experience are evident within a conceptual framework, the specific application of a constructivist methodological approach to this grounded theory research is contained within this chapter.

A review of the research question.

By way of introduction to the chapter the research question is restated.

> *How does previous work experience influence the leadership style of NHS managers?*

A conceptual framework is a framework of ideas, which underpins the research and frames the questions researchers ask and allows the researcher to communicate the focus of their study, explain the research design, and inform data collection and analysis (Wisker 2009). The conceptual framework considers:

- Managerial staff in the NHS.
- Managers employed at middle management level (Band 8AfC).
- How managers from professional and non-professional backgrounds perceive their leadership style.
- How a manager's previous work experience influences their perception of leadership.

The conceptual framework

I began this research by considering my philosophical perspective, considering the nature of reality and how the world is understood (Thomson and Walker 2010). Scotland (2012) asserts that researchers must take a position regarding their perception of how things are and how they work. As such, I recognised a

preference for understanding the individual beliefs and values of health care professionals. Flick (2014) recognises this as a post-positivist ontological approach, where features of qualitative research, such as diverse participant perspectives, application of research methods and researcher reflexivity are welcomed.

The two ontological approaches of constructivism and interpretivism support the conceptual framework. Constructivism is concerned with the nature of reality, believing individuals construct reality from past experiences and an ongoing relationship with the world. Within this, the final methodological approach is constructivist, supposing individual's minds are not a mirror of the world as it is, it differs from one person to another (Guba and Lincoln 1994). There are as many realities as there are people to conceptualise them (Gergen 2009, Dewey 1929). Likewise, Bryman (2008) suggests the ontological approach of interpretivism also considers truth a perception of individual's interactions in social worlds, and as perceptions change, nothing is definite, and truth only happens in the moment. I favoured these approaches that focus on the interpretation of the actions and meanings of individuals, and not explanation, prediction, or measurement (May and Williams 1998). My decision to adopt an interpretive approach is supported by Cohen et al (2007), believing reality is individually constructed, and social worlds can only be understood from the viewpoint of individuals who participate in them. Recognising both approaches is important as this thesis aims to understand how previous work experience influences individual participants approach to leadership, and how they construct an approach within an organisation.

A constructivist view offers an alternative view of knowledge, not one associated with the search for truth, but knowledge generated by a community's belief, values, and assumptions, and as all communities are unique, one truth cannot be applied to all. The originality of communities permitted Kuhn (1970), to suggest communities generate their own paradigms. While rules are usually common to a broad scientific field, paradigms are not, allowing the researcher to formulate as a way of relating within the community, an ontological approach rejected by empirical research. In agreement, Gergen and Gergen (2008) suggest communities, like those in NHS organisations, hold things to be true.

Within such organisational cultures, constructions made are embedded in the community's way of life, rooted in the members' social relationships.

Hyslop-Margison and Strobel (2008:76) warn that despite knowledge being constructed from Values, beliefs, and assumptions. These beliefs must be true and supported by "*publicly confirmable evidence"* Individuals can construct beliefs that are factually inaccurate and not considered true knowledge. They must recognise knowledge is not simply created through their own perceptions and understandings. Indeed, pre-existing beliefs may impede true knowledge generation. Interpretive research aims to understand how members participating in social groups, such as health care professionals or managerial staff, bestow a meaning to their experience, and how this meaning establishes their actions within the social group (Goldkuhl 2012). Cummings and Borycki (2011) therefore consider grounded theory as a methodology that aims to understand how individuals and groups interact.

Interpretive studies are based on the researcher's interpretation of data that cannot be quantified (Birks and Mills 2011). To aid interpretation researcher's return to the research site to make sense of the data in context, to understand what happens in social situations, and ultimately, to interoperate meaning (Charmaz 2014) As such, the interpretative approach is central to inform this conceptual framework. The researcher uses personal knowledge and experience to investigate assumptions made throughout the research process.

While Charmaz (2014) recognises the researcher is central to the research process and values the researcher's previous knowledge to inform data collection. This may raise issues of confirmability to ensure the findings result from the experiences of the participants and not a result of researcher preferences or biases. One approach to ensure conformability proposed by Glaser and Strauss (1967) is to document a clear audit trail. An audit trail is a comprehensive set of notes that relate to the contextual background of the data and provide the rationale for all methodological decisions. An approach supported by Lincoln & Guba (1985) who agree audit trails are a principal technique for establishing the dependability and confirmability of qualitative

research findings, to ascertain whether research findings are grounded in the data.

One example of an audit trail to ensure the study's findings result from the experiences and ideas of participants' is a series of word documents completed following each participant interview. Each document aligned subsequent participants data to previous categories. The influence of new data to a category's development or merger with similar categories is clear throughout the research. This trial, as Bowling (2003) suggests endures assumptions that emerge from participant data form the basis of subsequent interviews. An example shown in Appendix A.

Symbolic interactionism

Blumer (1969) supposes the essence of society is in the ongoing process of actions, believing the world is changed through reason and action, forming an inseparable link between human knowing and human action. Symbolic interactionism recognises the meaning derived from interpretivism, to allow grounded theory researcher's a framework to build knowledge.

Symbolic interactionists believe through interactions individuals create and change meanings, they are active participants in their world and not passive recipients of greater social forces. The influence of interpretivism recognises individuals as social creatures who reflect, create, and react within their social world, to redirect or rethink their actions (Charmaz 2014). As a result of such actions individuals within a social group are unique, relative to the society or culture they belong.

The value of symbolic interactionism to this research is that it sensitises the researcher to the meaning's managers attribute to their surroundings. Current NHS managers are drawn from a range of different professional and academic backgrounds with diverse working experiences. Consequently, this unique experience offers a diverse view of leadership. The meaning each manager derives and the actions they take within their leadership approach, is also individual.

NHS Trusts cannot be considered equal, each having multiple realities and a unique social context (Charmaz 2014). Consequently, each Trust must be considered in isolation, and so exact repetition cannot be the aim in grounded theory. Generalisations are "*moderatum*" and not directly applicable to similar social contexts (Payne and Williams 2005: 297). Meaning the scope is moderated, it is not intended to be applicable across the NHS. It also acknowledges that time and political influences will moderate the impact.

The importance of a conceptual Framework

Ravitch and Riggan (2012) stipulate several reasons why a research study should be underpinned by an obvious conceptual framework. They assert the conceptual framework provides a sequence of logical propositions designed to convince the reader of the importance of the research. The conceptual framework also provides a critical lens, through which the researcher can view their work, and their role in carrying it out. The conceptual framework may not be apparent early in a research study. However, according to Urquhart (2013), hunches which the researcher may have, when planning the research study, should be acknowledged as elements of an emerging conceptual framework. As Walliman (2011) believes, any underlying assumptions, such as those introduced in chapter one to explain my previously held assumptions about the preferred route to managerial positions, will influence the researcher's ontological perspective, which connects the theoretical background to their enquiry.

The conceptual framework is unique to the researcher, becoming an aggregation of formal theories chosen to investigate a specific research question (Ravitch and Riggan 2012). According to Leshem and Trafford (2007) the conceptual framework will recognise the work of others, the researchers experience and observations, and the act of reflecting on experiences in developing research assumptions. As an example, the specific influence of existing theoretical frameworks as sensitising concepts, these are Bridges *transitional theory* (1995), Benner's (2001) *novice to expert* theory, and the theory of *social worlds* (Koveshnikov and Ehrnrooth 2016).

There are limitations to any conceptual framework, including the researcher's desensitised ideas obscuring what truly emerges from the data. Researchers are reminded to maintain an open mind, to avoid imposing preconceived ideas on the developing theory (Birks and Mills 2015). Objectivity, Strauss and Corbin (1998: 42) believe, should be reflected in a conceptual framework as this will ensure researchers arrive at *"An impartial and accurate interpretation of the events".* However, they also recognise sensitivity is required to comprehend the subtle connections between concepts.

Reflexivity is discussed in detail in chapter four. However, as a component of the conceptual framework. It is important to recognise reflexivity as a process of critical self-reflection (Schwandt 2001) and a process of thoughtful, conscious awareness of my role in the process of the research (Finlay 2002). Engward and Davis (2015) recognise a lack of practical guidance on how to be reflexive as a researcher. However, they do acknowledge a reflexive model proposed by Alvesson and Skolberg (2009) that presents a practical approach to develop levels of reflexivity in a research project. The Reflexive approach adopted in this research was influenced by Charmaz, and while Charmaz does not structure this approach into a formal model. The four stages proposed by Alvesson and Skolberg of data collection, data analysis, refining the final categories and questions of representation and authority are represented throughout this thesis.

Grounded theory in application to research

Grounded theory is a preferred qualitative methodology. Preferred, as unlike phenomenology, where the research aims to understand how individuals make meaning of their lived experience, grounded theories explain social processes in a specific context (Starks and Trinidad 2007, Kempster and Parry 2011). Grounded theory supports a research process driven by insight (Corbin and Strauss 2008). A researcher's personal insight allows them to recognise the constructed effects of leadership in a social context. Leadership cannot be seen, only its influence observed in context.

Grounded theory, a methodological approach to research

Whilst the discussion in the preceding section focused on the importance of a conceptual framework, the next section identifies the specific theoretical framework chosen to address the research question.

Grounded theory is crucial when the aim is to understand the interaction between individuals and their environment (Grbich 2013). Adopting an inductive approach, researchers make interpretations in the data to identify an emerging theory. When constructing grounded theory, Creswell and Creswell (2018) explain the process of multiple stages of data collection and analysis reveals a theory ground in the views of participants.

Glaser and Strauss (1967) describe grounded theory as a general method of analysis, one not aligned with a specific quantitative or qualitative approach. They believed qualitative research consisted of long detailed descriptions that produced very little theory; it was either not theoretical enough, or too impressionistic. In contrast, the aim for grounded theory is to develop a structured and systematic method of collection, coding, and analysis of qualitative data to generate theory.

Silverman (2013) warns that as grounded theory is open and fluid in the hands of a novice researcher, the methodology could simply produce empty descriptive categories if used unintelligently. A criticism at times directed toward novice researchers, a criticism addressed throughout the research process by ongoing supervision and reflection.

The following section explains why Charmaz's (2014) constructivist perspective of grounded theory, to view the researcher as central to the research process, and not a neutral participant, is fundamental to the conceptual framework.

A constructivist interpretation of grounded theory

A constructivist approach understands the world by investigating the interactions of those within it, the norms, practices and roles of individuals and their relationships within the research setting (Charmaz 2014). Grounded theory as a methodology offers the ideal perspective from which to understand how previous work experience influences an individual's current approach, thoughts,

and interpretation of leadership. The hierarchical practices embedded within health care organisations establish a pre-constructed meaning and culture among its employees. However, managers will not be inert and inactive within this culture. Previous work experience will influence their interaction and understanding of the culture to develop a unique and personal meaning.

This approach is not a passive process; participants are encouraged to recount their individual perspectives, alongside the subjective and social meanings related to it (Flick 2014). This approach also explores how participants interpret their surroundings and alter behaviour, based on work experience in a deliberate and considered manner. A position supported by Gergen and Gergen (2008) who believe we all construct the world in different ways, it is rooted in our social relationships, everything we consider real is socially constructed. Gergen (2009) further suggests, what we see has a different meaning to others, the difference is in our social relationships, through these we construct a unique view of the world. As a result, theory produced is an interpretation of the studied world, not an exact representation developed through an analytical process that focuses on properties and dimensions.

A criticism of a constructivist approach is that rather than present their findings as definitive results, researchers present a convincing argument to support the emerging theory (Andrews 2012). A key problem for some with this criticism is that knowledge is created by the researcher and participants within the social area under study and the findings presented in the study are specific to the realities and meanings of the researcher and participants within a specific social setting.

Key elements of grounded study.

This section provides a clear overview of the key elements of grounded theory, before its application in this thesis is discussed in chapter four.

Grounded theories inductive approach emerges from a cyclical approach to sampling, data collection and analysis known as the constant comparative analysis (Charmaz 2014). When applying grounded theory, the researcher develops categories from incidents and codes to generate theory grounded in the data (Birks and Mills 2011). Unlike other methodologies the process is not

designed to ensure two researchers working independently will achieve the same results, it aims to generate plausible categories and themes relating to the situation, without the need to test or prove them (Glaser and Strauss 1967). The process is essential for raising questions and discovering properties from data (Strauss and Corbin 1998).

This simultaneous iterative process of data collection and analysis builds theory through an inductive examination of the data (Charmaz 2014). Data is not merely described or sorted into themes; it develops over time as the researcher returns to the data after each new episode of data collection, looking to substantiate previous themes, variations and emerging trends until theoretical saturation occurs. The participant selection criteria (Appendix B) support this approach within the research. As a result of comparing similarities and differences in the data, new questions were identified to build on the emerging categories (Strauss and Corbin 1998). Constant comparative analysis cannot be used to deductively prove a theory; the data must inductively generate and dictate the theory.

How the research was done

Twelve interviews were conducted over a thirteen-month period (June 2016-July 2017). Data was collection in Trust one June 2016 to January 2017 and Trust two to July 2017. Glaser preferred note taking throughout the interview to capture essential information over recordings and verbatim transcription (Glaser 1978). In this study, recorded and transcribed semi-structured one to one interviews were used to gather rich data, allowing the researcher to see the participant's world from the inside. Interviews also give the researcher more control over data generation than other forms of data collection (Charmaz 2014).

Theoretical sampling

In grounded theory, the data generated from the inductive approach informs the selection of ongoing participants. As the resulting theory is unknown, researchers cannot manipulate the sample to generate the information they want to find. Only as codes are discovered, and efforts made to achieve

saturation by looking for comparable individuals are participants identified (Glaser 1978).

Theoretical sampling informs the researchers approach to participant selection. It is therefore a cumulative process, as concepts and their relationships in the data accumulate throughout the cyclical constant comparative analysis (Strauss and Corbin 1990). It was my intention to interview participants from all three employment pathways introduced in chapter two, to understand the breadth of views and experiences from numerous perspectives. I did not want the views of nurses or health care professionals to dominate the findings. While I was successful in recruiting participants lacking a professional background. I was unable to recruit a participant from the graduate management scheme in either research site. An issue recognised in future research opportunities in Chapter eight. Despite this, the reflexive dialogue, memos, and situational maps support confirmability, with the research findings representing the views of the participants recruited.

Appendix B summarises the decisions made to progress from one participant to another, leading to twelve in total. Appendix B explains the need to interview participants from many professional and non-professional backgrounds. To understand the influence of managers located in the community or acute setting.

Theoretical sampling does not stipulate or estimate the number of participants required in the study, the objective is to refine emerging ideas and themes to reach theoretical saturation (Bryman 2008). Theoretical sampling also allows the researcher to revisit and re code previously sampled data, while revisiting previous participants for additional knowledge (Strauss and Corbin 1990) as data previously coded may have new significance as themes develop.

Theoretical saturation

In a review of qualitative research Monique et al (2016) believe code saturation was achieved after nine interviews, with the first interview contributing up to 75% of eventual high prevalence codes. Therefore, by nine interviews the range of common thematic issues is known. However, further interviews are required to add richness and depth to data known as meaning code.

Through constant comparative analysis, data collection and analysis continue until theoretical saturation is reached, when no new data is uncovered, or new data does not add value (Strauss and Corbin 1998). Charmaz (2014) believes saturation as a concept is difficult to measure, suggesting theoretical saturation may be an impossible goal, as something new can always be found in the data. Saturation occurs when collecting new data is counterproductive and further data adds no real insight. This point known as density signifies that all properties and dimensions of a category have been identified (Strauss and Corbin 1998). Dey (2007) considers saturation to be a metaphor, to emphasise the density of categories, not their termination. Once theoretical saturation has been achieved, the researcher can move to understanding the emerging fit between theoretical codes, producing hypothesis that explain the relationships between concepts and underlying social behaviour of the emergent theory.

The decision not to interview one manager volunteering to participate is another example of the constant comparative approaches influence. While useful data may have been collected, the individual's involvement could not be justified in the participant selection criteria. Holton (2007) supports such exclusion, declaring the role of the constant comparison analysis when the core category is identified is to focus continued data selection and analysis to saturate and add density, not to collect large amounts of unnecessary and needles data.

Iterative process during the collection of data

In this research coding was used to break down and compare emerging themes in data, building sub categories leading to larger categories and an eventual core category and theme. In essence, coding breaks down and deconstructs data to generate new meaning (Strauss and Corbin 1990). According to Charmaz (2014) coding provides the pivotal link between data collection and emerging themes.

Terminology and process for the initial stage of coding has altered since Glaser and Strauss's seminal text. Originally, Glaser and Strauss (1967) compared incidents in the data to develop many categories; through constant comparative analysis categories develop properties. Focus then changed from comparing incidents with incidents to comparing incidents with the properties of developing

categories, demonstrating the unique approach of grounded theory to return to the data and look for new insights considering emerging properties. In this study open coding started from P1's interview and describes the initial phase of the coding process. Or, as described by Strauss and Corbin (1998), Bryman (2008), Glaser (1978) and Charmaz (2014), to look for phenomena in the data that are grouped to make concepts, leading to categories.

Strauss and Corbin (1990, 1998) describe the next stage as axial coding, where connections are made between categories to form larger more complex categories. Researchers return to the data in an inductive approach to seek evidence to strengthen sub categories to generate larger categories, leading to one substantive category in the final selective coding process is what makes the theory grounded (Strauss and Corbin 1998).

I have adopted Charmaz's (2014) approach to open coding in the constant comparative analysis as it is less formal at this stage. Preferring a fluid approach accepting my theoretical sensitivity, lacking the complicated structure of the paradigm I believe would diminish this influence and restrict data analysis. Continued theoretical coding gave form and structure to categories, at this point a story begins to emerge before theoretical sorting finally reduced the remaining categories to one final substantive theory.

Memo writing and situational maps

Memo writing and situational maps are important in reflexivity to avoid the researcher forcing preconceptions on the data. They encourage the researcher to stop, compare and define the links between emerging categories (Charmaz 2014). Situational maps were used as a quick visual check to understand how categories developed. Displayed on a wall, the progress viewed as a continuum supported a scrutiny of the research, decisions and interpretations made in a reflexive approach on how the research was conducted.

Glaser and Strauss (1967) assert memo writing is useful in generating theory, memos can record ideas during the coding process, and document ideas immediately after leaving the research setting. To support the constant comparative analysis, transcripts, field notes and memos are used to identify areas of potential theoretical significance from the data (Bryman 2008), further

cycles, compare emerging concepts, allowing a theory to emerge (Glaser and Strauss 1967). Glaser and Strauss (1967) also assert memo writing is useful in generating theory, memos can record ideas during the coding process, and document ideas immediately after leaving the research setting.

The role of sensitising concepts

Strauss and Corbin (1990) identify literature, professional and personal experience as sources of theoretical sensitivity. Here, sensitising concepts acknowledge one aspect of engaging with the literature to compliment the research process. Blumer (1940: 707) recognises a limitation in social research as *"one of the vague and imprecise nature of most concepts"* implying concepts that are vague and unclear impede scientific research. Blumer suggests that to overcome such impediments, a working relationship between emerging concepts and researcher experience is needed. Blumer (1954: 148) also suggests that sensitising concepts *offer "directions along which to look"*. A direction influenced by the researcher's unique experiences.

Sensitising concepts do not define the emerging concept; they inform it. Supporting researchers to see how emerging data may fit within conceptual categories (Bowen 2006). Three sensitising concepts informed the process of this research: the *managing transitions framework* (Bridges 1995) *novice to expert* theory (Benner 2001) and *Social Worlds theory* (May and Williams 1998, Koveshnikov and Ehrnrooth 2016). These were set out in detail in chapter two. Their influence on the emergent grounded theory will become clearer later in the thesis.

Methodological Rigour

Glaser and Strauss (1967) believe the developments of rigorous quantitative research had the unfortunate consequence of doubting theory generation in flexible qualitative research. The focus of science is truth, and scientists rely on the scientific method to establish truth (Stangor and Lemay 2016). In quantitative research the evaluating criteria for establishing truth are widely agreed, good research is reliable and valid, and can be generalised to the wider population.

Generalisability refers to the extent the accounts of one population or surroundings can be applied to settings other than those under study (Maxwell 2002). The issue with qualitative research is the findings are related to a specific context and the relationships that exist within it. Therefore, qualitative researchers redefined the concept of generality in a way that is meaningful to them. Schofield (2002: 198) believes generalisation should be considered a matter of *"fit"* between those studied and others the conclusions of the study could be applied to.

Hammersley (1987) considers qualitative research valid if it accurately represents the phenomena it is intending to describe or explain. Nevertheless, many qualitative researchers do not feel comfortable using the terms "*validity*" and "*reliability*" as they carry too many quantitative implications and prefer the term *"credibility"* (Corbin and Strauss 2008). Indeed, Glaser and Strauss (1967) believe qualitative research never gets to the stage of rigorous testing because the social context being studied continually changes.

To establish methodological rigour, I will use the terms *credibility, transferability, dependability, and conformability* proposed by Lincoln and Guba (1985) and Miles and Huberman (1994). Table 3 illustrates how Lincoln and Guba's criteria correspond to the criteria employed by positivist researchers. Adapted from Shenton (2004) and Lincoln and Guba (1985):

Table 3: Methodological rigour

Qualitative criteria	Positivist terminology
Credibility • How the study's findings agree with reality.	Internal validity • Has the study measured or tested what it intended?
Transferability • The responsibility of the researcher to ensure sufficient contextual information about the research site to enable others to transfer the findings to their situation.	external validity/generalisability • The extent to which one study's findings can be applied to other situations.
Dependability • The processes within the study should be reported in detail, enabling future researchers to repeat the study, but not necessarily to gain the same results.	Reliability • If the study was repeated in the same context with the same methods and participants, similar results would be obtained.

Confirmability • Are the study's findings the result of the experiences and ideas of participants', and not the preferences of the researcher.	Objectivity/ • The use of instruments in the study that are not dependent on human skill or perception.

Credibility

Credibility is considered the main criteria of the four (Flick 2014) and will be discussed in greater detail. Credibility is concerned with how faithful a description of the phenomenon is represented in the research (Beck 1993). Asking if the research provides sufficient evidence for the claims made to allow a reviewer to agree with the findings (Charmaz 2014). In essence, are the findings credible to the participants studied and an authentic representation (Miles and Huberman 1994). The limitations of this approach for some stem from its focus on the product of the research, not the process undertaken to achieve it. Recognising rigour can be measured focusing on the methodological approach, signifying the conduct of the research. Or, the interpretative approach, explaining how researchers reach conclusions that are grounded in the data (Elliott and Lazenbatt 2005). In reality, a combination of both is considered (Charmaz 2014), with reviewers judging the grounded theory process as an essential part of the eventual product.

Multiple perspectives among participants were pursued to *"secure an in-depth understanding of the phenomenon in question"* (Denzin and Lincoln 2011: 5). To achieve this, a wide range of participant's, including non-clinical staff, and clinical staff from a range of health professional backgrounds in two organisations was used to triangulate the attitudes beliefs and behaviours of participants. Miles and Huberman (1994) support this approach utilising multiple sources of evidence to build the verification process into the research, using triangulation to get the right findings in the first place. Triangulation is also seen in recognising P3 as an *"outlier"* in the sample (Miles and Huberman 1994: 264). An outlier represents an individual that does not *fit* with the generalised findings, introducing this individual further enhances triangulation.

Frequent debriefing sessions between the researcher and supervisors are important for the credibility of junior researchers, supervision sessions can draw attention to flaws in the intended course of action, allow for an open discussion

to develop ideas and discuss interpretations of the data (Shenton 2004). To facilitate these discussions, Strauss and Corbin (1998) suggest a list of questions for use during evaluation, such as:

- How the original sample was selected and on what terms.
- What major categories emerged?
- What examples are there to evidence the existence of the categories in the data
- How did theoretical sampling proceed?
- How did the core category emerge and on what grounds were the final analytical decisions made?

Examples exist within this thesis to justify credibility under these questions. For example, the original participant was chosen as their career was similar to the researchers; following this clear justification is given for selecting subsequent participants in accordance with theoretical sampling (Appendix B); evidence of the existence of categories in the data is seen with the use of participant direct quotes.

Transferability

The findings of qualitative research are applicable to a specific population and location. As a result, it is impossible to demonstrate if the findings are applicable to other populations and situations (Shenton 2014). Therefore, Braun and Clarke (2013: 282) propose transferability as a concept suited to the *"flexible generalisability*" of qualitative research, this refers to the extent that aspects of the research can be transferred to other groups and contexts (Miles and Huberman 1994). The key to transferability is the responsibility of the researcher to describe the specific contexts, participants, settings and circumstances of the research in detail.

To support transferability the thesis makes clear the number of NHS organisations taking part is two (Shenton 2014). The characteristics of all twelve participants are fully described in Appendix C, a matrix from the participant information sheet, and Appendix B, the participant selection criteria. Research methods are discussed in detail in Chapter four, including how theoretical

sampling identified participants who volunteered to partake in semi structured interviews. This information satisfies Miles and Huberman (1994: 279) requirement for *“thick description”* where the phenomenon under study is presented in sufficient detail for others to judge the degree of transferability to other settings, people and situations.

Dependability

In reliability, positivist researchers demonstrate if the work was repeated in the same context, with the same participants and methods, similar results would be achieved. However, the changing nature of the phenomena under study in qualitative research makes this problematic. For this reason, Shenton (2014: 71) view’s qualitative research design as a *“prototype model”* to permit others to develop a full understanding of the methods and their effectiveness. Whereas Flick (2014) considers dependability as a procedural process of auditing the research, allowing procedures and developments in the research process to be assessed.

To ensure dependability, monthly supervision meetings allowed a reflective appraisal of the project and effectiveness of the process (Shenton 2014 and Flick 2014). During supervision meetings, the application of grounded theory to reconstruct the data, themes, subcategories, and their developing relationships leading to the four final categories described in Chapter five was discussed. While Appendix D is an example of how information from P5 contributed to data reconstruction.

Confirmability

Throughout the research steps must be taken to ensure the research findings result from the experiences of the participants and not the researcher’s preferences or bias (Shenton 2004). To facilitate this Miles and Huberman (1994) deem key criteria for confirmability is that researchers acknowledge the decisions made and methods adopted. In chapter three, I explained I chose Charmaz’s approach to grounded theory as it allows the researcher to study the interactions and perceptions of participants employed as managers in the NHS. Charmaz’s appreciation of the researcher’s previous knowledge and experience to co-construct data was a significant influence in choosing this approach.

According to Blaxter et al (2010) different types of research produce different types of knowledge. When considering their methodological approach researchers consider the nature of the knowledge they seek, their role in the research, and which method is best. In agreement, Steier (1995: 4) maintains researchers *"co-produce"* research with the communities they study. For this reason, the conceptual framework also recognises my reflexivity, being open about assumptions and beliefs, values and biases from the beginning. An openness that Steier (1995) believes increases the likelihood that I would hear what participants are saying. In chapter one I revealed assumptions, beliefs and values as the research began. These constructed from a career as a clinician and manager. However, the reflexive approach taken and documented in this thesis offers reassurance the findings result from the participants experiences and not my own.

Confirmability was further enhanced by identifying the constant comparative analysis as the approach to data collection and analysis (Miles and Huberman 1994). Within this the application of theoretical sampling is evident in Appendix B. Finally, Miles and Huberman (1994) ask if the study data is retained and available for scrutiny. All data is stored for a period of at least one year after the study's conclusion in accordance with Northumbria University (2015) Research data management policy and the Data Protection Act (1998).

Summarising the conceptual framework

This chapter outlines the importance of a conceptual framework suggested by Ravitch and Riggan (2012) to recognise the three elements of personal interests, topical research and theoretical framework. Theoretical framework has been discussed. The remaining two elements of personal interest and engaging with literature are now presented in turn.

From a personal perspective, my long standing interest in NHS management was discussed in the introductory chapter. Currently, employed in an academic role, I meet NHS managers undertaking leadership and change management programmes, to discuss the influences behind their decisions in changing health care organisations. This research study will contribute to the ongoing debate surrounding the role of NHS managers in such dynamic environments.

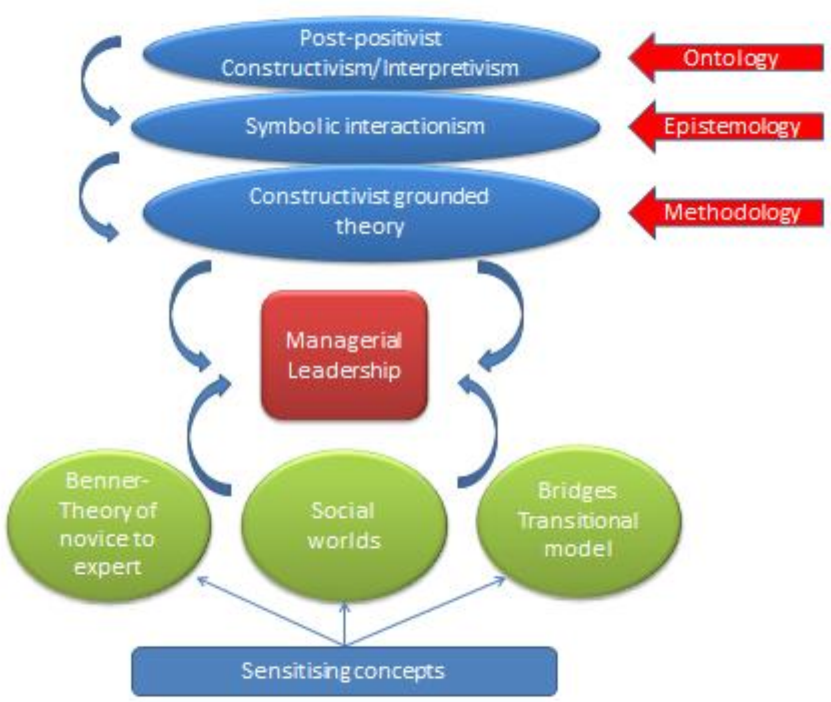
With regards to the literature and topical research, the changing approach to leadership and managerial development, underlines the complexity of leadership within the NHS. Previous research into the roles and impact of managers in the NHS emphasise the uncertainty such a myriad of approaches creates. Grounded theory is an ideal approach to capture the uncertainty that results within individual organisations, each with their own social worlds, practices and cultures.

Theory generation

In their seminal text, Glaser and Strauss (1967: 31) believe the constant comparative approach adopted in grounded theory studies offers a *"running theoretical discussion, using conceptual categories".* In this approach, researchers generate conceptual categories from the evidence to illustrate an overall concept. While recognising the conceptual evidence may not be accurate, its emphasis is on theory as a process, not a perfect product, but a relevant theoretical abstraction of what is happening in the research area. According to Flick (2014: 137) theories in this approach are not applied to the participants under study, but theories are *"discovered"* by working with participants and data in the research field.

The model in figure 7 depicts the conceptual framework. It demonstrates how the epistemological approach of symbolic interactionism to understand the relationships between individuals, supports the ontological aim to understand the nature of leadership, and how constructivist grounded theory provides the methodology to construct the knowledge required to generate a final theory. The model also reveals how sensitising concepts influence managerial leadership.

Figure 7: is a visual expression of the conceptual framework



Conclusion

In this chapter I have conveyed the importance of outlining an explicit conceptual framework to this research design. The merit of declaring the importance of the three essential elements of personal interest, topical research and theoretical framework to underpin this research design are presented. This chapter also recognises the value of sensitising concepts to offer an alternative view of the data and support category development. The ontological approaches of constructivism and Interpretivism, alongside the epistemological importance of symbolic interactionism are given. The grounded theory approach taken in the study on which this thesis is based has been explained.

The following chapter outlines the methods applied within the context of this conceptual framework.

Chapter Four- Research Methods

Introduction

This chapter summarises the methods used in this research study to inform a development of a grounded theory of leadership in NHS managers. It explains how the tools of grounded theory were applied and begins by revisiting the research question and introducing the research objectives, followed by an overview of the application of my constant comparative method, including data collection, analysis, and theoretical saturation. The chapter also contains the reflexive approach applied during the research

The research question.

Rationale

Initially, the research focus was vague, intending to understand if the path taken by NHS managers to management positions would influence their approach to leadership. A lack of focus at the start was not concerning however, as Barbour (2014) suggests, it is a widely held view that students begin the research journey with a broad topic. Creswell (2009) expects the research question to evolve and change as the study evolves, however, in this research the studies focus remained consistent. In part, because band eight managers cover all three employment pathways introduced in the literature review, giving access to a diverse cohort of managers. Despite, the lack of graduate management training scheme managers, and the abundance of managers with previous clinical experience, the question did not change.

Participants were restricted to NHS managers (Band 8 AfC), it was believed they held the employment experience necessary to reflect on previous positions, and understand its influence on leadership approach, being the most suitable to generate data in this area of study.

The conceptual framework guided this research in answering the research question. Ravitch and Riggan (2012) assert a well-articulated conceptual framework helps a researcher to select the appropriate tools to organise and filter data and make visible how the researcher's interpretations and choices are guided by values, beliefs, and backgrounds. In chapters one and three I

revealed pre-conceived ideas about a preferred route to managerial positions. I also acknowledged that an essential part of my conceptual framework considers personal interest, as this was the predominant driver for undertaking this research, it accounts for maintaining a focus on the original question.

The conceptual framework explains my rationale for adopting grounded theory as my theoretical framework, acknowledges personal interests and recognises the value of engaging with the literature at an early stage. Reflexivity allowed me to recognise any biases I may have in relation to meaning making and knowledge by considering my approach in the research to that outlined in the conceptual framework. An example given using memo's on page 81.

The agreed research question was:

> *How does previous work experience influence the leadership style of NHS managers?*

Research objectives

- To understand the leadership approach taken by a range of health care professionals and managers lacking a professional health care identity
- To appreciate how participants in a community role differ from those in acute care management.
- To understand how leading a small team with a specific role, is dissimilar to leading an organisation wide team.
- To understand the influence of academic achievement to participant leadership

Recruitment and sampling

Approaching Trust one

Purposive selection was used to identify NHS Trust one. NHS Trust one was a Trust I knew, it is a teaching hospital in the North East of England, serving a population in both rural and city locations. NHS Trust two was accessed at a later point in the study when there was a need to expand the potential sampling population. Charmaz (2014) supports this purposive approach to choosing the

general population site as a good place to start but recognises this is not theoretical sampling.

Trust one granted access (Appendix E) to approach the Research and Development manager identified as a gatekeeper (Costley et al 2011). A Trust management meeting attended by all band eight management staff was identified as an ideal opportunity to discuss the proposed research as it was not restricted to managers from clinical areas. The meeting was attended by managers throughout the Trust and interest would be welcome from non-clinical areas such as the estates department and hospitality services. Unfortunately, sue to time restraints I was not permitted access to address the group in person. For this reason, the Research and Development manager agreed to send e-mails to meeting attendees on my behalf (Appendix F), the e-mail proved successful with six managers volunteering to participate. These six managers all held one of many professional qualifications (nurse, midwife and dietician), and could be a homogenous group, lacking the diversity of non-clinical respondents. As a result, two further e-mails were sent over the subsequent six months, resulting in eleven eventual participants. Appendix C is a matrix displaying the participants' questionnaire details.

Approaching NHS Trust two

Over the initial month of data collection from managers with a health care background, two participants did not have a professional registration. The theoretical sampling participant form (Appendix B) justifies the approach to participant selection to this point. However, for participant twelve, there was a need to understand the emerging themes with managers not having a health care registration. As sampling in grounded theory is purposive, the researcher's judgement identifies participants to guide their developing theory (Robson 2011), it was for this reason Trust two was approached.

It is important to note this research is not a comparison study, and at no time was a deliberate decision made to compare the experiences of clinical and non-clinical staff. However, as the research aimed to understand the impact of previous work experience, the need to understand the impact of work experience outside the clinical area was important. NHS Trust two was chosen

due to its links and close working relationship with the University. As advised by my supervision team, E-mails were sent to Trust two's operational service managers. As with Trust one, the human resources department sent an e-mail to all managers in the trust, regardless of role or background. Among these one held no health care qualification and they volunteered to participate. Total participants now equalled twelve from both research sites. Appendix C summarises all twelve participants.

Sampling - Choosing the initial participant

The Research and Development manager was chosen as the initial participant as their career pathway was like the researchers.

Appendix B provides rational for choosing each participant throughout the research. The comparative approach discourages researchers from identifying subsequent participants until the relevance of each participant's data to the emerging categories and sub categories is understood.

Data Collection

Interviews

Charmaz (2014) recommends new researchers should construct an interview guide as a way of learning how to obtain data and ask questions, preparing an interview guide also helps to fulfil the research objectives. Charmaz further recognises the value of supervision to agree an initial interview schedule, as asking the wrong questions will fail to explore participants' experiences. Questions were discussed during supervision and an original schedule of ten questions was agreed (Appendix G). The initial question asked participants to tell me the roles and responsibilities involved in their current position. This was deliberately broad and open to allow participants to speak freely and become comfortable.

The interview schedule (Appendix H) developed over time, with additional questions posed to explore emerging categories. However, the initial ten remained, allowing an in depth exploration with participants to understand the influence of previous work experience on their approach to leadership, while allowing the researcher to explore certain responses (Charmaz 2014).

However, Miller and Dingwall (1997) emphasise an interview is not a conversation, but a deliberate opportunity for the researcher to talk about something that interests them. It is also a chance for the interviewee to explore the topic of leadership, to show what they understand.

All twelve semi structured interviews were recorded with a digital voice recorder, reflecting the common approach to collecting data in health studies (Backman and Kyngas 1999). Eleven conducted in Trust one and the final twelfth in Trust two. Interview lengths ranged from 30 to 60 minutes. As Dingwall (1997) believes an interview is order deliberately placed under stress, to minimise participants stress, all interviews took place in participants work environments. I had originally intended to use Nvivo to store recordings and conduct data analysis. However, I found Nvivo overcomplicated and visually difficult to use. I chose to use a sequence of word documents, using the word search function to identify key words and phrases.

Like the first stage of Alvesson and Skolberg's (2009) reflexive model I used a semi-structured interview schedule to allow participants to discuss what was of importance and of relevance to them. My role during the interviews was to listen, reflect on information given and ask relevant questions without being directive of the content. I was aware previous knowledge of participants roles could allow me to dominate the interview. To ensure this did not happen I began with open and broad questions, pausing often to reflect on participants answers and ask if my understanding was correct, allowing participants to add to previous answers to gain further explanation. As participant interviews are transcribed before the subsequent interview, Engward and Davis (2015) recognise the constant comparative approach enables researchers to reflect on their questioning as they transcribe, to ensure questions are appropriate and not leading. I recognised I did ask questions early in initial interviews. Aware of this, I resisted the urge to question in later interviews to allow the participants time to answer questions in detail.

Barber (2014) recognises that interview schedules may be brief; however, Strauss and Corbin (1998) maintain that experience and knowledge sensitise the researcher to ask appropriate questions that do not rely on luck. Despite

needing some structure and pre-prepared questions, a reflexive approach is evidence that participants guided the enquiry and that concepts presented by them led to an evolving interview schedule (Cooney 2011).

Theoretical sensitivity

Theoretical sensitivity is the ability to identify elements within the data to conceptualize and formulate an emerging theory (Glaser and Strauss 1967). Sensitivity draws on the researcher's personal, professional and experiential history, introduced as significant to an evolving conceptual framework in chapter three. One approach to theoretical sensitivity previously endorsed by Strauss and Corbin (1990) was by engaging with the literature relating to the area of inquiry

Bryman (2008) suggests researchers should not undertake research they may influence. However, I support Kelle's (2007) belief that an approach to collecting empirical data without a theoretical preconception is not feasible. My knowledge and experience from a similar managerial role would not simply produce disjointed and confused descriptions, but empirically grounded theories. A view shared by Charmaz's constructionist belief, central to the conceptual framework.

Ravitch and Riggan's (2012) judgement is like that of Charmaz, recognising alternative explanations and emerging concepts may be missed by those lacking sensitivity. Kelle (2007) considers a justification for adopting a grounded theory approach is the concept of emergence, as a theoretically sensitive researcher can decipher emerging theoretical categories. It is the structured use of the constant comparative analysis and memo writing which Hallberg (2010) believes compels the researcher to remain open to emerging categories.

Data Analysis

Data Analysis utilised coding techniques developed by Strauss and Corbin (1990) and Charmaz (2014) to apply an analytical approach to generate data. Coding examines, breaks down and compares emerging themes to develop categories, that lead to concepts and the emerging core theme. Breaking down and deconstructing data to build new meaning (Strauss and Corbin 1990).

Coding is the pivotal link between data collection and emerging themes (Charmaz 2014).

The term *open* coding is used to describe a line by line approach to the initial phase of the coding process, where meaningful data is identified and labelled. Line by line coding was used in all twelve-interview transcript. Appendix I an example of coding from participant four. Initially, codes were generalised, however, successive coding focused on concepts of interest in the data, leading to properties and categories. Strauss and Corbin (1998), Bryman (2008), Glaser (1978) and Charmaz (2014) describe this process as looking for phenomena in the data that are grouped to make concepts. Open coding of the data on a line by line basis was followed by focused coding, where many codes are reduced leading to categories. Sensitizing concepts were important at this stage to offer a more detailed analytical understanding of the data. Theoretical coding gave form and structure to categories, at this point a story began to emerge before theoretical sorting finally reduces the remaining categories to one theory (Charmaz 2014). I adopted Charmaz's (2014) focused coding approach to constant comparative analysis which is less formal at this stage, removing the rigidity of axial coding proposed by Strauss and Corbin (1998).

Constant comparative analysis

Constant comparative analysis is a continuous process of data collection, analysis and developing categories from incidents and codes until a grounded theory is fully integrated (Birks and Mills 2011). My conceptual framework values the researcher's personal interest and pre-existing knowledge and experience to underpin their perception of how things work. A belief permitting the researcher to decide what is meaningful in the data, leading to unique involvement in the research (Charmaz 2014). Like the second stage of Alvesson and Skolberg's (2009) reflexive model, transcribed interviews allowed me to listen to the interviews while re-reading the transcripts, to check I understood the meaning in the dialogue. This was essential to explain the rationale for why some data was included and some excluded. A word document audit trail demonstrates this process throughout data collection. An example is contained in Appendix D.

Comparison began with the initial interview and continued with subsequent interviews. As new codes and categories developed, they were compared with codes and categories from previous interviews. This process is an essential instrument for raising questions and discovering properties that exist be in the data (Strauss and Corbin 1998).

An example of the comparative approach is identifying P2 from the codes generated from P1's interview. P1 held a nursing qualification and was employed as the organisational lead for Research and Development. Coding revealed a strong identity as a clinical nurse that shaped their leadership approach, determining what was essential to the role and what was not. P1's team was not aligned with their professional registration or clinical experience; they had been in post for seven months. Based on this initial data, the criteria for P2 were for another health care profession, but non-nurse, who managed an organisational team associated with their professional status, who was also newly promoted. P2's selection allowed the importance of identity to be pursued, to understand if its importance spanned professions, and approach to role. The significance of time in role could also be understood, to appreciate its impact on transitioning to a managerial role.

As interviews and data analysis continued, the word documents chronicled the interview data mapped to themes. Data analysis from P1 resulted in 14 themes, these included challenges and opportunities in the role, leadership approaches then and, in the future, identity, and the impact of non-clinical managers. The paragraphs above explain how the constant comparative analysis led to P2. Data analysis following P2 increased the number of themes to 18, with additions including managing friends, resilience, and post graduate level education. This approach continued to P4 where 22 themes were identified. At this point it was possible to recognise similar themes and themes were merged. Appendix D is an example of how by P5 the number of overall themes was reduced. Appendix D reveals how theme 10 identity and theme 11 professional role shared similarities with theme 13 prototypical behaviour and social identity. As a result, they represented one theme moving to P6 of maintain nursing identity with subcategories including prototypical behaviours, social identity, identity, and professional role. This process continued leading to the final 4 categories and

sub-categories discussed in chapter 5. An example of how interview data mapped to themes to support category development and eventual merging of categories is demonstrated in Appendix A. This is an example after participant 7 in relation to the category of maintaining an identity. These documents provided a snapshot for quick reference to understand how each participant contributed to the emerging themes. A cumulative process to further support confirmability.

Memo writing and situational maps

When I began this research, I initially viewed memos as formal written record of thoughts, they were hand written in a journal, and methodical, as the research progressed I made the decision to move from paper memos to electronic notes. As theoretical saturation was achieved, and no new data collected, I realised I had entirely reverted to paper memos and notes. It seems the constant comparative analysis had altered my approach to data collection and record keeping. The creative aspect of memo writing to allow the researcher to see the patterns and connections to developing concepts (Punch 2014) transformed my approach.

Memo writing supported me to engage in the constant comparative process and reflect on the value of the conceptual framework. Ravitch and Riggan (2012) recognise memo writing will contribute to the continued development of the conceptual framework and maintain a focus on my identity and any methodological concerns. Like the third stage of Alvesson and Skolberg's (2009) reflexive model, the importance of memo writing, and situational maps to refine the final questions, was to generate an evidence trail for others to see how each part fits together.

The combination of memo writing, and situational maps enhanced my understanding of the relationships in emerging themes and support a claim for theoretical saturation. I also found situational maps useful. Khaw (2012) describes Situational maps as visual representations of the elements surrounding a phenomenon, to show how the elements relate to one another. Situational maps allowed old connections to be revised and identify new connections. An approach the researcher found useful during times of "*analytic*

paralysis" (Clarke 2005: 84) when fear of analysis, or fear of making early and poor analytical commitments hindered data analysis.

Theoretical saturation

The need for meaning discussed in chapter 3 supports approaching Trust two. There was a need to speak to a manager without a professional qualification, to offer insight into the modern view of leadership in the NHS. As no additional participants from Trust one volunteered, the meaning within the categories for such managers was not saturated. It was essential to discuss the emerging themes with such a manager to resolve any final uncertainties in the data. Monique et al (2016) recognise saturation is not one dimensional and can be declared on many levels. Saturation was achieved in this study as P12 added to the meaning of previous categories but did not present any new information.

Reflexivity

Reflexivity is an essential feature of qualitative research, recognising preconceptions may have influenced my research. The conceptual framework employed in this research recognises an ontological approach to constructing knowledge that I believe to be useful and valuable. It also accepts my personal interests as an essential element in the conceptual framework's development (Ravitch and Riggan 2012). Charmaz (2014) reminds us that just as the methods influence what the researcher sees, so do the influences researchers bring to the study. Reflexivity is essential to qualitative research, and as a researcher I am not simply a passive vessel into which data is poured (Glaser 1978). Sensitivity from previous roles and experience allows me to make assumptions about what is real and relevant and pursue interests relevant to their perspectives. Therefore, it is my responsibility as a researcher, not participants to be reflexive about what they see and how they see it.

Like the fourth stage of Alvesson and Skolberg's (2009) reflexive model, it is also the responsibility of the researcher to consider how the research is written, how material is presented for potential audiences. Grounded theory does not explain the whole of the social context and only presents a snapshot of a specific time. By being reflexive during the research process and producing audit trails and illustrations, researchers create an open approach to data

collection and analysis that can be challenged by others. Evident in this research process when assumptions and claims made in the data were questioned in supervision meeting.

Methods may be the tools applied to data collection and analysis; however, it is reflexivity that defends my conduct in this study (Charmaz 2014). As a previous NHS manager who held a position like that of the sample group, the intention was always to recognise and acknowledge the value of insight and past experiences throughout this research. Indeed, Simmons (2011) believes it is impossible to understand and research a subject without involving yourself at some level. In accounting for pre-existing knowledge and understanding of the research setting, it is important to recognise myself as an "*inside researcher"* (Berger 2015, Merriam et al 2001), as what an insider see's and understands is different from a researcher lacking insight.

Ethical approval

Ethical scrutiny of this research was undertaken by Northumbria university ethics process and NHS Trust committees. Northumbria University (Appendix J), Trust one (Appendix K) and Trust two (Appendix L) ethical approvals were granted. Following this, an e-mail was sent on my behalf by the chief executive's personal assistant in Trust one (appendix M) and Human Resources in Trust two (Appendix F) to both Trusts management groups. These e-mails contained the participant information sheet (Appendix N and O) and a participant information questionnaire (Appendix P and Q). The questionnaires were important from a theoretical sampling perspective as they asked participants to clarify their current role, previous roles and registration with professional governing bodies. To acknowledge participants had volunteered to participate, participants were given the right to refuse to participate and the right to withdraw at any time, this agreement based on full and open information (Denzin and Lincoln 2011).

Full knowledge of the possible consequences of participating in the research was discussed with participants to obtain Informed consent. Participants are aware any data collected from this study will be confidential. The only exception to this confidentiality is if the researcher feels that the participant or others may

be harmed if information is not shared. Participants understood they are free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.

My previous role in Trust one was like participants in this study. Trust one ethical feedback wanted reassurance this would not influence the data collection. The relationship with participants is in this study is academic, not as previous work colleagues, Participants should not feel obliged to participate as the researcher left the organisation in 2011, and the voluntary nature of participation and fully informed consent is clear in the participant information sheets to mitigate against any perceived coercion (Northumbria University 2011).

The British Educational Research Association (BERA) (2018) believe researchers need to devise a specific ethical course of action within their research project to consider consent, right to withdraw, protection from harm and privacy and data storage. In accordance, the ethics application states participants will be allocated a unique I.D number, with names removed from any documents resulting from the research. In addition, all electronic data and data analysis; including the recordings from interview will be stored on the University pass protected drive, with printed documents stored in a locked cupboard on the Universities campus.

The ethical process changed between approvals from Trust one and therefore an application through the Health Research Authority (HRA) was required. The HRA replaced the need for local ethical approval by each participating organisation in England. No issues were encountered during participant interviews; all participants agreed and gave written consent (Appendix R), no participants asked to withdraw their data.

Chapter conclusion

This chapter justifies the grounded theory approach taken to develop knowledge and understanding to build on significant and relevant knowledge that pre-exists in the field of health care leadership. The inductive approach of constant comparative analysis in grounded theory allows knowledge to be generated where a substantive theory is not known. Theoretical sampling

identified twelve participants volunteering to contribute. All twelve were interviewed individually and interviews transcribed verbatim by the researcher. Reflexivity acknowledges my knowledge and experience in the communities and cultures of the participants and adds strength to undertaking a grounded theory approach. This chapter also describes the ethical scrutiny leading to the studies approval. The following chapter presents the research findings.

Chapter Five - Presentation of findings.

Introduction

This chapter presents the findings from interview data and introduces the four categories of managing uncertainty in the leadership role, management capabilities, role conflict and changing the leadership approach. In managing uncertainty in the leadership approach the need to maintain a credible and legitimate professional role identity to uphold a preferred Image is introduced. This category also considers how these influence participants interactions in social worlds and the steps participants take to compensate for managerial uncertainty. In the second category of Management capabilities, the value of transferrable skills from previous roles is recognised, alongside how participants shift their skill set to acquire new skills and relinquish others. The third category of role conflict reveals the pliable nature of middle management roles, alongside the impact of non-clinical managers that can lead to frustrations among participants. The final category of changing the leadership approach explains how participants adapt their leadership approach in managerial positions, and how many access education to enhance their understanding of leadership to build resilience, self-awareness and coping strategies. This chapter ends with a summary of the findings and initial theory development.

Table 4: Participant information Questionnaire summary

Participant number	Current position in the organisation	Time in role	Previous manager positions.	Registered Health professional	Highest academic qualification	Gender
01 Trust one	Band 8 Organisational lead	7 months	Clinical	Registered Nurse (Adult and Chid) (NMC)	MSc	Female
02 Trust one	Band 8 Head of department	23 months	Clinical	Dietician (HCPC)	MSc	Female
03 Trust one	Band 8 - Non-acute role	18 months	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc	Female

04 Trust one	Band 8 organisational Lead	12 Years	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc	Female
05 Trust one	Band 8 - Acute role	2 Years	Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
06 Trust one	Band 8 organisational Lead	7 years	Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
07 Trust one	Band 8 Head of department	2 years	Non-Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
08 Trust one	Band 8 - Acute role	5 years	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc, BSc (Hons)	Female
09 Trust one	Band 8 Head of department	4 years	Non-Clinical Non-NHS	Nil	MSc	Male
10 Trust one	Band 8 Head of department	20 years	Non-Clinical	Audiologist (HCPC)	H-Tec Physiological measurement. Level 4 Management	Female
11 Trust one	Band 8 organisational Lead	4 years	Non-Clinical (Non-NHS)	Nil	BSc (Hons)	Female
12 Trust two	Band 8 Head of department	2 years	Non-Clinical	Nil	MSc	Female

- NMC- Nursing and Midwifery Council
- HCPC- Health Care Professionals Council

Table 4 provides the key characteristics of the twelve research participants. Nine participants held a professional registration, with previous roles in clinical environments. Three did not and were promoted through non-clinical support services. Eleven participants are female and one male. Nine participants held post graduate degrees, with two holding relevant degree and undergraduate

qualifications specific to their role. Participants held their current positions from under one year, to 20 years.

Presentation of categories

Table 5 presents the four categories and their sub categories. These categories represent the key elements raised by participants. For example, category one captures the uncertainty participants experience in the leadership role. The sub categories summarise the measures participants take to reduce uncertainty. Through maintaining a credible professional role and preferred image, and utilising ways to compensate for uncertainty, the sub categories explain how participants manage feelings of uncertainty.

Table 5: Four categories and sub categories to be presented

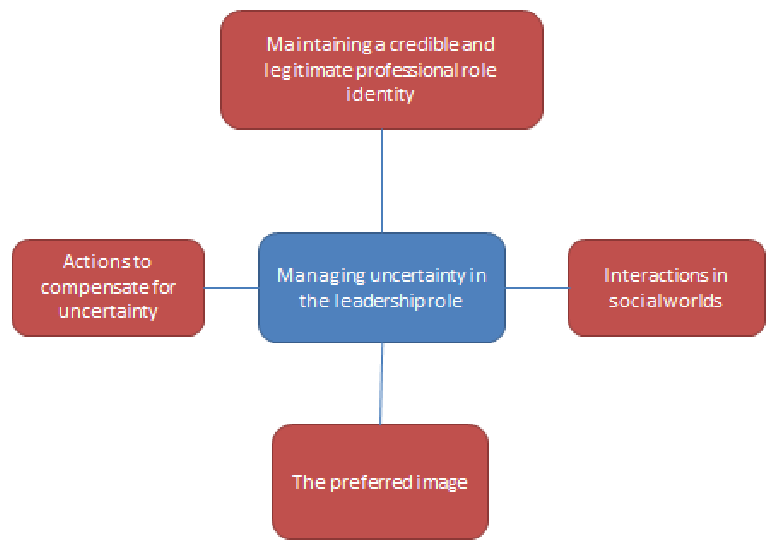
Category number	Category name	Sub categories Key themes	Data provided by participants
One	Managing uncertainty in the leadership role.	Subcategories • Maintaining a credible and legitimate professional role identity. • The preferred Image • Interactions in social worlds • Actions to compensate for uncertainty	1 2 4 5 6 7 8 9 10 11 12 Nil by P3
Two	Management capabilities	Subcategories • Recognising transferrable skills • A unified approach to managerial skills • A shifting skill set	1 3 4 5 7 8 9 10 11 12 Nil by P's 2,6
Three	Role conflict	Subcategories • Middle Management, the pliable workforce • Impact of non-clinical managers • Frustrations with management	2 3 5 6 7 8 9 10 11 Nil by P's 1,4,12
Four	Changing the leadership approach	Subcategories • Modify the leadership approach • The role of education • Resilience; Self-awareness and coping strategies	1 2 3 4 5 6 9 10 11 12 Nil by P's 7,8

Each category will now be outlined. Examples from participants will be presented in the format P1-12 with transcript line numbers.

Category 1: Managing uncertainty in the leadership role.

This category reveals how participants can use identity, rely on a professional image, and maintain previously established social world connections to manage uncertainty in their leadership role. Figure 8 represents this first of four categories in this chapter *managing uncertainty in the leadership role*. The subcategories in red represent the influences leading to managerial uncertainty, with one subcategory recognising the actions managers take to offset such influences. The sustainability of the NHS Itself is in question because of a long-term strategy to secure an appropriately skilled, trained and committed workforce (The Lancet 2017). Within this uncertainty of the workforce, this category recognises the actions managers take to handle uncertainty in individual roles. Managers act as the face of the organisation, seen as knowledgeable and in control while also presenting themselves as credible human beings (Watson 2008). Hay (2014) believe this leads managers struggling with how to be a manager, leading to identity and credibility concerns.

Figure 8: managing uncertainty in the leadership role.



Maintaining a credible and legitimate professional role identity

This sub category reveals how participants can rely on a previously established identity to offset uncertainties in a managerial role. The data revealed that participants support professional identity as an important consideration. Identity was significant to participants', as it provides a source of motivation and knowledge to influence an individual's approach towards leadership. In particular, the notion of credibility:

> *"I think you automatically lose credibility if you're not a nurse or clinician in their (employees) eyes, because you're just another manager and pen pusher, its true that's how people look at them you know"* *P4: line 535*

Although non-clinical managers associated credibility with previous non-clinical roles, they recognised clinical credibility was viewed as superior to their experience, believing it could undermine their role, adding to uncertainty. As P11 a non-clinical organisational lead who is not a registered Health care professional asserts:

> *"I have none (identity) because I am a non-persona that is how I feel in here. Cause I'm not a nurse, certainly I'm not a doctor, so you know I'm not…. I'm not a nurse, I'm not a doctor, I'm not an allied health professional, you're not a clinician, so…..and, and it only seems that people have ever been interested in me because I had a pot of money".* *P11: line 295*

P11 recognises the importance of professional identity in the NHS. So much so, that despite significant experience in organisations external to the NHS, they considered themselves as having no identity in the organisation. In addition, they believed this organisational anonymity diminished their capacity to influence clinical staff. Identity provides a structure for non-clinical managers to underpin the interpretation of their roles. This can be as simple as having a belief in one's legitimacy to manage in the NHS. As further illustrated by P11, looking to recover a specialist identity important in previous roles:

> *"I think I should be classed as a training professional".* *P11: line 335.*

The Importance of legitimacy is managers' reluctance to relinquish previously established credible identities, leading to undertaking roles and responsibilities no longer within their remit. Such resistance to transition can occur if managers

favour a previous identity, perceiving their self-worth is embodied in the past. To preserve and maintain legitimacy participants reported a reluctance to move from previous roles, to actively preserve them to support a solid and credible identity. As illustrated by P2, a dietician:

> *"Leaving the patients is always really hard, I've got a few who will not go to anyone else, they know I still work in the Trust, I'm still registered, I've still got the skills and competence, so that's why I kept them. Now I know the cold hard answer is I shouldn't have, but… but the parents* ***want*** *to keep me". P2: line 164.*

Work Identity can permit managers to adopt alternative personas outside their immediate team of responsibility. As a result, P9 chose to offer a unique insight and perspective within a health care setting:

> *"What I have to try and remember is that what a chaplain brings is a unique insight….he, or she adopts a variety of roles, you know a variety of personas as it were. You can be the clown, you can be the buffoon, you can be the profit, you can be the challenger, you can be the critical friend, you can be the inquisitor". P9: line 336*

Important to legitimacy was participants' reluctance to relinquish previously established credible identities, leading to undertaking roles and responsibilities no longer within their remit. Important, as resistance to transition can occur if participants identify with the way things used to be, to perceive their self-worth is embodied in the past. Despite P1, an organisational wide manager moving away from a clinical role, their priority remained clinical:

> *"I probably have a slightly different priority, because the patient is very much the focus for me, and then my clinical research delivery staff and then the wider financial management, kind of thing, that I probably think about last of all probably". P1: line 206.*

Legitimacy is composed of different elements, clinical competence seen as one important element to protect legitimacy as competencies were acquired over many years of professional practice. A desire to maintain such skills, and therefore an appearance of legitimacy justifies its continued use. For example, P7, a clinical service manager:

> *"I like to keep my skills up, and I also do the occasional bank shift as a nurse practitioner on the urgent care side, because I've trained to that level and it's quite easy to de-skill… I don't want to lose those skills…. I think its good credibility ….staff see that I'm ready to support them, roll my sleeves up. P7: line 265.*

Credibility is important to participants and viewed as essential to their role, as functions of their role can rely on professional expertise. This function was not aligned with their day to day organisational requirements; Participants viewed this as professional leadership, not organisational management. As illustrated by P10, an audiologist:

> *"So, it's not just in the department, I make sure that across kind of national meetings we're there, so as a Trust we have got representation…. If you had a manager that wasn't audiology they wouldn't go to those audiology Head of Service meetings would they, so the Trust would then not be, not be up there with the rest".* *P10: line 458.*

The preferred image

This sub category recognises participants have a preferred image they believe will uphold and maintain credibility, and they actively project this image among their teams and the organisation. For example, for some it was a deliberate decision to wear a uniform and be seen and visible in clinical areas, to use imagery to enforce a preferred and often previous identity.

A uniform was important for participants to convey legitimacy within their role. Within the NHS, the uniform is used to identify profession and seniority. Among the participants, nurses, midwives, audiologists and dieticians all used uniform to revert to their old clinical identity and present a vital nonverbal method of communicating role through power of imagery, and as a reminder to others of their position within the hierarchy. As recounted by P's 7&8:

> *"I put it on sometimes (the uniform) so there's that, that recognition, they notice me more, if I'm going around, because I'll often go round and see how things are" P7: line 730.*

> *"I'll put the uniform on because that signifies to the patients and erm, the GP's that I'm a clinical manager, not just a pen pusher, that I'm a clinical manager, I understand the workings of the teams and the midwives and what they are expected to do, and how that interaction works". P8: line 508.*

Uniform for health care staff has long been associated with role legitimacy, as uniforms underpin status, power and identity (Kucuk et al 2015). For legitimacy, uniforms remain a visual representation of the individual they were in previous roles. Participants lacking previous positions in clinical posts also use clothing to portray a positive and professional image. As opposed to a clinical uniform,

business attire was used to differentiate management roles. As illustrated by P12, an operational manager:

> *"I guess that's a sense of you put a suit on it almost projects something different than if you're just sort of normal, day to day. So, yeah, we don't have a, a uniform in that sense, but there are ways and means of portraying yourself in different ways, by the clothes you wear I guess". P12: line 375.*

Clothing in general projects an image of professionalism, regardless of the individual's role or professional affiliation. P11, a non-clinical organisational manager commented on how clothing altered the appearance of colleagues:

> *"I even look different to my colleagues. In fact, I joked on, I said "am I the only person who doesn't wear a cardigan" I see, I'm sorry for sounding like a snob, but when I go to senior meetings and all the women are sat there. I think, are you the chief exec, you look like you've just come out of the charity shop. And I have always been in a uniform environment where your appearance was very important, because it was part of the professionalism". P11: line 672*

The attraction of wearing a uniform for clinical managers was that it increased their visibility, reinforced their status among clinical staff, to underpin their leadership role. Visibility here is related to a physical presence among staff, more than one that simply communicates legitimacy through uniform. Participants used visibility to be seen and approachable among the teams they lead. Visibility encouraged participants to walk around their areas of responsibility, to listen to the concerns of front line staff, offer solutions to immediate problems and uphold a preferred image to legitimise time spent in uniform. However, during this time the organisation did not stipulate managers wore uniforms, as some do not have this option. Therefore, to the organisational, managerial visibility was key, not visibility to maintain a clinical identity. P3 explains an approach encouraging managers to spend each Friday visible among colleagues:

> *"I suppose, I think….I thought it was removed from the front line, where I have incorporated the back to floor Fridays we have, so I try to do them. I'm very much meeting the teams, so we've put forums there, so I am still visible". P3: line 136.*

Visible presence maintained clinical and professional credibility among colleagues, to remind staff of their clinical significance, despite moving into a managerial role. As articulated by P's 5&6:

> *"Some people don't go on the wards every day, it depends what you have to do so you can have a visible presence, so they can see the leader, so they have clinical respect as well. So, they can say, yeah she did understand, or she can get that". P5: line 552.*

> *"I kind of think that allows me to get out there so people can see who I am, they can see me, not just a name on a board". P6: line 119.*

Visibility used to reinforce a preferred image and acquire respect can have a negative effect on a manager's ability to undertake their core roles and responsibilities. A desire to maintain clinical credibly, to provide a feeling of power and influence was a clear driver for some. Despite acknowledging its outdated approach, as exemplified by P7, a clinical services manager:

> *P7: line 308.*

> *"Maybe I'm old fashioned here because I don't ask people to do things that I wouldn't do myself, and I think that's probably me being old fashioned because you had more respect for your nurse, your managers if they came and helped you with what was going on there".*

Interactions in Social Worlds

This sub category acknowledges that participants can maintain connections with established social worlds to maintain a preferred and professional identity. To benefit from the culture and the confidence of maintaining this connection. Essential components of social world theory discussed in Chapter Two. It is important to understand how individual manager's identities influence their interaction with many of the social worlds they encounter. This is an important consideration in relation to Social World theory, as Van Knippenberg and Hogg (2003) suggest the stronger an individual identifies with a group, the greater the personal motivation to respond to threats faced by the group. This exposes a complex reality; participants may be required to implement organisational change that may threaten the social groups that uphold their professional credibility.

Participants relied on a set of shared values, beliefs, attitudes and basic assumptions to inform their decision making. Participant's justification for their actions in management would often stem from knowledge gained in previous roles. This underlying motivation to associate with specific social groups to support role legitimacy influenced the decisions participants made. To recognise the importance of social identity and its influence on managerial roles, P4 declared:

> *"I said to, when I had my conversation with the manager, erm, I said I worked hard for my nursing, I'm a nurse by background, management has come from within my nursing" P4: line 190.*

Like the authority gained from wearing a uniform, the relationships participants established in their social worlds were an important source of power. Power that must be recognised to reduce the likelihood that managers will use the influence of social groups to bestow legitimacy in undesirable ways. As illustrated by P1:

> *"I did go to all of the nurses and say "look, right somebody needs to do it and I'm prepared to step up…somebody else from the outside might come in….. and not know what they're doing….and putting extra pressure on you lot…. Or, me who knows nothing about managing a department at that level, but at least I know you all, and I know how you all work". P1: line 767.*

There was no evidence in the data that the legitimacy manager's gain from doing this does not equip them with the skills, knowledge and experience to undertake the role. However, it offered legitimacy through offering protection to the team. Through social worlds managers are connected to the teams they lead; this can lead participants to question the decisions they make. Participants' reported a reluctance to make managerial decisions because they see the impact on their staff. For example, P7, said:

> *"They work incredibly hard and it's been, they have had some awful months where you know, I just feel so sorry for them sometimes". P7: line 281.*

Actions to compensate for uncertainty

This sub category explains how participants can take deliberate steps to compensate for a lack of uncertainty by forming connections with clinical teams

and staff. To compensate for a lack of clinical identity, managers from non-clinical backgrounds would build a common identity with clinical staff through sharing the experience of working in clinical roles. An interesting finding in the data revealed that managers who did not have a specific professional background encountered the same struggles as professional staff. P11's response demonstrates how managers can align with the professional worlds of clinical staff, despite lacking the key characteristic off the group's professional identity:

> *"I haven't got the director of nursing (support), but I have the nurses' sympathy when he is having a go at me, because he's having a go at them as well (laughs). So, in that, it's almost as though you are together, in that culture". P11: line 436.*

Participants' recognised these shared experiences could add legitimacy to their leadership. Managers who share a professional registration, or clinical experience with the teams they lead are known as prototypical. Because of this connection, prototypical leaders may be trusted by teams to represent their interests, regardless of their effectiveness as a manager. P1 and P11 used the same terminology to refer to team members support. P1 when referring to team support that was given because of prototypical influences, as opposed to P11 who earned team support:

> *"When I got seconded into it they were all really happy the staff…they were all really happy (laughter) well I think they are, I think they all think that I've got their back". P1: line 782*

> *"I feel like as far as the nurses go I've broke their back". P11: line 418*

Non-clinical managers managing clinical services, but not line managing clinical staff, found alternative ways to build social connections and trust, to understand the role of clinical staff. They did not have the same shared experiences of working in clinical practice, as recognised by P12:

> *"For me you know, they have kind of got that link, you know when there is vomit and cleaning, and whatever, and all that kind of stuff, and they can relate to that kind of experience. You know, obviously when you come in and you can't, you know?" P12: line 415.*

To overcome this barrier, participants had to use alternative approaches to establish their reputation and enhance their right to lead. One approach utilised by P12 was through developing knowledge, while also acknowledging and appreciating the roles performed within the team. P12, a service manager, explains how they used this knowledge to establish a basis for legitimacy.

> *"Well, for me it's just about, erm, just trying to….understand what the drivers are around that particular area, what the policy is…what the direction of travel is and that kind of thing, and what's on the horizon….. obviously by doing that I'll try to advocate for those services". P12: line 176.*

The second method to establish clinical legitimacy is through an active participation in the roles and duties members perform. P's 11 and 12 made time to work alongside clinical colleagues, to demonstrate a willingness to form a connection and understand their role. Not to supervise them as a manager but appreciate the intricacies of clinical care. As illustrated by P12, an operational manager:

> *"I mean they don't just, they want you kind of coming on in your suit, going you know what's happening with that, or blah, blah, blah, there's no beds, blah, blah, blah….. I think it's something you have got to make yourself do, that you are willing to roll your sleeves up and do some of what they, you know even a tiny, tiny portion of what they do". P12: line 438.*

Participants appointed from the clinical environment also maintained clinical links to preserve their membership in social worlds. The data reveals the legitimacy of a managerial position alone at times is not viewed as sufficient for previously clinical staff. This lack of managerial legitimacy compelled P7 to actively maintain clinical links:

> *"I'm their matron and their manager, I haven't done a lot of clinical in resus for a long time, I'm there as a pair of hands, as a nurse. You know I'll go and support them and do what I can". P7: line 294.*

An additional benefit to maintain clinical links for managers in organisational wide roles is an enhanced level of cooperation and collaboration from their peers throughout the organisation. As a result, maintaining clinical links ensures the leadership roles of others deliver their operational objectives.

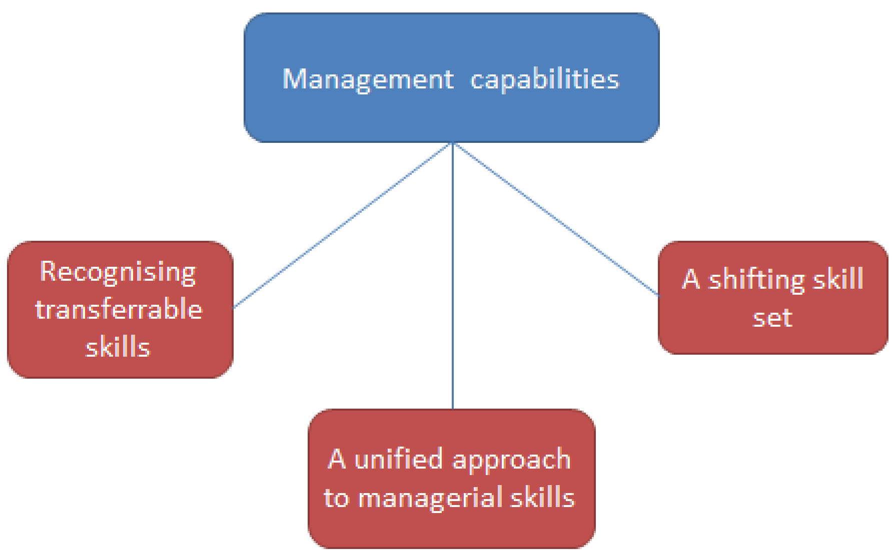
"building all those relationships up with ward managers and matrons, erm you know over time counts for a lot of how I get things done and how people will become engaged with me when I need to get them to listen". P6: line 450

Category 1: M*anaging uncertainty in the leadership role* contains many elements including professional identity, credibility, the importance of the clinical environment, and a preferred identity for participants. These demonstrate how a leader's influence is built on more than organisational title alone. Using the power of identity and social connections to enhance their leadership role. This dependency may compel managers to prolong relationships established in previous roles. Managers from non-clinical backgrounds lacking the professional and clinical characteristics of their team, proactively build relationships with clinical staff to understand the clinical environment, to work towards a shared goal, all with the aim of improving their credibility to lead to the team. This insight has implications for how NHS managers are prepared which will be discussed later in this thesis.

Category 2: Management capabilities.

This category reveals how participants can use transferrable skills from previous roles and shift their skill set. Acquiring new skills with others are relinquished. Figure 9 represents Management capabilities, the second of the four categories to emerge from the data. The subcategories in red acknowledge the influence of management capabilities on managers approach to leadership. Leadership is linked to managerial knowledge; it is an important consideration for leaders transitioning into management roles. Yamazaki et al (2018) consider the public sector a good research site for investigating how individuals become managers, due to ongoing technical, political and economic transitions. However, while Hall and Rowland (2016) appreciate managers need to possess skills to cope with uncertainty and change, not enough is being done to support managers to cope in fluctuating management landscapes.

Figure 9: Management capabilities



Recognising Transferrable skills

Clinical judgement to support decision making

This sub category reveals how participants transfer skills acquired in previous roles to managerial positions. One important skill among participants was decision making. Clinical judgement to support decision making was important

to inform leadership decisions. Participants believed clinical judgement developed in clinical roles was an important transferrable skill in managerial posts:

> *"So, there are aspects of the job that are really easy for me, so I can look at the protocol and the costings and say yeah, yeah, yeah I can make those kind of clinical judgements really easily that they (managers without clinical experience) might struggle with". P1: line 297.*

P1 believes clinical knowledge aids managerial decision making, as both occur in a health care context. While this may provide some justification, clinical knowledge is not equivalent to managerial knowledge, and managerial experience is needed to guide managerial decision making. In effect, it is not decision making aided by clinical judgement that manager's value, but clinical knowledge and expertise, which are seen as credible. As articulated by P3:

> *"Clinical element gives me that foresight and the underpinning knowledge to manage some of those issues and manage some of those complexities of the job. If I didn't have the clinical element I wouldn't be able to support the staff as well, as I can". P3: line 220*

Participants believe the transferrable skill of understanding the clinical system allows them insight, because it helped to assess the clinical impact of decisions they make. Having worked clinically they understand how a managerial decision will impact front line staff, in a way non-clinical manager cannot. In addition, the importance of clinical knowledge as a transferrable skill could simply be a result of a health care culture dominated by clinical experts. Clinical knowledge alone therefore ensures credibility to provide authority for managerial decisions among clinical staff. For example, a clinical service manager, P8 said:

> *"It's the clinical knowledge component which sort of, I think is the key driver for, for my leadership and the way I manage the services. I think you have to have that underpinning clinical knowledge, erm; otherwise it's hard to understand how it all interacts". P8: line 131.*

Participants highlight that clinical knowledge provided a known and trusted subset of information to support decision making. Although the decision making process stemmed from a clinical environment, the process can be used to make sense of complicated and incomplete managerial information. P1

acknowledged their current area of responsibility is not a clinical area. However, they had clinical knowledge they could apply to resolve managerial problems:

> *"For me, it's the only way I can make any sense of it in my head. So, I think that in patient safety and complying with you know legislation, and trust policy and things like that if I managed it the same way that I managed a ward….. and I think that if I manage it like that…. (A) it makes sense to me in my head, and (B) were not going to fall out of Trust policies" P1: line 214.*

In contrast to the value of clinical judgement, non-clinical leaders spoke of making decisions in a context of competing goals and objectives, focusing on efficiency and productivity. This view alone would underestimate the complexities of health care management which is influenced by more than just the delivery of patient care. Consequently, leaders must react to competing managerial and clinical priorities. Participants' spoke of transferring skills and knowledge from previous positions, regardless of role and context, and that non-clinical managers would view their knowledge and experience as equally important as clinicians do theirs. By way of contrast, P9 explained how experience gained in education was applied to health care:

> *It's like when your teaching kids algebra, you show them how, you work out how to get the answer…..That is still how I work, or try to work with staff, you know it's about gather your facts, what's the situation, what are the options, now how do you want to take this forward, rather than me saying this is what you have to do". P9: line 364*

Those leaders that had experience from roles other than the NHS recognise the transferability of skills and knowledge. Despite their experience not aligning with a health care organisations clinical norms and cultures, they recognise the value of generic skills. As an example, P12 recalls the value of previous experience of managing staff when moving into a managerial role in the NHS,

> *"I feel like I had some good, some foundations to trans….to transfer. Lots of transferrable skills and knowledge which really helped coming into the operation role. You know cause it ticked off some of those boxes around how to deal with staff. Which is obviously a massive part of the job". P12: line 76*

Participants with previous NHS roles identified experience of prioritising patients as a strength to inform their managerial role; however, this transferrable experience can lead to complacency when considering the severity of

management decisions. Participants spoke of developing a sense of immunity to stressful bureaucratic situations, believing no managerial decision had the intensity and stress of decisions in clinical care. However, participants were aware this may be a weakness, as complacency may lead to a failure to recognise the severity of the decisions they make. For example, P1, compared decisions made during clinical emergencies and management:

> *"You kind of just go into autopilot in an emergency situation on the ward that you've done it so many times, although its stressful you kind of know what you're doing and you do it, and again…again here I suppose if there's an emergency or deadline, I suppose I'm….if somebody rings up and says something has gone wrong, I'll say right ok then that's fine, take a breath, let's think about it, has the patient died, no, then we're alright". P1: line 595.*

Participants recognise that all leaders make decisions. However, in this instance the response to clinical decisions usually follows an agreed protocol or pathway, clinicians are taught to respond to emergencies in a structured and specific manner, similar to situational leaders taught specific responses to specific situations.

A failure to acknowledge skills with no links to clinical practice acquired outside the NHS is important, as experience gained in previous roles influences a manager's leadership in the NHS. Participants report skills acquired external to the NHS are valued less than those acquired during NHS careers. P9 a hospital chaplain, and P11 a Learning and Development manager were recruited from outside the NHS. P9 explains a lack of skills recognition is not an issue specific to the NHS. When P9 moved from role's in education to the church, they experienced the same lack of skill recognition as participants recruited from outside the NHS:

> *"When you are ordained as a curate you are…. you have no responsibilities, no leadership, you are treated as though you know nothing. So, at 36 year old, it was as if I knew nothing". P9: line 50.*

P11's experience was similar moving from another public service. In that service, a hierarchy based on professional status and experience did not diminish their influence and impact. However, moving to the NHS, the clinical hierarchy and power of professional expertise dominated and diminished the

effectiveness of skills acquired elsewhere. The clinical hierarchy within the NHS reduced their effectives, impeding one line of recruitment aimed to deliver effective leadership:

> *"Public sector to public sector….the culture is so very different here, so very different, and whilst I had the management skills, it was so very different, it was almost like they didn't want the new girl coming in, and bringing her silly new ideas, because we have done it like this for years (laughs) and it might not work, but we have done it like this for years. So, it really, really was a culture shock". P11: line 83.*

A unified approach to managerial skills

This sub category reveals how participants attempt to acquire a unified set of managerial skills to build overall capabilities. It also recognises the value of coaching to support this development. Participants showed a broad range of previous skills to reflect the diverse functions NHS managers perform in their roles. Participants' reveal a lack of one clear skill set among managers to underpin capability is a constant cause of uncertainty. A limitation overcome through acquiring new skills and recognising previously developed skills may no longer be appropriate. My finding acknowledges the limitations of applying clinical knowledge to managerial roles, a limitation participants from non-clinical backgrounds recognise when comparing nurse managers to what P11, a learning and development manager, refers to as "*proper managers and a proper management programme":*

> *"We have a lot of managers who don't manage, because they haven't got the skills, because they haven't been on a proper management programme" P11: line 658*

> *"I see a nurse as having a fantastic career, fantastic skills, in, dealing with medicine, dealing with patients, da,da,da . but, if you just pluck them out of their environment and sit them in a manager's chair without the training, without the support, without the mentoring and the feedback, so that's what I mean by a proper manager". P11: Line 760.*

P11 is highlighting the significance of context when referring to *proper managers*. Recognising health care professionals are skilled and capable in health care roles, but this training and experience does not equip them with the skills to manage. The important question to consider is what are the essential leadership skills for health care managers? The skills identified by P3, an

integrated community team manager with a health care background, are both generic when striving to comprehend the health care context, and specific within their areas of responsibility. For example, P12 focused on the following managerial skills:

> *"It was kind of things like finance, erm…..just things like using data and writing business cases, erm, you know writing that kind of language". P12: line 104.*

Culture and context do not require a unique skill set, but they did reinforce the need for the same basic skill set among participants. Skills include, communicating with staff, planning and managing employees' motivation and commitment.

All participants held (AfC) Band eight middle management posts, for seven of the participants'; this was their first strategic management post. Participants underlined the lack of a unified approach when making this move, reflecting on how they responded to a lack of direction. As explained by P7, a clinical services manager:

> *"As a service manager I would probably say I've blagged it a bit, and a lot of us have, we can do the Matron part very well, the service manager, we've, we've learnt to do it through mistakes sometimes". P7: line 226.*

Participants want to be seen as competent and focus on managerial skills to boost their confidence. Comments from P5 however reflect the need to maintain a non-managerial, clinical identity. Participants associated financial management with a business identity, and despite holding a managerial role and acknowledging the need for financial awareness, they view finance as peripheral to their professional identity, not an essential constituent of a role to support colleagues:

> *"I think you do have to have a financial awareness, especially in this Trust because that's a priority and that's a shame…. have to be aware of it because of the budgets, and I have to make sure the ward managers are in line with that….but I would do the bare minimum of that, because I would never see myself going into accountancy or the business side of it. I'm a humanistic person; I need to be around humans and not numbers and calculators". P5: line 418.*

Some participants valued the need for training to develop an understanding of changes to health policy and adapt to health care management. This knowledge was not crucial to their managerial role but was essential to support a strategic leadership role. For others, this knowledge was not important, continuing to view clinical skills and knowledge acquired in previous roles as sufficient to undertake a managerial role, dismissing the need to develop a different set of managerial competencies.

Coaching supported participants to improve their personal effectiveness and acquire the competencies to be effective in their role. The primary motivation participants gave to seek coaching was to improve managerial knowledge in areas such as finance. As highlighted by P3, a community based manager:

> *"I was asked….what did I need, I said I need some business mentoring. So, I had a lot of finance mentoring at the time with the finance director…. Erm, and I've kept that up as I knew that was the side that I couldn't do this without understanding*". *P3: line 274.*

While participants from clinical backgrounds sought in-house coaching for managerial skills. Participants sought educational programmes to support leadership, realising the value of coaching offered through leadership development courses, or as part of a Post graduate education level leadership programme, a popular option to fulfil the role requirement for Master's level study.

Later in this chapter, the discussion focuses on how participant's leadership approach may have changed from previous roles. Participants were not only in receipt of coaching, but also used coaching to support members of their team who considered them leaders. P7 revealed a change in their approach to coaching on leaving the clinical area. Previously, in a clinical role they took a supportive approach, enabling staff to develop their own approach with guidance and assistance; however, they now use a more directive approach in a managerial role, reducing their level of support and directing staff how to perform:

> *"This is how I expect it to be, you know, you did this, that was great, however this is how I expect it be done from now on…. So, I'm , I show people how to do it, give them that support, I do bit of coaching, I do coach them". P7: line 380.*

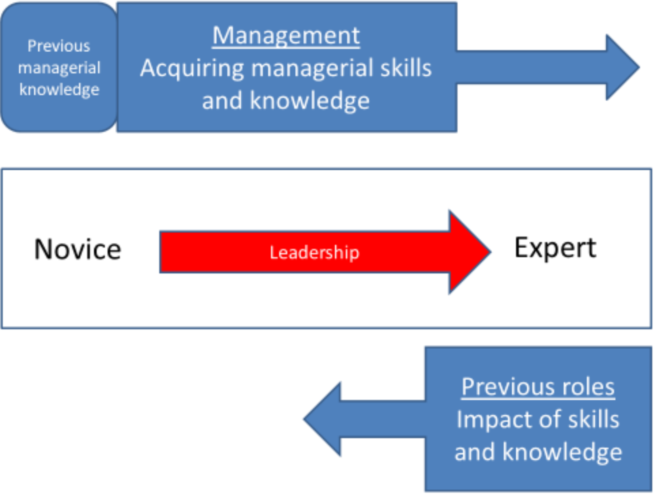
Participants found difficulty acting as a coach and developing staff they know on a personal level. Many were previously part of the teams they now manage. As a result, participants place within the social world changed; relationships with friends were no longer simply personal or professional, participants were now responsible for friends' performance. To facilitate this move, a change in relationship was necessary to establish the parameters of a new relationship. As explained by P10:

> *"I think at the time you want to be everybody's friend, but then you learn you can't be everybody's friend, and you have to manage them, and I think that was probably the biggest learning curve of having to take a step away and say, I have to manage them, I can't be their best mate". P10: line 164.*

A shifting skill set.

This sub category acknowledges that while participants acquire new skills, they also relinquish others they cannot sustain. In the main, those linked to clinical practice. Figure 10 is a pictorial representation of how participants identified an increase in managerial skills, alongside a reduction in previously acquired clinical skills. Clinicians may possess some managerial skills above that of a novice, Clinical skills however cannot be effectively maintained in a managerial role, and while they will never return to a novice state, a reduction must be acknowledged.

Figure 10: A shifting skill set. (Adapted from Benner 2001)



As Participants move from previous roles requiring a specific skill set, into formal managerial roles, they experience an offset in competence. P8 manages a clinical speciality they had previously worked in as a clinician. They reflected on how a focus on managerial roles led to a loss of clinical competence:

> *I was known as a ward sister and a labour ward operator I was at the top of me game, you know I knew that, but when you become detached, and especially with the complexities and changes in health care, it changes….you don't forget the process, it's the paperwork and everything else that changes, guidelines change" P8: line 547.*

Participants spoke of feeling unprepared for managerial roles, with uncertainty resulting from not possessing the required competencies. As illustrated in figure 10, participants moved in both directions of Benner's model until reaching an acceptable balance, moving between novice and expert gaining managerial skills, and between expert and novice with a loss of clinical skills. An uncertainty P1 was mindful of when moving from a clinical to organisational role:

> *"This is what I really struggled with, that novice to expert…I've gone right back to the beginning". P1: line 250*

The loss of clinical/professional knowledge associated with a professional registration is significant. For example, three participants were midwives and because of moving into managerial roles, they could no longer continue as supervisors of midwives. In these situations, they recognised a change in role from clinical/technical proficiency to focusing on managerial development. Despite this loss, they continued to support women during labour; however, their capability to continue with this was uncertain. A challenge for P8, for example:

> *"It doesn't say that I can't be (a midwife), because during the times of escalation I have put my uniform on, but I'm very careful because you lose your clinical skills…I can go and deliver a baby, that's not a problem, but if I go to help I have to help on the areas where I still have the skills". P8: line 546.*

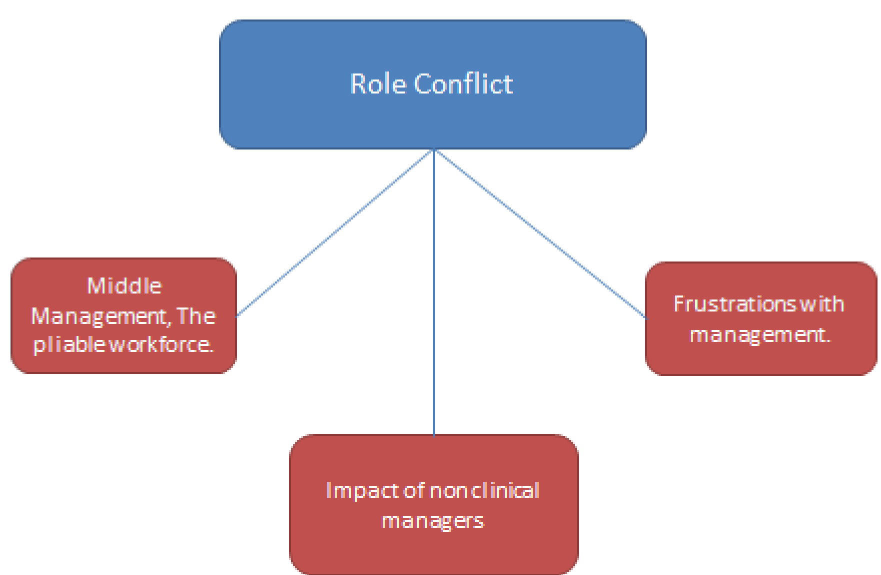
Category 2, *management capabilities,* reveals how skills developed in previous roles are viewed by participants as transferrable to managerial posts. The distinction between managerial decisions and clinical decisions based on clinical judgement exposes a complex reality, one where managers lacking

appropriate managerial skills have no option but to apply an approach to problem solving developed in clinical practice. Managers without NHS experience do not consider this a disadvantage, however, those with NHS experience value it.

Category 3: Role Conflict

This category explains how the pliable, and at times ill-defined role of middle managers, alongside the impact of recruiting non-clinical managers to middle management roles can lead to frustrations in management among participants. Figure 11 represents Role conflict, the third category to emerge from the data. The subcategories in red acknowledge the tensions confronting managers positioned between the staff they lead and the organisations executives, a position requiring flexibility and adaptability. Role conflict is identified as one of the main constructs leading to role stress. Role stress is defined as the degree to which expectations of an individual's role are dissimilar to their values, expertise and abilities (Gauri 2016). Furthermore, Aninich and Hirsh (2017) demonstrate that individuals who move into roles of higher power, such as managerial roles, are more likely to experience role conflict. Particularly those in middle management positions, caught between demands from superiors and subordinates.

Figure 11: Role Conflict



Middle managers- the pliable workforce

This sub category reveals how an ill-defined role and the opposing needs of clinical teams and strategic objectives can lead to a conflict of role and priorities. The research sites add to managers' uncertainties with subjective

language leading to confusing titles that may not accurately reflect managers' roles in the organisation. P5 spoke of the title Matron and clinical operation manager used for the same role, while P7 said they were both the Matron and clinical service manager. Participants felt these vague titles permitted the organisation to modify their role and position in the workforce. An approach recognised by P8, who's title was clinical matron, although they believed their role reflected the responsibilities of an operational service lead:

> *"I'm probably a service lead……Matron is a title that is not really community based title, for me Matron is very much, erm, signifies …..your standards of cleanliness, erm, you know, everything that was classed under a Matron, but I think they just lumped titles onto different people because, of course there was no additional funding". P8: line 90.*

In health care the hierarchical structure results in directives from above that may oppose the needs of team members, such opposing forces create conflict for individuals in their roles. Conflicts that may lead to the hybrid role, as explained by P11:

> *"My manager demands one thing of me, and the managers demand that I hit financial targets x,y,z which you would expect, but what my team like is that I give them the personal time and the personal attention". P11: line 542.*

The hybrid role was defined in the chapter two to describe middle managers caught between the opposing demands of upper management and clinical staff. P5 described this role as a *bridge* between higher management and clinical staff. While P6 describe the role as a *balancing act* to deliver strategic objectives while maintaining a clinical service. P8, a clinical lead and operational manager articulates the difficulties with a hybrid role:

> *"I feel sometimes like I'm the meat between the sandwich, and I'm sure that all managers in my position, that middle management line fully understand the stressors and the issues going on within the clinical field". P8: line 252.*

These opposing demands allow managers to choose the focus of their leadership attention. Some see their priority as strategic, supporting patient care through managerial actions, while others prefer to remain focused on clinical care. P's 6&7 expose the complex reality of NHS middle management that can lead to uncertainty. P6, prioritising policy, while P7 prioritises patient safety:

“My role is actually about providing strategic policy development and offering assurance to the board, that kind of thing, rather than the day to day clinical issues”. P6: line 28.

“You know the performance in ED (Emergency Department) is the focus, but I need to make sure that patient safety isn’t compromised as a result of getting those breaches. And that’s where sometimes the role that I’m in at the minute, you know, the Jekyll and Hyde”. P7: line 758.

Impact of non-clinical managers

This sub category reveals how participants can view the managerial capabilities of non-clinical managers as positive, while also recognising the limitations of these individuals lacking clinical experience. The data revealed Participants’ viewed recruiting external managers positively but also with reservation and concern, recognising the value of business skills as a positive, while a lack of understanding the complexities of health care troubling. P’s 2&3 offering justification for these divergent opinions:

“Yes, they (non-clinical managers) absolutely could, and a lot of what we do now….we are so financially driven now at (Trust named) our work is integrated business planning, its monitor, its finance, its budgeting its service lines” P2: line 132.

“I think sometimes they (non-clinical managers) struggle with the understanding of it (health care), and the complexities. P3: line 378.

The triumvirate is based on a triangle, with a medical lead, general manager and clinical leader at each point; to provide an overall approach to management and leadership within a defined clinical speciality (Haines and Mackenzie 2010). Triumvirates combine the best of each professional skill set, sharing a sense of purpose without fear of conflict, driving performance within their organisations (Moore and Buchanan 2019). The triumvirate ensures the appropriate knowledge and expertise is utilised to inform decision making. P10 recognises the triumvirate permits clinical leads to focus on clinical issues, while operational managers focus on management. An approach enabling P7 to priorities clinical care over management. P5, a clinical operational manager summarises the approach:

“Here they have a triumvirate, they have a clinical lead that’s medical, they have a senior nurse and they have a business lead, a business manager, so I think that kind of

works well because you have the clinical element feeding in all of the time". P5: line 320.

The impact of non-clinical managers to the triumvirate approach is highlighted in out of hours management structures. On evenings and weekends, on-call managerial responsibility are shared across the clinical directorates and triumvirates. One manager has overall responsibility, with the support of a clinical lead. P3 observed that non-clinical managers would often rely on the clinical lead to approve decisions related to clinical care. Whereas mangers with previous clinical knowledge had the confidence to make an independent decision. An observation supported by P5, agreeing managers with clinical backgrounds were more effective on call, suggesting:

"Someone with a business background making clinical decisions it's a bit difficult". P5: line 502

A surprising finding in the data was support for the triumvirate approach because of conflicts among clinical professionals. When clinical professionals are not led by an equivalent professional, this may be viewed as a weakness by the team, as the beliefs and values of both may not be comparable. An example offered by p10, an audiologist:

"I kind of think, some of my worst managers have been clinical managers, because they come with….well let's say its nursing background, so it's all really nursey based, so they are not really interested in our side of things…..So we have come off worse when we have been under nurse managers". P10: line 647.

Participants' recognise the uncertainties they experience are witnessed by the teams they lead, for example, the conflict that results from the need to deliver targets while supporting clinical care within financial constraints. Therefore, participants acknowledge junior team members were reluctant to seek promotion, having observed participants working patterns and behaviour. To remedy this, the triumvirate approach can also support succession planning. For example, P5 a clinical operation manager and lead cancer nurse has witnessed the decline in staff applying for promotion:

"We have a shortage of people now……when I was a junior staff nurse you aspired to be a clinical sister, or a ward manager, or something like that, I don't think people do

now, I think people see the pressures that are on them and what they have to adhere to and they are not interested. And already we're starting to see we're getting less and less applications". P5: line 585.

Frustrations with management

This sub category reveals how opposing cultures among clinical and non-clinical managers can build frustrations in participants, with presenteeism used as one approach to manage frustrations. The data revealed participants were frustrated with several organisational structures and practices, including the organisational culture and workload which added to uncertainty in their role. Participants from non-clinical backgrounds reported feeling frustrated, unsupported and undervalued with a professional hierarchy in the organisations culture that supressed their influence. As illustrated by P11 who was appointed to coordinate training from an organisational perspective, but found nursing staff acted independently when determining their educational needs:

> *"I think I should be responsible for all training in the Trust, but I'm not…..I've come in the Trust and they have said, no, you can't be responsible for….and then they (nurses) go off and do their own things". P11: line 335.*

Such opposing cultures supress the skills and knowledge acquired elsewhere and leave non-clinical managers feeling undervalued. Interestingly, despite a lack of engagement from nursing staff, managers in clinical areas report a lack of time to provide education and support. As indicated by P5 who unknowingly contributes to P11's frustrations to support clinical education:

> *"I think we lack certain things that would really help, for example team work training within a ward or within a clinical environment. I don't think we have the time to provide the education and support". P5: line 605.*

Participants recognised presenteeism as a frustration in the organisation. Presenteeism refers to individuals who are pressured to be present at work, working above contracted hours. The pressure to remain at work can be two-fold. Firstly, because of the volume of work participants must complete that cannot be accomplished during a standard working day. As demonstrated by P8:

> *“it’s when that balance is wrong and everybody sees you running around…..you’re getting stressed, you’re getting frustrated, they can see, you know people have said to me “what are you doing here at 9 o:clock at night” that kind of thing”” p8: line 418.*

Secondly, a culture that expects managers to work extended hours to lead a service, regardless of whether they are accomplishing any meaningful work. For example, P5, a senior organisational lead:

> *“The expectation of higher managers, the clinical directors is that you will work whatever you need to work…I’m not prepared to come in unnecessarily and work till silly o: clock. I do if I have deadlines that I have to meet. I will come back in, but I think there is the expectation when you get to a higher level that you will do stupid hours” P5: line 312*

Presenteeism can permit participants to offset role tension, as extended work hours removed the anxiety of underperforming in their role. Adopting this approach, participants recognise presenteeism can be self-inflicted, working constantly to cope with the anxiety and apprehension of leaving work to accumulate, which denies them the detachment from work to convalesce. P8 explains how they justify working extra hours to reduce the anxiety and pressure of completing an unrealistic workload:

> *“If I don’t take my works phone on holiday, you come back and you’re inundated, it’s like a title wave. I can feel the anxiety….on a Sunday night before I come back. I can feel it, Oh, what am I going into, you know 300, 400 e mails sitting, and with the best will in the world trying to manage them it’s just so hard, trying to manage them and its overwhelming”. P8: line 412.*

Ultimately, the use of presenteeism to cope with role tension can lead an individual to succumb to pressure of overwork. Whether it is the stress of managing uncertainty because of role identity, credibility, competence or tension, presenteeism may not be achievable in the long term. As P2 discovered:

> *“Unfortunately, it’s all too high (workload), and then working to that performance level…..and yeah I went pop. I had burnt myself right out”. P2: line 564.*

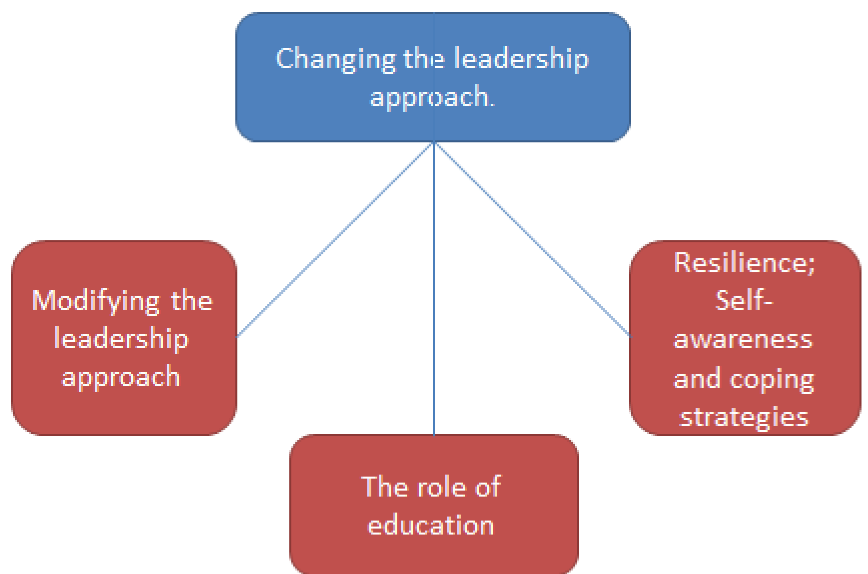
In category 3, Role tension recognises the opposing demands from organisational executives and clinical teams. Demands that may conflict with a participant’s previous identity or the needs of the teams they lead, demands that

leave participants frustrated as they struggle to appease both groups. A struggle that can lead to presenteeism and working above contracted hours. The impact of non-clinical managers in clinical environments was also considered, including their influence on a changing NHS managerial structure.

Category 4- Changing the leadership approach

This fourth category reveals how participants can change and adapt their leadership approach and acquire knowledge through education to build resilience and coping strategies. The subcategories in red value the role of education to support participants' development through academic study, or organisational learning and development programmes. It will also acknowledge the significance of building resilience in participants and their teams, while recognising how participants modify their leadership approach transitioning to management roles. In a study by Stanley et al (2017) identifying clinical leadership skills, two skills were identified above others, those of clinical competence and excellent communication skills, while management skills scored low, supporting the need for clinicians to change their leadership approach in managerial contexts. A change of approach supports uncertainty by adding to managers' resilience, an essential attribute according to Chada (2018) for leaders to cope with the pressure of a changing NHS.

Figure 12: Changing the leadership approach



Modify the leadership approach

This sub category recognises a change in role, responsibilities, context and environment require participants to modify their leadership approach.

Participants acknowledge managerial roles require a change in leadership approach. Whereas previous clinical conversations may have been informal and suggestive, managerial conversations are more directive. P5 explains this shift, and why they have adapted their leadership approach to follow up conversations with written instructions:

> *"I think because there's so much pressure now in this type of role and there are so many standards that you have to adhere to, sometimes you haven't got the time to be that caring, nurturing person, yes you can still do it, but I think you have to be more direct….Now I follow up conversations that I have with ward managers with letters that stipulates everything that I expect and how we are going to get better standards and better quality of care, which I never had to do before". P5: line 140.*

It is not surprising participants ensure an audit trail exists to document conversations with staff, to evidence what previously may have been casual and informal conversations, as the purpose and function of their role has changed. For many participants their leadership approach was influenced by a career in clinical care, the focus then, a personal interaction with staff. However, as managers their role now directs clinical staff in providing care, their role has moved from providing to enabling, a shift in identity, ideology and priority that some struggle to accept. As demonstrated by P1:

> *"I think it's probably that I don't want to change. I like….I think and that's another conflict that I have is that I see this very kind of, erm, paperwork, paper driven kind of job, that is all about paper and reports and going to this meeting and reporting to this person, and I think in my head I don't think that that's important. Well I think it is important, but I struggle because it's not important to me". P1: line 628.*

As participant one suggests, adapting an approach developed in the context of previous roles can be both beneficial and problematic. Participants from clinical backgrounds repeatedly emphasised how their approach to leadership was grounded in clinical care and clinical practice, supported by P's 1&3:

> *"I think, you know I think it goes back to being a nurse doesn't it, it's about that clinical management isn't it, like when you're on the ward you do need to know what everyone else is doing, as well as what you're doing". P1: line 326.*

> *"I'm a nurse by background; management has come from within my nursing". P3: line 190.*

Interestingly, while clinicians viewed clinical experience as an advantage to support decision making. Participants' from non-clinical backgrounds also viewed clinical experience as an advantage. Therefore, when non-clinical participants discussed their role and influence they were comfortable viewing themselves as managers rather than leaders. Choosing to see clinical staff in their teams as leaders, their role aligned with managing and directing. Acknowledged by P12:

> *"I'm not sure if people see me as a leader, I don't know it's more. Like I said the clues in the title and I'm operation services manager". P12: line 298.*

Decision making is central to leadership and was earlier recognised as a transferrable skill, despite some confusion over the use of the term when considering managerial decisions. However, the ability to make autonomous decisions on a regular basis in health care could offer justification for some participants to easily adapt their leadership approach. Decision making is dependent on context, and despite a change of role, the context remains health care, a position supported by P6:

> *"So you kind of got used to having that level of responsibility and making decisions about things……I've always felt able to make decisions without having to go back and ask people all the time". P6: line 45.*

Context is an important finding in the data, as participants from outside the NHS also referred to previous leadership roles when discussing their influence in current roles. Despite the context changing to health care, an established and known approach to leadership remains useful. For many clinical participants, the reliance on transformational leadership in a clinical career, instilled a transformational approach. However, in management, some consider this transformational approach unrealistic and not applicable to a managerial context. Requiring a more directive leadership approach. As illustrated by P's 6 and 9:

> *"I think the theory is great and it makes total sense to me, but the harsh reality is you don't have time to be a transformational leader because, because you don't have that time to sit back and reflect on what needs to happen and where you need to go…P6: line 520.*

"Oh, yes I recognise it, and I know I am doing it (directive approach), but I'm doing it for the right reasons. It's a case of, a case of, no, this is, you've been asked to do something, this is something that we have asked you to do…… now please get on and do it". P9: line 198.

Several participants recalled the impact of micro-management within a health care context, seeing in others an ineffective leadership style they did not want to copy. Recollecting managers who had scrutinised their work and reduced autonomy, participants' where conscious not to duplicate this approach. Because of these experiences participants actively refrained from appearing to micro manage staff. Experiences recalled by P's 2&6:

"They micro managed us and it was hideous and we hated it…., what I've tried to do is flip that on its head so that I am giving people that autonomy". P2: line 331.

"I have had a line manager that tried that with me (micro managing), and I found it very frustrating and very claustrophobic, so that's when I left….It was always what you doing now, you don't want to do that, you want to do it this way, and I did find that really suffocating". P6: line 68.

As micro-management focuses on the process by which a task is completed, it is not an approach affiliated with one building autonomous teams through motivation and vision. However, it is important to recognise participants hold positions that require team members to fulfil their responsibilities and deliver tangible results. Therefore, managers' actions could be misinterpreted as lack of trust in their team, whereas they may be seeking transparency and reassurance that team members are performing as expected. A distinction made by P9:

"If somebody said to me that's micro management, my question to myself would be "what has this person got to hide" If I'm working with professionals, as I believe I am, then a professional should be able to say on any particular day, this is what I did, and it will stand up to scrutiny, then there will be no question of me saying, why did you do that, and that's not micro-management". P9: line 642

The role of education

This sub category reveals how participants viewed education as a means to acquire knowledge to develop and adapt their leadership approach. Participants previously recognised education as an important source of coaching, to improve

their personal leadership abilities. Here, Post-Graduate education provided an opportunity to understand their role as leaders in the wider NHS Trust, no longer accountable for providing clinical care, but for overseeing its delivery. Ten of the twelve participants held an MSc. The data reveals health care managers are moving away from traditional clinically focused MSc pathways to programmes that focus on leadership and management. This move may reflect participants accept leaving a clinical career, despite the need for many to continue to associate with previous clinical identities. Participants also felt they had saturated their knowledge base from a professional stance. P's 2&6, who both hold post graduate degrees support the notion of saturation, leading to undertaking non-professional programmes:

> *"So, you get to a point where other than your clinical practice you can't go off and do any further training, unless something weird and wonderful turns up. So, people have to grow otherwise they become stale. It's certainly helped me to look at where people can go wider and do different things". P2: line 647.*

> *"I kind of got to where I wanted to be. You can go on as many courses as you like, but you don't really get any extra knowledge……..and so I felt that I wanted to do something different for me and my own development". P6: line 171.*

To enhance professional knowledge and skills, by far the most common Post-Graduate degree participants undertook was focusing solely on leadership, to better understand their role and explore the organisations expectations of them. For example, P4 chose a leadership programme specifically to seek this clarity, to understand how behaviours natural to them were conceived as leadership attributes:

> *"So, I looked at the leadership, looking at the skills, because if I wanted to do something I wanted to do it well, and I wanted to look at the different facets, and although people said I was a good leader I didn't really understand what that meant". P4: line 482.*

Leadership development programmes aim to develop skills and attributes for effective leadership. Competencies are not aligned with clinical knowledge and task development, preferring to focus on individual's self-awareness, advocacy, empowerment, decision-making and communication. Eleven of the twelve participants had experience of leadership development in their career. Ranging

from simple in-house personality tests to regional development programmes. Ten were within the NHS, one within another public service. Only P9 had no experience of leadership development. Instead, recognising the value of work experience over development programmes:

> *Yeah, you can be a great leadership guru, in theory, in terms of all the theory, you've got them all at your fingertips, but actually leadership comes down to how you act when you are placed under pressure in a particular situation". P9: line 270.*

Participants transitioning into management roles will adapt their approach within the context of a new role. This can lead to questioning old approaches, or recognising new challenges lead to modifying their approach moving forward. P1 realised it was acceptable to show your limitations and vulnerabilities as a leader:

> *"It's actually taught me that it's okay to be vulnerable, and to show that vulnerability, and actually that's the side of a good leader, that you show that. You know that you put your hand up and say….I'm really not afraid to say I don't really know what I'm doing, but I'm going to find out". P1: line 822*

The future of NHS Leadership Development Programmes is uncertain; a decline in supported studies from the NHS may see the cost of post graduate study exclude some managers from attending. This may result in an increased use of in house organisational programmes. If so, it is essential whatever approach they take the programmes meet the needs of NHS managers. Ineffective programmes will not lead to certainty in manager's abilities: for example:

> *"It was very, very badly run, they were using a lot of external speakers, and erm, honestly you weren't getting anything out of the session. you were sitting there, and it was a lot of people telling you what they had done in their lives, but nothing that you could think, I can relate to that, I can do that, so everyone really dropped off really quickly. It was very poor". P10: line 285.*

Resilience; Self-awareness and coping strategies

This sub category understands how participants build resilience and coping strategies as part of a developing and modified approach to leadership. As an example, presenteeism was previously identified as an approach to deal with frustrations with management, it can also be viewed as one of many coping mechanisms to enhance resilience. The need to develop personal resilience

reflects the pressures participants encounter working in the NHS. Resiliency is the ability of individuals and organisations to absorb stress that arise from challenges, to learn and grow from adversity and emerge stronger than before. Many Participants' developed resiliency in clinical care, its place in category 4 reflects the need for some to change their leadership approach to remain resilient in new roles. Stepping away from clinical care and supportive colleagues can also reduce resilience and leave managers feeling isolated. As illustrated by P2:

> *"You need to understand where you are going, why you are doing it, otherwise you are not going to get any resilience. Because no one is ever going to support you, the higher you get the support is less, and less and less all the time. P2: line 626.*

As resilience is personal and context dependent, what stresses one manager can have no effect on another. Although, within the context of these data, managers transitioning through identities, dealing with uncertainties regarding capability and conflict over role priorities will increasingly encounter stressful situations, potentially reducing resilience. If measures are not taken to identify these managers, they could struggle for prolonged periods of time while constructing coping mechanisms. As illustrated by P11:

> *"I think half of it is they have beaten me down (laughs). Erm, I was exceptionally unhappy for the first couple of years… I just thought I'm going to go, can I afford to walk, it was that bad, it really was that bad. And then I think you sort of build-up and work through it". P11: line 120.*

In the participant interview schedule (Appendix P) the length of time in participants' present roles ranged from 7 months to 20 years. Despite not documenting participants' career length in the NHS, many participants acknowledged on average twenty years work experience. This length of time was significant to resilience, as participants referred to age, experience and personality. A view supported by P6, a clinical manager:

> *"I think the bit older you get the more relaxed you get (laughs) it's about……knowing about me I suppose, about knowing how I do things, but it's also about worrying about the things I can change and not worrying about the things that I can't. You know and learning to let that go". P6: line 141.*

Participants' often spoke of ways to enhance resilience within teams; many have been presented in previous chapters. Some used the power of previous identities and clinical connections to maintain connections to social worlds and adopting a visible presence. However, these measures will support staff in the moment and will not provide a long term solution that is effective when they are not present. P3 explains:

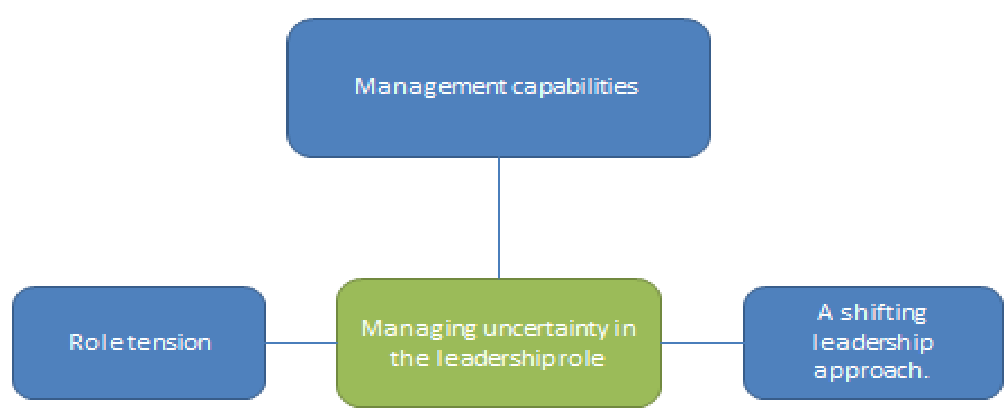
> *"We're missing a trick when we don't support people going into leadership, because it is about resilience, learning different techniques to manage…...it's all about your leadership, to quiet down that conversation and get it dealt with appropriately". P3: line 612:*

Category 4 appreciates a shifting leadership approach to compensate for feelings of uncertainty, recognising how managers attempt to build resilience in organisations that may not actively look for struggling managers. The value of education for participants to study leadership at post graduate level recognises a shift from traditional studies focusing on clinical skills among managers, to studies supporting a transition into management.

Summary of the findings and initial theory development.

This chapter presented the four findings to emerge from the data of *managing uncertainty in the leadership role, management capabilities, role tension and a shifting leadership approach*. Of the four, *managing uncertainty in the leadership role* emerged as the core category, the remaining three identify the internal and organisational influences leading to uncertainty, with the action's managers take to minimise uncertainty in their role.

Figure 13: Interrelationship between the categories and the core category



Uncertainty developed from the individual influences in *managing uncertainty in the leadership role* category.

Previously clinical managers held onto their clinical identity because it is what they know and what they have worked to attain. In doing so, participants used the legitimacy and esteem of previously clinical roles to offset uncertainty in managerial roles. In doing this, they continue the perceived dominance of clinical experience and the clinical hierarchy, leading non-clinical managers to feel their managerial experience lacks this important component.

The categories of *management capabilities* and *role tension* demonstrate how individual managers heighten uncertainty. The lack of an agreed set of competencies and strategy to equip participants with the core skills required to be effective in their role, permits participants to determine the skills and competencies they consider most appropriate. While this supports autonomy, it can lead to tensions if they do not align with organisational objectives.

Managers' recognised many transferrable skills from previous roles, however, none aligned with an agreed organisational standard. The lack of an agreed

unified approach permitted managers to focus on the skills and knowledge they considered essential, while dismissing others they considered secondary. This lack of clarity builds uncertainty because of ill-defined role functions.

In the final sub-category, participants in this study shift their leadership approach to build confidence and resilience in themselves and their teams. They recognise the changing context of their role and moved away from Post-Graduate degree programmes designed to meet the needs of their profession, to programmes designed to develop leadership capabilities. While these may not minimise the internal and organisational uncertainty, participants perceived a reduction in uncertainty through self-confidence. It signifies managers' motivation to maintain identities and skills perfected in previous careers, supporting a desire to maintain a preferred identity to offset feelings of legitimacy.

The impact of feeling apprehensive about a role and its associated identity, is a weaker managerial structure, as managers spend time supporting identities not essential to their managerial role. However, it also recognises a move to undertake leadership specific education and development, a move away from a focus on clinical speciality, to recognising their role in the organisation.

This chapter presents the research findings, how work experience influences approaches to leadership. This research was undertaken at a time of organisational change, where the traditional approach of promoting clinical experts is shifting to recruit managers from non-professional backgrounds. This transitional stage in the organisation with a shift in power away from the clinical hierarchy leads to managerial role tension.

Chapter Summary

This chapter presented the research findings in the final four categories of *managing uncertainty in the leadership role, management capabilities, role tension* and *a shifting leadership approach*. Participant quotes ground the categories in the data to support these as significant to understand managers' approach to leadership. Managing uncertainty in the leadership role emerged as the final category, with management capabilities and role tension recognising the organisations influence in establishing uncertainty, while a shifting

leadership approach recognises managers' actions to limit uncertainty. The following chapter uses Docherty and Smith's (1999) structure to present the discussion of findings. The chapter introduces the six principal findings with relevance to NHS managers.

Chapter Six- Discussion of findings

Introduction

This chapter begins with a theoretical discussion of the key findings in relation to current knowledge and understanding of managerial uncertainty among NHS leaders. It then presents a summary of the conceptual framework and sensitising concepts that feed into the model and help interpret the findings. Explaining how each of the three components link to the key findings. The chapter concludes discussing the implications of the findings.

Theoretical discussion

Managing uncertainty in the leadership role emerged as the core category from the data, supported by the categories of management capabilities, role tension and a shifting leadership approach. Participants found it easier to talk about management as opposed to leadership, they spoke of the divergent skill sets required to lead at clinical or organisational levels, accepting leadership as a process focused on influence and inspiration (Parkin 2012), while management focuses on process and rules through structured policies and monitoring (Gopee and Galloway 2014). According to Gill (2013) uncertainty is amplified in health care as public-sector leaders hold high levels of accountability yet little authority, requiring a more engaging and collaborative approach. This lack of authority permitted some participants to discount the need to enhance managerial skills, choosing instead, to focus on clinical issues that aligned with previous roles focused on clinical accountability.

All but one of the twelve participants had been promoted to their current leadership roles from within the NHS, only participant 11 employed from outside the organisation. This approach supports the view by Hewison (2001) and Hewison and Dodwell (1994) that organisations understand the value of developing staff with a shared set of values and knowledge of the organisations processes and culture. Gill (2013) and Thompson and Flynn (2014) support this view, believing the unique differences such as values and norms in health care can be at odds with non-public sector organisations. However, the findings reveal the same opposing values and norms exist within the two NHS Trusts in

this study, with managers impeded by a lack of managerial skills and not leadership abilities on promotion.

The influence of Professional role identity

One attempt to minimise the uncertainty experienced by managers from previous clinical roles is to rely on professional expertise. Identity is central to eight of the nine participants with clinical backgrounds, their role in the organisation may change, but their identity remains consistent (Watson 2008). Bolton (2005) found, a change in identity can hinder individuals from accepting their managerial role. Participant's' spoke of the need not to be seen as *pen pushers* and acquire an unwanted identity. Agreeing with Petriglieri (2011) and Morales and Lambert (2013) who suggests individuals will oppose a new managerial identity if it is inconsistent with their professional identity. The data shows the impact of such opposition, when organisational and professional priorities clash (Simpson et al 2002, Rai 2016). Participants' would prioritise supporting colleagues in clinical areas, make themselves available out of hours, or remain at work for long hours. P's 2, 5 and 8 recognised the need to work extended hours as presenteeism. The reasons for this however were different. In P8's case the volume of work to meet both clinical and managerial responsibilities was the cause. Whereas P5 recognised a culture that expected managers to work longer hours. Despite the reason, P2 warned the danger of presenteeism was burn out and ill health.

Reed (2001) believes an individual's role in an organisation is modified by how they perceive the purpose of their role. Identity was not an issue for P3. P3 recognised their role identity was a combination of both health care professional and manager, they did not rely on one more than the other or use one to add legitimacy to the second. P3 constructed an identity that acknowledged the value of both clinical and managerial roles (Pratt and Rafaeli 1997). A reconstruction Tansley and Tietze (2013) view as essential if staff are to transition into senior roles. P3 successfully maintained a professional identity, preserving the prototypical characteristics to ensure they continued to be one of the team (Van Knippenberg 2011, Van Dijke and De Cremer 2009). The fundamental difference for P3 was to recognise acquiring managerial skills

would not diminish their professional identity but enhance it. Through acquiring managerial capabilities, they were in a stronger position to lead their team.

The activities of participants in this research to maintain a professional identity mirror those in other public sectors. Research looking at leadership in the Police service viewed experience as a serving officer as essential to maintain legitimacy, credibility and respect in managerial roles (Hoggett et al 2018). My research not only recognises the influence of professional role identity in professionals, such as health care and the police, but that its influence extends to managers lacking a professional identity. Participants spoke of the need to obtain the support of professional colleagues by working alongside clinical teams, to acquire knowledge in the context of clinical care. Aycan et al (2014) and Schedlitzki and Edwards (2014) suppose this contact allowed participants to appreciate the beliefs driving the social worlds of team members, knowledge that can be used to construct a basis for a different form of legitimacy, to align their managerial identity with those in professional roles.

In chapter 3 the term hybrid manager was introduced to communicate added managerial responsibilities given to clinical managers (Kippist and Fitzgerald 2009). However, the three participants lacking clinical backgrounds also spoke of the tensions of leading clinical teams, while delivering organisational objectives (Gatenby et al 2015). The findings support Hay's (2014) suggestion that uncertainties experienced by managers are generic and not aligned with specific groups of individuals. Suggesting the belief by managers from clinical backgrounds that appointing non-clinicians to managerial roles, to remove role tension and subsequently uncertainty is incorrect.

Characteristics of situational leadership were revealed by participants, especially those from clinical backgrounds. Participants did not use the term, or recognise their approach as situational, however they relied on applying technical skills specific to clinical environments (Mannix et al 2013, Gopee and Galloway 2014). P8 believed they adopted this approach because of their lengthy NHS career and the way they were mentored and supported. Recognising *younger managers* have a different approach. Overall, participants continued to apply a transformational approach in managerial roles. Despite a

change in role, the context remains health care, with a focus on individual's beliefs, attitudes and values (Belle 2013, Alimo-Metcalfe and Alban-Metcalfe 2006). A continued reliance on a transformational approach is not problematic, as Plesk and Greenhalgh (2001) suggest transformational leadership is relevant to complex and complicated environments in constant reform, such as the NHS.

Specific to this research, a gap exists exploring the influence of previous work experience on managers' approach to leadership. This research recognises how pre-existing knowledge and skills from previous roles influence and inform leadership, specifically in organisations with diverse populations, such as the NHS. Managers use the experience and knowledge gained in previous roles to support their transition to managerial roles. Relying on the confidence gained in previous roles to lessen uncertainties as they build managerial confidence. A manager's approach to leadership is distinct as their previous work experience is unique to them.

Conceptual Framework Revisited

The conceptual framework provides a critical lens to help in the interpretation and understanding of data (Ravitch and Riggan 2012). This section will revisit the three key elements of personal interest, topical research and theoretical framework defined in chapter 3, including sensitising concepts, to understand how they influenced analysis and the study's findings. In doing so, to demonstrate objectivity, which Strauss and Corbin (1998) believe is reflected within the conceptual framework.

This thesis recognises how personal interest from a previous managerial role influenced the direction of this research, to appreciate how participants understanding of leadership in the NHS is demonstrated by their responses to the interview questions (Appendix G). Theoretical sampling may permit the researcher to approach the most suited participant to construct knowledge; however, personal Interest and experience of health care professional roles and managerial responsibilities also informs the selection of subsequent participants in the constant comparative analysis (Charmaz 2014). Insight gained from interest and experience improved understanding of the interaction between

individuals and their environment (Grbich 2013). An insight furthering interpretation made in the data to identify the emerging theory.

These findings recognise managers continue to view their environment based on previous constructivist interpretations of their surroundings, to approach managerial posts based on a reality established in previous roles. The lack of a managerial identity also limits the organisations constructionist influence to guide managers through transition. Without the social pressure to conform to a managerial identity, managers continue to apply a constructivist approach, and so the reality of their role is different from managers in similar positions.

Symbolic interactionists believe through interactions individuals create and change meanings, health care professionals or managerial staff, bestow a meaning to their experience, and this meaning establishes their actions within the social group (Goldkuhl 2012). The value of symbolic interactionism to this research is that it sensitises the researcher to the meaning's managers are attributing to their surroundings. Current NHS managers are drawn from a range of different professional and academic backgrounds with diverse working experiences. Consequently, this unique experience offers a diverse view of leadership. The meaning each manager derives is also unique. And so, the action each will take in their leadership approach is equally individual.

This research acknowledges managers interpret the meaning of health care leadership based on previous work experience. To reinforce this meaning, managers would continue to interact in social worlds that support their meaning of health care. The conceptual framework also recognised the work of others (Leshem and Trafford 2007), this was important for many reasons. Initially, to understand leadership within the NHS in general, afterwards to consider leadership in similar public services, and throughout the research to apply the sensitising concepts of Bridges *transitional theory* (1995), Benner's (2001) *novice to expert* theory, and the theory of *social worlds* (Koveshnikov and Ehrnrooth 2016).

Bridges "transitional theory"

The application of Bridge's model (1995) helped inform data analysis. It sensitised me to the uncertainty participants expressed as they adapted to their

managerial roles. In the neutral zone Individuals sequence through emotions likened to the grieving process, they experience anger, sadness, fear and confusion as they mourn the old ways. Returning to the literature to understand these emotions, Bridges' model mirrored the participants' experiences, reflecting the psychological changes individuals encounter when transitioning to a new beginning. The neutral zone is where individuals experience insecurity while they create a new sense of identity. An insecurity common in both clinical and non-clinical managers. Despite Bridges model focusing on individuals transitioning through an organisational change, the neutral zone captured the participants' emotions during a personal change, as they adapted to uncertainties within managerial roles.

One unanticipated finding was the presumption in Bridges transitional model (1995) to assume individuals intend to transition to a new beginning. As a sensitising concept I found the model was excellent as a lens to frame participants' experiences and captured the participants' emotions during a transition, as they adapted to uncertainties within managerial roles. However, it does not account for individuals who do not want to transition and choose to remain in the neutral zone, for some, a considerable length of time waiting for retirement or alternative roles to become available.

Benner's theory of "novice to expert"

Benner's (2001) specific relevance to this research is a lens to explore emerging data relating to a loss of expert knowledge and skill in previous roles and contexts. Benner's theory of novice to expert relates to nursing at a specific point in an individual's career. However, it illustrates the loss and acquisition of skills as Participants change roles, and how these changes can increase insecurity. Nine of the twelve participants were clinical practitioners who transition into a management context, moving from a context in which experience matters, to one where clinical expertise has less significance, with the anxiety and uncertainty described by participants a lack of knowledge and skill. Benner's theory focuses on nursing development, and not all participants hold a health care qualification. Regardless of this, this research will demonstrate the significance of a lack of knowledge and skill to managerial leadership. It will also demonstrate the steps managers will take to maintain

expert skills and knowledge, even those not specific to their managerial role. As previously illustrated in figure 10, participants moved in both directions of Benner's model until reaching an acceptable balance.

Social worlds

In this research, it was apparent that the *social world* of health care professionals was an important interaction (Koveshnikov and Ehrnrooth 2016). Social worlds are a reliable route to knowledge as they link the thoughts of the individual to the world (May and Williams 1998). This link allowed a lens to understand why, regardless of professional background, professional managers returned to previous social worlds for support, guidance and reassurance. The uncertainties and lack of knowledge and skill participants experience in the neutral zone, were offset by the recognition participants received from social world members. As recognised by Bradley and Cartwright (2002) Who find the maintenance of supportive relationships in the workplace as an important consideration in reducing stress.

While it is important to recognise the support offered by social worlds, it is also important to recognise the influences within them. The literature review considered the influence of gender among social worlds. This is important in this research as Murphy (2001) believes the social worlds of health care professionals, where many participants in this research are promoted from, can therefore offer collaboration, mutual respect, and replace a sense of powerlessness with one of achievement. When considering the participants in this research, 11 of the 12 are white females and 9 of these 11 are health care professionals employed in middle management positions. According to Yoder and Kahn (2003) this is significant as the difference between genders is not simply gender itself, it is nuanced by race, ethnicity and class.

Summary of key findings.

Table 6: The principal findings that emerged from the data

Organisational	Summary
Finding 1: A shared understanding is needed for successful leadership in the NHS	How managers approach leadership is influenced by their previous work experience and the context of these positions. To develop managers with a shared understanding of leadership within an NHS organisation, a developmental route for clinical staff like that available to non-clinical staff will support managerial development
Finding 2: An increase in recruiting individuals with management capabilities over clinical competence.	Participants recognise the value and limitations in recruiting *professional* managers as opposed to promoting clinical experts to management posts. The value is in established management capabilities. Limitations can see clinical experts as a supporting role, as seen in the triumvirate approach.
Individual	**Summary**
Finding 3: A predominant clinical hierarchy can stifle the effectiveness of non-clinical managers	The perceived influence of a clinical hierarchy can lead non-clinical managers feeling constrained. It can also lead managers from clinical backgrounds to focus on clinical issues over managerial.
Finding 4: Managers adjust their leadership style in response to new roles and contexts.	Managers adjust their leadership approach to meet the demands on new roles. offset uncertainty and doubts in their managerial leadership. The strategies they employ lead to an in-effective use of their time and inhibit their overall effectiveness.

Significance of the findings for Hospital Trusts

The findings recognise leadership is complex, and its meaning changes depending on individual managers previous roles and experience. Of the 4 findings, finding one most reflects the research question. Acknowledging the

need for a shared understanding among mangers to support managerial development. An understanding that recognises the value of previous roles and its influence on leadership development, while providing a formalised pathway to management for clinical staff.

Findings 1 and 2 have implications for employing Trusts, while findings 3 and 4 have implications for the individual manager.

Finding 1: A shared understanding is needed for successful leadership in the NHS

A key finding to emerge from this study is that no specific programme exists in the NHS to support clinical staff aiming for non-clinical managerial posts. As a result, clinical staff continue to approach managerial roles as they would clinical roles, relying on known and trusted knowledge, skills and capabilities developed in clinical practice. The recommendations in Chapter eight support my belief a route for clinical staff equal to that of the graduate management trainees is essential to support clinical progression. Otherwise, the pool of clinical staff will continue to enter management with issues identified in this research.

I contend the implication for continuing to offer structured programmes for non-clinical managers, while failing to recognise the developmental needs of clinical staff, supports an approach that leads to a disjointed understanding of what is expected from an NHS manager.

A unified managerial approach

To develop a shared understanding of management, it is necessary to apply a unified approach to managerial development. An approach that recognises the value of clinical experience and non-clinical managerial development. Findings from this research indicate this need for a shared understanding of NHS management among the diversity of managers and backgrounds. The data suggests common concerns among managers could be used to develop programmes that meet the needs of both non-clinical and previous clinical managers.

A simple approach would be to use the graduate management training scheme as the sole development pathway for middle management positions. Unfortunately, there are two drawbacks to this approach. Firstly, clinical staff

complete post graduate degree level education as part of previous role developments to aid promotion, already possessing a post graduate qualification. Secondly, Hall (2004) and Day and Harrison (2007) believe the issue remains that clinical experience and knowledge possessed by clinical staff could influence their approach to training and education, limiting the value of the programme as clinical staff continue to focus on clinical care throughout.

Considering prospective managers would enter a programme with such diverse identities, knowledge and skill sets, my contention is that a dual approach would be preferred. The graduate training scheme or similar in-house programmes devised by organisations, remaining the development of choice for graduates lacking NHS experience, an approach that would support the introduction of apprenticeship programmes. Alongside this, a managerial development programme would exist for clinical staff within the organisation who aspire to managerial roles. What is vital, and discussed later in this chapter, is that both programmes must work toward an agreed set of capabilities, and the programmes must work in partnership, with candidates meeting on a regular basis to exchange ideas and discuss issues encountered in practice. One such issue could be to discuss how previous roles and experience influence leadership.

Therefore, it can be suggested that a dual approach to managerial development will enhance managerial capabilities and leadership by allowing continued access to recruit clinical staff, and not a preference to develop non-clinical staff. Indeed, The Kings Fund (2014c) warn against excluding clinical staff at times of financial constrain in favour of individuals with proven management capabilities, to ensure existing workforce numbers are sufficient to meet current and future staffing demands.

The advantages of having one approach for existing staff employed in the NHS are many. It ensures organisations continue to attract and retain key talented employees that can be nurtured through training and development (Myers and van Woerkom 2014). Furthermore, it supports Collings and Mellahi's (2009) approach to developing elite groups within the workforce, not applying one approach to all prospective employees. It is also worth noting that Sturges et al

(2002) suggest an experienced generation of employees seek job security and promotion in the organisation they are currently employed, and so to dismiss these individuals is unwise.

My research supports the need for a shared approach to develop managerial capabilities. However, alongside the distinct development of clinical staff and non-clinical managers, it is imperative both groups meet in a forum within Trusts to share experiences and discuss managerial issues, allowing candidates to develop a shared managerial identity. Meetings exist where procedural and strategic decisions are made, but these do not allow time for managers to reflect on their actions and the decisions they make. This forum would be separate from established managerial groups. Mengiste and Aanestad (2013) confer, believing members of both programmes would share an identity in a collective goal in the pursuit of a common task.

Managers in this new forum will originate from professional and non-clinical supporting roles, but within the forum a new managerial identity would be established, one that did not replace existing identities, but recognised them as the foundation for future development. The collective aims, objectives and unified goal of the forum's members would support the development of a new managerial social world.

`Finding 2: An increase in recruiting individuals with management capabilities over clinical experience.

Having discussed the implication of no shared approach to managerial development in the NHS Trusts, another important finding is the impact on the role of clinical staff. The current approach favours non-clinical recruitment; consequently, the role of clinical professionals is repositioned to one of supporting non-clinical managers. This finding may help to understand the significance of managerial recruitment to the context and timing of this research.

A changing recruitment strategy

A recent study by Chong et al (2013) concluded public sector competencies differ from the private sector, believing private sector managers operate in high-risk environments, requiring managers to respond rapidly to capitalise on

business opportunities, whereas public sector managers make drawn-out decisions aiming to please as many as possible.

Acknowledging this variance, I suggest the findings in this research recognise the NHS Trusts acknowledge the need for managers with private sector managerial capabilities (Jasper and Jumaa 2008). This is important, as Brownwell (2008) accepts management competencies are context specific and private sector competency standards do not align with the behaviour, values, and attitudes crucial to health care (Calhoun et al 2008). Consequently, participants reflect the issues organisations currently face, experienced clinical staff with limited managerial competence requiring development, while competent managers need to develop an understanding of what influences clinical staff.

The approach to recruiting NHS managers reflects those of new public management (NPM) with an emphasis on service quality and consumer orientation (Carlstrom 2012). In fact, the NHS intended to move from a target driven service to one measured by patient outcomes (Department of Health 2016a) a re-focus intended to reduce the burden of chasing targets with a focus on patient outcomes. Unfortunately, The Kings fund (2018a: 28) report the "c*hallenging financial and operational climate of the NHS"* has led to an increase in regulatory burden, not a reduction, consistent with research conducted by Howard et al (2018) who found little empirical evidence to support the appropriate level of required capabilities to guide health service management recruitment.

Surprisingly, the finding suggests a preference for leadership development over managerial development. The literature review recognises the perceived importance of championing a transformational agenda. Unfortunately, the focus of such programmes continues to concentrate on individual manager's transformation, aligning leadership capabilities with managerial success. Because of this continued approach, many development programmes, such as the NHS Leadership Academy (2013) framework, focus on leadership as the core competency.

Finding 3: A predominant clinical hierarchy may stifle the effectiveness of non-clinical managers

The results of this study indicate an influential clinical hierarchy may stifle managerial effectiveness at a time when organisations are facing financial pressures and increasing demand. As non-clinical managers are not members of their team's professional social world, they may be excluded, or given limited access to this influential hierarchy. The findings suggest participants felt clinical staff do not recognise managerial identity as equal to professional identity. Two possible explanations are now presented.

An accepted managerial identity

Knorring et al (2014) suggest managers view themselves as powerful and knowledgeable individuals in a context of health care where medical staff occupy the top position. However, Ashforth and Kreiner (2014) and Black (2017) suggest managerial significance may be threatened by stigmas attached to some occupational identities. Therefore, it is unsurprising in health care hierarchies that managers experience uncertainty and struggle to build an accepted managerial identity among the clinical teams they lead.

An important finding was the impact of professional identity and membership to social worlds on managers supposed credibility to lead. Managers from professional roles with strong identities and members of established social worlds are hesitant to move toward new managerial identities. However, as this finding will demonstrate, identity can be actively constructed for others (Fournier 2001), to enhance credibility when leading new teams.

The findings suggest managers must acknowledge previous identities may not align with a managerial position, as clinical credibility and specialist knowledge in previous roles was a legitimate source of influence. For example, the continued use of wearing uniforms for managers removed from the clinical setting was actively used by P's 7 and 8 as a mechanism to negotiate identity issues (Pratt and Rafaeli 1997). Hardy and Corones (2016) and (Newton and Chaney 1996) believe when an individual wears a uniform they acquire the occupational identity and symbolic influence associated with it, minimising the perceived loss of credibility from professional to manager (Ashton 2014).

The significance for NHS organisations is a prolonged dominance of the clinical hierarchy; it mistakenly leads to continued uncertainty and ill-defined identity. This was not only seen in the findings with a preference for a clinical identity, where managers achieve legitimacy in the organisation by retaining a strong occupational identity (Dellve and Wikström 2009), but also by non-clinical managers looking for credibility among clinical staff to share experiences and understand the clinical environment.

Removing uniforms from operational managers would send a positive message, eliminating one form of legitimacy that diminishes non-professional manager's credibility. P7 a clinical manager, admits using a uniform to attract respect and recognition. P12, a non-clinical operational manager who does not have access to a uniform, also recognises uniforms project intent and meaning. Participants view the use of uniforms as a positive step to maintain credibility. However, the continued reliance on uniforms may limit the transition away from a clinical identity. For example, P6 suggests wearing a uniform makes them appear more approachable when in clinical areas, while P8 suggests a uniform is a visual representation of a clinical member of staff.

To limit the need for clinical staff to maintain previous identities, it is important to recognise the value in developing a unified managerial identity. One of equal importance to an identity held in previous roles. Despite Spragley and Francis (2006) assertion that with an increasingly business focused NHS, a move away from professional uniform to business attire has occurred, the findings in this research suggest otherwise. In the face of a transformed NHS, managers are permitted to use identity through uniform to offset uncertainty in managerial roles.

Minimising the need for clinical acceptance

Despite holding positions that do not require a commitment to contribute to clinical duties, P's 7 and 8 chose to perform responsibilities aligned with previous roles outside their managerial obligations. Through these actions P's 7 and 8 maintain and strengthen previous connections, to uphold formerly established values and relationships, to maintain a positive and credible identity their managerial role may not.

The implication for the NHS is relevant at a time of increasing financial and operational challenges and regulatory requests for information. Participants, such as P's 2, 5, 7 and 8 chose to work in the clinical context to maintain and uphold skills not required in management to maintain a preferred identity. For P8 this included assisting in childbirth, while P2 continued to support a cohort of children that could be passed to a team member. These actions were defended to uphold an identity they view as essential (The Kings Fund 2018a). While it may maintain relationships and esteem, it limits the time managers' focus on core managerial roles and responsibilities.

Maintaining a credible identity

Miscenko and Day (2016) recognise identity as a prominent factor behind many individuals' work-related behaviours following a role transition, a topic yet to be addressed in much detail in the literature. The Health Service Journal (2015: 9) assert a move from clinical to managerial roles continues to be seen as having *"gone over to the dark side"* This belief negatively impacts the identity and credibility of managers' with responsibilities covering both organisational objectives and oversight for clinical services. Consequently, Hogg & Terry (2000) suggest individuals will maintain an identity related to their sense of self-worth, such as a preference for a professional identity over a managerial identity among clinic staff. Unfortunately, Gabriel et al (2011) suggest managers unable to validate their identity experience conflicted priorities.

Clarke et al (2009) suggest a conflict can result from managers delivering organisational objectives that oppose personal or professional beliefs, resulting in emotional distress and anxiety. As finding 3 reveals a predominant clinical hierarchy in the Trusts studied, a hierarchy supported by professional values and beliefs. It supports Carollo and Guerci's (2017) finding that the pull to be a business orientated manager over a value orientated manager can generate managerial conflict.

These orientations expose the complexity of NHS management, as clinicians are recruited from a value orientated professional role, into a business orientated role.

The implication for NHS organisations in this twofold approach is a pull from the organisation to deliver strategic objectives, alongside a pull from the needs of clinical teams (Carlstrom 2012), with McConville (2006) recognising managers move between these opposing forces dependent on their previous roles in clinical care or management. To meet the demands of both managers can be a constant presence at work, pressured to overwork to *"secure their role, purpose and future*" in the organisation (Thomas and Linstead 2002: 89). This finding has relevance beyond managerial engagement, as Schmidt et al (2014) found role conflict and ambiguity were contributors to depression, while Kivimaki (2005) found an association with employees that did not recover from work at weekends with an increased risk of death from cardiovascular disease.

NHS organisations must recognise they cannot continue to allow managers to develop conflicting priorities (Sambrook 2007). However, I am not suggesting all managers must approach change in the same way, with the same actions. The importance of the finding is recognising managers from diverse backgrounds lacking a unified development programme are free to influence the outcome of change depending on values and beliefs developed in previous roles.

These values and beliefs influence the managers social positioning within the organisation (Battiliana 2011) a position that influences how their actions deviate from the organisations initial request, where managers lacking a clinical background are shown to be more compliant. Indeed, this research does not suggest focusing on one route to managerial positions but recognises the value of clinicians and non-clinicians developed alongside one another. Harman (2011) believes where managers learn together in diverse groups, the provisional identities of group members should allow one identity to emerge. Dawson and Andriopoulos (2017) agree, advocating an organisation that promotes homogeneity in its workforce restricts employing a diverse group of individuals to boost the organisations knowledge base.

Finding 4: Managers adjust their leadership style in response to new roles and contexts.

Another important finding was the uncertainty managers' experience because of a limited skill set and managerial knowledge base. Managers who lack

confidence in their capabilities adopt strategies to offset feelings of managerial uncertainty; these include actions to acquire management capabilities and modifying their approach to leadership.

Enhancing leadership through acquiring management capabilities.

This finding identified an opposing skill set from managers appointed from previously clinical roles, to those recruited from managerial posts. A central issue that spans the importance of this findings is reluctance among previously clinical managers to move away from skills perfected in clinical situations. Indeed, P's 2, 5 and 7 demonstrated the compromises they were prepared to make, such as presenteeism to maintain links to clinical roles. While only P3 among the participants chose to relinquish clinical skills in favour of developing managerial capabilities. To demonstrate this overreliance, *developing capability,* domain eight of the Health Care Leadership Model (NHS Leadership Academy 2013) focuses on leaders' abilities to build capabilities within teams and individuals, and fails to address a lack of management capabilities in any way.

One interesting finding that emerged was health care managers' desire for technical skills mirror those of managers in health care organisations globally. Toygar and Akbulut (2013) report resource management, including cost and financial aspects the highest rated requisite management capabilities. The lowest rated skills included knowledge and abilities related to job specific technical skills, interestingly like those in clinical contexts. One interesting aspect of this findings is clinical cultures can repress managerial skills and competencies acquired external to the NHS. This is unfortunate, as NHS Improvement (2016) recognise culture as the most powerful factor influencing leadership in the NHS.

Managerial skills acquired outside the NHS may not be as obvious as health care skills developed through patient care. However, Pettinger (2001) acknowledges a desire to professionalise general management. This finding supports the view that culture and context may influence the development of a unique skill set in the NHS. However, according to Hoffman et al (2014) cultural preference should not override the need for the same generic skill set that allows managers to accomplish results through their employees' efforts.

Alongside a desire to acquire managerial capabilities, this finding also reveals how uncertainty results from losing clinical competencies in managerial roles. Health care competencies demonstrate an exceptional level of knowledge and understanding that commands respect from fellow practitioners (Litwack 2015). As an example, Calvert et al (2017) recognise midwives moving into managerial roles find it difficult to maintain a level of competence to practice independently.

Modifying the leadership approach

To overcome uncertainty, this finding helps to understand why managers may modify their leadership approach in response to new roles and contexts. Within health care the needs of managers and clinicians can be at odds, with clinicians encouraged to adopt a transformational approach central to clinical leadership, or an enabling approach adopted by the Health Care Leadership Model (NHS Leadership Academy 2013). Vince and Pedler (2018) consider these approaches to leadership development that view leadership as optimistically positive as a poor preparation for the unpredictable and messy reality of organisations.

Regardless of role, the context for managers and clinicians' remains health care (Ledlow and Coppola 2014). However, this finding helps to understand how a significant rise in demand for care and financial constraint in the NHS (NHS England 2015b) encourages some managers to modify their approach to leadership as their functions within organisations change.

This finding reveals the complexity of managing in the NHS, where the traditional transformational approach to visionary and inspirational leadership (McSherry and Warr 2010) does not consider the influence of power or politics (Hutchinson and Jackson 2013). Therefore, I believe the confidence clinicians developed in clinical practice is short lived when real difficulties in management are met (Vince and Pedler 2018). This finding reveals a transformational approach focusing on the intrinsic motivation of staff underpinned by professional values and beliefs may no longer be the preferred approach for business focused managers in health care. Nguyen (2017) believes it lacks the extrinsic motivations required to compensate staff for their efforts.

This finding demonstrates the change to a more methodical and structured approach to leadership, alongside a more direct communication style, less participative and more instructive, with time restrictions cited as an oppressive force behind these changes (La Monica Rigolosi 2013). In general, it seems therefore, that managers respond to work pressures in similar ways. An interesting finding was managers also looked to education for similar answers to offset the uncertainty they experience. While it is recognised educational development plays an important role in creating a quality organisation (McSherry and Warr 2010), to prepare leaders to meet the challenges of healthcare environments (Bondas 2006). It is noteworthy that managers are looking for educational and development opportunities outside of their previous roles or professional careers, to programmes focusing on leadership and management. One reason proposed by Gerard et al (2014) is it provides an opportunity for managers to understand the overall function of the organisation, including the processes that govern care.

This finding has important implications for managerial development within NHS organisations, it recognises managers may adjust their leadership style in response to new roles and contexts, and with no internal programmes providing the answers to uncertainties in leadership approach, managers adapt their own approach, or look to post graduate level studies for answers. Shiu (2018) recalls uncertainty navigating a new world with a language, finances, and operational management processes they did not understand. A continued focus on learned behaviour to develop individual managers skills and attributes, focusing on self-awareness; advocacy, empowerment, decision-making and communication (Patton et al 2013, Larsson 2017) is not providing all the answers for successful management.

It is essential that NHS organisations recognise the need to deliver programmes that supports potential managers. Without investment in training and education for leaders to develop the skills and capabilities in management alongside leadership, leaders will not meet future challenges in the NHS (Jasper and Jumaa 2005). A view reinforced by Mabey (2013) and Harding (2018) who conclude current leadership development programmes lack basic people management abilities.

Resilience through education.

One of the issues that emerged from this finding was the need for managers to become resilient in their roles to offset workload pressures and uncertainty. Personal resilience motivated managers to shift their leadership approach, to *harden up* to survive the pressures of their roles. Managers recognised the need to absorb stress in their roles, and not only recover to the same level (Rai 2016), but also to learn and grow from adversity to emerge stronger than before.

The need for resilience reflects the pressures managers encounter working in the NHS, and as services are working at full stretch staff resilience is not inexhaustible (The Kings Fund 2017). Although, it is important to recognise resilience is context dependent (Jagger 2016) what stresses one manager can have no effect on another. However, difficult environments are increasingly commonplace for NHS managers, and Lown et al (2015) contest, eventually everyone will crumble when placed in very difficult environments.

Implications of the findings

To understand the implications, I will return to the research question.

> *How do NHS managers perceive their leadership style is influenced by previous work experience?*

In this research I have found previous work experience does indeed influence the leadership style of NHS managers. A professional qualification is not essential for managing clinical services, however, the possession, or lack of a professional qualification was the underlying influence in determining the impact of previous roles. In both cases, clinical practice was the common denominator. For clinical staff a desire to maintain the credibility and identity of a health care professional within practice, while for non-clinical managers, the desire to gain recognition and support from clinical staff.

I have found NHS organisations continue to pursue an approach that favours the transformational/collaborative agenda favoured in the NHS regarding managerial development. One way NHS organisations can influence leadership development is by failing to provide a managerial identity equal to that of

professional identities, NHS organisations permit managers to choose an identity and leadership approach while adapting to new roles. Importantly, while an authoritative approach may not be the preferred approach desired among managers, the lack of an alternative approach to a managerial problem may, as seen in P5 increase its use.

Figure 14 recognises the impact of uncertainty and how it can restrain individuals from moving to new beginnings. Managers have reservations regarding their performance regardless of previous roles, as there is no clear development towards an organisational standard. This leaves managers focusing their attention on what they are comfortable with, know and understand. They rely on identities and social worlds associated with previous roles, while looking for credibility in the skills and knowledge developed in past roles. As a result, managers can return to the securities of previous roles to offset feelings of uncertainty.

Figure 14: The cyclical influence of previous roles

Managers may experience uncertainty in their roles regardless of previous work experience, while the basis of their uncertainty differs depending on context and functions of previous roles; the influence on their approach to leading teams is consistently similar. Similarities include doubts in credibility, developing competent skill sets and role tension. However, managers also recognise the

value of previously developed skills to provide a known and trusted foundation, while actively modifying their approach to leadership to meet the demands of middle management.

A review undertaken by NHS England (2015b) concluded NHS organisations should develop strategies setting out their approach to talent management and leadership development to meet the needs of their local system. This strategy acknowledges the lack of a clear structure to meet the needs of NHS managers from divergent backgrounds, to develop the skills and knowledge necessary to lead an array of clinical and non-clinical services at an organisational level. As a result, the findings of this research support managerial uncertainty as a disrupting influence on leadership development, both for the individual and the organisation. The emergent grounded theory supports the need for a unified approach to minimise the influences leading to uncertainty identified in this research.

In answering these questions, this research makes noteworthy contributions to understanding the influence of previous work experience on NHS managers within the context of an evolving NHS. The emergent theory offers NHS organisations the ability to understand the influences of previous employment, while recognising the divergent needs of managers recruited from within the organisation's clinical hierarchy and those from the graduate management training scheme and externally.

Chapter 7- Emergent theory and implications

A unified management approach

This research has demonstrated that previous work experience can both help and hinder individuals as they move into or adapt to NHS managerial roles. One of the ways experience can hinder adaptation is through uncertainty. This research finds uncertainty results from the lack of a unified approach to managerial development. This omission permits managers to select the areas of their role they find important, to focus on the issues relevant to them. As a result, managers uncertain of their focus can prolong a previous identity or clinical capabilities not essential to their current role. Uncertainty for some, for examples P's 1, 5 and 8 who maintain connections with previous roles and social worlds to offer the role certainty they lack.

Figure 15 represents the emergent grounded theory of a unified management approach. Central to the model is a training framework. The framework ensures all managers, regardless of previous roles, receive the same core skills/knowledge, to exit with equivalent capabilities. These capabilities are not purely managerial, to meet the needs of Participants such as P's 1, 2 and 5 who recognised a lack of management capabilities but did not seek the knowledge they lacked. It also meets the needs of non-clinical managers such as P's 9,11 and 12 who possessed managerial capabilities but lacked the knowledge to understand the role of clinical staff.

The framework will acknowledge previous roles and work experience, flexible in its approach to meet the needs of individual managers. Leadership is one component of the model; it recognises the importance of communication and decision making to allow managers to articulate their vision and organisational objectives. Remaining areas of the model will also support leadership. The combined forum will allow managers to discuss their role, share problems faced and discuss the approaches taken to resolve common challenges, building confidence in their abilities. The forum is available to managers throughout the organisation, many of which will not manage clinical services and therefore are not recruited from clinical backgrounds. It is worth noting that my data is based on a narrow group of participants of mainly female health care workers. I have

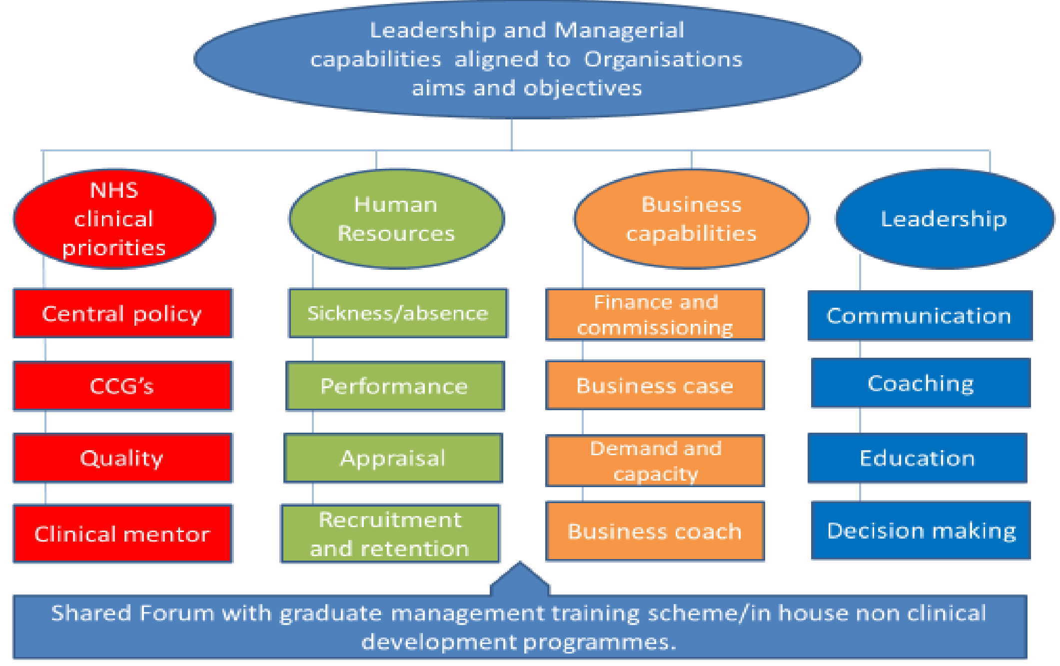
acknowledged this when discussing social worlds in chapter's 2 and 6, and how I was unsuccessful in recruiting more non-clinical managers in the recruitment and sampling section of chapter 4.

Each component of the model is discussed in the following section.

Figure 15: Unified management approach

Figure 16 represents the management capability framework at the centre of the unified managerial approach, an approach I believe will minimise the influences leading to uncertainty identified in this research. To be clear, by unified I refer to a development programme for clinical staff that mirrors the programmes offered for non-clinical staff, it cannot apply to managers appointed from outside the NHS. Unified is used to signify both approaches share a common set of capabilities and experiences, this explains the importance of the shared forum, where both cohorts meet to discuss managerial issues.

Figure 16: Management capability framework



Recognising the limitations of generalisation, the framework stipulates the need to align each of the four components with the organisations aims and objectives. This is essential, as while NHS organisations are governed by central operating and outcome frameworks, their approach to local collaboration across health care boundaries to meet the needs of a defined population are individual.

NHS clinical priorities

This component of the framework recognises clinic staff may not manage a service aligned with their professional registration or experience, an issue raised by P10. The framework supports the need to understand the changing NHS landscape with regards to clinical commissioning groups (ccg's) and developing care models. In addition, the framework stipulates the need for a clinical mentor, a mentor and not a coach, as the purpose is to understand the social systems within a clinical environment, and not to acquire the skills of those working within it. The role of mentor will include arranging clinical visits and working alongside clinical colleagues. It is also important the mentor is not the clinical lead within the triumvirate; the mentor must be independent of the

managers' daily responsibilities. I feel this is important and agree with Cole (2015) that the reciprocal nature of the mentor/mentee relationship must be based on trust, friendliness and reassurance. The role of the mentor influences the personal development of both involved and for this reason I suggest the mentor should offer impartial support with regards to the mentee's substantive role, allowing the business coach to focus on acquiring and developing business capabilities. This distinction is supported by P11 who valued the generic support and feedback of a mentor in their development, while P3 looked to strategic managers for specific and targeted development in financial and business capabilities.

Human resources

Human resource policies and procedures are generic capabilities required by managers throughout NHS organisations. However, the focus of capabilities developed in previous roles is dependent on context. Clinical managers responsible for a specific clinical area may have experience in these areas; a clinical specialist with a defined patient case load may not. This was identified as an issue by P's 2 and 5 who held specialist patient focused roles with no managerial responsibilities prior to accepting their current role. In contrast to P1 a previous ward manager held some experience in managing budgets and staff recruitment. The inclusion of human resources as a core component ensures all managers acquire a minimum skill set applicable to a variety of organisational settings.

Business capabilities

One central occurring theme to emerge from the data was a lack of business capabilities among clinical managers. While human resource experience may be acquired in specific clinical roles, such as those recognised by P1 above. Participants reported a lack of organisational capabilities when promoted from these junior managerial roles, areas such as, to write business cases, understand financial targets and commissioning implications from an organisational perspective. Within this component a coach and not mentor is required, as managers must develop specific capabilities. As business capabilities were an area of expertise among non-clinical managers, this

stipulates the need for the forum as an area to share experience and knowledge across the developmental pathways.

Leadership

The inclusion of leadership recognises the value of leadership development programmes in the NHS, it is also specific to managers with clinical experience for two reasons previously discussed. Firstly, as with ten of the twelve participants, clinical staff are required to study to post graduate level to obtain clinical roles, within these studies many chose leadership and management programmes. The decision to study leadership at a post graduate level for P2 was to meet the need to understand leadership, a need not met by their employer. Consequently, knowledge and understanding of leadership approaches will vary among managers. The role of the coach in this component is to support the manager adapting a leadership approach developed in clinical practice to management. It would be acceptable for the business coach to undertake this role.

International comparison

The approach suggested has similarities to an international programme established in 2001, where shared norms and values were established during a programme for management trainees in Norwegian hospitals. The programme was delivered over 2 days and aimed to establish a "*unitary management model"* to create a sense of "*managementhood"* (Teig 2015: 12). The Norwegian model differs from this research, as applications were welcome from anyone with relevant knowledge of the health sector, as the programme focused on individual and general competence in leadership and not clinical or professional competence, refocusing member's responsibilities toward the organisation and not a group of health care professionals. There is one important difference to the approach offered in this research from that in Norway, the value of building a managerial social world. Chapter two introduced social worlds as a group of individuals with a common social identity and interest who share the same values and beliefs. This research reveals the lack of a managerial social world, compels managers from a health care background to return to professional social worlds, while managers without clinical backgrounds attempt to make connections with clinical staff to build an identity

accepted by staff. The proposed forum, to allow managers a space to share experiences and discuss managerial issues would support the development of a new managerial identity, regardless of previous experience. It is not designed to replace existing support structures, but to recognise the identity of managers, through building a common social identity. Regardless of professional or non-professional backgrounds. As discussed above, it would also support the transition of predominantly female staff with clinical backgrounds, reflected in this research, into a more diverse managerial population. I consider it essential to the success of this framework that both groups meet to establish a shared identity and purpose as health care managers.

Removing uncertainty through coordinated development

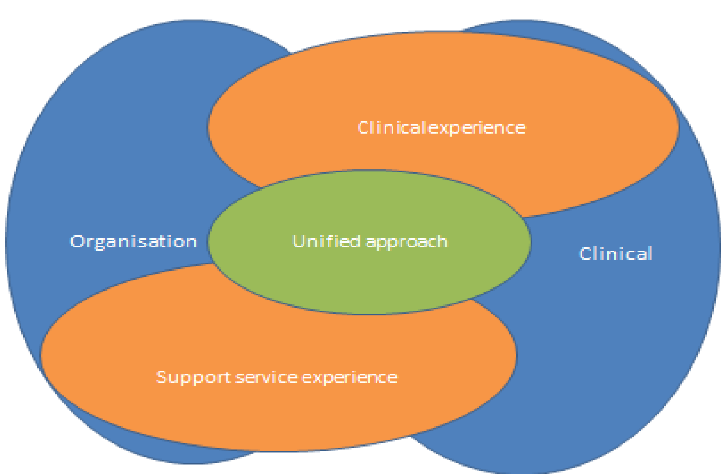
The findings are important as they add to existing knowledge influencing managerial development. The intention is to highlight the limitations in the current approach that limit individual's transition from previous roles to management, a limitation that prolongs time spent in the neutral zone due to managerial uncertainty.

This research adds previous work experience to the many influences on managerial development. It recognises a gap in current approaches that do not account for the influences and limitations previous roles bring to instil doubt and uncertainty, uncertainty that prolongs time in the neutral zone. Effectively, developing a loop where managers return to the security of previous roles to offset uncertainty.

The neutral zone is associated with confusion and disorientation because of *ending* something known and trusted. Here the lack of an agreed *new beginning* leads to continued confusion and disorientation, which manifests as uncertainty, leading to ineffective working practices and a lack of organisational cohesion for its managerial workforce.

How is the study useful- the utility of a unified management approach

Figure 17: Managers alignment within the organisation



NHS managers make decisions that directly or indirectly affect patient care, responsible for both organisational objectives and supporting clinical teams. The lack of a unified programme to prepare and equip managers for organisational roles was a significant finding. As figure 17 illustrates, managers with previous roles in clinical care occupy more space in the clinical sphere, while managers with previous roles in support services occupy a greater proportion of their space in the organisation sphere. This research reveals the influences that determine where managers position themselves.

Managers rely on trusted identities and social relationships to compensate for uncertainty, relying on experiences and connections developed during previous roles. A unified approach would instil a common and shared identity among managers, unfortunately, as this is missing, I maintain a disjointed managerial team is the result. Due to uncertainties managers maintain connections with clinical staff that are not key functions of their role. These actions detract managers from their key functions as a result of time of conflicting priorities, an imbalance that could reduce their impact on organisational efficiency.

Examples of such diversions include the compromises some participants will make to maintain previous experiences and social relationships. In a study by Bradley and Cartwright (2002) they recognise meeting deadlines as one of the

most frequently cited stressors in the workplace. A stress recognised by P8, a manager of clinical services and previous health care professional commenting the balance in their workload was wrong. As part of frustrations with management in category 3, they experienced stress to meet the objectives in their role, frustrated with working long days to achieve. However, they also undertook clinical roles and worked alongside clinical colleagues, expectations outside their managerial role to maintain skills and connections. Another distraction from managerial objectives was some participants also focused on clinical priorities and not managerial. P's 1, 6 & 7 viewed the focus of their role differently, while P6 prioritised policy and strategic development as their focus, P's 1 & 7 prioritises patient safety, identifying the patient and clinical safety as their focus

This study is useful as it recognises the impact of a fragmented approach to managerial development and offers recommendations to remove some of the uncertainties hampering managers. However, it is important to recognise this is not at the expense of previous identities, knowledge, skills, and affiliations. The recommendations do not suggest managers should forgo important values and beliefs that shape their individuality and influence their approach to leadership, the aim is to help managers move toward a unified managerial set of capabilities, ones that recognises the skills they have, but importantly, recognise those they do not.

To demonstrate the impact of an organisation lacking a unified approach, three scenarios within the data will be compared. They are:

- Non-clinical management pathway.
- Progression through a clinical hierarchy with limited management capabilities.
- Progression through a clinical hierarchy recognising the need to acquire management capabilities.

The focus in these scenarios is how previous work experience influences current role, what limitations were self-reported, what actions were taken to

overcome these limitations, and finally, what organisational assistance was available to support managers through transition.

Non-clinical management pathway

Managers lacking a professional qualification attained their posts in one of two ways, either progression through a non-clinical support service hierarchy such as human resources, or externally appointed. Managers reported previous work experience outside of clinical care equipped them with essential skills in management, including data management, writing business cases, finance, and a confidence to manage staff.

These participants strongly identified themselves as managers, with some recognising clinical staff within their teams as leaders, not themselves. Despite holding managerial posts for many years, some believed they would not be leaders until they gained more experience of understanding the clinical element of the staff they lead. More so, they believed this limitation reduced their credibility among clinical staff, as they had no shared experiences of clinical roles.

Importantly, despite supporting the triumvirate approach where clinicians support management decisions, they believed it was clinical experience that gave confidence to decision making. To overcome these limitations, they actively engaged with clinical staff, taking time to work alongside their team in clinical areas, going over and above to establish a shared connection to become team members, time they acknowledge extended their working day and added to an already stressful role.

The organisation supported their career progression through attending a post graduate qualification in management. The significance of this organisational approach is a focus on managerial capabilities, one that furnished managers with the practical skills to become capable in their role. However, despite this they viewed clinical staff as leaders and credible in their role, something they could only achieve through connecting with clinical staff, as if seeking their approval.

Progression through a clinical hierarchy with limited management capabilities.

Many participants progressed through a clinical hierarchy, from junior clinicians to managers, often remaining in one speciality throughout their career. The advantages of this approach are a confidence in clinical practice and engaging with the clinical environment. Managers undertaking this pathway report an ability to work independently, a result of specialist clinical roles fostering a self-reliant and structured approach to working, communication skills were perceived as high, resulting from years of patient contact. Despite many restricting their careers to one speciality, the dynamic and changing pace of clinical care prepared managers to work in a variety of settings, utilising a fluid and unrestricted approach to managing patient care. However, by way of contrast, managers acknowledged patient care and clinical colleagues remained a priority, not finance.

The limitations of a career in clinical practice were predominantly in business capabilities, including writing business cases, demand and capacity plans and commissioning contracts. While managers reported an ability to work flexibly, they did not report a confidence in managing a profession other than their own, believing specialist knowledge was essential to lead a specialist clinical service. Unfortunately, to overcome a lack of business capabilities, many did not seek guidance in the management capabilities they lacked. Instead, choosing to focus on acquiring leadership and coaching strategies, their focus was to become a better leader, not a better manager.

The significance of previous work experience is upholding the role of clinician, with patient care remaining the priority over financial and managerial obligations. Despite recognising a lack of core and essential management skills, many chose to delay acquiring the skills to become a capable manager. In fact, their inability to lead outside of their professional field, demonstrates that professional identity, not management ability, continues to underpin many professional managers legitimacy.

Progression through a clinical hierarchy recognising the need to acquire management capabilities.

While professional identity remained essential for some managers, it did not restrict all managers from recognising a career providing clinical care may not provide a sound basis for a career managing clinical care. P3 is recognised in the methodological rigour section as an *outlier,* an individual peripheral to the generalised findings. Such managers recognise the limitations of previous roles focusing on quality of care, not the business of care; acknowledging they lack a *cutthroat* approach to finance decisions.

To overcome these limitations managers focused on acquiring the management capabilities they lacked, relinquishing clinical competencies no longer essential to their role. Like many, they undertook post graduate level studies in leadership programmes; however, they also negotiated additional coaching and guidance in finance and managerial competence from organisational executives. While links would be maintained with clinical practice, they accepted the performance and management functions of their role as a priority.

The significance of a unified approach

Managers from non-clinical pathways and clinicians with managerial limitations had opposing strategies to remove uncertainty. It supports the discussion throughout the research that a clinical hierarchy exists that maintains clinical credibility is preferred to managerial. Whereas clinicians lacking managerial capabilities choose to focus on the strength of their profession, to enhance their leadership potential, this may be at the detriment of developing managerial competencies.

As an example of clinical staff willing to move beyond a clinical identity. P3 chose to relinquish connections to their clinical career, deciding to enhance the limitations in their management capabilities. In contrast to many participants' in this research, they moved away from relying on clinical credibility, choosing to recognise their role as a manager, and so accept a change of skill and capability was required. Interestingly, all three supported the belief that clinical decision making was paramount, despite the triumvirate approach recognising

clinical decision making as one aspect of informed management decisions, not superior to it.

Chapter 8- Recommendations and conclusions

Strengths and weaknesses of the study

The findings of this study do not imply that managerial uncertainty is an issue throughout the NHS. Reporting of findings has been explicit in terms of research question and context of the study. Limitations are in the spirit of generality, the issues concerning transferability were discussed throughout the research to acknowledge the findings may not apply to the wider NHS.

Participants from this research were mainly female and held professional clinical registrations. While this focused and small sample recruited from one geographical area must be seen as a limitation, with later recommendations acknowledging this, the in-depth data gathered is also a strength in the research. Despite this limitation, the participants were experienced and held organisational leadership roles, the sample also contained health care professionals from diverse professional backgrounds and managers with previous experience outside the NHS. These combined to create a robust sample, despite attempts to recruit a participant from the graduate management training scheme, this was ultimately unsuccessful. As participants were mainly clinical, my past experience not only as a manager, but also a nurse informed my interpretation of the data.

Grounded theory supports novice researchers to construct knowledge in a systematic way while allowing flexibility in its approach (Denscombe 2017). As a novice researcher, grounded theories explicit procedures for data collection and analysis structured the development of concepts in this research, alongside constant reference to the data demonstrated throughout. However, the limitations of full-time work and part time study meant participant interviews were held in a comparatively short time, additional time between interviews would have been helpful.

Strengths and weaknesses in relation to other studies

The specific value of this research is in understanding the effect of complex identities constructed in previous roles. Important, as Kragt and Guenter (2018) recognise research studies into the influential role of leadership experience is limited. The literature review recognised research focused on the role and

impact of leaders in their substantive role (Leggat and Balding 2013, Gallop et al 2014, Martin et al (2012). However, far too little attention has been paid to the influence of previous roles prior to management positions. This research recognises how pre-existing knowledge and skills from previous roles influence and inform leadership. Denscombe (2003) asserts that researchers must be clear what is different and new in their research, moving knowledge on from previous studies and making it unique. The findings from this study do so in several ways and contribute to the current literature as follows.

This research was conducted at an appropriate moment in the NHS; post Health and Social Care Act (2012), with increasing demand for services amidst widespread financial deficits, a cause of significant strain (The Health Foundation 2018). According to Denscombe (2003: 47) this adds value to the findings, making them *"timely"*.

A further strength of this study was to focus on the views of managers, and not those they lead. Studies such as Nielson et al (2008) interview health care staff and often conclude a transformational leadership style is closely associated with followers' job satisfaction and well-being. However, this research focused on managers and found a transformational approach, while useful in clinical care, may no longer support managers in achieving their objectives.

Implications of the research findings

The findings of this study have several important implications for future policy, education, and practice. However, it is important at this stage to again stress the notion of *moderatum generalisation* meaning the scope and influence of this research is moderated (Payne and Williams 2005). The research was conducted in two NHS Trusts in the North of England, each Trust was unique, with a distinct culture and context, limiting direct repetition throughout the NHS.

Implications for central policy development

These findings add to the body of evidence which informs managerial and leadership development in NHS organisations. In suggesting a need for a refocus in managerial capabilities, NHS England and Health Education England (2018) acknowledge the current business focused context requires

organisations to take a fresh look at what constitutes leadership. A fresh look recognises the need for NHS organisations to attract leaders with the requisite management and leadership capabilities from other sectors (Kerr 2018). I concur with Hancock (2018) that what matters is we get the best leaders, either clinicians who learn to lead through tailored training programmes, or external recruits taught how the NHS works at all levels, an approach that recognises the findings and implications in this research to unify an approach to managerial development.

I support The Kings Fund (2018a) in highlighted their concerns over the pipeline of future leaders, they ask NHS England and NHS Improvement regional teams to clearly model the behaviours expected of future leaders and be clear what good looks like. A clear picture of *good* is evident for health care staff in the health care leadership model (NHS Leadership academy 2013) and the clinical leadership competency framework (NHS Leadership academy 2011b). However, no framework for general managers in the NHS exists to model behaviour and expectations. A key policy priority should therefore be to adopt such a framework. The North-East Leadership Academy (2018) advocates getting people with the right capabilities, commitment, and behaviours to drive success. This can only be achieved if central policy recognises the need to develop both health care professionals and individuals lacking a professional registration toward one managerial identity.

Implications for Education and practice

Implications for central policy recognise the need to align capabilities of health care professionals and managers lacking a clinical background. To achieve this, current development programmes must recognise managerial competencies as equal to clinical competencies.

The NHS graduate management training scheme has been successful in recruiting and developing graduate trainees to become future leaders in the NHS (NHS Graduates 2015). Janke et al (2018) recognise the value of this post graduate programme in improving the management capabilities of middle managers in hospitals, however, they warn against seeking a rapid change to hospital performance through appointing single dynamic individuals, instead,

asking NHS organisations to focus on nurturing and sustaining the skills of middle managers.

The comments in the preceding paragraph echo the issues in current education. The focus remains to educate graduates for management positions or improve the skills of existing managers in post. It does not address the needs of clinical staff aiming to secure a management position. I have demonstrated a clear need to recognise the educational and developmental needs of staff in practice. An issue acknowledged in the literature by Kerr (2018) who advocates for clinicians to be given more training in management, to prepare greater numbers for a move into leadership positions.

Recommendations

- It is my belief a route for clinical staff equal to that of the graduate management trainees is essential to support clinical progression.

- Recruitment to identify staff willing to move towards a managerial identity can be assessed in two ways. Psychometric testing, commonly incorporated in managerial interviews could focus on individual's priorities within the role, to understand how previous roles influence their decisions.

- Establish an agreed set of capabilities such as those suggested in the framework within the model, to support managers to move towards a new identity. It provides those from previously non-managerial roles with a clear identity and skill set, while also providing those with an established managerial identity and skill set, a clear understanding of how they may need to adapt to a new managerial role in a health care setting.

- Establish a managerial social world to support managerial development, while also providing an ongoing support mechanism for established managers. This will remove the need for managers to return to social worlds aligned with previous roles.

- A unified approach to managerial development. It may seem at odds with the recommendations above to offer separate development pathways for graduate management trainees and existing NHS staff. However, the rational within the research links to values, beliefs, and health related knowledge base. The importance of the recommendation is that while both sets begin with different needs, development ensures both move toward a singular identity and skill set.

- Remove the option for previously clinical managers to wear a clinical uniform, at times to portray a preferred identity. This also strengthens the role of the senior clinician within the triumvirate, a role that could be undermined when managers reinforce a clinical identity.

- Remove ineffective clinical working and focus managerial time and resources to deliver Trust aims and objectives. Removing uniforms, may remove the need for some managers to return to supporting clinical colleagues to gain recognition and credibility.

- NHS Organisations to address the continued dominance of clinical professions and be proactive in developing a coherent managerial identity.

- Managerial development for clinical professionals to be enhanced to compensate for an overreliance on leadership development.

Unanswered questions and recommendations for future research.

Ross and Matthews (2010) contend that, although the researcher has accomplished everything they set out to do, there is always a need for further research, and more can be done by the researcher and others. This research has identified some interesting lines of inquiry. These include the impact on the triumvirate approach to clinical staffs' progression into management, to understand how managers lacking a health care profession recruited from outside the NHS transition to a culture dominated by a clinical hierarchy, to understand the experiences of graduate management trainees, and to consider if the findings in this research are similar in other public funded services.

The key aspects for future research are listed as follows:

Research opportunities

- The introduction of the triumvirate approach has focused the role of clinical staff towards a supporting role for operational management. Participants were concerned a preference for managerial staff is replacing hierarchical progression. There is an opportunity to understand how clinical staff perceive this change to their role within NHS organisations, and to appreciate its impact on career development and aspirations.

- Managers recruited from outside the NHS reported a dominant clinical hierarchy that restricted their managerial effectiveness. The lack of a professional qualification and identity was seen to reduce their managerial credibility among clinical staff. Although this was an aspect of the research, it would be worthwhile to focus on these managers alone, to further understand the strategies they take to adapt to the clinical dominance and culture of the NHS.

- A proportion of managers in this study are no longer the preferred candidate for their roles, as job specifications increasingly focus on managerial experience over professional experience. Essentially, their professional qualification and clinical experience are no longer the dominant specification. It would be valuable to understand how this impacts their role.

- Research to measure the effectiveness of graduate management training schemes was difficult to find. Despite no participants in the study undertaking the formal programme, its effectiveness and value to NHS organisations should be understood.

- The experience of managers moving from private organisations to publicly funded organisations is limited in the literature. If recruitment is based on managerial effectiveness alone, understanding if managers translate private sector success to NHS organisations, under both political and public scrutiny would be valuable.

- Future research into managerial uncertainty might usefully focus on similar publicly funded services with an established identity, such as the Police service. To understand if managers experience similar issues with a move into managerial roles.

Conclusion

In this thesis I have found the need to consider previous work experience as a significant influence on managerial leadership. This thesis demonstrates uncertainties in management can stem from the credibility, identity and social connections associated with previous roles. In addition to these, the influence of a powerful clinical hierarchy can lead to managerial tension and compel managers to modify their leadership approach to offset feelings of uncertainty.

The implications of these findings require central policy to consider the specific needs of clinical staff, recognising they are not offered the opportunities of non-clinical managers. To overcome this discrepancy education programmes reflecting the components of the framework offered in this thesis should be available for clinical staff.

The recommendations offered in this research are important to ensure future NHS managers can be cultivated within numerous developmental pathways with one approach. Not an approach that rejects clinical knowledge or diminishes the standing of managers lacking clinical experience but leading to one managerial team with a shared skill set and identity.

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Appendices

Appendix A: Audit trail of study's findings that result from participant experiences.

	Coding	Direct coding – plain text In Vivo- underlined Value- bracketed (V) participants' values, attitudes, beliefs and identity Emotion – bracketed (E) participants experiences and actions
Theme No	Theme 1	Importance of Identity
1a	Visible- likes to be seen and visible among team	P1- This increases travel time between sites and makes her less efficient but wants to be seen by all team members, Can't be distant as a people person. Uses need to be seen to procrastinate and avoid boring M functions that she feels are irrelevant (V), but will stay in office to get jobs done to meet deadlines. P2- Not visible as in nursing (Matron)way, but accessible P3- Visible- her choice to wear uniform and be seen in practice Visible and in uniform, adopted by the Trust after CQC visit (back to the floor- BTF) has an open door and diary policy to be seen. Also visible by friends of the hospital at social events in own time. Friends of the hospitals are important , personal time invested in supporting fund raising. Used "visible" again I've tried to be visible at all of those, but it obviously impacts on the day off P4- No comment P5- Visible L- visible presence- I'll go around the wards and make sure everybody is ok for staffing, make sure no one has an issue and try and alleviate any issues there and then *but also does it to maintain clinical respect- (identity)* so they can see the leader so they have clinical respect as well P6- Being credible and seen I clinical areas- Visits wards in uniform as part of role but also for self - I also do go on and do the occasional audit, but that's more for me, making sure the front line staff know who I am and that I'm approachable. As staff governor also need to be seen - so I kind of think that allows me to get out there so people can see who I am, they can see me, not just a name on a board. Being seen supports credibility for decision making. I want people to know that I have some credibility, you know value of the decisions I've made on their behalf. P7- Identity and prototypical behaviour As a junior sister took empty shifts (mirrors what she still does now). I'm very passionate about being a nurse (e),

Appendix B: Theoretical sampling criteria

Theoretical sampling criteria of Participants

Participant	Criteria for participant interview	Match to theoretical sampling
1	Initial interview P1 chosen as they held a health care professional qualification (Children's nurse), but held an organisation management position that was not aligned with their professional qualification or clinical experience. They also held Masters level academic study that was specific t their role.	
2	1. HC professional again in an organisational role, not the manager of a localised or contained speciality. One that collaborates throughout the Trust- *I want to see if the ideology and strong professional identity in general is maintained.* 2. Not a nurse to gather views from another professional- *P1's identity was first and foremost as a nurse, would another speciality be the same?* 3. Someone also new to role as P1, so they have the same recent transition from clinical to Management positions.- *To see if time frame is important, as P1 managed the service as a ward, would another new manager do the same?*	Organisational Wide Dietician 7 months in substantive post.
3	1. Not to be based in an acute Trust like P1&2- *To understand if being based outside the acute setting made any difference* 2. Will be a H.C professional to continue to look at themes, but outside an acute setting- *with comments from two different specialities P3 will still be a H.C professional as P1&2 had very different clinical experiences.* 3. Another Masters in Leadership as P2 to explore the value and impact of such a specific and focused MSc to current role. *Masters in Leadership had a huge impact on how P2 lead the service and the team. Whereas, P1's was linked to knowledge of role function.*	Based in a community hospital Registered General nurse and Midwife MSc in Leadership
4	1. A health care professional with an organisational remit to oversee the delivery of patient care, but not deliver it themselves- *to explore if they also undertake additional roles outside of expected roles to maintain clinical/patient contact.* 2. Health care professional to continue to look at identity- *P1-3 have maintained a strong professional identity* 3. Health care professional to see if the lack of a clear and deliberate career path continues- *P1-3 made some career choices but in the main they did not see themselves in their current position when clinical.* 4. Health care professional to look further at transferrable clinical skills- *it has been mentioned but need to look at specifics, what skills do they mean?*	Organisational lead for patient safety Registered General nurse and Midwife (points 2-4)
5	1. A health care professional that works in the clinical setting,	

	and has both managerial and leadership responsibilities- *I want to look at how prepared someone in a clinically focused post is for a move into a truly management post. What have they/organisation done to prepare. As a lack of management skills has been common when moving roles.* 2. Need someone not in a truly management role yet, to understand if they have a clear career path to move forward- *common theme is participants don't.* 3. Someone with responsibility for staff in clinical practice to look at developing staff for future M roles,	Role- Matron for acute services Clinical role. Regularly wears uniform and in clinical areas. Matron
6	1. Health care professional- *as many of the emerging categories focus on changing leadership approach when moving from a clinical post to a clinical leadership/management post* 2. Need someone not in a truly management role yet, to understand if they have a clear career path to move forward- common theme is participants don't. 3. Someone with responsibility for staff in clinical practice to look at developing staff for future M roles, *Points 2 and 3 require more information and details to support further analysis to understand the category and have a deeper understanding of their properties*	Matron Organisation clinical lead for infection prevention and control
7	Health care professional in clinical role to further understand the emerging themes of 1. Resilience and their leadership role in developing future leaders from within the clinical environment 2. Identity and need to be visible in clinical areas Also to continue to develop the themes of 1. Changing leadership approach the further removed from a clinical post 2. Deliberate career path or external influences 3. Choice of masters education	Matron and service manager for emergency services Has a "Hybrid" role
8	Participant in a similar position to participant 7, with a clinically focused leadership role, containing managerial functions and responsibilities. 1. To further look at leadership style with this Hybrid role 2. Further explore visibility and if why wearing a uniform is important 3. Further explore transferrable skills, are they rooted in knowledge and experience 4. How do they perceive their leadership role supports the organisations structure 5. How they build resilience in self and others	Matron for community midwifery and maternity outpatients Has both clinical and organisational responsibilities
9	Participants are needed from non-nursing/midwifery backgrounds to understand the influence of previous work experience on approaches to leadership. As a result participant 9 was chosen as they have a strong presence in the clinical environment, but not as a member of the nursing/midwifery workforce. The focus going forward will be to look at non clinical managers and managers from specialties outside nursing	Head of chaplaincy service

	/midwifery Participant 9 chosen: 1. To further look at leadership style outside a clinically focused profession 2. Further explore visibility in the organisation and its influence on leadership 3. Explore transferrable skills from a non-clinical career pathway and experience. 4. How do they perceive their leadership role supports the organisations structure, both clinical and operational	
10	While struggling to recruit Band 8 staff that has no professional background, I need to consider the emerging themes in an environment that is not aligned with a 24/7 acute service, but still for a service that is patient focused. Participant 10 chosen to 1. Explore themes in a Monday to Friday patient focused service, where no emergency/acute admissions are seen which is very different to the majority of participants so far. 2. No input from nursing/midwifery staff 3. Self-contained unit with only one professional group.	Head of Audiology
11	Through discussions at the Trust I have identified an individual that works alongside others that manage, but do not have a clinical background. It's unclear at this time how many staff, and if any are Band 8. However. I need to discuss the categories with a non-clinical manager to. 1. Understand how much the clinical element of previous work experiences has influenced participant's leadership, by speaking to a manager without this experience. 2. Understand a non-clinical manager's identity, where their beliefs and values originate.	Head of learning and development
12	Trust two access to interview a participant without a clinical registration. 1. To further look at leadership style outside a clinically focused profession 2. Further explore visibility in the organisation and its influence on leadership 3. Explore transferrable skills from a non-clinical career pathway and experience. 4. How do they perceive their leadership role supports the organisations structure, both clinical and operational	Operational Service manager-Pathology a cancer services

Appendix C: Matrix from Participant Information questionnaire

Participant number		Current position in the organisation	Time in role	Previous manager positions.	Registered Health professional	Highest academic qualification	Gender
01 Trust one		Band 8 Organisational lead	7 months	Clinical	Registered Nurse (Adult and Chid) (NMC)	MSc	Female
02 Trust one		Band 8 Head of department	23 months	Clinical	Dietician (HCPC)	MSc	Female
03 Trust one		Band 8 - Non-acute role	18 months	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc	Female
04 Trust one		Band 8 organisational Lead	12 Years	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc	Female
05 Trust one		Band 8 - Acute role	2 Years	Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
06 Trust one		Band 8 organisational Lead	7 years	Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
07 Trust one		Band 8 Head of department	2 years	Non-Clinical	Registered Nurse (Adult) (NMC)	MSc	Female
08 Trust one		Band 8 - Acute role	5 years	Clinical	Registered Nurse, Registered Midwife (NMC)	MSc, BSc (Hons)	Female
09 Trust one		Band 8 Head of department	4 years	Non-Clinical Non-NHS	Nil	MSc	Male
10 Trust one		Band 8 Head of department	20 years	Non-Clinical	Audiologist (HCPC)	H-Tec Physiological measurement.	Female

						Level 4 Manage ment	
11 Trust one		Band 8 organisation al Lead	4 years	Non-Clinical (Non-NHS)	Nil	BSc (Hons)	Femal e
12 Trust two		Band 8 Head of department	2 years	Non-Clinical	Nil	MSc	Femal e

- NMC- Nursing and Midwifery Council
- HCPC- Health Care Professionals Council

Appendix D: Example of category formation at P5:

13	Prototypical behaviours, social identity, (after P5 include Focuses on the professional MDT members they manage)	Keep as now 3 themes merged into this one	keep
14	Non clinical M's having responsibility for clinical staff/functions	Keep as major emerging theme	keep
14b	As M appointed non nurses to traditional nursing roles	Merge with 14 completely	Merge with 14
15	Role priorities as manager and clinician	Keep as central	Keep
16	Masters level education	Keep as choosing leadership and non-clinical courses is shared across all	Keep
17	Managing Friends	No longer relevant	Discard
18	Resilience	Major emerging theme	keep
19	New proposed structure	Discard- is timely and ongoing in Trust now, but not key to understanding past experience. Will align with non-clinical managers in role which is same issue.	Discard
20	Likes/needs a challenge (move P1 and P2 in)	Same as number 2 so discard	Discard
21	Lacked Management functions in new role (move P1 and P2 in)	Merge with number 12 (Loss of skill moving to M role, having to learn new skills and abilities) as same issue	Merge with 12
22	Current clinicians may not see management as a future career	Keep, key issue in recent P interviews	keep

After P5 themes are becoming clearer, currently there are 22 in the table, but not all have been relevant to P's and so list reduced as below

Theme No	Theme	Comment	Take forward or discard
1	Focuses on the professional MDT members they manage	Only relevant to P1 and so included on first theme list, it may still be relevant so will merge with prototypical and social identity as that was rational for code.	Merge with prototypical and social identity
2	Increased opportunities and challenges in role	Very relevant to all and reason for taking new opportunities was often looking for a new challenge, and not merely seeking promotion.	keep
3	Bureaucracy and frustration from M functions	Not relevant to all but has been mentioned and too early to discard at P5	keep
4	Transferrable clinical exp and skills into M role	Keep, need to explore transferrable skills in more detail.	keep
5	Leadership approach (in general) Also describing a change in L approach	Keep- lots of data and focus of research	keep
6	Leadership (future)	Keep- lots of data and focus of research. May consider merging with above No 5 but not as yet.	keep
7	Visible- likes to be seen and visible among team	Keep, important link to clinical past	keep
8	No career path to Role	Keep, one of the major themes to emerge	keep
9	Importance of Patient contact and voice	Not relevant to all but has been mentioned and too early to discard at P5	keep
10	Identity	merge with prototypical and social identity as comments are related	Merge with prototypical and social identity
11	Participants professional role was also important	merge with prototypical and social identity as comments are related	Merge with prototypical and social identity
12	Loss of skill moving to M role, having to learn new skills and abilities	Keep as central to question and number 21 brought in	keep

Appendix E: Centre for Clinical research and Innovation confirmation of Trust permission (Trust one)

County Durham and Darlington **NHS**
NHS Foundation Trust

Centre for Clinical Research and Innovation
Fifth Floor
Darlington Memorial Hospital
Hollyhurst Road
Darlington
DL3 6HX

Tel: 01325 743366

All studies are subject to the requirements of the DoH's Research Governance Framework 2005 Second Edition and subsequent amendments. If you have not read this document, or are unfamiliar with its contents you are strongly advised to refer to it before commencing with any research or data collection. You may not commence data collection until you have written formal authorisation from the Director of R&D and an appropriate research ethics committee.

8th April 2016

Mike Stephenson
Northumbria University
School of Health, Community & Education Studies
Room G217
Coach Lane Campus (East)
Coach Lane
Newcastle-upon-Tyne
NE7 7XA

Dear Mike

Re: R&D Confirmation of Trust Permission

R&D Ref: MED-465-2016
SHORT TITLE: Professional Doctorate in Health 2014 Stephenson

I am writing to inform you that I am happy to authorise Trust permission for the above study. Please liaise with the Pathology or Pharmacy prior to recruiting a patient to ensure that these support services are ready to support you in your recruitment.

Key Documents Reviewed (please note this is not exhaustive)

Document Type	Version	Dated	Date of Ethics Letter
R&D Form 195499/926916/14/486	5.2.1	24/02/2016	N/A
Site Specific Information Form 195499/926921/6/758/306396/341902	5.2.1	04/01/2016	N/A
Protocol	3	29/09/2015	N/A
Information sheet	3	29/09/2015	N/A
Consent	3	29/09/2015	N/A
Questionnaire	3	29/09/2015	N/A
Interview Guide	3	29/09/2015	N/A

Permission granted is on the understanding that the study is conducted in accordance with the Research Governance Framework 2005, ICH GCP 1996, Medicines for Human Use 2004 as amended, Data Protection Act 1998 (including Caldicott Guidelines) and any other NHS Policies and Procedures.

7. Non CTIMP Permission Letter

Appendix F: E-mail of invitation to sample group (Trust two)

May 10th 2017. Version 4

Content of invitation e mail to be sent to prospective participants

Dear (name to be inserted)

I'm sending this e mail as you've been identified as someone in a position to take part in a research study I'm undertaking in Northumbria NHS foundation Trust.

The research is carried out as part of a taught Professional Doctorate in Health at Northumbria University. The research aims to understand if NHS managers perceive their leadership style is influenced by previous work experience.

I'd be grateful if you would take the time to read the attached participant information sheet and return the signed agreement, along with the completed questionnaire to me at the e mail address given if you agree to participate

Your time is greatly appreciated

Mike Stephenson
Senior Lecturer- CPD in Health
Northumbria University – Faculty of Health and Life sciences
Room G217
Coach Lane Campus (East),
Coach Lane,
Newcastle-upon-Tyne
NE7 7XA
01912156783
mike.stephenson@northumbria.ac.uk
CPD website- www.northumbria.ac.uk/cpd

1

Appendix G: Semi-structured interview schedule (Trust two)

May 10th 2017. Version 4

Initial Participant interview guide

Project Title:
How do NHS managers perceive their leadership style is influenced by previous work experience?

Principal Investigator:
Mr. Mike Stephenson

1. Discuss the roles and responsibilities involved in participant's position.
2. Explore participants previous work experiences
3. How have previous positions influenced participants approach to meeting the roles and responsibilities in their current position
4. How do participants describe their leadership style
5. Discuss how participants leadership approach in previous positions has influenced their current approach
6. Encourage participants to provide examples of how previous work experience has influenced their current leadership style
7. Understand if participant's leadership style has changed in current position from previous positions
8. Have any influences or experiences in participant's current role resulted in modifying their leadership style
9. Has leadership development in participant's current role influenced their approach to leadership

Explore specific challenges in current position that influence participant's leadership style

1

Appendix A: Semi-structured interview schedule (Trust one)

County Durham and Darlington NHS
NHS Foundation Trust

Initial Participant interview guide

Project Title:
How do NHS managers perceive their leadership style is influenced by previous work experience?

Principal Investigator:
Mr. Mike Stephenson

1. Discuss the roles and responsibilities involved in participant's position.
2. Explore participants previous work experiences
3. How have previous positions influenced participants approach to meeting the roles and responsibilities in their current position
4. How do participants describe their leadership style
5. Discuss how participants leadership approach in previous positions has influenced their current approach
6. Encourage participants to provide examples of how previous work experience has influenced their current leadership style
7. Understand if participant's leadership style has changed in current position from previous positions
8. Have any influences or experiences in participant's current role resulted in modifying their leadership style
9. Has leadership development in participant's current role influenced their approach to leadership

Explore specific challenges in current position that influence participant's leadership style

1

Appendix I: One page example of line-by-line coding from P4.

	Line	Transcript	Coding
	125	Is your remit across the organisation?	
		• Participant everywhere	
	130	• Principal Investigator Up to…past Durham and Shotley Bridge?	
	135 140	• Participant Cumbria. My remit is Trust wide, so all the urgent care centres, all the community hospitals, all the community teams like district nurses, podiatry etc., all of them is under my remit. So I do education, we do mandatory F1, we go into teams and we do bespoke training, if we identify through our theming that we have an area that we're got concerns about, we'll go in and we'll do some bespoke work and we might do some leadership work as part of that, because it might be that poor leadership, or poor knowledge of management structure, because of all the changes, my opinion, is that we haven't given every level like band 7 or band 6….and I feel quite strongly that the organisation should have a strong remit so that every newly qualified nurse has got their preceptorship, then from preceptorship you've got another piece of training to make sure that you have all the skills like the sickness absence and the managerial aspects. That was called great line management, but I went and looked at it and was disappointed.	Trust wide remit Targets areas that are a concern, process and leadership- poor leadership, or poor knowledge of management structure Believes staff (Band 6&7) are not prepared with many changes and they need skills- have all the skills like the sickness absence and the managerial aspects- *link to transferable skills*
	145	• Principal Investigator Ok.	
	150 155	• Participant And I think it could be much better, and when you get a band 7 and the remit, I think most of our staff should go and have a look at the NMC, because that's where a clinician, a nurse etc. will end up if they get it wrong, and I think they should all go and look at it and see how the NMC works on all of that. And then the other thing is the GMC, I mean I feel, the, because I'm quite well accepted by the medical staff…and not everybody is, because you know it's about understanding that our doctors, because of history they just think more traditionally that they don't have to tow the line(v).	Staff to look at NMC investigations to see how nurses are investigated, when they get it wrong Historical and hierarchical context with doctors- traditionally that they don't have to tow the line(v), but have now been brought into the fold
		• Principal Investigator	

Appendix J: Northumbria University ethical approval

Professor Kathleen McCourt CBE FRCN
Executive Dean

This matter is being dealt with by:
Professor Pauline Pearson
Ethics Lead
Department of Healthcare
Faculty of Health and Life Sciences
Coach Lane Campus
Newcastle upon Tyne
NE7 7XA
Tel: 0191 2156472
Email: *pauline.pearson@northumbria.ac.uk*

9 December 2015

Dear Michael

Faculty of Health and Life Sciences Research Ethics Review DHCStephenson170715
Title: How do NHS managers perceive their leadership style is influenced by previous work experience?

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard

You may now also proceed with your application (if applicable) to:

- NHS Trust or Health Research Authority for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).

You must not commence your research until you have obtained all necessary external approvals.

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Pauline Pearson

Professor Pauline Pearson
Ethics Lead for Healthcare, on behalf of the Faculty Research Ethics Review Panel

Vice-Chancellor and Chief Executive
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle

Appendix K: Centre for Clinical research and Innovation letter of access (Trust one).

County Durham and Darlington **NHS**
NHS Foundation Trust

Centre for Clinical Research and Innovation,
5th Floor,Darlington Memorial Hospital,
Darlington
County Durham
DL3 6H

Tel: 01325 743737
Fax: 01325 743768

All studies are subject to the requirements of the DoH's Research Governance Framework 2005 Second Edition and subsequent amendments. If you have not read this document, or are unfamiliar with its contents you are strongly advised to refer to it before commencing with any research or data collection. You may not commence data collection until you have written formal authorisation from the Chair of the Research Review Board and an appropriate ethics committee.

Private & Confidential

15 April 2016

Mr Mike Stephenson
Northumbria University
Faculty of Health and Life Sciences, Room G217
Coach Lane Campus (East)
Coach Lane
Newcastle Upon Tyne
NE7 7XA

Dear Mike

Letter of access for research -
Study Ref: MED-456-2016 – How do NHS Managers perceive their Leadership style is influenced by previous work experience

This letter confirms your right of access to conduct research through County Durham & Darlington NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on **15 April 2016** and ends on **01 June 2018**, unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at County Durham & Darlington NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **County Durham & Darlington NHS Foundation** Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through County Durham & Darlington NHS Foundation Trust, you will remain accountable to your employer **Northumbria University**, but you are

with you all the way

Version 2.1, September 2010
Research in the NHS: HR Good Practice Resource Pack

required to follow the reasonable instructions of **myself** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with County Durham & Darlington NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with County Durham & Darlington NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on County Durham & Darlington NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where required by law, your HEI employer will initiate your Independent Safeguarding Authority (ISA) registration, and thereafter, will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity. You MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

County Durham & Darlington NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Tarn Nozedar
Clinical Research & Innovation Manager

cc: Recruitment
County Durham & Darlington NHS Foundation Trust
Darlington Memorial Hospital
Memorial Hall
Hollyhurst Road
Darlington
DL3 6HX
cdda-tr.recruitment-helpdesk@nhs.net

Andrea Clarke – HR Coordinator
Northumbria University
Sutherland Building
Newcastle NE1 8ST
andrea.clarke@northumbria.ac.uk

Please refer to relevant CDDFT R&D SOPS which can be found on the R&D intranet page or by emailing research@cddft.nhs.uk.

Conditions of Trust Permission are as follows:

- You notify the R&D Manager immediately should any concerns arise about the safety and welfare of a patient.
- You establish and maintain an Investigator Site File for CDDFT. *(as per SOP 3)*
- Where Sponsor SOPs are used please ensure details / links are available in the ISF, additionally CDDFT SOPs applicable to the study are to be listed in the ISF – check with R&D if uncertain. A list of SOPs is available on the R&D Trust Intranet site.
- You complete and return to the R&D Department all requested monitoring forms. *(as per SOPs 11&14)*
- The NHS Retention and Disposal schedule (HSC 1999/053) states that clinical notes of patients entered into clinical trials of medicinal projects should be retained for 15 years after conclusion of treatment. Please find enclosed the procedure for the identification of patients in clinical trials of medicinal products and study labels to identify notes
- You must notify the R&D Department of any amendments to the protocol. Please note that all amendment documentation as approved by ethics must be submitted to the R&D Department for acceptance and continued Trust permission.
- Please ensure that anyone involved in this study are listed on the Site Specific Information Form and/or on the delegation log and attend GCP training every 2 years. Please notify the R&D Department of a change of Principle Investigator and consenting team members.
- Appropriate contracts / letters of access are in place should new members join the team post approval.
- You should notify the R&D Department immediately when the Trial has ended at CDDFT.
- On completion of the study I would be grateful if you could forward a copy of the final report and any publications as a result of the study to the R&D Department at the above address.
- A copy of all external monitoring reports are to be sent to the R&D Department.

Please note that CDDFT is required to monitor and audit research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements.

The R&D team wishes you every success with the completion of your study.

Yours sincerely

Professor Jerry Murphy
Research Review Board Chair

7. Non CTIMP Permission Letter

with you all the way

Appendix L: Letter of access (Trust two)

NHS CONFIDENTIAL

Ref: 319-RP/AW

9th June 2017

Private and Confidential
Michael Stephenson
Northumbria University
Coach Lane
NE7 7XA

Dear ***Mike***

Letter of access for research

This letter confirms your right of access to conduct research through Northumbria Healthcare NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on **9th June 2017** and ends on **9th October 2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at Northumbria Healthcare NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to Northumbria-healthcare NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Northumbria Healthcare NHS Foundation Trust, you will remain accountable to your employer **Northumbria University** but you are required to follow the reasonable instructions of **Dr Alison Machin** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Northumbria Healthcare NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Northumbria Healthcare NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others

Human Resources Department, Northumbria House, Unit 7/8 Silver Fox Way
Cobalt Business Park, Newcastle upon Tyne, NE27 0QJ
Tele: 0191 203 1415 option 2 or Fax: 0191 203 1420

while on Northumbria Healthcare NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice:
(http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.
You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Northumbria Healthcare NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Ann Stringer
Director of Human Resources & Organisational Development
Northumbria Healthcare NHS Foundation Trust

cc: Caroline Potts, R&D Manager, Northumbria Healthcare NHS Foundation Trust
HR Department, **(Employer)**

Human Resources Department, Northumbria House, Unit 7/8 Silver Fox Way
Cobalt Business Park, Newcastle upon Tyne, NE27 0QJ
Tele: 0191 203 1415 option 2 or Fax: 0191 203 1420

Ref: 319-RP/AW

I hereby accept the appointment of Researcher on the terms and conditions set out in the Statement of main terms and conditions in this Letter of Access.

NAME: **Michael Stephenson**

SIGNED: ....

DATE: 15.6.17 ....

Appendix M: E-mail of invitation to sample group (Trust one)

<u>Content of invitation e mail to be sent to prospective participants</u>

Dear (name to be inserted)

I'm sending this e mail as you've been identified as someone in a position to take part in a research study I'm undertaking in County Durham and Darlington NHS foundation Trust.

The research is carried out as part of a taught Professional Doctorate in Health at Northumbria University. The research aims to understand if NHS managers perceive their leadership style is influenced by previous work experience.

I'd be grateful if you would take the time to read the attached participant information sheet and return the signed agreement, along with the completed questionnaire to me at the e mail address given if you agree to participate

Your time is greatly appreciated

Mike Stephenson
Senior Lecturer- CPD in Health
Northumbria University – Faculty of Health and Life sciences
Room G217
Coach Lane Campus (East),
Coach Lane,
Newcastle-upon-Tyne
NE7 7XA
01912156783
mike.stephenson@northumbria.ac.uk
CPD website- www.northumbria.ac.uk/cpd

Appendix N: Participant Information sheet (Trust one)

Study title- How do NHS managers perceive their leadership style is influenced by previous work experience?

Participant Information Sheet and questionnaire

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve. Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you would like to take part.

What is the Purpose of the Study?

As a Professional Doctorate student at Northumbria University, I would like to understand how managers in grade 8 positions perceive their leadership style is influenced by previous work experience. NHS managers are recruited internally from existing health care professionals, externally from outside the health sector, or developed through graduate management programmes. I aim to understand if previous work experiences influences their approach to leadership in current NHS management posts. This is important to understand the developing needs of existing managers, and inform the recruitment process for future managerial staff.

Why have I been invited?

You hold a band 8 management position in the trust.

Do I have to take part?

No. It is up to you whether you would like to take part in the study. I am giving you this information sheet and questionnaire to help you make that decision. If you do decide to take part, remember that you can stop being involved in the study

whenever you choose, without telling me why. If you choose to take part please complete the enclosed questionnaire and return in the envelope provided. I will then contact those chosen to participate.

What will happen if I take part?

You will be interviewed by me and no other. Interviews will be informal and take place in a location, date and time of your choosing. Interviews will record voices only for analysis, no video footage is taken. Interviews are not expected to exceed one hour. During the interview you will be asked about previous work experience and how this may influence your approach to leadership in your current role.

Will my participation involve any physical discomfort?

We'll be seated while the interviews are recorded, if you need to pause the interview at any time just let me know.

Will I receive any financial incentive/travel expenses for taking part?

There are no financial incentives to participate in the research study. Interviews will take place in a location, date and time of your choosing to ensure no travelling or financial inconvenience.

What are the possible disadvantages of taking part?

You will be asked to give up some of your time to attend the interview. To minimise this disruption Interviews will take place in a location, date and time of your choosing. All participants will remain anonymous.

What are the possible benefits of taking part?

By taking part in the study, you will help to understand how previous employment background influences approaches to leadership. This knowledge is important when considering appointing to new posts, and when considering the developmental needs of existing post holders.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your name will not be written on any of the data we collect; the interview transcripts will have an ID number on them, not your name. Your name will not be written on the recorded interviews, or on the typed versions of our discussions from the interview, your name will not appear in any reports or documents resulting from this study. Any information and data gathered during this research study will only be available to the research team identified in this information sheet.
The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

How will my data be stored?

All electronic data and data analysis, including the recordings from your interview, will be stored on the University U drive, which is password protected. Any printed documents will be stored in a locked cupboard on the Universities campus.
All data will be stored in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

We will share the findings from this study with:

- Yourselves as participants in this study
- Northumbria University, in the form of the written professional doctorate
- County Durham and Darlington NHS foundation trust will receive an anonymised report of the studies final outcomes.
- It will be published anonymised in academic and professional peer reviewed journal

Who has reviewed this study?

Before this study could begin, permissions were obtained from County Durham and Darlington NHS Foundation Trust and Northumbria University. The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Contact for further information:

Researcher: Mike Stephenson
Senior Lecturer- CPD in Health
Northumbria University – Faculty of Health and Life sciences
Room G217
Coach Lane Campus (East),
Coach Lane,
Newcastle-upon-Tyne
NE7 7XA
mike.stephenson@northumbria.ac.uk

Research Supervisor: Dr Alison Machin
Dr Alison Machin
Business and Engagement Lead
Department of Healthcare
Faculty of Health and Life Sciences
alison.machin@northumbria.ac.uk

Study title- How do NHS managers perceive their leadership style is influenced by previous work experience?

Principal Investigator- Mr Mike Stephenson

I have read the enclosed participant information sheet and agree to be contacted to participate.

Signature of participant.. Date..........................

(NAME IN BLOCK LETTERS)..

Preferred contact details

Address

Telephone

E mail.

Participants link I.D number…………………………………………………………….. (To be completed by M. Stephenson)

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Appendix O: Participant Information sheet (Trust two)

May 10th 2017. Version 4

Study title- How do NHS managers perceive their leadership style is influenced by previous work experience?

Participant Information Sheet and questionnaire

> You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet so you understand why the study is being carried out and what it will involve.
>
> Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you would like to take part.

What is the Purpose of the Study?

As a Professional Doctorate student at Northumbria University, I would like to understand how managers in grade 8 positions perceive their leadership style is influenced by previous work experience. NHS managers are recruited internally from existing health care professionals, externally from outside the health sector, or developed through graduate management programmes. I aim to understand if previous work experiences influences their approach to leadership in current NHS management posts. This is important to understand the developing needs of existing managers, and inform the recruitment process for future managerial staff.

Why have I been invited?

You hold a band 8 management position in the trust.

Do I have to take part?

No. It is up to you whether you would like to take part in the study. I am giving you this information sheet and questionnaire to help you make that decision. If you do decide to take part, remember that you can stop being involved in the study whenever you choose, without telling me why. If you choose to take part please complete the attached questionnaire and return to me at mike.stephenson@northumbria.ac.uk I will then contact those chosen to participate.

What will happen if I take part?

You will be interviewed by me and no other. Interviews will be informal and take place in a location, date and time of your choosing. Interviews will record voices only for analysis, no video footage is taken. Interviews are not expected to exceed one hour. During the interview you will be asked about previous work experience and how this may influence your approach to leadership in your current role.

Will my participation involve any physical discomfort?

We will be seated while the interviews are recorded, if you need to pause the interview at any time just let me know.

Will I receive any financial incentive/travel expenses for taking part?

There are no financial incentives to participate in the research study. Interviews will take place in a location, date and time of your choosing to ensure no travelling or financial inconvenience.

What are the possible disadvantages of taking part?

You will be asked to give up some of your time to attend the interview. To minimise this disruption Interviews will take place in a location, date and time of your choosing. All participants will remain anonymous.

What are the possible benefits of taking part?

By taking part in the study, you will help to understand how previous employment background influences approaches to leadership. This knowledge is important when considering appointing to new posts, and when considering the developmental needs of existing post holders.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your name will not be written on any of the data we collect; the interview transcripts will have an ID number on them, not your name. Your name will not be written on the recorded interviews, or on the typed versions of our discussions from the interview, your name will not appear in any reports or documents resulting from this study. Any information and data gathered during this research study will only be available to the research team identified in this information sheet.
The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

How will my data be stored?

All electronic data and data analysis, including the recordings from your interview, will be stored on the University U drive, which is password protected. Any printed documents will be stored in a locked cupboard on the Universities campus.

All data will be stored in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

We will share the findings from this study with:

- Yourselves as participants in this study
- Northumbria University, in the form of the written professional doctorate
- Northumbria NHS foundation trust will receive an anonymised report of the studies final outcomes.
- It will be published anonymised in academic and professional peer reviewed journal

Who has reviewed this study?

Before this study could begin, permissions were obtained from Northumbria NHS Foundation Trust and Northumbria University. The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Contact for further information:

Researcher: Mike Stephenson
Senior Lecturer- CPD in Health
Northumbria University – Faculty of Health and Life sciences
Room G217
Coach Lane Campus (East),
Coach Lane,
Newcastle-upon-Tyne
NE7 7XA
mike.stephenson@northumbria.ac.uk

Research Supervisor: Dr Alison Machin
Dr Alison Machin
Business and Engagement Lead
Department of Healthcare
Faculty of Health and Life Sciences
alison.machin@northumbria.ac.uk

Study title- How do NHS managers perceive their leadership style is influenced by previous work experience?

Principal Investigator- Mr Mike Stephenson

I have read the enclosed participant information sheet and agree to be contacted to participate.

Signature of participant.. Date.......................

(NAME IN BLOCK LETTERS)..

Preferred contact details

Address

Telephone

E mail.

Participants link I.D number... (To be completed by M. Stephenson)

Appendix P: Participant information questionnaire (Trust one)

Participant information questionnaire

Information provided is confidential and only used to select participants to contribute to the study.

Thank you for completing the questionnaire

1. What is your current position within the organisation?

2. How long have you held this position?

3. If any, what previous managerial positions have you held in this or other organisations?

4. If you have a background as a health professional, please state which one

5. What is your highest academic qualification?

Thank you for taking the time to complete and return the information

Mike Stephenson

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Appendix Q : Participant information questionnaire (Trust two)

May 10th 2017. Version 4

Participant information questionnaire

Information provided is confidential and only used to select participants to contribute to the study.

Thank you for completing the questionnaire

1. What is your current position within the organisation?

2. How long have you held this position?

3. If any, what previous managerial positions have you held in this or other organisations?

4. If you have a background as a health professional, please state which one

5. What is your highest academic qualification?

Thank you for taking the time to complete and return the information

Mike Stephenson

Appendix R: Consent form (amended)

Faculty of Health & Life Sciences

FOR USE WHEN PHOTOGRAPHS/VIDEOS/TAPE RECORDINGS WILL BE TAKEN

Project title: How do NHS managers perceive their leadership style is influenced by previous work experience?

Principal Investigator: M. Stephenson

I hereby confirm that I give consent for the following recordings to be made:

Recording	Purpose	Consent
e.g. facial photograph	*e.g. for measurements of facial symmetry*	
e.g. video of bodily movement	e.g. for rating *by opposite-sex individuals* on various personality characteristics	
e.g. voice recordings	e.g. for rating *by opposite-sex individuals* on various personality characteristics	**X**

Clause A: I understand that other individuals may be exposed to the recording(s) and be asked to provide ratings/judgments. The outcome of such ratings/judgments will not be conveyed to me. My name or other personal information will never be associated with the recording(s).

Tick or initial the box to indicate your consent to Clause A ☐

Clause B: I understand that the recording(s) may also be used for teaching/research purposes and may be presented to students/researchers in an educational/research context. My name or other personal information will never be associated with the recording(s).

Tick or initial the box to indicate your consent to Clause B ☐

Clause C: I understand that the recording(s) may be published in an appropriate journal/textbook or on an appropriate Northumbria University webpage, **which would automatically mean that the recordings would potentially be available worldwide**. My name or other personal information will never be associated with the recording(s). I understand that I have the right to withdraw consent at any time prior to publication, but that once the recording(s) are in the public domain there may be no opportunity for the effective withdrawal of consent

Tick or initial the box to indicate your consent to Clause C ☐

Signature of participant.. Date..........................
Signature of Parent / Guardian in the case of a minor
.... Date..........................

Signature of researcher.. Date..........................

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